Shropshire Council

Date: Thursday, 10 May 2018

Time: 2.30 pm

Venue: The Wakes - The Wakes, Oakengates, Telford TF2 6EP (opposite Oakengates Theatre 'The Place'

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JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

TO FOLLOW REPORT (S)

3 Minutes (Pages 1 - 6)

To confirm the minutes of the Joint Health Overview and Scrutiny Committee held on 6 March 2018 (attached marked: A) and 22 March 2018 (to follow)

Minutes of 22 March 2-18 attached

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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 Thursday 22 March 2018 2.00 pm – 3.40 pm in the Shrewsbury Room, Shirehall, Shrewsbury

Members Present:

Shropshire Councillors: Karen Calder (Co-Chair), Madge Shineton
Telford and Wrekin Councillors: Andy Burford, Stephen Burrell
Shropshire Co-optees: David Beechey, Ian Hulme
Telford and Wrekin Co-optees: Hilary Knight, Dag Saunders

Members of Shropshire Health and Adult Social Care Overview and Scrutiny Committee:

Councillors Roy Aldcroft, Simon Harris, Paul Milner, Pam Moseley, Simon Harris, Paul Wynn

Ohers Present:
Fiona Ellis, Programme Manager, Shropshire and Telford and Wrekin, Local Maternity System
Adam Gornall, Clinical Director, Women & Children, Shrewsbury & Telford Hospital Trust (SaTH)
Amanda Holyoak, Committee Officer, Shropshire Council (minutes)
Sarah Jamieson, Head of Midwifery, SaTH
Dr Jessica Sokolov, Clinical Lead, Shropshire Clinical Commissioning Group
Anne-Marie Speke, Public Health, Shropshire Council
Julian Povey, Chair, Shropshire CCG
Jessica Tangye, Senior Democratic and Scrutiny Services Officer, Telford & Wrekin Council
Danial Webb, Scrutiny Officer, Shropshire Council

1. Apologies for Absence

Apologies were received from Councillor Heather Kidd - Shropshire Council, Mandy Thorn – Shropshire Co-optee, Councillor Hilda Rhodes -Telford and Wrekin Council, and from Carolyn Henniker – Telford and Wrekin Co-optee.

2. Disposable Pecuniary Interests

Members were reminded that they must not participate in the discussion or voting on any matters in which they have a disclosable pecuniary interest and should leave the room prior to the commencement of the debate.

3. Minutes of the last Meeting

It was noted that the minutes of the meeting held on 3 March 2018 would be presented to the next meeting of the Committee for approval.

4. Shropshire, Telford and Wrekin Midwife Led Unit Service Review

The Chair explained that members of Shropshire's Health and Adult Social Care Overview and Scrutiny Committee had also wished to scrutinise the midwife led unit service review and it had been agreed that members of that Committee could attend and ask questions at the Joint HOSC to avoid duplication of effort.

Fiona Ellis, Programme Manager, Shropshire and Telford and Wrekin Local Maternity System, Adam Gornall, Clinical Director – Women and Children (SaTH), Jessica Sokolov, Clinical Lead, Shropshire CCG and Sarah Jamieson – Head of Midwifery – SaTH were welcomed to the meeting.

The Clinical Lead provided a presentation (a copy is attached to the signed minutes) which set out: why the review had been necessary; the three-phase process involved in designing the service; the proposed service model for pre-pregnancy, pregnancy, birth, and postnatal; and the next steps for the review.

During the following discussion members asked questions relating to:

The number of proposed maternity hubs – the presentation had referred to 'at least five'.

In response, the Clinical Lead said it was known that five hubs were sustainable and would provide a service that women and staff could rely on and trust.

Would there just be one maternity hub in Telford, in an area where population was rising and there was deprivation, particularly south of the M54. Had thought been given to access to a maternity hub at Princess Royal Hospital – when for many in Telford this could involve three bus journeys? If the Women's and Children's Unit moved to Shrewsbury post Future Fit when the population was rising in Telford, an area of deprivation, had these access factors been considered?

It was confirmed that there was an expectation that hubs would provide outreach support to respond to local needs if there was an issue around accessing a hub. The proposal was for provision of a maternity hub in Telford with outreach, so that all could access services.

