NHS
Shropshire, Telford and Wrekin
Clinical Commissioning Group

AGENDA

Meeting Title	Extraordinary Governing Body Part 1 Meeting	**Date**	Wednesday 8 December 2021
Chair	Dr John Pepper	**Time**	1pm
Minute Taker	Corporate PA	**Venue/ Location**	Via Microsoft Teams

A=Approval R=Ratification S=Assurance D=Discussion I=Information

Reference	Agenda Item	Presenter	Purpose	Paper	Time
EGB-21-12.098	Introduction and Apologies	John Pepper	I	Verbal	1:00
EGB-21-12.099	Members' Declarations of Interests	John Pepper	I	Enclosure	
EGB-21-12.100	Introductory Comments by the Chair	John Pepper	I	Verbal	1:00
EGB-21-12.101	Proposed Changes to Inpatient SaTH Cardiology Services In attendance: Nigel Lee, Chief Operating Officer, SaTH Julia Clarke, Director of Public Participation, SaTH Dr Jayesh Makan, Cardiology Consultant	Julie Davies	A	Enclosure	1:05
EGB-21.12.102	Any Other Business	John Pepper		Verbal	1.35
	Date and Time of Next Meeting – Wednesday 12 January 2022 time to be confirmed				
RESOLVE:	*To resolve that representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest (section 1(2) Public Bodies (Admission to Meetings) Act 1960.)*				

Dr John Pepper
Chair

Mr Mark Brandreth
Interim Accountable Officer

Members of NHS Shropshire, Telford and Wrekin CCG Governing Body

Register of Interests - December 2021

Surname	Forename	Position/Job Title	Committee Attendance	Type of Interest				Nature of Interest	Date of Interest		Action taken to mitigate risk
			SCC = Strategic Commissioning Committee FC = Finance & Performance Committee Q&PC = Quality & Performance Committee PCCC = Primary Care Commissioning Committee AC = Audit Committee RC = Remuneration Committee AIC = Assuring Involvement Committee	Financial Interest	Non-Financial Professional Interest	Non-Financial Personal Interest	Direct or Indirect?		From (ie review date form completed)	To	
Ahmed	Astakhar	Associate Lay Member for Patient and Public Involvement (PPI) - Equality, Diversity and Inclusion **Attendee**	SCC, F&PC, RC, AC					None declared	1.2.21		
Allen	Martin	Independent Secondary Care Doctor Governing Body Member	Q&PC, F&PC	X			Direct	Employed as a Consultant Physician by University Hospital of North Staffordshire NHS Trust, which is a contractor of the CCG	22.1.21	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
					X		Direct	Member of CRG (Respiratory Specialist Commissioning)	22.1.21	ongoing	Level 1 - Note on Register
					X		Direct	Chair of the Expert Working Group on coding (respiratory) for the National Casemix Office	22.1.21	ongoing	Level 1 - Note on Register
					X		Direct	Member of the Royal College of Physicians Expert Advisory Group on Commissioning	22.1.21	ongoing	Level 1 - Note on Register
				X			Indirect	Wife is a part-time Health Visitor in Shrewsbury and employed by the Shropshire Community Health Trust	22.1.21	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
					X		Direct	Board Executive member of the British Thoracic Society	22.1.21	ongoing	Level 1 - Note on Register
					X		Direct	NHSD. Member of CAB (Casemix Advisory Board)	22.1.21	ongoing	Level 1 - Note on Register
					X		Direct	National Clinical Respiratory Lead for GIRFT NHS Innovation (NHSI)	22.1.21	ongoing	Level 1 - Note on Register

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					X		Direct	Member of the Long Term Plan Delivery Board (respiratory) with responsibility for the pneumonia workstream	22.1.21	ongoing	Level 1 - Note on Register
					X		Direct	Member of National (regional reporting and program) and Regional Long Covid Boards	01.04.21	ongoing	Level 1 - Note on Register
					X		Direct	Advisory Board Member (at request of RCP) for assessing mechanisms for innovation payment under the aligned incentive scheme (NHSE/I)	01.04.21	ongoing	Level 1 - Note on Register
					X		Direct	Member of the RCP and HQIP NACAP Board, including the coding and QI improvement agendas	01.04.21	ongoing	Level 1 - Note on Register
					X		Direct	Undertakes work with the AHSN (Academic Health Science Networks) in the West Midlands supporting respiratory	14.7.21	ongoing	Level 1 - Note on Register
Braden	Geoff	Lay Member for Governance & Audit - **Attendee**	F&PC, RC, AC, Q&PC				Direct	None declared	20.1.21		

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Brandreth	Mark	Interim Accountable Officer/ICS Executive Lead				X	Indirect	Close friends with Director of Innermost Consulting	2013	ongoing	Level 1 - Note on Register
						X	Indirect	Close friends with Corporate Team at Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust	2012	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
Bryceland	Rachael	GP/Healthcare Professional Governing Body Member	Q&PC	X			Direct	Employee of Stirchley and Sutton Hill Medical Practice	26.1.21	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
				X			Direct	Self employed agency work as an Advanced Nurse Practitioner (ANP) for Medical Staffing in the West Midlands region	26.1.21	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
				X			Direct	Self employed agency work as an Advanced Nurse Practitioner (ANP) for Dream Medical in the West Midlands region	26.1.21	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
				X			Indirect	Husband is a provider of executive coaching and consultancy	26.1.21	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
				X			Indirect	Husband is CEO of Tipping Point Training, provider of Mental Health First Aid	26.1.21	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions

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Cawley	Lynn	Representative of Healthwatch Shropshire - **Attendee**	Q&PC					None declared	1.2.21		
Clare	Laura	Interim Executive Director of Finance	F&PC			X	Indirect	Sister is a physiotherapist at Midlands Partnership	27.1.21		Level 2 - Restrict involvement in any relevant commissioning
Davies	Julie	Director of Performance - **Attendee**	PCCC, Q&PC					None declared	1.2.21		
Ilesanmi	Mary	GP/Healthcare Professional Governing Body Member	SCC	X			Direct	GP Partner of Church Stretton Medical Practice	16.2.21	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
				X			Direct	Practice is a Member of the South West Shropshire PCN	16.2.21	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
				X			Indirect	Husband is a Locum Consultant in Obstetrics and Gynaecology at SaTH	16.2.21	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
James	Stephen	Chief Clinical Information Officer (CCIO)	SCC					None declared	20.1.21		
MacArthur	Donna	Lay Member for Primary Care	PCCC, RC, AC, SCC			X	Indirect	Son's partner is the daughter of a Director working at Wolverhampton CCG	20.1.21	ongoing	Level 1 - Note on Register
Matthee	Michael	GP/Healthcare Professional Governing Body Member	North Localty Forum, F&PC	X			Direct	GP Partner at Market Drayton Medical Practice	1.2.21	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
				X			Direct	GP Member of North Shropshire PCN	1.2.21	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
				X			Indirect	Wife is Practice Manager at Market Drayton Medical Practice	1.2.21	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions

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Noakes	Liz	Director of Public Health for Telford and Wrekin - **Attendee**		X			Direct	Assistant Director, Telford and Wrekin Council	29.1.21	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
					X		Direct	Honorary Senior Lecturer, Chester University	29.1.21	ongoing	Level 1 - Note on Register
Parker	Claire	Director of Partnerships - **Attendee**	PCCC, Shropshire North, S&A, South Loc Forums, TW Membership Forum			X	Indirect	Daughter worked as student temp in POD - 15/8/21 to 15/9/21	5.10.21	ongoing	Level 1 - Note on Register
Pepper	John	Chair	PCCC, Shropshire North, S&A, South Loc Forums, TW Membership Forum	X			Direct	Salaried General Practitioner at Belvidere Medical Practice (part of Darwin Group)	8.7.21	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
				X			Direct	Belvidere Medical Practice is a member of Darwin Group of practices and Shrewsbury Primary Care Network	8.7.21	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
				X			Direct	NHS England GP Appraiser	8.7.21	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
						X	Indirect	Family member provided evidence to Ockenden Review	8.7.21	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions or discussions on historical issues raised within the scope of the Ockenden Review. This does not exclude from commissioning decisions or discussions on current maternity and neonatal services or any service provided by SaTH more generally.

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Pringle	Adam	Vice Clinical Chair and GP/ Healthcare Professional Governing Body Member	PCCC, TW Membership Forum	X			Direct	GP Partner, Teldoc General Practice	2.2.21	4.8.21	
				X			Direct	Teldoc is a Member of Teldoc Primary Care Network	2.2.21	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
				X			Direct	Work on a sessional basis for Shropshire Doctors Co-Operative Ltd (Shropdoc) an out of hours primary care services provider, which is a contractor of the CCG.	2.2.21	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
				X			Direct	Work on a sessional basis for Churchmere Medical Practice	22.3.21	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
				X			Direct	Property owner of Lawley Medical Practice site	2.2.21	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
Robinson	Rachel	Director of Public Health for Shropshire - **Attendee**		X			Direct	Director of Public Health for Shropshire	25.1.21	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
Shepherd	Deborah	Interim Medical Director - **Attendee**	PCCC, Q&PC					None declared	19.1.21		
Skidmore	Claire	Executive Director of Finance	F&PC, AC, PCCC					None declared	17.09.21		
Smith	Alison	Director of Corporate Affairs - **Attendee**	AC, AIC, Q&PC			X	Indirect	Related to a member of staff in my portfolio structure who is married to my cousin. The individual is not directly line managed by me.	25.1.21	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
Tilley	Samantha	Director of Planning - **Attendee**	SCC			X	Indirect	Brother in Law holds a position in Urgent Care Directorate at SATH	27.1.21	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions

