IRP

Independent Reconfiguration Panel

ADVICE ON PROPOSALS FOR CHANGES TO EMERGENCY SURGERY SERVICES IN SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

Submitted to the Secretary of State for Health

30 November 2007

IRP

Independent Reconfiguration Panel

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RECOMMENDATIONS

1. NHS West Midlands (the SHA), Heart of Birmingham and Sandwell PCTs and Sandwell and West Birmingham Hospitals NHS Trust should ensure that plans for future healthcare provision including new buildings are delivered as rapidly as possible.

2. The Trust should develop and deliver effective ways of integrating clinical services across the two hospital sites.

3. The Trust must ensure that workforce plans are developed and agreed which support a sustainable and safe service in and out of hours and which supports increased levels of sub specialisation.

4. The IRP support the Trust's proposal and agrees that the right approach for delivery of surgical services is to concentrate the majority of emergency surgery at Sandwell Hospital and inpatient elective surgery at City Hospital.

5. The Trust Board, PCTs and SHA must satisfy themselves prior to implementation that it is safe to proceed with the detailed arrangements of the interim proposal.

6. Appropriate out of hours protocols, including a clinically appropriate 'Hospital at Night' concept, must be developed for immediate emergency surgery provision at City Hospital.

7. The Surgical Assessment Unit (SAU) should be regularly monitored to ensure a safe service is delivered for patients in and out of hours and as part of a wider healthcare model.

8. Patients that are transferred from City Hospital to Sandwell Hospital for emergency surgery must be taken in a safe and appropriate manner. Appropriate protocols must be developed and agreed to underpin this process.

9. Ambulance protocols must be agreed with West Midlands Ambulance Service to arrange for patients requiring or likely to require immediate emergency surgery to be taken directly to Sandwell Hospital, other than in exceptional circumstances.

10. A solution, such as an inter site shuttle bus, to take relatives of emergency surgery patients transferred to Sandwell should be introduced.

11. The Trust should adopt National Confidential Enquiry into Patient Outcome and Death (NCEPOD) categorisation of surgery lists.

1. OUR REMIT

What was asked of us

1.1. The Independent Reconfiguration Panel's (IRP) general terms of reference are included in Appendix One.

1.2. On 18 May 2007, Councillor Deirdre Alden, Chair of Birmingham City Health Overview and Scrutiny Committee (OSC), wrote to the Secretary of State for Health, then Patricia Hewitt, exercising powers of referral under section 4(7) of the Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002. The referral concerned the proposal to consolidate the Trust's inpatient emergency surgery provision at its Sandwell Hospital site.

1.3. The Secretary of State responded to Councillor Deirdre Alden advising that she had asked the IRP to undertake a review of the proposals. Terms of reference were sent out in the new Secretary of State, The Rt Hon Alan Johnson's, letter of 30 August to the IRP Chair, Dr Peter Barrett and were agreed in his reply of 10 September. Copies of all correspondence are included in Appendices 2 to 4.

1.4. The Panel was asked to advise the Secretary of State:

a) whether in the light of the grounds of referral as set out in the correspondence from Birmingham City Health Overview and Scrutiny Committee to the Secretary of State of 18 May 2007, it is of the opinion that the proposals to consolidate emergency surgery provision at Sandwell Hospital, as set out in the decision of Sandwell and West Birmingham NHS Trust Board on 10 May 2007, will ensure safe, sustainable and accessible service for the people of Sandwell and Birmingham, and if not, why not
b) on any other observations the Panel may wish to make in relation to the proposals for changes to emergency service provision and implications for any other clinical services
c) in the light of a) and b) above on the Panel's advice on how to proceed in the best interests of the local people

2. OUR PROCESS

How we approached the task

2.1. Sandwell and West Birmingham Hospitals NHS Trust was asked to provide the Panel with relevant documentation and to arrange site visits, meetings and interviews with interested parties. The Trust completed the Panel's standard information template. This can be accessed through the IRP website (www.irpanel.org.uk).

2.2. The Birmingham City and Sandwell Health OSCs were also invited to submit documentation and suggest other parties to be included in meetings and interviews.

2.3. The Panel Chair, Dr Peter Barrett, wrote an open letter to editors of local newspapers on 19 September 2007 informing them of the IRP's involvement (see Appendix 5). The letter invited people who felt that they had new evidence to offer or who felt that their views had not been heard adequately during the formal consultation process to contact the Panel. Press releases were also issued on 11 and 19 September, 9 October and on 13 November 2007 providing information on the progress of the review.

2.4. A sub-group of the full IRP panel carried out the review. This sub-group was chaired by Gina Tiller. The panel also consisted of John Parkes and Ray Powles. Panel secretariat accompanied members on all visits.

2.5. Panel members made nine visits to the Sandwell and City sites of the Sandwell and West Birmingham Hospitals NHS Trust. Details of the people seen on these visits are included in Appendix 7. They included meetings with the Birmingham City and Sandwell OSCs, local residents and PPI Forums. We wrote to all local MPs and met with Adrian Bailey (West Bromwich West) and Gisela Stuart (Edgbaston).

2.6. A list of all the written evidence received – from the SHA, PCTs, NHS Trusts, Joint Scrutiny Committee, individual scrutiny committees and all other interested parties is contained in Appendix 8. The Panel considers that the documentation received, together

with the information obtained in meetings, provides a fair representation of the views from all perspectives.

2.7. Throughout our consideration of these proposals, our aim has been to consider the needs of patients, public and staff taking into account the issues of safety, sustainability and accessibility as set out in our terms of reference.

2.8. The Panel wishes to record its thanks to all those who contributed to this process. We also wish to thank all those who gave up their valuable time to present evidence to the Panel and to everyone who contacted us offering views. The panel are always impressed by the commitment shown to the NHS and the time that people are prepared to dedicate to support the progress and development of healthcare services.

2.9. The advice contained in this report represents the unanimous views of the Chair and members of the IRP.

2.10. Definitions of key issues covered in this report

2.10.1. The IRP were asked to look at the provision of emergency surgery services at Sandwell and West Birmingham Hospitals NHS Trust. The NCEPOD[1] recommends that Trusts use the following classification of all surgical procedures.

a) Immediate life or limb or organ saving. Target time to Operating Theatre is within minutes of decision to operate e.g. major trauma to abdomen or thorax.

b) Urgent conditions which threaten life limb or organ survival, plus fixation of fractures and relief of distressing symptoms. Target time to theatre, within hours of decision to operate.

c) Expedited stable patient requiring early intervention, but condition not an immediate threat to life, limb or organ survival. Target time to theatre, within days of decision to operate.

d) Elective Surgical procedure booked in advance (typically following outpatient appointment).

[1] National Confidential Enquiry into Patient Outcome and Death 'Who Operates When? II(2003)

2.10.2. The NHS typically uses the phrase ‘elective surgery’ in accordance with the above definition; but then uses the phrase ‘emergency surgery’ to encompass the first three categories. This was the case in the Trust consultation document. The term ‘immediate emergency surgery’ is used in the remainder of this document to describe the patients in category a). The term ‘non immediate emergency surgery’ is used to describe the patients in categories b) and c).

2.10.3. Emergency surgery is made up largely of emergency general and orthopaedic surgery. There are also sub categories such as breast and colorectal surgery which may be carried out as an emergency procedure.

2.10.4. The terms ‘hot’ and ‘cold’ are often used to describe surgical services provided by hospitals. ‘Hot’ sites provide full emergency medical and surgical services, ‘cold’ sites provide non-urgent medical services, elective surgery and outpatient services. The proposal at Sandwell and West Birmingham Hospital NHS Trust is for Sandwell to be a ‘hot’ site. Several people in the Trust have described City as becoming a ‘warm’ site, which will provide some emergency surgery services when required.

2.10.5. A physician or surgeon scheduled to deal with emergency admissions to a hospital is said to be ‘on take’. An A&E department that accepts patients suffering from any type of accident or emergency is described as accepting an ‘unselected take’. If patients are directed to other departments for certain services (for example if a 999 ambulance takes patients needing immediate surgery to another site), then the take is ‘selected’. The proposals at the point of OSC referral were for both sites to have an unselected take.

2.10.6. The Hospital at Night concept ensures that night cover is provided by a team of doctors working a wider range of specialties than has been the norm (including medical /surgical cross-cover), and senior nurse practitioners. Hospital at Night teams tend to include trainee surgeons at junior level and are focussed on minimising the doctors in training needed at night so, for example, specialist trainee surgeons can focus their time on better quality training and seeing more patients in the day. This concept is one gaining ground across the UK - Hospital at Night services are now provided in half of acute Trusts.

3. THE CONTEXT

An overview

3.1. Historical context

3.1.1. Sandwell and West Birmingham Hospitals NHS Trust was formed in 2002, bringing together three hospital sites - City Hospital, Sandwell General Hospital and Rowley Regis Hospital. Yvette Cooper wrote to Richard Steer, Chair of City Hospital NHS Trust on 8 March 2002, confirming that the Trust would be created from 1 April 2002 (appendix 6). In this letter she stated that *"the two hospitals will continue to provide the full range of clinical services to support local A&E services …. should there be proposals for service reconfiguration these will be the subject of feasibility studies involving key stakeholders, public consultation, and national independent scrutiny"*.

3.1.2. Since amalgamating into a single Trust, the organisation has sought to provide more joined up services across the geographical area and using clinical teams working across the hospital sites in some specialties.

3.2. The long term proposals for future healthcare services

3.2.1. The Trust has a long term plan, developed with local Primary Care Trusts and working with the councils in Sandwell and Birmingham, to improve health and social care services by:

- Bringing care closer to home and into local communities
- Providing high quality care in high quality places
- Making Sandwell and the Heart of Birmingham healthier places to live and work

3.2.2. Proposals for longer term changes to the health services provided by Sandwell PCT, Heart of Birmingham PCT and Sandwell and West Birmingham Hospitals NHS Trust were set out in the consultation *'Towards 2010 – Investing in a Healthy Future'* (20 November 06 to 16 February 07). Key to this was the proposal to increase the community provision of healthcare services and linked to this, to replace two current general hospitals with a new single-site acute hospital by 2014/15. This long term plan is widely supported with a chosen site at Smethwick, in Sandwell PCT.