The Clinical Director, Women & Children, said that areas of deprivation were recognised, particularly south of the M54. Most contact in pregnancy was during the antenatal period and currently 2 days of scanning was provided a week in Sutton Hill. A hub and spoke model would lead to strengthening of antenatal care and access provided south of the motorway.

If the outcome of Future Fit was to move the Women and Children's Unit than location of birth was the issue of hadn but most travelling was in fact related to antenatal and postnatal care rather than the birth itself. Unfortunately Shropshire did not quality for NHS sparsity money and good planning was essential so that women

would get a better deal. Dr Povey added that it would not be possible to pre-judge the outcome of Future Fit.

If services were being 'levelled up' why was there still no provision of a hub in the North of Shropshire?

The Chair referred to page 21 of the document presented to CCG Boards. The Clinical Lead said that this map illustrated what was currently provided and the new model would change that so that each hub would provide the same service and outreach would be designed around the needs of communities.

What was happening to the midwives currently located at Whitchurch, was there to be any change in service provision?

The Chair referred to rumours that two midwives located at Whitchurch Community Hospital were to be relocated to Oswestry. The Head of Midwifery explained that the midwives themselves were moving their base from Whitchurch to Oswestry and the reasons for it, however, the service provision would not change in the north of the county. Women would still be able to see a midwife locally but these midwives would start their day from a different base.

Were the proposals in line with the Better Births report?

The Clinical Lead referred to the four free standing units which were currently not used well. The future default would be for a midwife led setting with a decision on location of birth to be made later in pregnancy. The Clinical Director, Women & Children, added that Better Births was a broad document for application across the whole country. It was unusual to have freestanding MLUs, many areas had none or alongside consultant led units only. There had been a definite trend of desire for security around the birth but still a demand for a midwife led delivery. The guidance followed by Obstetricians meant more inductions, and more scans could lead to higher anxiety levels. The Programme Manager reported that additional scans and monitoring could be done at hubs. The midwife led unit proposals were absolutely in line with Better Births and would increase the number of midwife led births.

Reference was made to para 5.29 of Better Births regarding the need to address the difficulties for very remote localities in sustaining obstetric services. The Clinical Lead confirmed that Shropshire CCG had not been deemed sparse enough to receive the 'sparsity adjustment' into the funding formula used to allocate CCG budgets.

How was the local maternity system working together to deliver maternity transformation, and who was driving this, who made up the Local Maternity System.

It was confirmed that the CCG was legally responsible for the transformation. The Local maternity system had a programme board comprised of SC, CCGs, T and S service providers, service users – maternity voices, WMAS, neo-natal and mental health representatives. Under that programme board there were delivery groups for each of the six workstreams.

Why had staff morale been so low, were staff fully engaged with the model proposed?

Members referred to the reports of staffing issues and issues around some midwifes not feeling supported; with potential friction between consultant led units and maternity led units. At some of the pre-modelling workshops that members had attended, evidence and input from midwifes had been hard to hear and it had appeared that the service was only running due to their professionalism. Members asked what was going to be done to address this.

The Clinical Lead said that staff engagement would lead to better patient care. Part of the reason staff were unhappy was due to the pressure they were under. The Head of Midwifery reported that the way the service was provided in Shropshire had changed significantly in terms of numbers. There had been a shift in where services were being provided from, some undoubtedly had chosen the Consultant Led Unit whereas others had clinically needed it. This had led to the need to distribute staff differently and there had to be a robust escalation policy to ensure staff were in the right place to support labour. Prior to the suspension of inpatient services, suspensions had been on an ad hoc basis, sometimes in the middle of the night, which was inappropriate and not a sustainable service. To increase morale midwives needed clarity and they fully supported the direction of travel. They wanted more than anything for clarity as to where would be providing midwifery led care from.

What would be the impact on provision of health visitors when public health funding came to an end?

This was an issue for the local authorities but the best would be made of resources available.

What would 24-hour community care consist of?

It was confirmed that the proposal provided for the availability of a phone call, video link or fact to face contact, depending on what the mother wanted, 24 hours a day.

