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**SHROPSHIRE COUNCIL,TELFORD & WREKIN COUNCIL**

**JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE**

**Minutes of the meeting of the Joint Health Overview and Scrutiny Committee held on Tuesday 5 December 2017 3.00 pm – 4:50 pm in The Arthur Rowley Suite, Shrewsbury Town Football Club**

**Members Present**:

Shropshire Councillors: Karen Calder (Co-Chair), Madge Shineton
Telford and Wrekin Councillors: Stephen Burrell
Shropshire Co-optees: David Beechey, Mandy Thorn
Telford and Wrekin Co-optees: Carolyn Henniker, Hilary Knight

**Officers Present:**
Tom Dodds, Statutory Scrutiny Officer, Shropshire Council
Fiona Ellis, Programme Manager, Shropshire and Telford and Wrekin, Local Maternity System
David Evans, Chief Officer Telford & Wrekin CCG; Senior Responsible Officer, Future Fit
Amanda Holyoak, Committee Officer, Shropshire Council (minutes)
Simon Freeman, Accountable Officer, Shropshire CCG
Niki McGrath, Senior Communications and Engagement Manager, NHS Future Fit Programme
Jessica Tangye, Senior Democratic and Scrutiny Services Officer, Telford & Wrekin Council
Rod Thomson, Director of Public Health, Shropshire Council
Debbie Vogler, Future Fit Programme Director
Simon Wright, Chief Executive, Shrewsbury and Telford Hospital Trust

## 1. Apologies for Absence

Apologies were received from Councillors Andy Burford and Rob Sloan, Telford and Wrekin Council, and from Councillor Heather Kidd, Shropshire Council. Apologies were also received from Telford Co-optee Dag Saunders and Shropshire Co-optee Ian Hulme.

## 2. Disclosable Pecuniary Interests

Mandy Thorn declared that she was Managing Director of a care company providing nursing and dementia services in Shropshire with clients also from Powys and Telford and Wrekin. Councillor Stephen Burrell declared that he was co-director of an independent provider of domiciliary and end of life care services in Shropshire, Telford and Wrekin and Staffordshire.

## 3. Minutes

The minutes of the meeting held on 2 November 2017 were confirmed as a correct record.

The Chair drew attention to a reference in the minutes to GP streaming and asked when an evaluation of the scheme would be made available to the Committee. The Chief Executive of SaTH said that a report would be prepared after 6 months of operation and this would be made available to the Committee in April 2018.

## 4. Sustainability of Services

The Chair requested that for future meetings the Committee receive a brief report in advance of the meeting on the sustainability of services. The Chief Executive of SaTH confirmed that it would be possible to provide standard papers which were produced for Trust Board meetings on this subject.

The Chief Executive provided a brief update on the position in fragile service areas since the last meeting of the Committee held on 2 November 2017. He confirmed that two opthalmologists had been recruited and that an advert for the single post would go out in the next two months. Progress was expected within the next week with regard to the new hub and spoke model for ophthalmology, subject to approval by both Commissioners. 1 April 2018 was the provisional date for introduction of this model.

Other services reported on at the last meeting were no longer deemed to be fragile, apart from Accident and Emergency Services.

The Chair confirmed that the Winter Plan had been received by the Co-Chairs and apologised to the Committee that this had not been more widely circulated. She asked in what ways this Winter Plan was different to previous winter plans.

The Chief Executive said all health and care organisations within the STP grouping had been involved in its production, including both Councils. Surgical beds could be converted into medical beds and planned surgical activity was reduced for the first three weeks of January. The number of doctors, nurses and pharmacists had been increased in addition to 7 day working but the focus was much more on better utilisation and prevention rather than increasing capacity. Focus was on reducing length of stay even further and SaTH was third best performer in the region for respiratory.

A Member of the Committee commented that the private sector had not been involved in development of the Winter Plan and felt it did not reflect the full system across the STP area.

In response to a question the Chief Executive confirmed that the current bed occupancy rate was 97% which was fairly typical in the NHS currently. SaTH needed to reduce this to 85% before Christmas and would deploy a similar approach as had been used previously which required the whole system to operate in a different way.

Members asked why the Winter Plan had not been signed off until the end of November and suggested that the oversight of the Committee would have been more valuable earlier in the process. The Chief Executive explained that the process had started in April with the bulk of the work completed in July. It had to complete a series of steps required by NHSI and NHSE which were still going through but these involved just small immaterial changes.