3.2.3. The PCTs and Trust stated that if the approach was taken forward they would:

- do more to encourage people to stay healthy, helping them to stop smoking and adopt healthier lifestyles
- bring GPs together into new larger health centres, where they could offer a wider range of services in close connection with social care and other community services
- deliver most diagnostic services from 'community hospitals' or 'community treatment centres', so most people could have tests done locally rather than having to travel to a specialist hospital
- open a number of urgent care centres, where people with minor injuries or illness would be able to be treated quickly and locally, while developing a new state-of-the-art A&E for those people requiring specialist care
- be involved more actively with people who have a long-term health condition in order to help them maintain independence, using telecare and rapid response teams to deal with crises locally where possible without the need for them to go to a specialist hospital
- deliver most outpatient appointments and specialist consultations in people's local communities and would use the latest techniques to ensure people recovered quickly and so needed to spend only the shortest time in hospital
- provide a range of intermediate care beds in the community, so people could recover or receive respite care closer to home rather than having to stay in a specialist hospital
- ensure the most advanced care was available from a state-of-the-art specialist hospital

3.2.4. The proposals for new community and acute hospital services are well received; the model is consistent with the national approach and is well supported by the SHA, PCTs, service providers, clinicians and the public. It is a key element of the Trust's application for Foundation Trust status which will be submitted in Spring 2008.

3.3. The proposals for interim reconfiguration, including emergency surgery

3.3.1. The Trust argue that, in advance of a new hospital being built, the status quo cannot be maintained because *"at present many hospital services are provided at both of the Trust's two main hospital sites, City Hospital and Sandwell General Hospital. This makes them smaller and leads to duplication in work, staff and equipment. This split also stops us*

making many of the developments and improvements that larger services can offer, particularly investment in new technology and techniques"[2].

3.3.2. The Trust developed plans for interim changes to services in four areas - pathology, neo-natal care, paediatrics and surgery – in order to address these perceived problems.

3.3.3. In support of developing these plans, the Trust commissioned an external expert review by Professor Sir John Temple, which reported in July 2006[3]. This suggested that interim configuration proposals for surgery should be implemented as soon as possible, that a "hot" surgical site should be established at Sandwell Hospital and a "cold" surgical site should be located at City Hospital. This review suggested that the proposed approach would:

- balance elective and emergency services across City and Sandwell Hospitals
- balance the services within the Birmingham conurbation
- ensure proper development and use of the Emergency Services Centre at Sandwell
- allow full development and use of the Birmingham Treatment Centre and other complimentary facilities at City Hospital

3.3.4. The Trust consulted on changes in a number of areas to be rolled out during the period 2007 to 2014, in a consultation called '*Shaping Hospital Services for the Future'* (20 November 06 to 16 February 07). The consultation sought views on the following proposals:

- Concentrate inpatient planned general and orthopaedic surgery and all of the inpatients in some other specialities (e.g. urology, ear nose and throat (ENT) and ophthalmology) at City Hospital; Concentrate inpatient emergency general and trauma surgery and all inpatient colorectal (lower bowel) surgery at Sandwell General Hospital.
- Develop a Paediatric Assessment Unit (PAU) at City Hospital. Concentrate children staying overnight at Sandwell General

[2] Shaping Hospital Services for the Future (Nov 06) para 2.6
[3] External Expert Review: Interim Configuration Project Sandwell and West Birmingham Hospitals NHS Trust, John Temple (July 06)

- Create a level 2 neonatal unit at City Hospital – for the youngest, sickest babies and a level 1 neonatal unit at Sandwell General Hospital.

3.3.5. In relation to surgery, the Trust's consultation document[4] stated that they would:

- Continue outpatient and day case surgery at both City and Sandwell Hospitals.
- Concentrate inpatient planned general and orthopaedic surgery at City Hospital as well as all of some specialist work e.g. urology, ENT and ophthalmology.
- Concentrate inpatient emergency general and trauma surgery at Sandwell General Hospital together with all colorectal surgery (lower bowel). This is a large proportion of the most complex planned general surgery.
- Provide cover for patients admitted to City Hospital who subsequently need emergency surgery or the very small number of patients who may arrive at City Hospital A&E too ill to transfer to Sandwell General Hospital for treatment.
- Increase the proportion of patients seen as a day case and reduce the lengths of stay for surgical inpatients.

3.3.6. The Trust argue that the approach set out for emergency surgery in the consultation document will work because:

The proposals fit well with the most recent investments in facilities at the Trust: the Birmingham Treatment Centre (BTC) at City Hospital and the Emergency Services Centre (ESC) at Sandwell General Hospital. The BTC is a state of the art facility for outpatients, day cases and planned surgery. The ESC provides emergency care in new, modern facilities and includes A&E and an emergency assessment unit (para 3.5 *'Shaping Hospital Services for the Future'*).

Without the proposed changes surgery may not be able to continue providing the current level and quality of services, let alone improve them. For example if we do not begin recruitment soon, six out of our 14 consultant general surgery posts will be vacant within 18 months. The changes are necessary to help to attract the best candidates to fill those vacancies (para 4.6 *'Shaping Hospital Services for the Future'*).

[4] Shaping Hospital Services for the Future (Nov 06)

With the proposed changes many specialties that are now split into two small teams will be joined together as one larger unit. These will be much more able to improve services, recruit the best staff and meet the challenges of providing better care for patients (para 4.7 *'Shaping Hospital Services for the Future'*).

3.3.7. The consultation on the interim reconfiguration ran alongside the *'Towards 2010'* consultation and was criticised by a number of groups, because of the confusion that this caused. The subject of the consultation was also found to be confusing by some, with a misinterpretation that the A&E at City Hospital was going to be closed down, which fuelled some of the opposition to the proposals.

3.3.8. Through the consultation, a number of concerns were raised in relation to the proposals for emergency surgery. Concerns centred largely around two groups of patients;

- those that self present at City, in particular those who are stabbed or shot and require immediate emergency surgery, and
- those patients that will be transferred by the Trust's patient transport service to Sandwell for emergency surgery, when stabilised.

3.3.9. Although some responses were supportive, the consultation[5] revealed local concerns in relation to emergency surgery:

- There was strong feeling that emergency surgery should remain at City Hospital
- The most commonly cited reason was the risk of transferring patients to another hospital, rather than being able to access urgent treatment including surgery at City Hospital
- Many respondents mention trauma injuries from gun and knife crimes, and that the greater need for treating these types of injuries was in Birmingham city centre
- Some respondents questioned where the finances were coming from to implement changes
- Respondents also suggest that transport links may be congested, particularly around the West Bromwich area

[5] Shaping Hospital Services for the Future: Analysis of Public Consultation

- There was a perception that staff at City Hospital are more experienced in dealing with trauma injuries, whereas staff at Sandwell are not so exposed to these types of injuries
- There was concern that staff training will be affected, particularly at City Hospital where the workforce may become de-skilled
- One respondent comments: "Local people need local services – not long journeys for sick people."

3.3.10. As a result of concerns raised through the consultation, the Trust considered the status quo and four options to revise their proposals, three of these in detail. Their conclusions are set out in the following table:

Option	**Conclusion**
Status Quo;	the status quo remained unviable for the reasons set out at the start of the consultation;
Option 1: Centralise inpatient elective general surgical specialities only;	did not represent sufficient change to make progress;
Option 2: Main inpatient emergency service at Sandwell Hospital and main inpatient elective service at City Hospital (consultation proposals);	Although viable, the extent of the risk to the Trust's emergency catchment and the possible impact on other specialities may be greater than originally assessed. The Trust also rejected this option in response to some of the issues raised in the consultation.
Option 3: Main inpatient emergency service at Sandwell Hospital and main inpatient elective service plus a 24 hour SAU at City Hospital;	The board wanted to see a more detailed assessment of option 3 (consultation proposals plus SAU) and option 4 (centralise elective general surgery specialties and orthopaedics) against the original objectives of surgical reconfiguration.
Option 4: Centralise inpatient elective general surgery and orthopaedics but retain inpatient emergencies at both sites.	

3.3.11. The Trust's Surgical Reconfiguration Steering Group, considered options 3 and 4 in more detail. Following this the Trust's Executive Team recommended option 3 as the preferred approach.

3.3.12. The Trust and its two main PCTs presented the revised proposals following the outcome of the public consultation to the SHA Executive team in April 2007. Following this review the SHA confirmed its support for the revised proposals.

3.3.13. The final proposals were set out for the Trust Board on 10 May 2007:

- to concentrate inpatient emergency general surgery services at Sandwell General Hospital;
- to develop a 24 hour Surgical Assessment Unit (SAU) at City Hospital to maintain maximum local access and support City Hospital's A&E department;
- to retain on-call surgical consultant cover for both hospital sites;
- to retain 24 hour access to emergency theatres and anaesthetic cover at City in the event that life-saving surgery is needed on that site.

3.3.14. The key differences from the original proposals are that City would remain open to all types of patients and that ambulances carrying emergency patients would not bypass City for Sandwell. Immediate emergency surgery could be undertaken at City, but non immediate emergency surgery would take place at Sandwell, with the SAU at City used to stabilise and assess patients' suitability for transfer to Sandwell.

3.3.15. The Trust has calculated the number of people that are likely to be affected by the approach selected:-

- Between one and three patients per week would fall into the category of needing immediate emergency surgery which required the use of the on call theatre at City.
- On average nine patients a day would present at City Hospital and need surgery on a daytime non-elective theatre list, which would require them to be transferred to Sandwell Hospital. Half of these would be emergency orthopaedic patients, the remainder emergency general surgery patients.

3.3.16. Sandwell and West Birmingham have a joint OSC, which followed the progress of the two consultations detailed above as a single body. However, the issue of emergency surgery caused an amicable split in the OSC, which is currently operating as two separate bodies.

The Birmingham Health OSC objected to the proposed approach and referred the proposals to the Secretary of State for Health on the 18 May 2007. The Sandwell Health Overview and Scrutiny Committee did not object to the proposals.

4. INFORMATION

What we found

4.1. A large amount of written and oral evidence was submitted to the Panel. We are grateful to all those who took the time to offer their views and information. The evidence put to us is summarised below – firstly general background information followed by information on how the proposals have developed since the OSC referral, issues raised by the OSC and others and finally other evidence gathered.

4.2. **Services provided and activity**[6]

4.2.1. Sandwell and West Birmingham Hospitals NHS Trust provide acute hospital services across three hospital sites:

- City Hospital, Birmingham with 550 beds currently
- Sandwell General Hospital with 400 beds currently
- Rowley Regis Hospital with 100 beds currently

4.2.2. At present, City and Sandwell Hospitals each provide acute general hospital services for their population including A&E, emergency medical and surgical services, maternity and paediatrics and elective services. City Hospital is also the base for the Birmingham and Midland Eye Centre and the regional Gynae-Oncology Centre. Rowley Regis provides continuing care and rehabilitation. It also has a range of outpatient and diagnostic facilities.