How was recruitment progressing?

The Head of Midwifery reported that there had been deficits last year but recruitment into band 6s, band 7s as well as newly qualified midwives had been successful and the Trust was now recruited to template. There was also a forward plan for recruiting every year into a preceptorship programme for newly qualified midwives. Attrition and turnover was being managed well, however, sickness rates were not going so well with up to 6.7% which was difficult to manage and had led to suspension of services and ad hoc suspension of services with only a few hours notice. Other issues included maternity leave which was currently at 12% and this meant nearly 19% of the workforce was being backfilled by overtime, in the context of 98% of women giving birth at Royal Shrewsbury Hospital or Princess Royal Hospital since 1 January. Stress figures had been increasing which was directly linked to morale in service, the number of suspensions and being asked to move location at short

notice. Staff were passionate about midwifery but desperately wanted clarity about where they were working.

Why had the trend in giving birth in consultant led units increased so much – was it a result of the uncertainty around whether midwifery led units might close at short notice resulting in a self-fulfilling prophecy, when people in fact said that they preferred midwife led units which felt less pressured and closer to home.

The Clinical Lead agreed that the uncertainty over the last 2 years had impacted on people's choices, but the way women were making their decisions in Shropshire was not different from the rest of the country and mirrored a national trend. Implementation of the proposals would increase midwife led births, maintain the full range of births and improve access to antenatal care.

There would always be some concern about travelling to have a baby as Shropshire was a big county and a good triage service was needed. However, most antenatal contact would be more local. It would never be possible to achieve a perfect system but it was possible to make the best use of resources available. A system was needed to reflect that few babies were born in the stand alone midwife units and staffing an empty building was not the best use of resources.

The Co-Chair questioned what the useage of midwife led units would be if they were reliably staffed. The Clinical Lead said that unfortunately high profile sad cases over the last decade had impacted on people's confidence and changes in NICE guidance meant that what would previously have been deemed low risk was now rated medium.

The Clinical Director reported that in 2013, 13% of women had a caesarean section but that this figure was now at 19%. He could not say why this had happened but it was likely to be linked to a change in demographic of those giving birth and changes in guidance on how to work. He added that a Birth Options Clinic had been introduced in January 2018 to provide information and help manage an increase in the number of caesarean sections for no obvious reason.

What input had West Midlands Ambulance Service had into the proposals?

It was confirmed that WMAS now had a midwifery lead and were well engaged in the broader maternity system and work was undertaken with them regularly to ensure pathways all worked as well as they could.

Would there be a clear pathway between Shropshire services and out of county services?

Work was underway to build better links with other areas bordering Shropshire with discussions to improve cross border pathways. At present, Shropshire women had a handheld record whilst some neighbouring areas had electronic records. There was a workstream on digital technology so that information could be shared more easily in future.

Was choice really an illusion, would there be enough capacity to facilitate home births, could that choice be supported?

There was a need to make sure that women had a real informed choice, with the vast majority in Consultant Led Unit a clinical need to be there. This was a key element of work in the broader maternity system – to ensure genuine choice.

The Head of Midwifery added that the service was staffing the birth itself rather than a location or a building. To truly follow women the service would support demand wherever possible depending on risk. A lot of work had been completed on capacity and the proposal would deliver the service needed.

How did the NHS Assurance process work; when would the Clinical Senate be involved; when was the proposal likely to come to consultation?

The Clinical Senate was part of the NHS Assurance process, proposals would go to the clinical senate where clinicians would check whether proposals would offer safe and appropriate care. The Senate report would be made to the Programme Board and then be made public.

Members asked if it was likely that a consultation might run at the same time as the Future Fit consultation. Advice on this was being taken from NHS England and the Consultation Institute.

Where does the Joint HOSC fit in particularly around the consultation plan.

The Clinical Lead said the Programme Team would oblige any requirements from the Joint HOSC and would endeavour to keep the Chairs in touch with progress.

The Committee thanked NHS colleagues for the presentation and honesty and candour in responding to questions.

The meeting concluded at 3.40 pm.

Chair: _____

Date: _____