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Vivian	Meredith	Deputy Chair and Lay Member for Patient & Public Involvement (PPI)	Q&PC, RC, AC, PCCC, AIC		X		Direct	Trustee of the Strettons Mayfair Trust (voluntary sector organisation that provides a range of health and care services to the population of Church Stretton and surrounding villages)	26.1.21	ongoing	Level 1 - Note on Register
				X			Indirect	Wife is a part-time staff nurse at Shrewsbury & Telford Hospital NHS Trust (SATH)	26.1.21	ongoing	Level 2 - Restrict involvement in any relevant commissioning decisions
Warren	Audrey	Chief Nurse	SCC, Q&PC					None declared	1.4.21		
Young	Zena	Executive Director of Quality	SCC, F&PC, Q&PC, PCCC					None declared	22.1.21		

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MEMBERS WHOSE BOARD ROLE HAS CEASED OR WHO HAVE LEFT THE NHS SHROPSHIRE AND TELFORD AND WREKIN CCGs WITHIN THE LAST 6 MONTHS											
Evans	David	Joint Accountable Officer	PCCC, Shropshire North, S&A, South Loc Forums, TW Membership Forum, JSCC		X		Direct	Shared post - Joint Accountable Officer of Shropshire and Telford and Wrekin CCGs	2.2.21		Left SCCG and TWCCG on secondment on 31.3.21
					X		Direct	Member of the Telford and Wrekin Health and Wellbeing Board	2.2.21		
						X	Indirect	Wife is an employee of Tribal Education Ltd, which contracts with the NHS, but is not a contractor of the CCG	2.2.21		
Smith	Fiona	Joint GP/Healthcare Professional Governing Body Member	SCC	X			Direct	Advanced Nurse Practitioner at Shawbirch Medical Practice	20.1.21		Left STWCCG on 31.7.21
				X			Direct	Shawbirch Medical Practice is a Member of Newport/Central PCN	20.1.21		
					X		Indirect	Son-in-Law works as a technician for the Audiology Team at SaTH	17.2.21		

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Trenchard	Steve	Interim Executive Director of Transformation	SCC, PCCC, F&PC					None declared	22.1.21		Left STWCCG on 30.11.21

NHS
Shropshire, Telford and Wrekin
Clinical Commissioning Group

REPORT TO: **NHS Shropshire, Telford and Wrekin CCG Governing BodyMeeting held on Wednesday 8th December 2021**

Item Number:	Agenda Item:
	SaTH Cardiology Centralisation Proposal

Executive Lead (s):	Author(s):
Nigel Lee, Chief Operating Officer, SaTH Julie Davies, Director of Performance & Delivery, STW CCG	Debbie Houliston, Cardiology Centre Manager, SaTH Jayesh Makan, Consultant Cardiologist, SaTH Barrie Reis-Seymour, Head of Transformation & System Commissioning, Elective Care

Action Required (please select):									
A=Approval	✓	R=Ratification		S=Assurance	✓	D=Discussion		I=Information	✓

History of the Report (where has the paper been presented:		
Committee	**Date**	**Purpose (A,R,S,D,I)**
SaTH Private Trust Board Meeting	11th November 2021	Approval

Executive Summary (key points in the report):

Cardiology services in SaTH continue to experience staffing pressures in medical and nursing staff, exacerbated by maintaining 2 inpatients bed bases. A number of high risks are evident. A plan has been developed to centralise Inpatient Cardiology at PRH, which has full SaTH Executive approval. This has been subject to public engagement and supported by a QIA and EQIA. The plan is to achieve the change in Q3 subject to specialist equipment lead times for delivery and installation. This plan has recently been approved by the SaTH Trust Board.

Recommendations/Actions Required:

The Governing Body is asked to:

1. Receive and note the contents of the proposal and rationale for the centralisation of Cardiology, including its benefits and mitigation of risk
2. Support the proposal to proceed with the planned cardiology centralisation and the move of RSH Ward 24 to be co-located with PRH Ward 6, and its approval already taken by the SaTH Trust Board.

Report Monitoring Form

Implications – does this report and its recommendations have implications and impact with regard to the following:		
1.	Is there a potential/actual conflict of interest?	No
2.	Is there a financial or additional staffing resource implication? *Not to the CCG.* *Staffing implication to SaTH in moving and combing workforce, staff briefings already completed.* *Capital implications for SaTH but internal funding identified.*	No
3.	Is there a risk to financial and clinical sustainability? *If not approved, will create additional unsustainable risk to delivery of Cardiology services and poses a risk to clinical safety.*	Yes
4.	Is there a legal impact to the organisation?	No
5.	Are there human rights, equality and diversity requirements? *The proposed change has undergone a robust EQIA process with any requirements factored into the proposed change and its implementation*	Yes
6.	Is there a clinical engagement requirement? *The comprehensive engagement undertaken is covered in the accompanying Engagement Presentation.*	Yes
7.	Is there a patient and public engagement requirement? *The comprehensive engagement undertaken is covered in the accompanying Engagement Presentation.*	Yes

Strategic Priorities – does this report address the CCG's strategic priorities, please provide details:		
1.	To reduce **health inequalities** by making sure our services take a preventative approach and take account of different needs, experiences and expectations of our communities.	No
2.	To identify and improve **health outcomes** for our local population. *Through consolidated resource provides a more efficient and effective, robust service*	Yes
3.	To ensure the health services we commission are **high quality**, safe, sustainable and value for money. *The proposed change and centralisation ensures the best and safest possible delivery of Cardiology through consolidated resource, that delivers positive health outcomes, improved patient experience and is value for money.*	Yes
4.	To improve **joint working** with our local partners, leading the way as we become an Integrated Care System. *Not a system piece of work, but a change to an existing service within SaTH.*	No – N/A
5.	To achieve **financial balance** by working more efficiently. *The proposed change and centralisation ensures the best and safest possible delivery of Cardiology through consolidated resource, that delivers positive health outcomes, improved patient experience and is value for money.*	Yes

NHS
Shropshire, Telford and Wrekin
Clinical Commissioning Group

Public Governing Body

SaTH Cardiology Centralisation Proposal – December 2021

Purpose of the Report
The purpose of this report is to provide the STW Strategic Commissioning Group Governing Body with an update on the current risk being held by the SaTH Cardiology Service borne out of consultant and nurse staffing challenges, and to request approval to centralise the service onto one site in order to mitigate that risk.

Local Background and Context
The SaTH Cardiology Department is experiencing ongoing and disabling staffing shortages in both the Consultant and Cardiology nursing workforce. With further retirements imminent and the lack of successful recruitment drives, staffing two inpatient cardiology bed bases has now become unsustainable and a significant risk to the Trust. The impact of the staffing shortages is acutely felt in the two Coronary Care Units; one on each ward (Ward 24 at RSH, and Ward 6 at PRH). The Coronary Care Unit (CCU) requires highly skilled Cardiac Nurses and the shortage has been particularly challenging in recent months. On occasion, the CCU has been without a specialist cardiac nurse due to sickness.

The current Consultant workforce has two long term locum Consultants in place at RSH supporting ward 24 and outpatient activity. Numerous attempts to recruit substantively to the general cardiologist posts have proved unsuccessful due to the challenges of having a two-site model. Consolidation of the Consultant workforce would provide greater resilience within this staffing group and specialty. Always ensuring cover would also improve recruitment and retention and enable more specialised job plans without cross site working.

The move would centralise the remaining highly skilled Cardiology nursing team and help to support reducing the risk associated with staffing numbers in particular those staff with the necessary skills required to support the new Acute Coronary Care Unit (ACCU).

With the move, cardiology patients would benefit from improved pathways, increased levels of care, reduction in length of stay for patients requiring intervention and standardisation of processes.

There was agreement within SaTH to explore the options of centralisation for Cardiology following a model that was proposed in 2020 COVID wave supporting the potential orthopaedic long bone centralisation. That included:

- Ward 24 RSH – to become Diabetes/Endocrinology and General Medicine Ward
- Ward 6 Acute Cardiology including an ACCU (Acute Coronary Care Unit).
- Ward 7 Acute Cardiology and Diabetes and Endocrinology Ward

To facilitate the move, estates work is required on the PRH site to repurpose the current Coronary Care Unit into a 6 bedded bay and Bays B and C would be converted to a new ACCU.
The current Telemetry system to support the ACCU has been condemned and a new system has been identified as part of the Trust replacement programme.

Local Background and Context
The table below summarises the Cardiology workforce challenges in SaTH at this time:

Risk Number	Description	Detail
1220	A shortage of Consultant and Specialist Nursing workforce within Cardiology Outpatient/diagnostic/interventional Service	• 2 x consultant vacancies currently covered by long term locums • Diagnostic technicians – 2 x band 7 and 1 x band 6
1848	An insufficient number of Coronary Care Unit trained nursing staff at both PRH and RSH	• B6 x 1.4 vacancies within Coronary Care Unit • B5 x 1 - scrub nurse (nurse that supports in the Cardiac Cath lab patients)
1849	A lack of availability of ILS (intermediate Life support) training for Cardiology nursing staff.	

These risks logged within SaTH are scored at 20, but with any mitigating actions leaving a residual risk score of 15. The situation however is becoming more difficult to maintain as the demand on the service increases, specifically following the Covid pandemic.

As a result of the staffing challenges, both within consultant and nursing workforce, the Cardiology department is holding a significant risk. Therefore, the service is requesting centralisation of the Cardiology Inpatient Service to the PRH site.

Centralisation Proposal
The SaTH Cardiology service currently has a bed base on each site, Ward 24 at Royal Shrewsbury Hospital (RSH) and Ward 6 at Princess Royal Hospital (PRH). It is proposed that Cardiology is centralised onto the PRH site (whilst Hospital Transformation Project is undertaken) to alleviate the workforce risks, improve patient care within the service and mitigate the associate risks.

PRH is currently the centre for all cardiac diagnostics and intervention and therefore most of the department is situated on this site already. Lack of co-location of critical functions of the department has seen a rise in the level of risk the department is now holding because of the area being across the two sites.

The transfer of patients has been significantly impacted by social distancing criteria and the need to keep green (outpatients) and amber (inpatients) pathways separate.