[6] This information is largely drawn from the Trust's standard IRP information template

4.2.3. The Trust sees the following patients each year:

Sandwell and West Birmingham Hospitals NHS Trust (SWBH) Activity Summary 2006/7 Outturn

		City	Sandwell	SWBH Total
A&E Attendances	Main A&Es	110,309	90,252	200,561
	Eye Centre	31,373	0	31,373
	Total	141,682	90,252	231,934
Outpatients	New	76,433	53,109	129,542
	Review	230,532	142,810	373,342
	Total	306,965	195,919	502,884
Electives	Inpatients	8,810	5,068	13,878
	Day Cases	24,365	21,485	45,850
	Total	33,175	26,553	59,728
Emergency Admissions		36,568	28,508	65,076

Of the emergency admissions:

	City	Sandwell	SWBH Total	% of 65, 076 total emergency admissions
Trauma	2,489	1,325	3,814	6%
General Surgical Emergencies	3,160	2,639	5,799	9%
Total trauma and general surgical	5,649	3,964	9,613	15%

4.2.4. The Trust employs about 6,000 staff across three hospital sites. Of these 13% are medical staff, 40% nursing, 12% healthcare assistants and support, 15% scientific and technical and 20% administrative, estates and managerial.

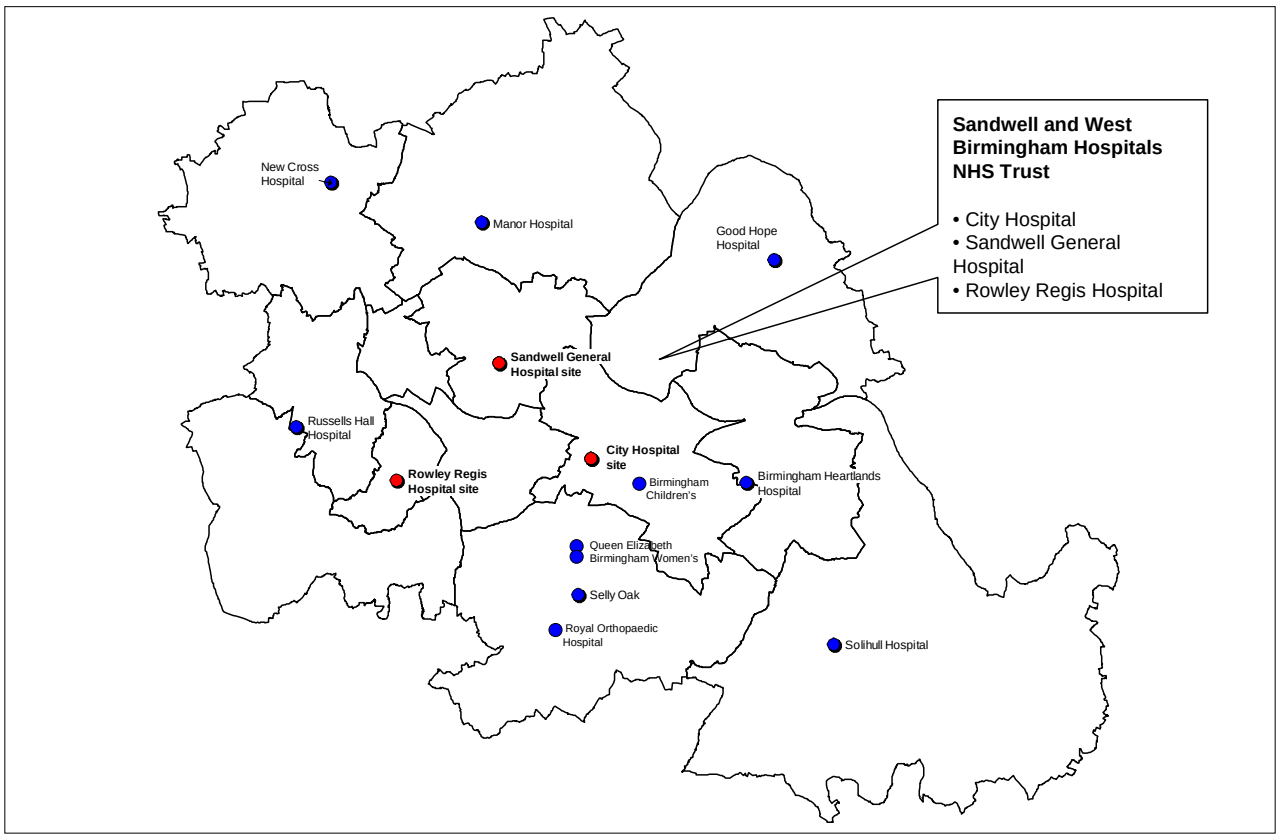
4.3. Population, geography, demography, access and transport

4.3.1. The Trust serves a catchment population of 500,000-600,000 mainly in the Metropolitan Borough of Sandwell and in central and western Birmingham at the heart of the West Midlands conurbation. This includes most of the borough of Sandwell and the areas of Handsworth, Ladywood, Aston, Lozells and Nechells along with parts of Perry Barr and Kingstanding in Birmingham.

4.3.2. The catchment contains significant levels of deprivation. Most of the electoral wards served by the Trust are in the 25% most deprived in England and many[7] are within the 10% most deprived.

4.3.3. The Trust serves a highly diverse population. In some areas served by the Trust over 70% of the population is from black and minority ethnic groups including large Afro-Caribbean communities as well as communities originating in India, Pakistan and Bangladesh.

4.3.4. The following map shows the three hospitals that form Sandwell and West Birmingham Hospitals NHS Trust, in the West Midlands context.



4.3.5. City Hospital and Sandwell General Hospital are 4.8 miles apart by road. The M5 motorway runs through the centre of the Trust's catchment area but there are good road

[7] The 2001 Census of Population showed that Nine Birmingham wards were estimated to have at least 75% of their population falling within the 10% most deprived Super Output Areas in England. They were Washwood Heath (98.9%), Lozells & East Handsworth (97.2%), Sparkbrook (88.6%), Aston (88.2%), Kingstanding (84.6%), Nechells (84.5%), Soho (81.3%), Bordesley Green (78.8%) and Ladywood (76.5%).

links between the two hospitals many of which are dual carriageways with a range of routes across or under the motorway. The main A-roads linking the hospitals include the A457 and the A41.

4.3.6. City Hospital is located close to Birmingham city centre and is served by a wide range of bus routes. Sandwell Hospital is located close to West Bromwich town centre, which has a major public transport interchange. There are a number of buses serving Sandwell Hospital from the interchange and elsewhere in the locality. There are no direct bus routes linking the two sites.

4.3.7. The Trust provides a shuttle-bus service between the hospital sites during normal working hours. This service is predominantly used by NHS staff; it is also occasionally used by relatives and visitors.

4.4. **Estate**

4.4.1. The hospital estate is old and in a poor condition. Much of the estate at City Hospital is over 100 years old and premises at Sandwell are also in need of modernisation. The Trust has completed two capital developments in recent years:

- a PFI funded £35m ambulatory care centre (the BTC) at the City Hospital site;
- an £18m Emergency Services Centre at Sandwell General Hospital funded with public capital following the destruction of the previous A&E by fire.

4.4.2. The Trust's future capital development plans centre on proposals to develop a single-site new acute hospital. This will be funded through PFI, and is expected to cost about £360m and to open in 2014/15. The Trust's long-term strategy to move to a new single-acute site will help to address the problem of outdated buildings.

4.4.3. In advance of the new acute hospital the Trust's capital programme concentrates on investing £10m over 2007/8 and 2008/9 in developments that support plans for service reconfiguration. The majority of this relates to investment in pathology, paediatrics and neo-natal services

4.5. Healthcare Commission annual assessment and Clinical Negligence Scheme for Trusts (CNST) status

4.5.1. The Trust Healthcare Commission annual assessment for 2006/7 was:

- Quality of Services: Good;
- Use of Resources: Fair.

4.5.2. The Trust CNST accreditation for 2006/07 is:

- General: Level 2
- Maternity: Level 1

4.5.3. The Trust has an annual income of c. £320m. The Trust had a deficit in 2005/6 of £5.6m but following a major cost improvement programme delivered a surplus of £3.3m in 2006/7 and is on target to deliver a further surplus of £4.5m in 2007/8.

4.6. **Changes to the plan since the case was referred to the IRP**

4.6.1. The final proposals set out for the Trust Board on 10 May 2007 were:

- to concentrate inpatient emergency general surgery services at Sandwell General Hospital;
- to develop a 24 hour Surgical Assessment Unit (SAU) at City Hospital to maintain maximum local access and support City Hospital's A&E department;
- to retain on-call surgical consultant cover for both hospital sites;
- to retain 24 hour access to emergency theatres and anaesthetic cover at City in the event that life-saving surgery is needed on that site.

4.6.2. Further to the 10 May Trust Board paper, the Trust has not published any further information about the development of the approach and no further protocols or details have been established. However, the Trust provided evidence for the IRP, which outlined in more detail the proposed patient flows for emergency surgical patients presenting at City Hospital after the proposed reconfiguration of surgical services within the Trust. These were based on discussion with some senior clinicians and the Trust advised us that they would require further development with a wider range of clinicians. The evidence provided to the IRP, describes patient flows in four groups:

- Critically ill patients requiring immediate resuscitation and stabilisation;
- Stable but unwell patients requiring assessment, observation and urgent surgery by a surgical team;
- Stable patients requiring assessment, observation and/or treatment by a surgical team;
- Emergency GP referrals to a surgical team.

4.6.3. The IRP has taken this additional information into account when making its recommendations.

4.6.4. The level of concern with the proposed approach appears to have reduced as a result of the revisions to the approach set out by the Trust Board on 10 May. However, unanswered questions have remained for some groups, which continue to object to the Trust's proposals. Opponents to the interim proposals present arguments, which include that they are no better than the status quo and that the proposed approach is not safe or functional.

4.7. **Issues raised by scrutiny committees**

4.7.1. The Birmingham Health OSC set out their concerns in a letter referring the proposals to the Secretary of State for Health dated 18 May 2007.