In response to a question regarding winter funding contribution from Shropshire Council through the IBCF, the Chief Executive said that funding received towards winter pressures was spent in the most effective way. SaTH was looking at alternative ways to support patients to get home earlier, for example, through 'SaTH at Home'. This would reduce pressure on hospitals and result in less spend on expensive agency nurses and doctors and extra beds. In response to further questions he explained that SaTH At Home identified patients who were receiving largely physiotherapy services and with the support of another provider got them home up to 3 days earlier with therapy provided to them at home. He confirmed that these patients would be fit for discharge.

It was agreed to revisit this after the winter period particularly as the independent sector had not been involved. The Chief Executive said he would be happy to do this.

**5. Future Fit**

Members considered the following Future Fit documents:

- Pre-Consultation Business case
- Public Consultation document and summary document
- Future Fit Survey
- Consultation Plan
- Communications and Engagement Event Planner

The Chair said it would be useful to have a clear version number on the documents and it was confirmed that it was Pre Consultation Business Case version 31.

David Evans, Senior Responsible Officer, Future Fit provided an update. NHS England had now confirmed it was satisfied that it had received the information it had requested and some other points of clarification had also been provided for them. A decision was expected within the next week.

A formal letter was awaited from the West Midlands Clinical Senate but verbal feedback had indicated that there had been significant progress against the action plan developed to address concerns raised by the Senate.

The cover sheet provided with the report identified the changes made to documentation since last time and some feedback provided by the Joint HOSC and NHSE had been common. The executive summary now made the rationale for change clearer, as did information regarding individual patients and key tables describing the bed changes. (Table 20a and 20b page 111). A revised timeline was also included.

The outstanding work on ambulance modelling (page 121) would be completed in the new year.

Both Future Fit Senior Responsible Officers commented that the whole NHS process has been opaque and laborious and the vast majority of recent changes were largely cosmetic and not material. Confusion around bed numbers had stemmed from multiple definitions of what a bed was as NHSE had insisted on a certain definition. They apologised for this confusion but said the number of beds had not changed since the original PCBC and there had been no changes to community models. Planning had been undertaken on all beds including escalation beds, this was different from the number of beds in a hospital.

Responding to questions from the Committee, it was confirmed that chairs and trolleys were not counted as beds. The Chief Executive, SaTH, went on to explain that a patient might be in a bed but then move on a subsequent day for treatment on a trolley or chair. This helped prevent conditioning to an admission and could be a more effective way of keeping patients independent and able to go home. More beds cost more to staff and run and a small bed base run efficiently would be better for the Trust.

The Chair said the Committee was still struggling to understand the tables on page 111 of the PCBC, where there was no mention, for example, of paediatric or maternity beds. The Senior Responsible Officer, Shropshire CCG asked the Committee what assurance it required that bed numbers were right.

The Chair referred to reduction in staffing levels. The Chief Executive of SaTH explained that there could be many reasons for different levels of staffing especially as there were two on call rotas for emergency services over the two sites resulting in a need for more staff. Introduction of different models of care allowed a hospital to admit less patients into an in-patient setting, this meant that the nature and concentration of staff would change with more staff getting in front of problems e.g. respiratory and heart failure, more so in the community setting. This meant there was not a need to increase bed numbers.

A member asked about beds in community hospitals and it was confirmed that these were not included in the PCBC which focused on acute beds. There were community and private beds some of which were step up and some step down, and some rehab. The CCG was reviewing these at the moment so that a case for change could be presented to CCG Boards.

It was agreed that the case for change for Community Services would be presented to the Committee once available.

A member asked about conditions for baselining the plan. There was no baseline as such, activity assumptions, bed numbers, and finances had been iterative as the Future Fit process had been progressed. The bureaucratic nature of the process meant that the draft document would have to go through many revisions. A more fixed point would come at the point of sign off of the Outline Business Case.

Members went on to question the demographic assumption of 2.8% growth. As part of the Marches LEP, Shropshire and Telford and Wrekin were looking for housing growth which would produce much more than the 2.8% growth that the PCBC anticipated over 5 – 10 years.

Mr Freeman reported that health economies were funded each year according to a population adjustment and demographic growth was identified through a national standard calculation.

A Committee Member said that a particular challenge for Shropshire was that it had traditionally been seen as a low growth area but with growth in older people. Both Shropshire and Telford and Wrekin were seeking to grow the whole population and there would be significant housing growth. Would these increased needs be recognised by the Health and Care economy.

The Committee heard that it was a statutory requirement on Councils to undertake an annual Joint Needs Assessment in partnership with CCGs. The Director of Public Health, Shropshire Council, confirmed that both local authorities regularly updated the Joint Needs Assessment which took into account both national and local data.