Pre-Covid, patients were transferred from RSH to PRH for their intervention/treatment in the Cardiac Catheterisation Lab (Cath Lab). They would be recovered in the Cardiac Day Unit (CDU) and then transferred back to their bed in RSH.

Post-Covid, patients are still transferred from RSH to PRH for their intervention/treatment but are recovered on Ward 6 where they stay until discharged. As CDU is an outpatient area (green pathway) this can no longer be used as an area for recovery of the patients (amber pathway) from RSH.

Having a bed available on Ward 6 at PRH for the transfer is a daily challenge but is more acute when the escalation levels are 3 and 4. This delays treatment for the RSH patients and increases their length of stay.

The transfer of ward 24 would require building and electrical work on Ward 6, including the installation of a Telemetry system used for monitoring patients in a new Acute Coronary Care Unit (ACCU).

The centralisation of Cardiology to one site will significantly reduce the risks in respect of the inpatient service and associated Consultant Workforce and Specialist Trained ACCU staff. Centralisation allows for the growth and future proofing of the Cardiology service which in turn will secure a sustainable, safe, and quality service for the population of Shropshire, Telford and Wrekin.

Actions Taken So Far

The table below summarises the actions already undertaken on this proposal by SaTH.

	Action
1.	EQIA developed and agreed at SaTH Medicine and Emergency Care divisional Committee and Senior Leadership Committee
2.	QIA developed and agreed at SaTH divisional Committee and Senior Leadership Committee
3.	Discussions within Cardiology Clinical Governance regarding the centralisation and signed off held and agreed
4.	Demand and Capacity modelling obtained from the HTP model indicating 44 bed base including a CCU and revisited for assurance
5.	Workforce template review – Nursing completed – cost neutral for first phase of plan. Any service developments to be taken through Trust prioritisation process Consultant Rota developed for new working model – no additional costing including the requirement for consultant cover on Ward 24
6.	Engagement (section 242 duties) with patient groups and partners supported by Julia Clarke • Health Watch • CHC • Local and National Cardiac Groups • Local Patient Groups
7.	Formal notification to the following • MP's • Health Overview and Scrutiny Committee (HOSC) • Powys Health Board • SCC & T&W Clinical Commissioning Group • NHS I/E
8.	Quotes obtained for works required on Ward 6
9.	Purchase orders raised for new Telemetry system in line with capital replacement programme
10.	Robust Pathways developed and agreed and signed off by both nursing and consultant workforce
11.	Discussions with WMAS/WAS regarding pathways – commenced and process for development underway
12.	Paper presented to SaTH JNCC in 2020 Update provided to SaTH JNCC in October 2021 Final paper to presented November 2021
13.	Communicated with Staffing groups on Ward 24 regarding move: • July 2020 • September 2020 • August 2021. • Staff side and Human Resources informed and present
14.	Presentation of this paper, QIA and EQIA to the SaTH Medicine and Emergency Care Division Committee, 8th October 2021 and SLC in October, where it was agreed.

The detailed QIA and EQIA documents are enclosed for information as Appendices 1 and 2.

Recommendations
The STW CCG Governing Body is asked to note the current staffing situation in SaTH Cardiology and the risks identified, the work done to develop the proposal and to support and agree to the centralisation of Cardiology onto the PRH site through moving Ward 24 RSH to be co-located with Ward 6 at PRH.

-ends-

Appendix H EQIA form

Equality Impact Assessment Form
Stage 1 – Initial Assessment

Managers Name	Debbie Houliston/Sarah Kirk	Centre	Unscheduled Care
Function, Policy, Practices, Service	As an interim measure until HTP is progressed, it is proposed that all Cardiology inpatient services are moved to PRH. The reasons for this are: • To support the fragile workforce issues • To prevent delays in diagnostic and interventional procedures for cardiology inpatients • To support the COVID-19 pathways Cardiology service could facilitate this by moving its inpatient provision on ward 24 on RSH to ward 7 at PRH which will then sit alongside the current cardiology Ward (ward 6) to create a single site inpatient service at PRH. Outpatients services will remain unchanged on both sites.	Purpose and Outcomes – intended and differential	Move of Cardiology ward 24 RSH to PRH Ward 7 to join ward 6. Outpatient services to remain on current sites Elective procedures already performed at PRH site
Implementation Date	December 2021 (TBC)	Who does it affect?	Residents of Shropshire, Telford & Wrekin and Powys
Consultation Process	Plan developed in response to Covid-19. Engagement/discussions undertaken with Healthwatch, HOSC, CCG's, NHS I and CQC Patient groups	Communication and awareness	Media Release drafted Healthwatch Shropshire and T&W informed Powys CHC informed OSCE informed CCG informed Gold Command informed Ward 24, 6 and 7 made aware on 24/07/20

For completion of the following table please see point 7 in the guidance notes.

Equality Target Group	(a) Positive Impact	(b) Negative Impact	Neutral impact	Reason/Comment
Sex	Positive		Neutral impact	Centralisation of Cardiac Services will improve patient quality of service but will have neutral impact on this group Currently the CCU at RSH has breached for having mixed sex bays on several occasions. Under the new proposal care will be provided in several single sexed areas and side rooms allowing for individual needs to be met.
Gender Reassignment			Neutral	Centralisation of Cardiac Services will improve patient quality of service but will have neutral impact on this group Please see second paragraph above (under Sex equality group)

Race			Neutral	Centralisation of Cardiac Services will improve patient quality of service but will have neutral impact on this group It is important that there is a robust communications plan which is part of the service change plan, which takes into account language and communication barriers.
Disability	Positive impact			Please note that most cardiac inpatient admissions are via ambulance (with the most serious cases being taken to Stoke or Wolverhampton). Transport needs will always be considered on discharge. For certain cardiac conditions (such as congenital heart conditions) these services are usually provided by special centres outside of the trust and so will not be impact upon by the proposed changes. It is important that as part of the service change that a robust communication plan takes into consideration accessibility issues.
Age	Positive impact			Please note that most cardiac inpatient admissions are via ambulance (with the most serious cases being taken to Stoke or Wolverhampton). Transport will be provided on discharge where required. Consolidation of expertise will see an improved service available for all ages.
Sexual orientation			Neutral impact	Centralisation of Cardiac Services will improve patient quality of service but will have neutral impact on this group
Religion or Belief			Neutral impact	Some individuals admitted to PRH will be further away from their local faith/religious community so will have less access to faith leaders and communities, however Trust does have links at PRH and RSH with local faith leaders, which can be contacted for support.
Pregnancy and Maternity				
Marriage and Civil Partnership			Neutral Impact	Centralisation of Cardiac Services will improve patient quality of service but will have neutral impact on this group

Following completion of the Stage 1 assessment, is Stage 2 (Full Assessment) necessary? ~~Yes~~ No not indicated however stage 2 completed to provide full response.

Date Completed: 02/09/21 Signed by Manager completing the assessment: Debbie Houliston

Equality Impact Assessment Form

Stage 2 – Full Assessment

Managers Name	Debbie Houliston/Sarah Kirk	Centre	Medicine Centre
What adverse/negative impact(s) were identified in stage one and which group(s) were affected/	Amalgamation of Cardiology improves the quality and safety of the service with centralised services pooling all skills onto one site. Reduction in travel for patients requiring a Cardiac intervention from the RSH site will overall reduce the length of stay for this group of patients.		
What changes or actions do you propose/recommend to improve the Function, Policy, Practices and Service to eradicate or minimise the negative impacts on the specific groups?	Pathways with WMAS and Welsh Ambulance Service to improve patient journey to appropriate site.		
How do you intend to communicate or consult in relation to the actions and proposals for improvements?	Service change planned in response to Covid-19 planning, limited opportunity for engagement however engagement session/ discussion held with Healthwatch, HOSC, CCG's, NHS I and CQC A communication plan has been developed as part of the implementation plan which includes both internal and external coms via a variety of sources. Cardiology Task & Finish Group reporting into Capacity and Locations T&F group which reports into the Trust Restoration committee, which in turn reports to the system Restoration and Recovery Committee.		
How will actions and proposals be monitored to ensure their success?	Quality indicators will be closely monitored Patient surveys and feedback	When is the date of the next review?	02/11/21

Date Completed:02/09/21

Signed by Manager completing the assessment: Debbie Houliston

Equality Impact Assessment Improvement Plan

As a result of Stage 2 departments must design an Improvement Plan clearly defining and planning the actions and proposals identified above. This must include

- Lead Manager
- Area(s) of negative impact
- Recommendations/amendments proposed
- Action to be taken
- Timescale
- Resource implications

Guidance notes for Impact Assessment Forms - Stage 1

1. What are the main functions, policies, practices and services?

A function is the key duty or aim which can be defined through the policy, practices and services in order to achieve its purpose or intended outcome.

2. What is the purpose of the policy and what are the intended outcomes or differential outcomes?

Policies should have set aims and objectives. Intended outcomes are the outcomes that you would expect to be achieving in accordance with the policy. Any differential outcomes are those that have not met the aims, objectives and purpose of the policy.

3. Implementation date?

The date the policy was implemented.

4. Who does it affect?

Services users i.e. patients, staff and other stakeholders, or others as appropriate.

5. Consultation process?

What process for consultation to the groups involved has been undertaken and when? The purpose of the consultation is to outline to the specific groups how the implementation of the policy will affect them and to raise awareness between the groups. e.g variety of groups are identified in “Health and Care information in Shropshire” document along with the PPI forum. Information on both of these can be found through PALS.

6. Communication and Awareness?

How are any changes/amendments to the policy communicated? How is the policy made aware to all concerned?

7. How to complete the high/low, positive/negative impacts table

Positive Impacts
The policy/service may have a positive impact on any of the equality groups outlined in relation to promoting equal opportunities and equality, improving relations within equality target groups, providing target need services to highlighted groups. An example of this would be if a targeted training programme for black and minority ethnic women had a positive impact on black and minority women, compared with its impact upon white women and all men. It would not, however, necessarily have an adverse impact on white women or men.