4.7.2. The Birmingham Committee said:

".. the Shaping Hospital Services for the Future Consultation relating to the provision of Emergency Surgery will result in a reduction of service for the people of Birmingham and is not premised on clinical need. In evidence provided to Birmingham and Sandwell Joint Health Overview and Scrutiny Committee the Trust stated that currently the greatest need for emergency surgery is located on the City Hospital site. The Committee does not believe that the decision to consolidate emergency surgery on the Sandwell Hospital site has been taken with patient safety as the prime concern.

The consultation process carried out by the Trust clearly demonstrates that the proposals for surgery set out in the consultation document were opposed by the majority of respondents. The Committee does not believe that the twenty four hour surgical assessment unit announced by the Trust as a result of the consultation is a sufficient variance of the

original proposal and will still result in a substantial diminution of service for one of the most deprived areas of Birmingham.

In addition the Committee believes that Sandwell and West Birmingham Hospital NHS Trust have not demonstrated a clear case as to why emergency surgery could not instead be consolidated on the City Hospital site. We feel this option should now be considered as a matter of urgency in order to safeguard the welfare of Birmingham patients. The Committee also believes that any decision taken by the Trust should be based on demographic and geographic indicators."

4.7.3. Further to this letter, at a meeting with the Birmingham Health OSC, the committee noted to the IRP that they would be happy with the status quo and that they did not feel this had been properly explored.

4.7.4. The Sandwell Health OSC did not object to the proposals. When the IRP met the committee, OSC members discussed the implications of Sandwell residents travelling to City Hospital for more elective care but felt this was manageable. They also noted that they were concerned that adequate emergency services were provided at City Hospital, as many Sandwell residents live closer to City Hospital than Sandwell Hospital and use City as their local hospital, others may have cause to use the hospital, for example, when they are visiting the city centre. 22% of trauma or general surgical emergency admissions at City Hospital are for residents of Sandwell. The Sandwell OSC were satisfied that the proposed service model would deliver these requirements.

4.8. **Issues raised by others**

4.8.1. The following sections of this report provide a summary of key points that were made by a range of individuals over the course of the review. They are not listed in any particular order and are not weighted, some views, for example, were put forward by individuals or small interest groups, whereas others have the backing of larger cohorts of the stakeholders with an interest in this reconfiguration.

4.8.2. Many groups stressed the need for a decision as quickly as possible; there was a feeling that there is planning blight and that this will remain until an approach is agreed. There

was a concern that, if the new hospital is not built, the interim arrangements could become permanent.

4.8.3. A number of specific views were raised by different stakeholder groups:

4.8.4. *Public, patient and carer views*

- The PPI forums for Birmingham City PCT and Sandwell Hospital felt that the benefits of the proposed approach had not been well sold nor had the consequences of no change, but that the Trust did listen to the consultation and made changes to their plans as a result of this
- There was a feeling that there is not enough evidence yet that treatment will be improved through the new approach
- Some felt that the loss of emergency surgery at City was part of a systematic erosion of services at the hospital
- Some patients and patient groups were confused about the plans and what they would mean for them.
- The Birmingham Mail told us that the majority of correspondence to the paper on this issue had been from staff rather than from the public and patients. They also noted that the amount of correspondence received was currently relatively small and that the letters they received were from people with very strongly held views.

4.8.5. *Clinician views – the need for change*

4.8.6. We spoke to a large number of clinicians from across the Trust including surgeons, physicians, nurses and other members of the multi-disciplinary team. It included staff from each site and staff that work across the sites. There was no single voice for the clinicians of Sandwell and West Birmingham Hospitals NHS Trust. There was a wide variety of often disparate views and little consensus of opinion.

- The majority of clinicians agreed that there was a need for improved cross site working, which would realise benefits including the opportunity to develop greater levels of sub-specialism

- It was felt that there would be improved quality of surgical outcomes, especially out of hours, by having more appropriately trained surgeons on call e.g. colorectal surgeons who carry out the majority of emergency surgery
- It was noted that the current model will only work in the short term and that there is currently duplication of services across sites
- A number of clinicians explained that the SAU provides a mechanism to manage the 30-50% of patients that need assessment and stabilisation but might not need emergency surgery and this takes pressure off A&E and surgery
- It was suggested that City Nightingale wards are not ideal, as long as they remain in use they are better for electives that can be planned and screened for infections such as Clostridium Difficile, than emergencies.
- Some felt that it is difficult to recruit with the current split site because of the pressure of rotas, although others disputed this view. They told us that most recruitment is now carried out on a Trust wide basis and that this is attracting better calibre staff
- Services that support emergency surgery indicated that they could cope with the changes in demand patterns across the Trust; these included imaging, anaesthetics, critical care and theatres
- Most clinicians expressed confidence in the likely safety of the proposed approach, as long as it was underpinned by agreed protocols

4.8.7. *Clinician views – the possible effect of the proposed approach on service delivery and patient care*

- Concern was expressed about the safety of patients transferred by ambulance between City and Sandwell Hospital sites for emergency surgery, with some clinicians feeling that patients that do not require immediate emergency surgery and who are transferred by ambulance to Sandwell Hospital, may deteriorate in the ambulance and be at risk. Clinicians had different views on the protocols that should be put in place to select patients suitable for this transfer and regarding clinical responsibility for patients as they pass from one site to the next
- Views were expressed that adequate arrangements were not in place to provide care for patients requiring immediate emergency surgery (within minutes of arrival at A&E) at City hospital. There was concern that a large proportion (up to 70%) of patients self refer to City A&E and that it would be difficult to manage this flow. There was a view that

A&E staff would have to be trained in more life saving skills, if on-call cover was to be used for emergency surgery

- The proposed rotas to cover emergency surgery and the SAU out of hours were challenged by some members of staff
- Some clinicians articulated worries about how the current Trauma team would work in the future, and its ability to support patients requiring immediate emergency surgery
- Staff on ITU and wards at Sandwell noted that they may not have the capacity to accommodate additional patients transferred from City
- Concern was also expressed that only one single CT scanner is available at the Sandwell site and that it is subject to breakdown, whereas there are two scanners available at the City Hospital site
- Support services stressed the need to consider the implications of changes on their role e.g. additional demand for dietetic services such as tube feeding at Sandwell
- Some felt there was a need for management to work more effectively across the two sites in order for this to happen with clinical services
- There was some concern about ability to deliver training and education requirements for trainee doctors as opportunities for learning across the two sites could be eroded e.g. the ability to follow a patient along their full pathway

4.8.8. *Clinician views – something completely different is required*

- A number of clinicians pointed out that when the interim approach was developed, the new hospital was planned for 2012, it has now slipped to 2014, and it may therefore be more appropriate to maintain two emergency surgery sites or to look at alternative solutions
- It was suggested that the Trust should explore the benefits that could be gained by working theatres for 3 sessions a day
- The distance between the two sites is not large and several clinicians suggested that it is easier for them to cover this than for patients
- Several clinicians argued that one of the A&E services should be closed completely, although there were different views about which one

4.8.9. *The wider economy – planning and commissioning services for Sandwell and Birmingham*

- The SHA were fully supportive of the proposed approach, which will result in greater clinical integration which is necessary as a step towards running an effective single site hospital
- PCT commissioners have a close relationship with the Trust and were supportive of the long term strategy, feeling that the interim arrangements are the right steps on the way towards this
- Commissioners mentioned that the changes would support other national priorities, including NICE and Cancer Plan commitments
- The local cancer network is familiar with the proposed changes and support the revised approach for elective colorectal surgery, they did not feel the need to take a view on emergency surgery
- Commissioners described the Birmingham Emergency Capacity Planning Service, which manages patients across Birmingham hospitals. They suggested that any ambulance diversions to Sandwell would follow this model and not present a major new approach
- It was felt that leadership is needed from clinicians to bind the two sites in the future
- There was a concern that the proposed changes to emergency surgery could erode the breadth of provision at City Hospital. Some suggested that this could lead to a reduction in the hospital's catchment area and its financial viability to progress the new hospital build.
- The Sandwell Council were very supportive of the proposed new build at Smethwick and had been closely involved in the development of this approach

4.8.10. *Trust Management views*

- Trust management clarified their view that the reason for change and the proposals that they had put to their Board on 10 May remained. They indicated that there was further work to do in drawing up patient pathways, clinical protocols and workforce plans which would be necessary to implement their proposals. To a certain extent they felt that referral to the IRP had meant that the impetus within their clinical groups had gone out of this process and locally people were awaiting the outcome and decision

4.9. **Other evidence - Published reports**

4.9.1. A number of reports have been produced, which the panel took into account when reviewing the proposed model for emergency surgery, these include:

- The relationship between distance to hospital and patient mortality in emergencies: an observational study Jon Nicholl, James West, Steve Goodacre, Janette Turner (May 2007);
- Emergency Admissions: A journey in the right direction? A report of the National Confidential Enquiry into Patient Outcome and Death (October 2007);
- Who operates when? II National Confidential Enquiry into Patient Outcome and Death (NCEPOD) report (2003)
- Saws and Scalpels to Lasers and Robots – Advances in Surgery Clinical Case for Change: Report by Professor Sir Ara Darzi, National Advisor on Surgery (April 2007)
- Hospital at Night Baseline Report (October 2006)
- Separating emergency and elective surgical care: recommendations for practice, Royal College of Surgeons, (Sep 2007)
- Trauma: Who Cares, NCEPOD (2007)
- Acute health care services: Report of a Working Party published in September 2007 by Academy of Medical Royal Colleges.
- Our NHS our future. NHS next stage review. Interim report. October 2007 published by the Department of Health
- Securing Local Services: A position statement from the College of Emergency Medicine and the British Association for Emergency Medicine on the reconfiguration of acute services published in September 2006

Separating emergency and elective surgical care: recommendations for practice, Royal College of Surgeons (Sep 2007)

4.9.2. This is a recent and key report, which provides evidence in relation to the proposed service model, recommending the following:

- A physical separation of services, facilities and rotas works best although a separate unit on the same site is preferable to a completely separate location.
- The presence of senior surgeons for both elective and emergency work will enhance patient safety and the quality of care, and ensure that training opportunities are maximised.
- The separation of emergency and elective surgical care can facilitate protected and concentrated training for junior surgeons providing consultants are available to supervise their work.

