Shropshire Council
Legal and Democratic Services
Shirehall
Abbey Foregate
Shrewsbury
SY2 6ND

Date: 25 October 2017

Committee:
Joint Health Overview and Scrutiny Committee

Date: **Thursday, 2 November 2017**
Time: **2.00 pm**
Venue: **The Wakes - The Wakes, Oakengates, Telford TF2 6EP (opposite Oakengates Theatre 'The Place')**

You are requested to attend the above meeting.
The Agenda is attached

Claire Porter
Corporate Head of Legal and Democratic Services (Monitoring Officer)

Members of Joint Health Overview and Scrutiny Committee

Shropshire	**Telford and Wrekin**
Cllr Karen Calder (Co-Chair)	Cllr Andy Burford (Co-Chair)
Cllr Heather Kidd	Cllr Stephen Burrell
Cllr Madge Shineton	Cllr Rob Sloan
David Beechey (Co-optee)	Carolyn Henniker (Co-optee)
Ian Hulme (Co-optee)	Hilary Knight (Co-optee)
Mandy Thorn (Co-optee)	Dag Saunders (Co-optee)

Your Committee Officers are:

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AGENDA

1 Apologies for Absence

2 Disposable Pecuniary Interests

3 Minutes (Pages 1 - 12)

To confirm the minutes of the meeting of the Joint Health Overview and Scrutiny Committee held on 25th September 2017. (Appendix A)

4 Update on the Fragility and Sustainability of Clinical Services provided by SaTH including Accident and Emergency Services

To receive a verbal update from the Chief Executive of SaTH

5 Update on the Future Fit Consultation Plans and Consultation Document (To Follow)

To receive a report for the Future Fit Programme Director and the Accountable Officers of Shropshire and Telford & Wrekin Clinical Commissioning Groups (Appendix B)

6 Co-Chairs' Update

Joint Health Overview and Scrutiny Committee	Item Public

MINUTES OF THE JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE MEETING HELD ON 25 SEPTEMBER 2017
3.00 PM – 6.02 PM

Responsible Officer: Amanda Holyoak
Email: amanda.holyoak@shropshire.gov.uk Tel: 01743 252718

Members Present:
Shropshire Councillors: Karen Calder (Co-Chair), Heather Kidd, Madge Shineton
Telford and Wrekin Councillors: Andy Burford (Co-Chair), Stephen Burrell and Rob Sloan
Shropshire Co-optees: Ian Hulme
Telford and Wrekin Co-optees: Hilary Knight, Dag Saunders

Also Present:
Tom Dodds, Statutory Scrutiny Officer, Shropshire Council
David Evans, Chief Officer Telford and Wrekin CCG &Senior Responsible Officer, Future Fit
Julie Davies, Director of Performance and Delivery, Shropshire CCG
Deirdre Fowler, Director of Nursing Midwifery & Quality
Debbie Kadum, Chief Operating Officer, SaTH
Amanda Holyoak, Committee Officer, Shropshire Council (minutes)
Rod Thomson, Director of Public Health, Shropshire Council
Jessica Tangye, Senior Democratic and Scrutiny Services Officer, Telford & Wrekin Council
Phil Evans, Future Fit Programme Director
Sam Tilley, Director of Corporate Affairs, Shropshire CCG
Simon Wright, Chief Executive, Shrewsbury and Telford Hospital Trust

1. Apologies for Absence

Apologies were received from David Beechey, Carolyn Henniker and Mandy Thorn

2. Disclosable Pecuniary Interests

Councillor Madge Shineton reported that she was a member of Health Concern.

3. Minutes

The minutes of the meeting held on 7 March 2017 were confirmed as a correct record.

4. Sustainability of Services

Simon Wright, Chief Executive, Debbie Kadum, Chief Operating Officer and Deirdre Fowler, Director of Nursing and Midwifery and Quality, Shrewsbury and Telford Hospital Trust were welcomed to the meeting.

The Chief Operating Officer introduced the report circulated to members (copy attached to signed minutes) which provided an update on Accident and Emergency, Ophthalmology, Dermatology, and Spinal Service. These were services currently provided by the Trust which were considered fragile due to workforce constraints. A separate report had been circulated in relation to neurology.

The Committee emphasised that it would wish to be notified immediately if a further consultant were to resign and the tipping point reached where it became necessary to implement the Service Continuity Plan.

The Committee also asked for more detail in relation to the following statement at 1.3 of the report "Nurse staffing levels, whilst not in itself a reason to close an Emergency Department, are also a concern due to the level of vacancies and agency cover. Currently the permanent and temporary gaps are the highest the Centre has seen". Members heard that there were 10 nursing vacancies at Princess Royal Hospital (PRH) and 5 vacancies at Royal Shrewsbury Hospital (RSH)

Members referred to the difficulties in recruiting consultants, middle grade doctors and nurses, particularly in the Emergency Department, and asked how much of this was due to the failure to implement Future Fit as opposed to national workforce difficulties.