The Chief Executive, SaTH, referred to the Community Infrastructure Levy (CIL) and said the Trust would be interested in how that additional funding would enter the system and support infrastructure.

Mr Evans reported that Commissioners wished to work more closely with Local Authorities in areas such as leisure and education in order to develop a healthier population over the long term. Telford and Wrekin had a significant childhood obesity problem which if not addressed would manifest itself as a major demand on services in 30 – 40 years' time. A joined up approach between health and local authorities would be needed, and more investment was needed to help make people make healthy choices. The Chair commented that this impacted on the commissioning decisions of all partners.

*Consultation Document*

The Senior Communications and Engagement Manager, Future Fit Programme said that comments made by the Joint HOSC, CCGs, Telford and Wrekin Council, Consultation Institute and NHS England had been taken on board to form the latest version of the consultation documents.

It had been requested that more prominence be given to the reasons for the preferred option and this now featured on page 6 of the main document. The changes made in the main consultation document were also reflected in the summary version.

A member of the Committee said that transparency was fundamental to the consultation document and the reasons for the preferred option 1 needed to be made extremely clear. There appeared to be some inconsistencies in the chart on page 29 and 30 which were repeated in the consultation document.

The Committee heard that four reasons had now been added for the preferred option 1, and a member asked for assurance that those were the basis of the preference as the Stakeholder Panel selecting this option had received the information to base decisions on and the Committee had not seen this. She felt that the integrity of the document would be compromised unless there was reasoning behind the choice for option 1.

Mr Freeman said that a three year process had led to the preferred option, and it had been agreed by a Programme Board which had represented all stakeholders including health and

local authorities. Mr Evans added that a stakeholder panel of 51 people had received the evidence, and assumptions around why individuals had scored the way did could not be made. The Programme had drawn on the combined scores of this Panel. An Independent Review had been commissioned following queries around this process, and it had been assessed as robust.

The Chair said that that it was accepted that we are where we are but a new member of the Committee wanted an explanation of the process and the detail provided and some members of the public would want that too.

The Future Fit website was currently being updated to make it more accessible and it was agreed to provide Appendix 12 to the PCBC to a Member requesting it.

A Member asked about the financial projection period as 60 years seemed a long time. Mr Freeman said that this was standard Treasury Guidance. Another member asked about a fact finding visit to Northumberland and asked if he could be given sight of the reasons for rejecting this approach.

The Senior Responsible Officers explained the process of development of a long list of options and then short list. One option considered in long list process was a single sight between Shrewsbury and Telford and they offered to provide the analysis leading to it being ruled out.

The Chair commented that the one site in Northumberland had featured significantly in the press as a potential option, it was not a question to answer now but reasons for its rejection should be made clear through the consultation process

Mr Freeman said that he did not agree with this, as the Future Fit Programme process had been progressed correctly. The Northumberland model had not been properly costed and was not relevant to Shropshire. The Chair asked how this would be responded to if it was raised as a proposal through the consultation process. Mr Freeman said that Future Fit was not consulting on that option – which had been on the long list. The process would not now be stopped to re-evaluate that option after a four year process which had led to this point. The Chair queried how responses would be made to the consultation.

*Consultation Plan*

The Chair said there were a number of questions around the consultation plan and the Committee was informed that the activity planner provided was a draft. Members asked if it was likely to go live before Christmas and heard that this was dependent on the timing of the decision from NHS England.

The Chair said she felt the consultation plan should be a wider and broader ranging document. She reported that there had been no conversations as yet with Shropshire Council as to how the process would fit in to Council business. At the moment the document inferred that arrangements had been made when they had not been.

Members were informed that the plan was still being built but it was difficult not knowing when day 1 of the consultation would be. It would be important to hit the right meetings at the right time and the plan for sharing and engaging was still open for comment.

A Member of the Committee said there would be an opportunity to engage with local Town Chambers of Commerce across Telford, Shropshire and Powys. She also emphasised the need to reach hard to reach groups, and recommended Age Concern, Age UK and the National Farmers Union as a means to do this. There were many different groups which were not referenced on the list which needed to cover a much wider scope than usual.

The Programme Director thanked the Committee for the suggestions and said that the list before the Committee was not meant to be exhaustive and encouraged anyone to make suggestions for addition.

In response to a question about the order of the consultation document, the Programme Director said that the full document could take up to 40 minutes to be read thoroughly and followed advice on layout from the Consultation Institute. The summary easy read version would also be available. The Questionnaire was located in the centre of the document so that it could be pulled out.

There would be large public exhibition events, and signposting to more information and multiple copies of both versions of the consultation document. It was confirmed that the consultation documents would be made available to Healthwatch and there would be very large runs made of these documents.