- Creating an ‘emergency team’, linked with a ‘surgeon of the week’ is a good method of providing dedicated and supervised training in all aspects of emergency and elective care.
- Separating emergency and elective services can prevent the admission of emergency patients (both medical and surgical) from disrupting planned activity and vice versa, thus minimising patient inconvenience and maximising productivity for the Trust. The success of this will largely depend on having sufficient beds and resources for each service.
- Hospital-acquired infections can be reduced by the provision of protected elective wards and avoiding admissions from the emergency department and transfers from within/outside the hospital.
- The improved use of IT solutions can assist with separating workloads (for example, scheduling systems for appointments and theatres, telemedicine, picture archiving and communication systems, etc), although it is recognised that developments in IT for the NHS are generally behind schedule.
- High-volume specialties are particularly suited to separating the two strands of work. Other specialties can also benefit by having emergencies seen by senior surgeons – this can help to reduce unnecessary admissions, deal with ward emergencies and facilitate rapid discharge.

5. OUR ADVICE

Adding value

5.1. **The Context**

5.1.1. The Secretary of State for Health asked the Panel to consider whether the proposals for changes to emergency services set out by Sandwell and West Birmingham Hospitals NHS Trust would ensure provision of safe, sustainable and accessible emergency surgery services. The IRP were satisfied that the proposals will support the delivery of sustainable services for the interim period that was consulted upon. Based on current legislation and medical training requirements, the proposals should deliver a sustainable service for a longer period. Recommendation three refers to the reasons why the proposals were felt to be more sustainable than the status quo. The criteria of safety (recommendations five to nine) and accessibility (recommendation ten) are addressed in more detail through the remainder of this section of the report.

5.1.2. The IRP were impressed with the Trust for achieving such a wide degree of consensus on its long-term future. The local NHS bodies (SHA and PCTs), local people and their representatives (such as the two OSCs and the PPI forums) and staff all in general support a single-site hospital with a smaller bed complement than the current two, as part of a network with increased community based health facilities.

5.1.3. The IRP felt that the proposal to establish a new hospital is essential for the future delivery of safe, sustainable and accessible services for the populations of Sandwell and West Birmingham. The current sites are out-dated and have expanded over time.

5.1.4. This vision is consistent with the national direction, including that of the NHS Review "Our NHS, Our Future". However, the implementation date for the Trust's plan appears to local people to be slipping and it is important that the SHA, PCTs and Trust ensure that plans are delivered as rapidly as possible.

5.1.5. **Recommendation One**

NHS West Midlands (the SHA), the Heart of Birmingham and Sandwell PCTs and Sandwell and West Birmingham Hospitals NHS Trust should ensure that plans for future healthcare provision including new buildings are delivered as rapidly as possible.

5.2. **Operating effectively in advance of a new single site hospital**

5.2.1. The IRP noted the lack of progress evident in integrating the clinical services across the two current hospital sites within the Trust, which was created in 2002. This was brought home to the Panel by some of the attitudes of clinical staff, although some clinicians also reflected to us that the maintenance of certain management functions on a 'site' basis was not helpful. Whatever the reasons, the Trust cannot continue in this manner. Neither can it wait for the acquisition of the single site to bring about integration of clinical services and management functions.

5.2.2. The interim arrangements will require some staff to work on both sites and for some teams and sub-specialties to be split geographically or focused on one site. The Trust Board will need to assure itself that there are common policies and procedures for patients that may receive different parts of their care at each site and for staff moving between and working across the sites.

5.2.3. The IRP noted that there were examples of services operating differently at each hospital. For example, each site operates different theatre times. Examples were also provided of services that work effectively across the sites and these should be encouraged and promoted, for example, vascular services and anaesthetics. By increasing consistency in service models, the Trust will aid progress towards operating as a single site operation by 2014.

5.2.4. The Trust will also need to consider what further equipment and technological investment is needed prior to the interim changes coming into effect. They will have to ensure that existing IT solutions are optimised. The integration of clinical services will require the development of an appropriate clinical management structure with strong leadership.

5.2.5. Clinicians must be involved in developing models for cross site working and contribute to the design of new ways of working.

5.2.6. **Recommendation Two**
The Trust should develop and deliver effective ways of integrating clinical services across the two hospital sites.

5.3. **Clinical sub specialisation and rotas**

5.3.1. The specific contested proposals for surgery, published reports listed in chapter 4, and discussions with leading figures in the context of other reviews, lead us to the conclusion that there is a firm trend towards sub specialisation of surgery, which is relevant to this review.

5.3.2. As advances in medical careers occur, clinical practice in surgery is moving to a position where, for instance, there will no longer be general surgeons 'with an interest' in breast surgery, but specialist breast surgeons. This is reflected in the way new consultant posts are advertised and filled, and for patients the existence of specialisation is resulting in a huge improvement in care. However, it does mean the construction of rotas and particularly out of hours rotas to support emergencies can become more difficult.

5.3.3. This trend is naturally reflected in the way training programmes are organised for junior doctors who are heading towards Consultant positions. This is recognised in the policies expressed in 'Modernising Medical Careers'. At the same time as there is increased specialisation requiring dedicated time to develop specialist skills, hours available for 'hands on' surgical training are reducing with the implementation of EU Working Time Directive.

5.3.4. The pace at which the impact of this specialisation is felt at any individual Trust will vary with the composition and skills of their existing workforce. Our evidence gathering at Sandwell and West Birmingham Hospitals NHS Trust brought conflicting views on this; with the Trust view that changes needed to be soon (hence the consultation) and opponents arguing that the status quo could prevail for the foreseeable future such that there need be no change ahead of the new hospital.

5.3.5. The IRP are satisfied that the Sandwell and West Birmingham Hospitals NHS Trust is correct in its assessment of trends, and that the direction of travel which they have laid out is the right one.

5.3.6. The wider workforce plans will also need to be worked up to support the interim proposals. For example, the nursing workforce needs to be managed across the two sites and the Trust should ensure that nurses at City Hospital are supported in retaining their skills in dealing with emergency surgery cases.

5.3.7. **Recommendation Three**

The Trust must ensure that workforce plans are developed and agreed which support a sustainable and safe service in and out of hours and which supports increased levels of sub specialisation.

5.4. **Appropriate site**

5.4.1. Some of the evidence that we heard suggested that there had been some confusion about the extent of the proposed changes. The IRP understands clearly that these do not amount to closing either of the A&E departments and that the interim changes will include keeping two A&E Departments open, one at City Hospital and one at Sandwell Hospital.

5.4.2. The question of the appropriate location for emergency surgery was addressed in our review. Most of those people we heard who opposed the Trust's plans were arguing for the continuation of current services, with both emergency surgery and elective surgery at City Hospital and Sandwell Hospital. The evidence we heard for the Trust's proposed choice of sites was about the optimum use of operating theatres, and the best – or possibly 'least worst'- use of old 'Nightingale style' open wards at City. We heard no convincing evidence to the contrary.

5.4.3. **Recommendation Four**

The IRP support the Trust's proposal and agrees that the right approach for delivery of surgical services is to concentrate the majority of emergency surgery at Sandwell Hospital and inpatient elective surgery at City Hospital.

5.5. **Safety**

5.5.1. On the question of safety, our visit took place four months after the Trust Board decision of May 2007 but there was a relative paucity of information concerning the expected emergency surgery patient pathways, together with clinical protocols supporting key points along those pathways and a lack of clinical workforce plans. Indeed, on some occasions we received conflicting views from those interviewed. The Trust management told us that as a result of the referral by the Birmingham OSC, a matter of days after the Trust Board decision, it had been difficult to maintain the momentum on planning, and also they did not wish to be seen to pre-empt the Secretary of States eventual decision.

5.5.2. The view of the IRP is that there is every reason to expect the proposed changes to be implemented in a safe manner but that given the relative lack of detail, there should be a specific duty placed on the SHA, Trust Board and the Boards of the two PCTs to satisfy themselves prior to implementation, that it is safe to proceed with the detailed arrangements.

5.5.3. In order to assist, the IRP sets out below some of those matters which it seems to them should be addressed in more detail by the SHA and Boards of the Trust and PCTs to help ensure that the interim service model is safe. It also sets out recommendations to support the practical implementation of the approach. The Trust, PCTs and SHA should have regard for the NCEPOD report 'Trauma: Who Cares' (November 2007) when they sign off the implementation plan.

5.5.4. **Recommendation Five**

The Trust Board, PCTs and SHA must satisfy themselves prior to implementation that it is safe to proceed with the detailed arrangements of the interim proposal.

5.6. Immediate surgery at City Hospital

5.6.1. City and Sandwell Hospitals both currently accept any patients presenting in an emergency, both are equipped to provide emergency surgery 24/7 and a trauma team can be summoned by group bleep to provide resuscitation and stabilisation.

5.6.2. The proposal is for the majority of emergency surgery patients to receive surgery at Sandwell Hospital. City Hospital will provide care for those patients that present to City and need immediate emergency surgery i.e. within minutes of the decision to operate. Under the new model, between one and three patients will receive immediate emergency surgery at City Hospital each week. The IRP is satisfied that City Hospital has the physical capacity to handle these patients requiring immediate surgery. They do note, however, that the distance and route from A&E to theatres is not ideal. This is one of the compelling arguments for a new hospital to be built.

5.6.3. The biggest concern that the IRP has with the proposed approach is whether there will be satisfactory workforce arrangements to provide immediate surgery, should it be required at night. During the day, the IRP is satisfied that the SAU on-site surgeon and a surgical team will be available quickly to provide surgery. However, at night, there is limited evidence of a robust workforce plan. To ensure safe provision of services for this group of patients out of hours, the IRP would expect an appropriate 'Hospital at Night' concept to be adopted by the Trust that is able to meet the clinical needs of self presenting emergency surgical cases out of hours. This should be underpinned by workable on-call rotas, which have been agreed with the surgeons.

5.6.4. **Recommendation Six**

Appropriate out of hours protocols, including a clinically appropriate 'Hospital at Night' concept, must be developed for immediate emergency surgery provision at City hospital.

5.7. Operation of the Surgical Assessment Unit (SAU)

5.7.1. The SAU is a key part of the interim solution, which the Trust has introduced having listened to responses to their consultation and modified their original plans. The Royal College of Surgeons promote the use of SAUs, where they are well designed and managed[8].

[8] RCS (2007)

5.7.2. The evidence presented to the IRP, suggests that the SAU at City Hospital could provide an effective model for managing emergency surgery patients.