Negative Impacts
The policy/service may have a negative/adverse impact upon any of the equality target groups outlined i.e. disadvantage them in any way. An example of this would be that if an event were to be held in a building with no loop facilities a negative/adverse impact would occur for attendees with a hearing impairment.

Factor Scores
Impact – None/ Low/ High
Any **High** Negative Impact score will illustrate a need to complete a **Full Impact Assessment (stage 2)**. However, it may be useful to conduct Stage 2 of the Assessment even if the negative impact scored low to ensure that a more thorough assessment is carried out.

NB: *Please retain a copy of the Impact Assessment(s) on your files for audit purposes and address any queries in relation to Patients Services to the Patient and Public Involvement Manager and any queries in relation to Employment Issues to the Lead for Equality and Diversity in the HR Department.

Equality Impact Assessment

1.0 Legal requirement of a Equality Impact Assessment.

1.1 The Equality Act 2006 requires public authorities to conduct an Impact Assessment upon their current or draft policies, practices, functions and services on the grounds of race. In anticipation of future legislative changes in relation to disability, the Trust's Impact Assessment will be implemented to consider the impact on all areas of diversity, i.e. gender, transgender, disability, race, sexual orientation, age, religious belief.

2.0 Examples of Equality Target Groups.

2.1 Age – The definition of age groups will need to be sensitive to the policy under consideration. For example, in relation to employment policies the middle aged are often a vulnerable group and pensionable age is different for men and women.
2.2 Gender – Men (including boys), Women (including girls) and Transgender people.
2.3 Disability – Persons with a disability as defined within the Disability Discrimination Act 1995 such as those with hearing impairment, visual impairment, physically disabled, learning disability or mental health problems.
2.4 Racial Group – A group of people defined by race, colour, nationality and ethnic or national origins. Examples include; Romany Gypsies, Jews, Sikhs, Chinese, Indian, Pakistani, Bangladeshi, Black African, Black Caribbean, White, Irish, Welsh, Turkish, Greek Cypriot, mixed ethnic group, any other ethnic group/nationality.
2.5 Faith/Religion - Religion or belief is any religion, religious belief or similar philosophical belief but does not include any philosophical or political belief unless it is similar to a religious belief. A religious belief is likely to include some form of collective worship, a clear belief system or a profound belief affecting the way of life or view of the world. Non-belief is also covered by the regulations. Examples include; Buddhism, Christianity (Protestant, Catholic etc), Hinduism, Atheist, Agnostic etc, any other religion.
2.6 Sexual Orientation – As defined under the Employment Equality (Sexual Orientation) Regulation 2003:

- Orientation towards persons of the same sex (gay/lesbian)
- Orientation towards persons of the opposite sex (heterosexual)
- Orientation towards persons of the same sex and the opposite sex (bisexual)

3.0 Why is it necessary to conduct an impact assessment apart from legal reasons?

3.1 Work has an impact upon other employees no matter what role people are in. Whilst it is right to stay within the law, it is also imperative that people should be able to receive fair and equal treatment. Therefore promoting fairness for all, cultural competence, promoting racial equality, ensuring discrimination does not take place and promoting good relations between employees of different racial groups is crucial for the organisation to be at it's best in relation to providing quality public services and policies.

4.0 An Impact Assessment.

4.1 The Impact assessment is an assessment of the impact of current, intended or draft policies, programmes or services for any adverse, negative or detrimental outcomes for individuals from diverse backgrounds. Additionally it provides the structure to implement actions to eradicate any adverse, negative or detrimental outcomes, issues or inequalities.

4.2 The purpose of the Impact Assessment specifically to the NHS is to improve the work carried out by ensuring that it does not discriminate and that the promotion of equality is achieved for both patients and employees.

5.0 When to conduct an Impact Assessment.

5.1 Impact Assessments should be carried out on the introduction of all new or revised policies, procedures, and protocols and on the modification or implementation of any new services.

5.2 In relation to service delivery the Impact Assessment should be repeated every three years.

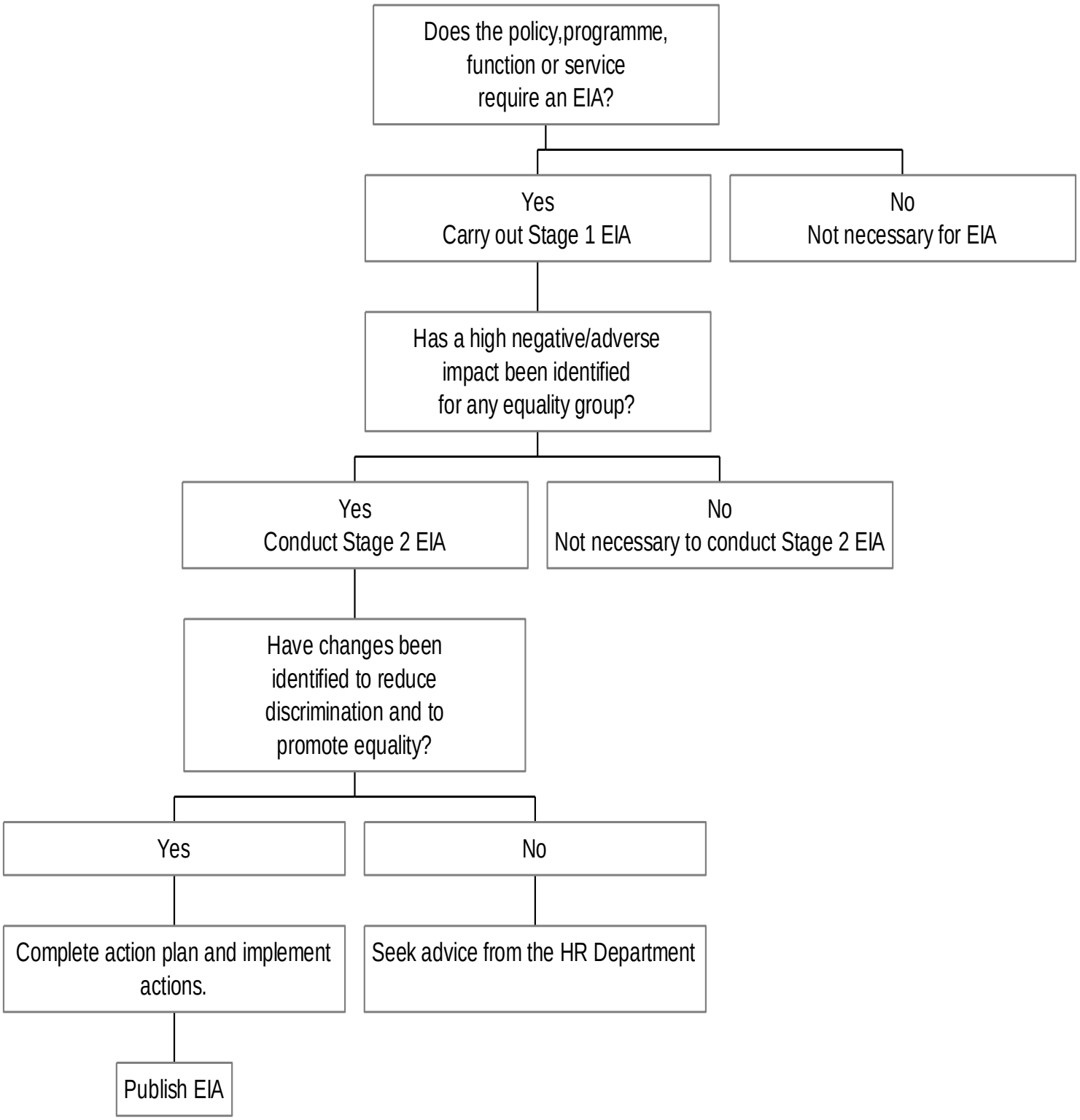
6.0 Process of an Impact Assessment.

6.1 Impact Assessments should follow a *two-stage process as follows:

- **Stage 1 –** Initial Assessment which enables areas of priority to be highlighted.

- **Stage 2 –** Full Impact Assessment of those areas highlighted as High Priority at Stage 2.

*** Stage 2 only requires completion if any negative impacts are identified in Stage 1.**


Does the policy,programme, function or service require an EIA?
Yes
Carry out Stage 1 EIA
No
Not necessary for EIA
Has a high negative/adverse impact been identified for any equality group?
Yes
Conduct Stage 2 EIA
No
Not necessary to conduct Stage 2 EIA
Have changes been identified to reduce discrimination and to promote equality?
Yes
No
Complete action plan and implement actions.
Seek advice from the HR Department
Publish EIA

Appendix 3

QUALITY IMPACT ASSESSMENT			
Risk Score 1-3 (Very Low)	Risk Score 4-6 (Low)	Risk Score 9-12 (Moderate)	Risk Score 15+ (High)

SUBJECT OF ASSESSMENT:	**Cardiology Inpatient Bed Base Relocation to The Princess Royal Hospital, Telford**	**DIVISION:**	Unscheduled Care
		SPECIALTY:	Cardiology
REASON FOR PROPOSED CHANGE:	**Business Continuity Plan** The purpose of this proposed change is to address the following key issues: • Cardiology inpatient beds centralised to the Princess Royal (PRH) Hospital provide the opportunity for improving patient care quality and pathways, with anticipated reductions in length of stay being achieved • There is the potential to consolidate the cardiology workforce to allow for greater resilience and specialism		
PLEASE LIST ANY RELEVANT STANDARDS / REGULATORY / STATUTORY REQUIREMENTS AND CONFIRM THIS PROPOSAL COMPLIES WITH THESE			
ASSESSOR:	**Debbie Houliston/Donna Moxon/Sarah Kirk/Jayesh Makan**	**DATE:**	**11/10/2021**