**6. Shropshire, Telford & Wrekin Midwife Led Unit Service Review**

Fiona Ellis, Programme Manager, Shropshire and Telford and Wrekin Local Maternity System, provided an overview of the review to date and the next steps planned. The first phase had been a desk top exercise review of local and nationally available information. The second phase had involved engagement with women who had used or were currently using midwife led services, staff in those areas and others, to gather new information about those services. Phase 3 involved bringing that information together and discussing future models of care. Proposals would be presented to Shropshire CCG in December and Telford and Wrekin CCG in January.

This was an early briefing on the proposed service model to keep the Committee informed of developments. Members heard that the model included at least five maternity hubs available for at least 12 hours a day for midwife led care – in Telford, Shrewsbury, Oswestry, Bridgnorth and Ludlow. Access and support would be available from a midwife for 24 hours a day, seven days a week, to include a triage service for women in labour, to help them get to their chosen place of birth on time.

It was proposed that the same types of services would be available at each maternity hub and these would be broader than those currently available including: Antenatal care from a midwife and support from women's services assistants; Planned antenatal appointments with an obstetrician; Scanning and foetal monitoring; antenatal day assessment, support with emotional wellbeing and mental health; support with long term conditions during pregnancy; healthy lifestyle services including smoking cessation and weight management

services; information and advice about pregnancy and parenthood and information and advice about birth options.

Births would be available at the Consultant led Unit at Princess Royal Hospital, the alongside midwife led unit at Princess Royal Hospital, the Freestanding midwife led unit at Royal Shrewsbury Hospital and Home Birth. The choice of birth settings would also include places over the Shropshire border, which may be more convenient for those living on the edges of the county.

Community Midwives and Women's Support Assistants would be available 24/7 with services available at the five hubs including postnatal care from a midwife - Support and advice from women's services assistants with regards to baby care; newborn checks and screening ; Drop-in service or planned access during a 12 hour period; a space for women and their families to reflect on the birth experience ; support with emotional wellbeing and mental health; support with confidence building and bonding ; support with feeding; support with long term conditions postnatally; healthy lifestyle services; information and advice about parenthood including postnatal groups, infant feeding, baby care and life skills such as budgeting and cooking and peer support. Inpatient postnatal stays would be available on Princess Royal Hospital postnatal ward for women who needed it.

A number of members of the Committee had attended the engagement workshops and observed that it was not meant to be a levelling down process, but one of levelling up of antenatal and postnatal services. It was hoped that the CCG Boards would consider where the gaps were, particularly in the North East of Shropshire where there would not be a hub. A strong and clear vision would be needed.

Members asked about the impact of proposals on resources, and whether they would prevent outreach services closing when staff were off sick. Members were informed that it was intended that the new model would be more sustainable than the current one, and this had been one reason for the review.

The Chair reported that she had attended an engagement workshop where it was obvious that services were under extreme pressure and only standing due to the good will and professionalism of those delivering them. The time for a review was right and the Committee looked forward to future briefings.

## 7. Sustainability and Transformation Plan (STP)

The Committee had been circulated with a summary of progress in regard to delivery of the STP Programme Development & Delivery.

Members asked for further detail about Neighbourhood Work and about the review of Minor Injuries Units, DAARTs and Community Hospitals. This was an ongoing process and the committee would be kept informed, there was not anything to propose yet. Any new models accepted by CCG Boards would be subject to consultation.

Members urged that more linkages be made with the Voluntary and Community Sector and Independent Sector, working jointly would help deliver solutions. They also questioned work on technology and connectivity and whether opportunities were being taken up. Members heard that the Independent Sector was currently working with NHS digital. Mr Wright agreed to look into the status of Shropshire Partners in Care in the STP.

A Member said that the public found it confusing that investment continued to be made at both hospitals for urgent care facilities. Mr Wright said SATH continued to invest in both hospitals, facilities were currently inadequate for patients at PRH. There would remain urgent care solutions on both sites which would need an appropriate environment.

If additional funding or staffing could be secured, SATH would do that, irrespective of Future Fit.

Members asked about Mental Health. It was confirmed that the Chief Executive of SSSFT attended the STP Board. The CCGs would be happy to bring the five year forward view on Mental Health and on Primary Care to a future meeting of the Committee.

The Chair confirmed that the STP would become a regular agenda item for the Committee and that it was exploring more ways to be involved.

The Chair thanked NHS colleagues for attending the meeting. She had received some questions from members of the public in regard to Future Fit and would be forwarding these on for a response.

Chair: _____

Date: _____