5.7.3. The Trust has indicated that they intend to keep the SAU model under review. For example, they will make a decision on whether or not to maintain resident on call surgical rotas at night. This would seem to the IRP a sensible and pragmatic approach, given that this is a relatively new service model for the NHS as a whole. Patient safety should always be paramount in making decisions about any changes to the service model.

5.7.4. **Recommendation Seven**
The SAU should be regularly monitored to ensure a safe service is delivered for patients in and out of hours and as part of a wider healthcare model

5.8. Transfer of surgical patients to Sandwell Hospital for surgery

5.8.1. The change to the delivery of emergency surgery services that will impact on most people is that patients that present to City Hospital who do not require immediate emergency surgery but require surgery in hours or days, will be transferred to Sandwell Hospital for their treatment. This will involve about nine patients each day.

5.8.2. The IRP would stress the need for protocols. These should include agreed processes for ensuring that patients are stable to travel and provide clarity about responsibility for patients and when this passes between the hospital sites.

5.8.3. There will be advantages to working more closely with the West Midlands Ambulance Service to provide transport for some or all patients.

5.8.4. **Recommendation Eight**
Patients that are transferred from City Hospital to Sandwell Hospital for emergency surgery must be taken in a safe and appropriate manner.
Appropriate protocols must be developed and agreed to underpin this process.

5.9. **The role of West Midlands Ambulance Service**

5.9.1. West Midlands Ambulance Service (WMAS) operate an Emergency Capacity Planning Service. This ensures that patients are taken to the most appropriate hospital for care and that hospitals are able to cope with demand. Currently, WMAS take patients to both City and Sandwell Hospital sites for emergency surgery.

5.9.2. About half of the patients receiving immediate emergency surgery at City Hospital arrive by ambulance. The Trust advised us this would amount to less than two patients per week. The current Trust plan is for this to continue. However, these patients could be directed to Sandwell Hospital, meaning that City Hospital only has to handle less than two immediate surgery cases a week, which are those that self present.

5.9.3. The IRP considers that, where at all possible, any patients picked up in the City Hospital catchment area by 999 ambulances, that appear to require immediate emergency surgery, should be taken directly to Sandwell Hospital. Only in exceptional circumstances and based on clear protocols, should these patients be directed to City Hospital. This is consistent with the national view that some patients may require more specialised care at centres with clinicians who have the right expertise and equipment.

5.9.4. WMAS indicated that it would be possible to implement this approach and that they already operate similar models for other hospitals in the area.

5.9.5. **Recommendation Nine**

Ambulance protocols must be agreed with West Midlands Ambulance Service to arrange for patients requiring or likely to require immediate emergency surgery to be taken directly to Sandwell Hospital other than in exceptional circumstances.

5.10. **Transport for relatives/ carers between the hospital sites**

5.10.1. On the subject of transport, patients and their representatives told us of the difficulties with public transport between sites. We were told that there could be nine patients a day on average transferred from City to Sandwell for their operation. We suggest that specific arrangements are considered to aid relatives and carers in their journey from the area around City Hospital to Sandwell Hospital. This could be by widening the use of the

existing intersite shuttle bus, which is currently primarily used by staff but could be made more widely available for patients and visitors.

5.10.2. **Recommendation T en**
A solution, such as an inter site shuttle bus, to take relatives of emergency surgery patients transferred to Sandwell should be introduced.

5.11. Surgery lists

5.11.1. With reference to the classification of emergency surgery, we noted that the Trust were not using the NCEPOD[9] three part classification, which distinguishes between 'immediately necessary surgery-within minutes', 'urgent- within hours' and 'expedited- within days'. If such classification had been in use, and the resultant data published with the consultation, some of the public concern which typically arises when the phrase "emergencies" is used might have been allayed. In any event as part of the preparation for implementation and the Board approval of detailed arrangements, we recommend that data be collected in future using the NCEPOD classification.

5.11.2. **Recommendation Eleven**
The Trust should adopt National Confidential enquiry into Patient Outcome and Death (NCEPOD) categorisation of surgery lists.

[9] 'Who operates when? II' National Confidential Enquiry into Patient Outcome and Death (NCEPOD) report (2003)

Appendix One

Independent Reconfiguration Panel general terms of reference

The Independent Reconfiguration Panel is an advisory non-departmental public body. Its terms of reference are:

A1. To provide expert advice on:

- Proposed NHS reconfigurations or significant service change;
- Options for NHS reconfigurations or significant service change;

referred to the Panel by Ministers.

A2. In providing advice, the Panel will take account of:

i. patient safety, clinical and service quality

ii. accessibility, service capacity and waiting times

iii. other national policies, for example, national service frameworks

iv. the rigour of consultation processes

v. the wider configuration of the NHS and other services locally, including likely future plans

vi. any other issues Ministers direct in relation to service reconfigurations generally or specific reconfigurations in particular.

A3. The advice will normally be developed by groups of experts not personally involved in the proposed reconfiguration or service change, the membership of which will be agreed formally with the Panel beforehand.

A4. The advice will be delivered within timescales agreed with the Panel by Ministers with a view to minimising delay and preventing disruption to services at local level.

B1. To offer *pre-formal consultation* generic advice and support to NHS and other interested bodies on the development of local proposals for reconfiguration or significant service change – including advice and support on methods for public engagement and formal public consultation.

C1. The effectiveness and operation of the Panel will be reviewed annually.

Appendix Two

Letter to Secretary of State for Health from West Birmingham Health OSC

COUNCILLOR DEIRDRE ALDEN
Chairman
Health Overview & Scrutiny Committee
Birmingham City Council
The Council House
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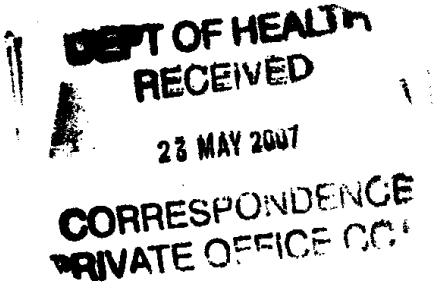
E-mail: deirdre.alden@birmingham.gov.uk



Right Honourable Patricia Hewitt MP
Secretary of State
Department of Health
Richmond House
79 Whitehall
London SW1A 2NS

18/05/07

Our Ref: DW/DA/SWBHREF
(Please quote in your reply)

Dear Minister

Referral of Sandwell and West Birmingham Hospitals NHS Trust Shaping Hospital Services for the Future Consultation

I write to inform you that the Birmingham City Council Health Overview and Scrutiny Committee is referring the decision by Sandwell and West Birmingham Hospitals NHS Trust's proposals to consolidate all of the Trusts emergency surgery provision at its Sandwell hospital site. This referral is made under Section 4(7) of The Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002.

The Committee feels that the part of the Shaping Hospital Services for the Future Consultation relating to the provision of Emergency Surgery will result in a reduction of service for the people of Birmingham and is not premised on clinical need. In evidence provided to Birmingham and Sandwell Joint Health Overview and Scrutiny Committee the Trust stated that currently the greatest need for emergency surgery is located on the City Hospital site. The Committee does not believe that the decision to consolidate emergency surgery on the Sandwell Hospital site has been taken with patient safety as the prime concern.

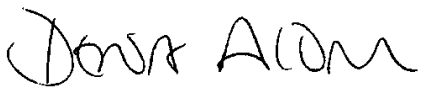
The consultation process carried out by the Trust clearly demonstrates that the proposals for surgery set out in the consultation document were opposed by the majority of respondents. The Committee does not believe that the twenty four hour surgical assessment unit announced by the Trust as a result of the consultation is a sufficient variance of the original proposal and will still result in a substantial diminution of service for one of the most deprived areas of Birmingham.

In addition the Committee believes that Sandwell and West Birmingham Hospital NHS Trust have not demonstrated a clear case as to why emergency surgery could not instead be consolidated on the City Hospital site. We feel this option should now be considered as a matter of urgency in order to safeguard the welfare of Birmingham patients. The Committee also believes that any decision taken by the Trust should be based on demographic and geographic indicators.

The Committee is extremely concerned that the decision to proceed with the proposals is not in the interest of patients in Birmingham and is contrary to the views expressed in the consultation process. The Birmingham City Council Health Overview and Scrutiny Committee requests that the decision is referred to the Independent Reconfiguration Panel as soon as possible.

I look forward to your response in this matter.

Yours sincerely



Councillor Deirdre Alden
Chairman of Health Overview and Scrutiny Committee

CC Cynthia Bower - Chief Executive – NHS West Midlands
CC John Adler - Chief Executive - Sandwell & West Birmingham Hospitals Trust
CC Tony Shaw – Chief Executive – Independent Reconfiguration Panel

Appendix Three

Letter to IRP from the Secretary of State for Health

From the Rt Hon Alan Johnson MP
Secretary of State for Health

Department of Health

Richmond House
79 Whitehall
London
SW1A 2NS

Tel: 020 7210 3000

SofS46456

Dr Peter Barrett
Chair
Independent Reconfiguration Panel
Kierran Cross
11 The Strand
London
WC2N 5HR

30 AUG 2007

Dear Peter

Following your letter of 14 August 2007, I am writing to confirm the Panel's Terms of Reference concerning the referral from Birmingham Health Overview and Scrutiny Committee and the proposals to consolidate emergency surgery provision at Sandwell Hospital.

Terms of reference

The Panel is asked to advise the Secretary of State by Friday 30 November 2007:

a) whether in the light of the grounds of referral as set out in the correspondence from Birmingham Health Overview and Scrutiny Committee to the Secretary of State of 18 May 2007, it is of the opinion that the proposals to consolidate emergency surgery provision at Sandwell Hospital, as set out in the decision of Sandwell and West Birmingham NHS Trust Board on 10 May 2007 will ensure safe, sustainable and accessible services for the people of Sandwell and West Birmingham, and if not, why not;

b) on any other observations the Panel may wish to make in relation to the proposals for changes to emergency service provision and implications for any other clinical services;

c) in the light of a) and b) above on the Panel's advice on how to proceed in the best interests of local people.

It is understood that in formulating its advice the Panel will pay due regard to the principles set out in the Independent Reconfiguration Panel general terms of reference.

The IRP's advice to me on this case should be provided in accordance with these Terms of Reference. I look forward to receiving your advice on this case.