Calculation of Total Mitigated Risk for each Section

Two or more risk totals at a certain level in any given section, overall score for the section = that level (e.g two ambers and one green = overall score of amber)

One risk total at a certain level with all other totals in the section being less, overall score for the section = one less than the highest total (e.g one amber and two greens = overall score of yellow)

***** are risk indicators that are considered one of the same.**

RISK INDICATORS	IMPACT			IMPACT DESCRIPTION	RAW RISK			MITIGATION STRATEGY	MITIGATED RISK			MONITORING	LEAD
	POSITIVE	NEGATIVE	NEUTRAL		C	L	Total		C	L	Total		
Duty of Quality													
Compliance with NHS Constitution	X			Sustainability of the Service and quality care for all patients to be maintained	2	2	4	Monitor performance via compliance with key quality metrics including SI, Datix and complaints. Along with nursing quality metrics.	3	1	3	Patients to be admitted to Cardiology bed base with cardiac conditions and intervention performed within national recommended time frames	Cardiology Matron/Operational Manager/Clinical Director
Impact on partner organisations and any aspect of shared risk			X	Potential increase of conveyance for WMAS/Welsh Ambulance Service Patient transport provider, E-ZEC - HDU patient transfer reduction due to the centralisation of Cardiology to the interventional site	2	4	8	Clinical pathways to be agreed with partners and will be managed via SaTH Governance process. Establish method and timetable to implement regular communications to discuss any issues or risks identified by partners. Reduction in HDU transfers via patient transport provider, for Cardiac Intervention from the RSH site as per current protocol.	2	3	6	Regular meetings between Operational team and partners to review KPI's and performance metrics. A&E Performance Cardiac admissions per site WMAS performance Ambulance off load	WMAS Lead Welsh Ambulance Lead Operational Manager Cardiology

Impact on duty to safeguard children / vulnerable adults			X	No Impact	1	1	1		1	1	1	Monthly	Clinical Director Cardiology
Impact on other services within the organisation		X		Radiology – transfer of Cardiac CT to the PRH site (New CT scanner at PRH is a higher spec than RSH). Radiology staff at PRH will require training for Cardiac Ct Angiography. This is in place at RSH currently.	3	3	6	Capacity for inpatient scanning to be sourced. Staffing group to be trained in use of CT for cardiac and training by external company for APs to commence	3	3	6	Weekly	Clinical Director/ Operational Manager
List any other risk indicators relevant to the Duty of Quality		x		Impact on RSH emergency department/acute medicine team of walk-pts.	2	3	6	Agreement around level of provision and in reach support by Cardiology service. Discussion and agreement on pathways. Provision of SoP.	2	3	6	Weekly updates. Clear communication and escalation strategy. Datix. Audits – 3 monthly moving to annual after the first year.	Clinical Director/ Operational Manager
		x		Impact on function/speciality of other ward areas within PRH due to existing wards having to be moved to accommodate cardiology.				Clear communication and consultation with staff in Princess Royal Hospital with detailed project plan for move.				Weekly updates. Clear communication and escalation strategy	Clinical Director/ Operational Manager
TOTAL											22		
Patient Safety													
Impact on patient safety	X			Improved Patient safety due to centralised department offering amalgamated support with workforce restraints mitigated	3	2	6	Continue to monitor/update the assessment of impact. Regular monitoring within clinical governance,	2	2	4	Weekly moving to monthly updates utilising SI, Datix and complaints, Nursing quality dashboards and LOS data.	Operational Manager/Clinical Director /Clinical Matron

		x		Timely effective treatment for inpatient at RSH who suffers cardiac event	3	3	9	Medical rota organisation – level and frequency of on call cover. To be shared with Emergency and Acute colleagues. Cardiac Chest Pain Nurses (training)	3	2	6	Weekly moving to monthly updates	Operational Manager/Clinical Director /Clinical Matron
Impact on preventable harm	X			Pathways and systems in place for WMAS/Welsh ambulance services to convey sickest patients directly to PRH significantly reducing any delays in obtaining required Cardiac Intervention	3	2	6	Improved workforce to receive urgent cardiology admissions. Amalgamated nursing workforce providing centralised Cardiac trained nurses and staff - offering greater specialised cardiac care	3	1	3	Daily incident review. Datix Harms reviews Regular review of action plans.	Clinical Director/Clinical Matron/Operational Manager
Impact on reliability of safety systems and processes (Administration)	X			Business Continuity Plan in place with pathways developed for agreement with partners. Reduction in processes due to centralisation and standardisation to be introduced	3	2	6	Lead clinician to oversee safety processes and reliability of systems	2	2	4	Incident reporting Escalation at point of issue for resolution Implement an issues log with clear action plan for regular review.	Clinical Director/Operational Manager
Impact on systems and process for ensuring that the risk of healthcare acquired infections to patients is reduced			X	Reduced length of stay as a result of the move aims to safeguard all patient groups by reducing risk of exposure to hospital acquired infections	2	2	4		2	2	4	Infection Reporting/IPC dashboards	Clinical Director/Clinical Matron
Impact on clinical workforce capability and skills and capacity	X			Centralisation of workforce to single site model will be an attractive model and as such has the potential to improve recruitment to consultant and nursing vacancies and subsequently support training, development and retention of staff.	3	2	6	Consistent review of staffing groups in forums, actively advertising and promoting single site model with workforce groups Nursing - Opportunities for relocation to another ward within the Care Group available	3	2	6	Monthly workforce review Cardiology Governance	Operational Manager/Clinical Director/Clinical Matron

				Provides resilience for the workforce Nursing – immediate negative impact on staff unable or not wanting to move to PRH site with service.									
List any other risk indicators relevant to the Patient Safety	X			Centralisation of Cardiology will see a reduction in delays of transfers from RSH to the PRH site for Cardiac intervention	2	2	4		2	1	2	Monthly Cardiology Clinical Governance	Operational Manager/Clinical Director
TOTAL											29		
Patient Experience													
Impact on self-reported experience of patients and service users in national / local surveys			X	Patient experience will remain unchanged other than relocation of service.	2	2	4	Seek and encourage patient experience feedback, monitor and provide assurance plans to address any identified concerns.	2	1	2	Number of complaints received per month. Datix raised. Patient feedback managed at point of contact. Key themes for complaints and datix and patient feedback reported at monthly Cardiology governance meetings	Operational Manager/Clinical Director
Impact on self-reported experience of patients and services users through the complaints process.			X	Patient experience will be impacted by additional travel time and potential financial implications to relatives	2	2	4	All complaints to be received and managed by SaTH during this process in accordance with policy. Offer mechanisms of obtaining feedback at ward level. Undertake communication	2	1	2	Monitor number of complaints received monthly. Complaints response within guidance times scale. Any subsequent action plans reviewed	Operational Manager/Clinical Director / patient Experience Lead

								strategy to explain rationale for interim service change and the positive impact expected upon patient care that is associated with the service change				through service meetings. Patient feedback managed at point of contact Monthly reporting to Cardiology Operational meetings and themes escalated to USC Board	
Impact on the self-reported experience of patients and service users through PALS contacts			X	As Above	2	2	4	All complaints to be received by SaTH during this process in accordance with policy	2	1	2	As above	Operational Manager/Clinical Director
Impact on patient choice		X		Patients right to be treated in a hospital of their choice	1	4	4	Patient literature to be developed detailing the benefits to the patient groups through the change and centralisation of service.	1	3	3	Complaints log and record of public engagement meetings to be kept. Issues to be discussed at clinical governance and learning shared.	Operational Manager/Clinical Director
Impact on patient access		X		Patient right to have access to a hospital of their choice	1	3	3	Clear written communication to all patients regarding rationale for relocation of service No patient to be refused treatment at either site	1	2	2	Monitored via patient surveys and healthwatch reviews of services. Recording complaints and key themes. Contact with PALs Datix system	Operational Manager/Clinical Director
Impact on the commitment to provide individualised care			X	Individualised care remains	1	1	1		1	1	1	Monthly Governance meeting	Clinical Director/Operational Manager / Matron
List any other risk indicators relevant		X		Potential impact upon patient visitors – longer to	3	2	6	Clear communication strategy to explain rationale	2	2	4	Monthly Governance meeting	Operational Manager/Clinical

to Patient Experience				travel and reliance on public transport and potential financial implications				for interim service relocation and the expected benefits for patient outcomes. To explore and improve communication channels to facilitate patient contact with family/relatives if required. To note, visiting currently restricted due to Covid-19					Director HoN / Matrons / Patient Experience Lead
		X		Transfer of Cardiology Service to RSH at a future date, in line with HST.	3	3	9	Effective Communication Strategy involving local stakeholders / public	2	3	6		Communications Clinical Directors
TOTAL											22		
Clinical Effectiveness													
Impact on the implementation of evidence-based practice			X	All patient care to be evidence based	2	2	4	SaTH Clinical policies, procedures and protocols to be adopted/utilised when patients are seen.	2	1	2	Cardiology Clinical Governance	Clinical Director/Clinical Matron/Operational Manager
Impact on clinical outcomes	X			Clinical outcomes will remain consistent, however there will be a reduced length of stay for patients that currently are admitted to RSH and transferred to PRH for intervention. Improvement in outcomes	2	2	4	SaTH Clinical policies, procedures & protocols to be adopted/utilised when seeing SaTH patients – to be monitored via key metrics	2	1	2	SI, Datix, complaints, LOS monitoring within Cardiology Clinical Governance	Clinical Director/Clinical Matron/Operational Manager
Impact on clinical leadership			X	There is a Clinical Director in post for cardiology with a cross site remit. This will remain. One Matron with responsibility for both cardiology wards.	1	1	1	Support from Medical and Matron/nursing team	1	1	1	Monitor staff and patient feedback Action accordingly	Clinical Director/Clinical Matron/Operational Manager

Impact on variations in care			X	There is a Clinical Director in post for cardiology with a cross site remit. This will remain. One Matron with responsibility for both cardiology wards.	2	2	4	Medical and Nursing Guidelines/clinical protocols and standardised work to be rolled out across the new bed base	2	1	2	Action plan to be formulated once moved with standardisation plan to be developed in conjunction with SaTH Improvement Team	Clinical Director/Clinical Matron/Operational Manager
Impact on ensuring care is delivered in the most clinically / cost effective way			X	As above	2	2	4	Support from Medical / Nursing Team. Criteria led discharge	2	1	2	As above	Clinical Director/Clinical Matron/Operational Manager
List any other risk indicators relevant to the Clinical Effectiveness		X		Moving the service to a single site would make in-reach to ED/AMU challenging at RSH	3	3	9	9-1pm in-reach support on the RSH site. Cardiologist will be available on the RSH site 1-5pm as per of outpatient session, to support with emergencies. 24 hour on call Cardiologist available. Development of chest pain nurses to support the ED/AMU chest pain pathway.	3	2	6	Cardiology Clinical Governance	Clinical Director/Operational Manager
		X		Impact upon quality of training for junior doctors seen as a major area of concern. New intake of doctors commenced in August will have specifically identified RSH site. Therefore to achieve cardiology development would need to move sites.	3	3	9	Discussion with Junior Doctor Workforce and Deanery to explore available options to support site move. Enhanced Cardiac training to be offered with centralisation of cardiology department.	2	2	4	Cardiology Clinical Governance Feedback from the Junior Doctor Forum to be collated Action log to be established.	Clinical Director/Operational Manager
		X		HEE likely to raise major concerns for both medicine and ED training	3	3	9	Medical Director to have discussions with Deanery.	3	3	9		Medical Director/Clinical Director
		x		Potential increase in vacancies within cardiology wards due to	3	4	12	Involvement of HR / Union representatives – workforce.	3	2	6	Workforce / Finance	Matron / Operational manager

				staff movement from base site resulting in decreased skill mix. Low staff morale				Training / skill mix review – Staffing establishment / Templates					
TOTAL											34		
Equality													
Impact on patient or staff within protected age groups			X	Lack of access to their own transport would impact on individuals within these groups who would be reliant on public transport to access centralised services in any capacity	1	1	1	Lead clinician along with ED Matrons to monitor compliance with policy and patient/staff feedback	1	1	1	Observation of practice patient and staff feedback	Operational Manager/ Human Resources/ Clinical matron
Impact on patients or staff with disabilities		X		Staff - whose base is currently RSH could potentially have further to travel should their base change to PRH. Patients – may be unable to travel the extra distance to PRH due their disability	3	3	9	Discussions with staff to understand their concerns and requirements. Opportunities for relocation to another ward within the Care Group available at their current grade. Travel allowance protected for 2 years provided for those staff wanting to move. Staff side and HR fully aware of the situation and happy to support.	3	2	6	Feedback via FTSUP. Staff Appraisals. Exit interviews	Operational Manager/ Human Resources/ Clinical matron
Impact on patients or staff of particular race or ethnicity			X	Lack of access to their own transport would impact on individuals within these groups who would be reliant on public transport to access centralised services in any capacity	1	1	1	Monitoring the impact of any service changes on this characteristic will continue throughout the entire process.	1	1	1	Monthly	Operational Manager/ Human Resources/ Clinical matron

Impact on patients or staff of particular religion or belief			X	Lack of access to their own transport would impact on individuals within these groups who would be reliant on public transport to access centralised services in any capacity	1	1	1	Monitoring the impact of any service changes on this characteristic will continue throughout the entire process	1	1	1	Monthly	Operational Manager/ Human Resources/ Clinical matron
Impact on patients or staff of a particular gender			X	Lack of access to their own transport would impact on individuals within these groups who would be reliant on public transport to access centralised services in any capacity	1	1	1	Monitoring the impact of any service changes on this characteristic will continue throughout the entire process	1	1	1	Monthly	Operational Manager/ Human Resources/ Clinical matron
Impact on patients or staff of a particular sexual orientation			X	Lack of access to their own transport would impact on individuals within these groups who would be reliant on public transport to access centralised services in any capacity	1	1	1	Monitoring the impact of any service changes on this characteristic will continue throughout the entire process	1	1	1	Monthly	Operational Manager/ Human Resources/ Clinical matron
Impact on patients proposing to undergo, undergoing or having undergone gender reassignment			X	Lack of access to their own transport would impact on individuals within these groups who would be reliant on public transport to access centralised services in any capacity	1	1	1	Monitoring the impact of any service changes on this characteristic will continue throughout the entire process	1	1	1	Monthly	Operational Manager/ Human Resources/ Clinical matron
Impact on pregnant patients or staff or staff who are expectant or new mothers			X	Lack of access to their own transport would impact on individuals within these groups who would be reliant on public transport to access centralised services in any capacity	1	1	1	Monitoring the impact of any service changes on this characteristic will continue throughout the entire process	1	1	1	Monthly	Operational Manager

Impact on patients or staff of a particular marital / civil partnership status			X	Lack of access to their own transport would impact on individuals within these groups who would be reliant on public transport to access centralised services in any capacity	1	1	1	Monitoring the impact of any service changes on this characteristic will continue throughout the entire process	1	1	1	Monthly	Operational Manager
TOTAL											14		

SUMMARY OUTCOME OF IMPACT ASSESSMENT

AREA OF QUALITY	OVERALL RISK RATING
Duty of Quality	
Patient Safety	
Patient Experience	
Clinical Effectiveness	
TOTAL	

AREA OF EQUALITY			
Age		Gender reassignment	
Disability		Sexual orientation	
Race		Pregnancy / Maternity	
Religion		Marriage / Civil Partnerships	
Gender			

Key Risks (based on mitigated score)

- Establish communications with community hospitals
- Establish where services cross over and identify gaps
- Essential communications with the public
- Public communication & signage within relocated areas

NHS
The Shrewsbury and Telford Hospital
NHS Trust

Cardiology Inpatient potential service change

Background

The Shrewsbury and Telford Hospital NHS Trust

- Currently inpatient Cardiology services are provided at the Royal Shrewsbury Hospital (RSH) on ward 24 and Ward 6 at the Princess Royal Hospital (PRH).
- At RSH there are 20 beds including 8 Acute Coronary Care Unit (ACCU) beds.
- At PRH there are 25 beds including 5 ACCU beds.
- For a number of years there have been workforce issues on both hospital sites within Cardiology. Historically the service has had challenges with medical workforce recruitment, however more recently the recruitment of trained cardiac nurses has also been an issue.
- Due to the nurse recruitment issues, the inpatient service has found it challenging to provide the required staffing levels. The department has now reached minimal staffing levels and any episode of sickness is putting the service at risk.

Background

- The majority (70%) of the cardiology service which comprises diagnostic, interventional procedures, Cath lab and outpatient services are currently located at PRH.
- Patients from RSH who require diagnostic or interventional procedures, often have an increased length of stay as they are required to be transferred and for a bed to be available and allocated on the PRH site. Although the department facilitate a treat and return facility within PRH this is often hampered by the availability of specialist transport.
- On an average 10 patients per week are needing to be transferred from RSH for diagnostic/intervention procedures. RSH patients can wait 5-6 days to be transferred and for some more specialist intervention this wait can be longer. This is primarily down to transfer time frames and bed availability.
- Due to the delays in patient transfers the Cath Lab is not being used to full capacity. The result of this is delay to the patient in obtaining treatment and empty capacity on lists allocated for inpatient support.
- During COVID there are Amber and Green pathways and patients on these pathways must remain separate at all times. As a result of this there is a reduced trolley recovery capacity within the Cardiac Day Unit, for example there is a reduction of two trollies when facilitating an amber patient from RSH.

HTP – The Future of Cardiology

The Shrewsbury and Telford Hospital NHS Trust

- Cardiology services are allocated on the Acute site (RSH) within the Hospital Transformation Programme (HTP).
- The move of all cardiology inpatient services to PRH is a temporary change and once HTP progresses services will be relocated in a new facility at RSH
- The temporary move of all inpatient cardiology services to PRH will support the service until the changes and help the team evolve into a single site model.
- It is hoped that the earlier move to a one site model will greatly enhance the patients experience of the Cardiology Inpatient Service.

Reasons for change

- The majority (70%) of the cardiology service which comprises diagnostic, interventional procedures, Cath lab and outpatient services are currently at PRH.
- A significant number of cardiology inpatients admitted to RSH are then required to be transferred to the PRH site for a diagnostic or cardiac procedure as part of their inpatient stay.
- Having a bed available at PRH for the transfer is a challenge when the escalations levels in the hospital are at level 3 and 4.
- As a result of COVID and the need to keep green and amber patients separate has had a significant impact on the ability to transfer patients from RSH to PRH to perform interventions in the Cath Lab.
- Specialist workforce is currently split across two hospital sites – issues with sickness absence etc.
- Please note that most serious heart attack cases are currently transported directly to either Wolverhampton or Stoke

Proposal

As an interim measure until HTP is progressed, it is proposed that all Cardiology inpatient services are moved to PRH. The reasons for this are:

- To support the fragile workforce issues
- To prevent delays in diagnostic and interventional procedures for cardiology inpatients
- To support the COVID-19 pathways
- The outpatient service provided by Cardiology, Cardiorespiratory and Cardiac Rehab at RSH would continue.

Proposal

The Shrewsbury and Telford Hospital NHS Trust

We would do this by:

- Transfer ward 24 cardiology inpatient beds (RSH) to ward 7 at PRH. Ward 7 is next door to our current cardiology ward (ward 6).
- Cardiology would have 15 beds for cardiac patients on ward 7. These beds are currently General Medicine beds, which currently are regularly used by Cardiology outliers.
- Under the new proposal the remaining 13 beds on ward 7 would be used for Endocrine.
- This would give Cardiology a total 38 beds over 2 wards. This bed base would comprise of 28 general cardiology, 8 ACCU beds and 2 high telemetry side rooms.
- The 20 bed released at RSH would then become General Medicine beds.
- On average this will affect up to 25 cardiology inpatients per week.