Yours

ALAN JOHNSON

DG2908

Appendix Four

Letter to the Secretary of State for Health from the IRP agreeing to take the referral

Kierran Cross
First Floor
11 Strand
London
WC2N 5HR

The Rt Hon Alan Johnson MP
Secretary of State for Health
Department of Health
Richmond House
79 Whitehall
London SW1A 2NS

10 September 2007

Dear Secretary of State

Referral of decision by Sandwell and West Birmingham NHS Trust to consolidate emergency surgery provision at Sandwell Hospital

Thank you for your letter received 30 August about the above.

I am happy to confirm that the Independent Reconfiguration Panel will provide advice in accordance with the terms of reference set out in your letter – and, as requested by 30 November 2007.

The process of calling for and reviewing evidence is already well advanced. Panel Members will shortly begin undertaking visits to the West Midlands. As usual, we will be meeting people and hearing views from all sides of the debate.

As you know, in keeping with our commitment to open and transparent working, we will be publishing our advice on the IRP website. Allowing for the Christmas break, we would expect this to happen in the new year.

Yours sincerely

Dr Peter Barrett CBE
Chair, Independent Reconfiguration Panel

Appendix Five

Letter to editors of local newspapers from Dr Peter Barrett

Kierran Cross
First Floor
11 Strand
London
WC2N 5HR

19 September 2007

For publication

IRP: Have your say on health review

Dear Editor

The IRP, the independent expert on NHS service change, has been asked by the Secretary of State for Health to carry out a review relating to contested proposals for changes to emergency surgery services in Sandwell and West Birmingham.

As part of our review, we would like to hear from local people who feel that they have new information that was not submitted during the formal consultation process or believe that their voice has not been heard. Please contact us via the team at NHS West Midlands by email at: **2010IRP@westmidlands.nhs.uk** or by calling **01216 952469**.

The referral to the IRP relates to the decision by Sandwell and West Birmingham Hospitals NHS Trust to consolidate emergency surgery services at Sandwell Hospital. Currently emergency surgery is provided at City Hospital and Sandwell Hospital.

Our review will look at whether the proposals will ensure the provision of safe, sustainable and accessible services for local people.

Over the coming weeks, we will be undertaking a number of visits to the area to talk to patients, clinicians, local authority representatives, interest groups and people living and working in the area who believe they have new evidence that the IRP should take into account.

It is important that our reviews are open and accountable to local communities. We will therefore publish our conclusions on our website - www.irpanel.org.uk - once they have been considered by the Secretary of State for Health.

Yours sincerely

Dr Peter Barrett CBE
Chair, IRP

Appendix Six

Letter from Yvette Cooper, Parliamentary Under Secretary of State for Health, 8 March 2002 to Chair of City Hospital NHS Trust

From the Parliamentary Under Secretary of State

DH Department of Health

Richmond House
79 Whitehall
London
SW1A 2NS
Tel: 020 7210 3000

Richard Steer
Chairman
City Hospital NHS Trust
Dudley Road
Birmingham
B18 7QH

CITY HOSPITAL NHS TRUST
11 MAR 2002
RECEIVED
CHAIRMAN

08 MAR 2002

Dear Richard Steer

A proposal to dissolve and merge the Sandwell Healthcare NHS Trust and City Hospital NHS Trust to form a new NHS Trust on 1 April 2002

Following Public Consultation and consideration of the proposal and consultation responses I am pleased to agree that a new NHS Trust should be created from 1 April 2002.

During my consideration of the proposal it became clear that while there was undoubted support for the merger, there were anxieties about the prospect of ensuing service reconfigurations, and the adverse effects these might have, or be perceived to have, upon locally accessible services. Accordingly, in approving the merger I do so against the background of a number of assurances which have been given to me. These are set out below and amount to conditions attached to my agreement to merger.

- A key feature of the merger proposals in the Consultation Document and repeated throughout consultation is that the two hospitals - both large district general and teaching hospitals in their own rights - will continue to provide the full range of clinical services to support local Accident and Emergency Services.

- By virtue of the standards already attained, the range of services provided, and the volume of patients seen individually by each A&E Department neither of them is under threat of closure nor is either expected to become under threat as a direct or indirect result of merger.

- Should there be proposals for service reconfiguration these will be the subject of feasibility studies involving key stakeholders, public consultation, and national independent scrutiny. Furthermore in the future all NHS organisations will be required to consult local authority overview

DH Department of Health

and scrutiny committees on proposals for service reconfigurations. These committees will have the statutory powers to refer those proposals to the Secretary of State if the consultation process is inadequate or the merits of the proposal are not in the interests of local people.

Where proposals are developed incrementally they will need to show how they fit together as part of an overall strategy in which the delivery of high quality and locally accessible services are the key tests.

In addition to local processes any results of consultation which have not been agreed by local consensus will be referred to Ministers because of due process, to ensure that the integrity of proposals is reviewed at a senior level, and that undertakings given as part of the merger decision are honoured. Secretary of State may refer concerns that have not been resolved locally to the national Independent Reconfiguration Panel which is being created precisely to ensure that local feasibility studies and consultation are properly conducted, and that local concerns and contested proposals are fully and independently examined.

- Similarly, newly provided services whether or not as a result of reconfiguration will be based on contemporary clinical and managerial practice shown by evidence to be effective. The testing of proposals will include for example how they meet standards and guidance set out by the Modernisation Agency and its component parts, (for example Clinical Governance); emerging recommendations on good practice by the Commission for Health Improvement; their contribution to the delivery of the NHS Plan and National Service Framework.

I wish the new organisation every success.

YVETTE COOPER

Appendix Seven

Site visits, meetings and conversations held

Wednesday 19th September
City Hospital

Isobel Bartram	Non-Executive Director
Richard Kirby	Director of Strategy

Visits to Departments:

Dr Peter Ahee	Associate Director - A&E
Jane Hamblett	Matron – Acute Care
Carmel Madden	Sister, SAU
Mr Hamish Brown	Surgeon on call, SAU
Lesley Hodgkinson	Theatre Manager
Mandy Green	Sister, Surgical Ward D21
Cheryl Hudson	BTC Manager, Ambulatory Surgical Unit

Thursday 20th September
City Hospital

Dawn Hall	Patient Transport Manager

Sandwell Hospital

Matthew Dodd	Deputy Chief Operating Officer
Mr Kevin Wheatley	Consultant Surgeon and Divisional Director Surgery (Sandwell)

Visits to Departments:

Krys Stein	Surgical Matron, Newton 3
Gaynor Farmer	Ward Manager, Newton 3
Corrine Bromley	Deputy Divisional General Manager Surgery, 3rd floor theatres
Norma Massih	Lead nurse, Sandwell theatres
Kathy Collins	Lead Nurse, Critical care
Emma Clarke	Deputy Divisional General Manager, Medicines, emergency services centre
Mr Colin Holburn	Lead consultant A&E

Wednesday 3rd October

Dr Hugh Bradby	Medical Director
Mr Maya Vishwanath	Divisional Director, Surgery (City)
Sue Davis	Chair, Non executive
Isobel Bartram	Non executive director
Judith Whalley	Staff Convener
Rachel Overfield	Chief nurse
Dr Nick Sherwood	Consultant in Critical Care
Dr Santhana Kannan	Consultant Anaesethetist and Divisional Director

Thursday 4th October

John Adler	Chief Executive
Dr Frank Leahy	Consultant Radiologist
Dot Gospel	Chair Trust PPI forum
Pamela Jones	Chair Sandwell PPI forum

Dr Peter Ahee	Associate Director A&E City
Mr Stan Silverman	Consultant Vascular Surgeon
Jayne Dunn	2010 Implementation Director
Dr Ken Taylor	City Hospital Supporters Group
Mr Sailesh Parekh	Consultant T&O Surgeon
Mr Richard Wolverson	Consultant General Surgeon
Dr Anne Aukett	Consultant Community Paediatrician
Dr Brian Cooper	Consultant Gastroenterologist
Richard Steer	Local resident and patient
Musthtaq Mir	Local resident and patient
Janet Jerome	Local resident
Raghib Ahsan	Local resident
Chris Rickards	Unison branch secretary
Mr Bob Spychal	Consultant General surgeon
Mr Subooh Deshmukh	Orthopaedic consultant
Local GPs	

Wednesday 10th October

Cllr Deirdre Alden	Chair Birmingham Health Overview and Scrutiny Committee
Cllr Keith Barton	Birmingham Health O&S Committee Members
Cllr Rev Richard Bashford	Birmingham Health O&S Committee Members
Cllr Zaker Choudhry	Birmingham Health O&S Committee Members
Cllr Catharine Grundy	Birmingham Health O&S Committee Members
Darren Wright	Scrutiny Manager, Health O&S Committee
Richard Miles	Committee Link Officer
Elizabeth Rattlidge	Scrutiny Research and Policy Officer

Friday 12th October

Kam Dhami	Director of Governance
Mrs Luna Vishwanath	Consultant breast surgeon
Mr Ed Harper	Consultant upper GI surgeon
Mr Raghuram Deverajan	Consultant Urologist
Mr Satish Bhalerao	Consultant Colorectal surgeon
Peter Spilsbury	Director of Strategy and Regulation, SHA
Jonathan Cook	Programme Consultant – Market Management, SHA
Mr Philip Nicholl	Consultant vascular surgeon

Monday 15th October

Denise Mclellan	Director of Commissioning/ Deputy Chief Executive HOB PCT
Dr Nick Griggs	Medical Director, Sandwell PCT
Dr. Niti Pall	General Practitioner & PEC Chair
Tim Atack	Chief Operating Officer
Mrs Janet O'Connell	Consultant ENT Surgeon
Dr John Wingate	Consultant Radiologist/Divisional Director - Imaging
Dr Hugh Bradby	Medical Director
Craig Cooke	Locality Director WM Ambulance Service
Mr Neil Cruickshank	Consultant Colorectal Surgeon
Mr Hamish Brown	Consultant Breast Surgeon and SAU
Mike Beveridge	General Manager Surgery
Jane Hamblett	Matron Acute Care

Tuesday 16th October

Tim Jones	Chief Operating Officer, University Hospital Birmingham NHS Foundation Trust
Cllr John Edwards	Sandwell Overview and Scrutiny Committee
Cllr Anne Hughes	Sandwell Overview and Scrutiny Committee
Alison Barrett	Scrutiny Manager, Sandwell MBC
Rosemary Jones	Senior Democratic Services Officer, Sandwell MBC
Anne Gallagher	Patient
Susan Mayo	Colorectal CNS, Sandwell
Denise Pugh	Colorectal CNS, Sandwell
Yvonne Joyce	Nutritional and Dietetic Manager
Mr Atul Khanna	Consultant plastic surgeon
Mr John Clothier	Consultant orthopaedic surgeon
Dr Rob Watson	Consultant Cardiologist, Clinical sub-Dean for Undergraduate teaching
Philip Andrew	Head of Medical Staffing

Wednesday 31st October

Kevin Dunkley	Patient Network Support Group
Joseph Mills	Patient Network Support Group
Clive Hicks	Patient Network Support Group
Elizabeth Bell	Patient Network Support Group
Jennifer Butler	Patient Network Support Group
Beverley Turner	Patient Network Support Group
Alison Dayani	Birmingham Mail
Steve Dyson	Birmingham Mail
Dave Wood	Sandwell Council, Planning Policy Manager

Wednesday 7th November

Adrian Bailey	MP West Bromwich West
Gisela Stuart	MP Edgbaston

Appendix Eight

Information made available to the Panel

Supporting papers and correspondence submitted to the IRP

	Title
1.	Shaping Hospitals for the Future - Full Public Consultation Document
2.	Shaping Hospitals for the Future - Analysis of public consultation 20.22.06-16.03.07
3.	Towards 2010 Investing in a Healthy Future - Full Consultation Document
4.	Towards 2010 - Easy Read Document
5.	Towards 2010 - Partnership Board response
6.	Towards 2010 - Consultation Report
7.	SWBH Report to the IRP re interim reconfiguration proposals
8.	Letter to John Adler, SWB Hospital NHS Trust from Cllrs John Edwards & Pauline Hinton re Shaping Hospitals for the Future 15.02.07
9.	Letter to John Adler, SWB Hospital NHS Trust from Cllr Deirdre Alden re Shaping Hospitals for the Future Consultation 15.03.07
10.	Sandwell and West Birmingham NHS Trust Press Release – 'Trust plans to change after public consultation' – 04.05.07
11.	Trust Board Paper - Outcome and Way Forward 10.05.07
12.	Formal Response by the 2010 Partnership to the Public Consultation on the 2010 Proposals 10.05.07
13.	Referral letter to the Secretary of State for Health from Cllr Deirdre Alden HOSC re SWB referral 18.05.07
14.	Letter to Dr KG Taylor, City Hospital Supporters Group from Elisabeth Buggins, NHS West Midlands re Birmingham proposal 25.05.07
15.	Email to IRP from Dr Ken Taylor re Birmingham referral 04.06.07
16.	Letter to DH from Steve Coneys, NHS West Midlands re Birmingham referral 08.06.07
17.	Letter to Cllr Deirdre Aldren from Assistant to Secretary of State for Health on Sandwell & West Birmingham referral 08.06.07
18.	Letter to DH from Cllr D Alden enclosing Birmingham HOSC meetings minutes 14.06.07
19.	Letter to Secretary of State for Health from Dr K Taylor, City Hospital Supporters Group 23.06.07
20.	Letter DH from Steve Coneys, NHS West Midlands re Birmingham referral 04.07.07
21.	Letter to Secretary of State for Health from Dr K Taylor re Birmingham proposal 06.07.07
22.	Letter to Dr KG Taylor from John Adler, Chief Executive SWB NHS Trust 11.07.07
23.	Letter to Mr J Adler from Dr KG Taylor re City Hospital Supports Group Ballot 15.07.07
24.	Letter to Dr KG Taylor from Secretary of State for Health re Birmingham referral 16.07.07
25.	Letter to IRP from Secretary of State for Health requesting advice on Birmingham referral 16.07.07
26.	Letter to Cllr Deirdre Aldren from Secretary of State for Health on Sandwell & West Birmingham referral 16.07.07
27.	Letter to MPs from Secretary of State for Health re Birmingham proposal - 16.07.07
28.	Letter to DH from Steve Coneys, NHS West Midlands re Birmingham referral 16.07.07
29.	Email correspondence to IRP from Ken Taylor, Lead Spokesman for the City Hospital Supporters Group re Birmingham proposal 19.07.07
30.	Letter to IRP from Dr KG Taylor with Template Providing Information to the IRP about Contested Sandwell & Birmingham Reconfiguration 22.07.07

31.	Updated Template Providing Information to the IRP about Contested Sandwell & Birmingham Reconfiguration 02.08.07. Produced by Dr K Taylor City Hospital Supporters Group
32.	Letter to IRP from Secretary of State with Terms of Reference regarding Birmingham Referral 30.08.07
33.	Letter from Dr KG Taylor to Secretary of State re Sandwell & West Birmingham Referral - 24.07.07
34.	Letter from IRP to Secretary of State re Sandwell & West Birmingham Referral - 14.08.07
35.	Sandwell & West Birmingham Maps
36.	Healthcare Commission Annual Performance Ratings-Results SWBH 2005/06
37.	Letter from Cynthia Bower, West Midlands SHA, to J. Adler, SWBH, re: Consultation on Interim Reconfiguration Proposals-03.05.07
38.	IRP Submissions Template SWBH-14.09.07
39.	Sandwell & West Birmingham Hospitals NHS Trust-Our Strategic Direction 2007-2014
40.	Letter from Alan Addison, DH, to Dr K Taylor re Sandwell & West Birmingham Referral-19.09.07
41.	Email from Susan Green, Grove Residents Association, re SWBH Referral-20.09.07
42.	Email from N Shah re SWBH Referral-24.09.07
43.	Email from Pauline Brough re SWBH Referral-24.09.07
44.	Email from Ann Gallagher re SWBH Referral-26.09.07
45.	Email from Linda Freakley re SWBH Referral-27.09.07
46.	Surgical Reconfiguration Stocktake-March 2007
47.	Surgery Steering Group: Interim Reconfiguration Surgery Option Appraisal-16 April 2007
48.	Consultant Surgeons at Sandwell & West Birmingham Hospitals-Sept 2007
49.	City & Sandwell Hospitals: General Surgery Admissions by Admission Hour-2005/06
50.	SWBH Emergency Surgery Admissions by top 20 HRGS-2006/07
51.	Sandwell & West Birmingham Hospitals: Consultant Surgeons as at Sept 2007
52.	Sandwell & West Birmingham Hospitals: Medical Rotas
53.	Sandwell & West Birmingham Hospitals: Inpatient Emergency Surgery Activity Flows-28.09.07
54.	Email from Richard Steer-02.10.07
55.	Sandwell & West Birmingham Hospitals: Combined SWBH Imaging Activity-2006/07
56.	Sandwell & West Birmingham Hospitals: Surgical Interim Reconfiguration-Clinical Risks 16.10.07
57.	Sandwell & West Birmingham Hospitals: Infection Control Issues associated with Reconfiguration-19.10.07
58.	Sandwell & West Birmingham Hospitals: Characteristics of Patients directly affected by Reconfiguration-19.10.07
59.	Sandwell & West Birmingham Hospitals: Summary of Patient Benefits-19.10.07
60.	University Hospital Birmingham-Divisional Structure
61.	Preserving Emergency Surgery at City & Sandwell Hospitals: The Surgical View (by Bob Spychal, Consultant Surgeon, SWBH)
62.	The Royal College of Surgeons of England: Separating Emergency & Elective Surgical Care-September 2007
63.	Letter from Y Cooper, Parliamentary Under Secretary of State, to Richard Steer, City Hospital, re proposal to merge Sandwell & City Hospital NHS Trusts-08.03.02
64.	Sandwell Metropolitan Borough Council: Smethwick Area Action Plan Submission Document-October 2007
65.	Sandwell & West Birmingham Hospitals: Inpatient Emergency Surgery Patient Flows-

	October 2007
66.	Various articles from local newspapers
67.	City and Sandwell Hospital Demand Patterns for surgery and trauma and orthopaedics
68.	Inpatient emergency surgery activity flows summary
69.	External Expert Review: Interim Configuration Project Professor Sir John Temple July 2006
70.	Email from Steve Sturman re SWBH referral 20.10.2007

Responses to the IRP enquiry line (emails, phone calls, letters)

71.	Richard Steer, no address given
72.	Waseem Ulfat, Aston
73.	Barry Clewer, Handsworth Wood
74.	Clive Hicks, no address given
75.	Ann Gallagher, no address given
76.	Dr K R Vincent, no address given
77.	Derek Rickard, no address given
78.	Linda Adshead, no address given

Appendix Nine

Members of the IRP Panel

* subgroup members that took a lead for this review

Chair

Peter Barrett	Chair, Nottingham University Hospitals NHS Trust Former General Practitioner, Nottingham

Members

Cath Broderick	Independent consultant for involvement and consultation
Sanjay Chadha	Trustee, Multiple Sclerosis (MS) Society Justice of the Peace
Ailsa Claire	Chief Executive, Barnsley Primary Care Trust Chair/Manager, Yorkshire and Humber Specialist Service Consortia
Nicky Hayes	Consultant Nurse for Older People at King's College Hospital NHS Trust Clinical Director of the Care Homes Support Team
Brenda Howard	Director of Strategic Development, East Midlands Strategic Health Authority
Nick Naftalin	Emeritus Consultant in Obstetrics and Gynaecology at University Hospitals of Leicester NHS Trust Former member of the National Clinical Governance Support Team
*John Parkes	Chief Executive, Northamptonshire Teaching PCT
Linda Pepper	Independent consultant for involvement and consultation Former Commissioner, Commission for Health Improvement
*Ray Powles	Head Haemato-Oncology Parkside Cancer Clinic, London. Former Head of Haemato-oncology, Royal Marsden Hospital
Paul Roberts	Chief Executive Plymouth Hospitals NHS Trust
*Gina Tiller	Tutor for the University of Northumbria and for the TUC Chair of Newcastle PCT
Paul Watson	Director of Commissioning, East of England Strategic Health Authority

Support to the panel

Tony Shaw	Chief Executive
Martin Houghton	Secretary
Keith Ford	Advisor to the Panel
Becky Farren	Review Manager

Appendix Ten

About the Independent Reconfiguration Panel

The Independent Reconfiguration Panel (IRP) offers advice to the Secretary of State for Health on contested proposals for NHS reconfigurations and service changes in England. It also offers informal support and generic advice to the NHS, local authorities and other interested bodies in the consideration of issues around NHS service reconfiguration.

The Panel consists of a Chair, Dr Peter Barrett, and members providing an equal balance of clinical, managerial and patient and citizen representation.

Further information about the Panel and its work can be found on the IRP Website:

www.irpanel.org.uk