Key benefits

The Shrewsbury and Telford Hospital NHS Trust

- Patients will see an improved inpatient service with timely access to diagnostics and intervention. In particular patients who would have previously been admitted to the RSH site and then transferred to PRH would have quicker access to diagnostic and interventional procedures.
- Reduction in the length of stay, which in turn will improve outcomes for cardiology patients.
- The department sees an improved recruitment, retention and sickness position for all staffing groups.
- It supports training for student nurses, junior doctors and middle grades, helping to develop the cardiac staffing models of the future.
- Risks held within the inpatient service around staffing and estate are addressed.
- Greater bed base for general medicine patients on the RSH site.

Issues

There is a requirement to upgrade the telemetry system at PRH (planned for 2021 before decision to move) and undertake some estates work within the cardiology base.

There will be a requirement to facilitate direct pathways to the PRH site liaising with the ambulance services. Conversations are already underway.

Some patients care will be delivered further away from their home which could potentially in the future impact on visiting (currently there is restricted visiting at our hospitals due to COVID19)

What next - Timescales

The Shrewsbury and Telford Hospital NHS Trust

Changes in the service will require approval by the Trust Board and a decision is expected before winter.

All staff are fully aware and have had regular updates in person from the Centre Manager and Matron since the initial discussions in July 2020.

EQIA was completed and presented last year. This will be reviewed again with patient and public input.

If the service move was to go ahead we would review this after 6 months with patient and public involvement.

Regular updates on the proposal, move and subsequent consolidated service will be given through the community members update email.

Contact details of who to contact if you want to email/telephone feedback –

Debbie Houliston, Centre Manager – Debbie.houliston@nhs.net or

Donna Moxon, Operations Manager – Donna.moxon2@nhs.net

Engagement Plan

The Shrewsbury and Telford Hospital NHS Trust

- We held a Stakeholder Event on Thursday 2nd September which had representatives from:
  - Healthwatch (Shropshire, T&W)
  - CHC
  - Members of Health Overview and Scrutiny Committee (HOSC)
  - Members of the Health and Wellbeing Boards (HWBB)
  - Local and National Cardiology patient groups
  - Local Patient groups (e.g Telford Patient First and Shropshire Patient Group)
  - Following the meeting we have sent the presentation slides and the draft EQIA to all who attended to share with their groups and provide any feedback.
- We have a website page which has a copy of the presentation, a question and answer sheet and the draft EQIA – this is accessible to all members of the public
- We have written the following:
  - MP's
  - HOSC
  - HWBB
  - We included a copy of the presentation and EQIA

Attendance at events to discuss the proposal:

- Quarterly Community Meeting – 22nd September 2021
- Powys Services Planning Committee – 21st September 2021
- Montgomeryshire Local Committee – Thursday 14th October 2021
- Telford Patient First - Wednesday 1st December 2021

NHS
The Shrewsbury and Telford Hospital
NHS Trust

Engagement Report

Proposed changes to Cardiology Inpatient Services

Julia Clarke, Director of Public Participation

Hannah Roy, Head of Public Participation

25 November 2021

Background

The Shrewsbury and Telford Hospital NHS Trust

- This presentation outlines the engagement that has been undertaken with our local communities around the potential service change of cardiology inpatient services at RSH and PRH
- Currently inpatient Cardiology services are provided at the Royal Shrewsbury Hospital (RSH) on ward 24 and Ward 6 at the Princess Royal Hospital (PRH).
  - At RSH there are 20 beds including 8 Acute Coronary Care Unit (ACCU) beds.
  - At PRH there are 25 beds including 5 ACCU beds.

  The cardiac catheterisation lab is based at the Princess Royal site
- For a number of years there have been workforce recruitment issues on both hospital sites, as well as nationally, within Cardiology. Historically the service has had challenges with medical workforce recruitment, however more recently the recruitment of trained cardiac nurses has also been an issue.
- Due to the nurse recruitment issues, the inpatient service has found it challenging to provide the required staffing levels. The department has now reached minimal staffing levels and any episode of sickness is placing great pressures on the service.
- COVID-19 pathways have also placed an additional constraint on the service
- The senior consultants in cardiology and more widely have developed a medium-term plan to strengthen cardiology services which has the full support of all the workforce.

Proposed Change

The Shrewsbury and Telford Hospital NHS Trust

As an interim measure until HTP is progressed, it is proposed that all Cardiology inpatient services are moved to PRH. The reasons for this are:

- To strengthen the cardiology workforce
- To prevent delays in diagnostic and interventional procedures currently experienced by RSH cardiology inpatients
- To support the COVID-19 pathways
- The temporary move of all inpatient cardiology services to PRH will support the service until the changes and help the team evolve into a single site model. This is an interim measure until HTP progresses. Under the HTP model Cardiology services are co-located with the ED at RSH.
- It is hoped that the earlier move to a one site model will greatly enhance the patients experience of the Cardiology Inpatient Service.
- The outpatient service provided by Cardiology, Cardiorespiratory and Cardiac Rehab at RSH would continue.
- To see the full proposal click here: Cardiology Inpatient Service - Temporary Service Change - SaTH

Reasons for Change

The Shrewsbury and Telford Hospital NHS Trust

- Currently the majority (70%) of the cardiology service which comprises diagnostic, interventional procedures, Cath lab and outpatient services are located at PRH.
- Inpatients from RSH who require diagnostic or interventional procedures, often have an increased length of stay as they need to be transferred to PRH when a bed becomes available
- On an average 10 patients per week are transferred from RSH for diagnostic/intervention procedures. RSH patients can wait 5-6 days to be transferred and for some more specialist intervention this wait can be longer. This is primarily down to transfer time frames and bed availability. It also means that the cardiology diagnostic facilities are not being fully utilised
- During COVID there are Amber and Green pathways and patients on these pathways must remain separate at all times. This impacts on the effective operation of the Cardiac Day Unit.

Engagement Process

The Shrewsbury and Telford Hospital NHS Trust

- As an NHS Provider organisation we have a legal duty under Section 242 of the Health and Social Care Act 2012, to ensure that patients and/or the public are involved in certain decisions that affect the planning and delivery of NHS services. (Staff have been engaged through separate processes)

- As an organisation we believe its is important that we engage with our communities and stakeholders, prior to any decisions being made

- This report outlines how we have engaged with our communities and have informed and involved them in the discussion around the proposed service change.

- From the discussions we have had with our communities we can address any issues prior to implementing any changes in services

Stakeholder Forum

The Shrewsbury and Telford Hospital NHS Trust

- On Thursday 2nd September we held a stakeholder event with attendance from the following organisations:
  - Healthwatch (Shropshire, T&W)
  - CHC
  - Members of Health Overview and Scrutiny Committee (HOSC)
  - Members of the Health and Wellbeing Boards (HWBB)
  - Local and National Cardiology patient groups
  - Local Patient groups (e.g Telford Patient First and Shropshire Patient Group)
- A presentation giving an overview of current service provision and the potential service change was given by Dr Tom Ingram (Consultant Cardiologist), Debbie Houliston (Centre Manager) and Sarah Kirk (Matron for Cardiology)
- Feedback from stakeholders was provided at the meeting and a discussion regarding further engagement with our community was discussed
- Following the meeting we have sent the presentation slides and the draft EQIA to all who attended to share with their groups and provide any feedback. Please see Appendix 1 for presentation slides and Appendix 2 EQIA.

Engaging our Stakeholders

The Shrewsbury and Telford Hospital NHS Trust

- As part of our s242 engagement plan the following organisations/individuals have been contacted to advise of the proposal and a copy of the Equality Impact Assessment
  - Local MP's
  - Health Overview and Scrutiny Committee
  - Health and Wellbeing Board
- We welcomed feedback and comments from any organisation and contact details of the Cardiology Centre Manager and Operational Manager were provided in the presentation pack
- Our Operational Team have also discussed the proposed service changes with the ICS Shropshire, Telford and Wrekin CCG and Powys Teaching Health Board

Engaging with our Communities

The Shrewsbury and Telford Hospital NHS Trust

- The Trust has a community membership of over **2500** members. Every month an **email update** goes to all community members, and an article on the proposed changes was part of the September update. Our email gave a link to our webpage which provided members with more information.

- The proposed service change was presented at the Trust's **Quarterly Community Update meeting** on 22nd September 2021. This meeting is open to all members of the public and to community groups and organisations. Questions were received from the public and were answered by the clinical and operational teams
- The proposal has also been covered in local media (Shropshire Star and Radio Shropshire)
- Throughout our engagement we have offered to attend any public meeting to discuss the potential service change, and as a result we have attended or are due to attend the following meetings:
  - Powys Services Planning Committee – 21st September 2021
  - Montgomeryshire Local Committee –14th October 2021
  - Ludlow Community Connectors – 9th November 2021
  - Joint Overview & Scrutiny Committee – 22nd November
  - Telford Patient First - 1st December 2021

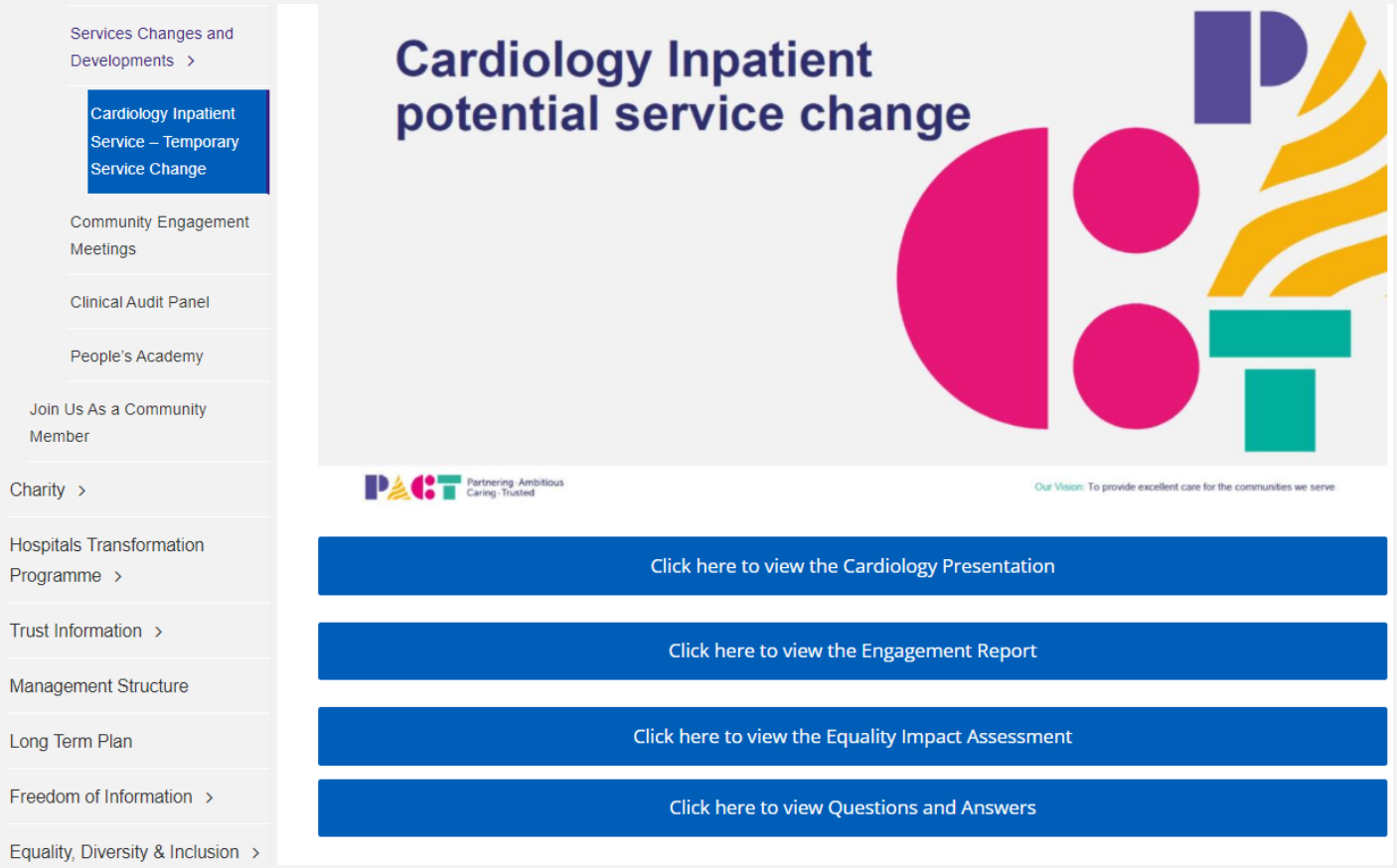
SaTH Website

The Shrewsbury and Telford Hospital NHS Trust

There is a dedicated webpage on our public website www.sath.nhs.uk regarding the potential service change to cardiology inpatient services.

This page is available to the public and the website has the functionality to change the language, and alternative formats to support accessibility.

- The webpage outlines the proposed service change and has links to the following documents:
  - Cardiology presentation
  - Equality Impact Assessment
  - Questions and Answers document
  - Engagement Report



Previous Engagement (2020)

The Shrewsbury and Telford Hospital NHS Trust

- In July/August 2020 the Trust engaged with the public about the repatriation of Trauma and Orthopaedic services, from Robert Jones and Agnes Hunt Hospital, following the services being temporarily relocated there as part of the local response to COVID-19 and the centralisation of cardiology inpatient service at PRH
- Whilst the proposals for inpatient cardiology services did not progress at that time, the following engagement was carried out:
  - Stakeholder Forum (17th August 2020) – with representatives from Healthwatches, Community Health Council and local patient groups
  - Attendance and presentation at the SaTH Equality, Diversity and Inclusivity Patient Group meeting (Thursday 13th August 2020)
  - EQIA Assurance meeting with Healthwatches, CHC (Thursday 13th August 2020)
- The proposed changes to inpatient cardiology services discussed in 2020, have not changed from the proposed service we are currently engaging on.
- The proposed changes were supported by our communities in 2020 however due to the lapse in time, the Trust decided that it was important to re-engage with our communities again around these proposed changes.

Key Themes

The Shrewsbury and Telford Hospital NHS Trust

From the Stakeholder engagement, key themes were identified from the questions and comments given by our stakeholders and communities, these are:

Key Theme	Comment/Issue	Response
Accessibility and Transport	• Concerns for those living the further away, and transport to PRH	• Nearly all inpatient admissions are by ambulance. The most serious heart attacks are currently transported directly to Stoke or Wolverhampton • For patients admitted to RSH they will be transported by ambulance to PRH
	• Has the impact on relatives visiting patients who are further away been addressed?	• It was acknowledged that the current proposal may impact on relatives visiting patients, particularly those who live further away from PRH. However currently there is restricted visiting at both sites due to COVID-19 guidelines. It was acknowledged by the public that the reduced length of stay created by a single site service would be beneficial to patients and relatives. There is also now a bus service between both hospital sites which could also be utilised.
	• What happens when I get discharged from hospital?	• When patients are discharged, arrangements will be made with the individual and their carers to ensure they return safely (e.g. via patient transport, relatives etc.) and outpatient follow-up, cardiac rehab etc will continue on both sites

Key Themes (2)

The Shrewsbury and Telford Hospital NHS Trust

Key Theme	Comment/Issue	Response
Accessibility of Cardiology Services	• Is there direct access to Cardiology inpatient services? • If all inpatient services are at PRH, what happens if you attend A&E at Shrewsbury?	• Individuals who have regular care from Cardiology will have a care plan around accessing services. The majority of patients requiring inpatient cardiology services will be admitted through A&E. It is important that there are strong links between A&E and Cardiology services, to ensure excellent patient care and we will develop the cardiac nurse team to deliver this and "pull" from admission areas when the service changes. • Most ambulances will be directed to PRH for potential cardiac issues. At RSH there are trained health professionals who will be able to provide care and treatment to patients with cardiac problems. The Cardiac Team will also provide support and on going to training to colleagues at RSH
Fragility of current services	• Are current services safe? • How soon can these changes happen?	• Current staffing levels are fragile at both hospital sites, and are reviewed regularly. The current proposal is to address the fragility of the service, however if staffing levels become unsafe the move to single site would need to be implemented on safety grounds. • There is a process which we need to follow, which includes taking our proposal to the HOSC and approval by Trust Board. The plan is for them to be introduced before winter

Key Themes (3)

The Shrewsbury and Telford Hospital NHS Trust

Key Theme	Comment/Issue	Response
Hospital Transformation Programme	• How do these current proposes fit with the Hospital Transformation Plan? • Will the HTP programme for Cardiology still go ahead? • How long will it take for HTP to come into place?	• Under the Hospital Transformation Programme, Cardiology inpatient services will be on the Acute site (RSH) – this proposal allows the single site model and its benefits to be introduced ahead of HTP • The move of all cardiology inpatient services to PRH is a temporary change and once HTP progresses inpatient services will be relocated in a new facility at RSH • Currently HTP plans are progressing and a business case has been submitted. There has been no date identified yet for services to move.
Which cardiology services which would be affected by the change	What cardiology services would be impacted by this proposed service change?	• The proposed service change would only affect RSH Cardiology inpatient services • Cardiorespiratory and Cardiac Rehab would continue on both sites

Feedback from our communities

The Shrewsbury and Telford Hospital NHS Trust

- Overall all organisations we have engaged with have been supportive of the plans to centralise Cardiology inpatient services at PRH
- The key benefits of reduced length of stay for patients and having a robust and specialised workforce were highlighted by many individuals.
- For many, these benefits outweighed the additional distance that patients/carers would need to travel. It was also acknowledged that currently acute cardiac cases were being taken to Stoke or Wolverhampton.
- For many members of our community it was also important to acknowledge this was proposal was a temporary change of service until HTP progresses.

Equality Impact Assessment (EQIA)

The Shrewsbury and Telford Hospital NHS Trust

- An Equality Impact Assessment was completed by our Operational Team.
- A meeting with the Healthwatches and CHC was held to review the EQIA.
- Additional feedback given in this meeting highlighted the following:
  - Under the new proposal care will be provided in several single sexed areas and side rooms allowing for individual needs to be met. This was highlighted to have an positive impact on those may feel more comfortable receiving their care in a single room. The example provided by the group was for those individuals who identify as non-binary or transgender.
- The EQIA has been sent out to stakeholders for comment and is available on our website https://www.sath.nhs.uk/wp-content/uploads/2021/09/H-EQIA-Form-Cardiology-Centralisation-v3.pdf
- .

Next Steps

The Shrewsbury and Telford Hospital NHS Trust

- This service change proposal was presented to the Joint Health Overview and Scrutiny Committee (JHOSC) on 22nd November, the members unanimously supported our proposals and our engagement activities to date within our local communities
- It was agreed with the JHOSC that we would contact all local Town and Parish Councils to offer to discuss our plans for Cardiology.
- Approval by Trust Board is required for this service change to go ahead and the CCG Governing Body
- If the service change is approved the Trust will continue to keep our communities informed and engaged, this will include:
  - Communications regarding the service change (local media, social media, through our membership and organisations we link with)
  - Ensure that any patients who are impacted by this change are kept informed
  - Ensure that all staff are kept informed and receive regular updates from the Centre Manager and Clinical leads and a formal management of change process is followed
  - Regular updates on the proposal, move and subsequent consolidated service will be given through the community members update email.
  - If the service move was to go ahead we would review this after 6 months (at the latest) with patient and public involvement.