The Chief Executive explained that Major Trauma Units employed a large number of the total emergency consultant workforce. He was aware of six emergency consultants who lived in the county who would be interested in working for SaTH once a Future Fit decision had been made. Middle grades were more of a national issue and a meeting was being arranged with NHS England to express concern about this. A workshop was also to be held to consider University Hospitals Leicester approach to recruiting middle grades.

Ophthalmology, Dermatology and Neurology were all areas of national shortage and there were not enough training posts to fill vacancies. This had made it increasingly difficult for smaller units to recruit as many wished to work in large tertiary centres.

The Co-chair commented that the future for sustaining services in the county appeared to be bleak but the Chief Executive said he did not agree with this. He reported that the backlog in ophthalmology was currently the smallest it had ever been, patients had not been inconvenienced in dermatology although the configuration was not as robust as hoped for. Alignment of the spinal service with a specialist provider would improve stability. These had been areas of concern for over a decade and there was now a strong positive message for all partners.

Members asked about contingency planning particularly with regard to the oncoming flu season when the emergency department was already so stretched and fragile.

They had heard that even large neighbouring hospitals were also under pressure and asked if there would be any help available from them. It was confirmed that it was hoped that larger hospitals would provide outreach services to General District Services if they could. However hospitals were also feeling under pressure in relation to middle grade vacancies and faced other problems including meeting the four hour target due to delays in admitting.

In regard to the contingency planning, the Chief Operating Officer reported that the whole health economy Winter Plan had just been submitted to regulators. This included more resources at weekends, with all partners contributing in different capacities.

Neurology

The Committee had received a report on Neurology (copy attached to signed minutes), an area which had been challenged for many years and had been closed to new referrals since March 2017. This was because it was not possible to follow them up in a timely way. Work was underway with commissioners on identifying what a future sustainable model might look like. There was a national workforce shortage in this area and much of the service was delivered through specialised nursing support. Neurological conditions tended to be long term with substantial follow up needed and demand was growing. Members noted that there were still some new referrals into the service but these originated from other in patient activity.

The Director of Performance and Delivery, Shropshire CCG, reported on the Task and Finish Group which had been set up to work up a longer term solution. The Group had been working with Wolverhampton, Chester and Leighton hospitals. Both CCGs were working with SaTH to maximise the impact of the specialist nurses available and were mindful of securing outpatient services and a sustainable solution for inpatients. A hub and spoke model with a Tertiary Centre at the centre was under consideration. The Walton Centre in the North West was the only specialist hospital trust in the UK dedicated to providing comprehensive neurology, neurosurgery, spinal and pain management services and was in receipt of vanguard funding. It already had a longstanding outreach arrangement with RJAH.

The Chair asked for assurance that new patients were being seen in a timely manner. The Committee was informed that both CCGs kept a track of any referrals from primary care and were tracking out of county providers, but currently no one was achieving the 18 week target. Members also asked about mitigation for access for people in rural areas. The Committee was informed that patients meeting the non-emergency patient transport criteria would continue to receive transport to any appointments.

The Chief Executive said he looked forward to providing an update on a more secure set of services at the next meeting. The direction of travel for Neurology would be also be shared with the Joint HOSC over the next few months particularly where there would be an impact on the population.

The Chief Executive and Chief Operating Officer were thanked for the update.

The Committee requested:

That it be advised immediately if the tipping point was to be reached and the service continuity plan required implementation;

Regular updates on all of the fragile service areas; and

Sight of the Winter Plan once feedback had been received from the regulators.

5. CQC Report

The Committee welcomed the Director of Nursing, Midwifery and Quality, SaTH to the meeting and she and the Chief Executive were asked for an update on the plans made to address the findings in the CQC report published in August 2017. The CQC had rated the Trust overall as requiring improvement.

The Chief Executive said that SaTH had accepted that it needed to do better and was currently not good enough. He also reported that 80% of all NHS Trusts required improvement and that SaTH aspired to be outstanding.

An action plan to address the findings had been submitted to the CQC. This included work by SaTH and the CCGs with Higher Education partners on actions to address medical vacancies and nursing recruitment and retention. Nursing students could now be offered employment during year 2 of their degree. It was hoped to recruit 120 Associate Nurses and one of the unique selling points of the Trust was the work with Virginia Mason. Consideration was also being given to skill mixing. Increased reports of incidents was regarded as positive by the Trust and a positive barometer of a safety culture.

The Chair commented that the aspiration for 100% performance appraisals was laudable but asked whether they were enabling people to enact their aspirations with regard to future training and whether there a budget to cater for this demand. Members heard that a training needs analysis helped inform who was going to do which training. Exit interviews were also conducted and themes shared, however retirement was a big factor as there was an ageing workforce. Support and encouragement was offered to encourage staff to work flexibly.

The Committee asked what was being done to improve circumstances for staff and improve retention. The Chief Executive said there was not a blame culture and people were supported to admit and learn from mistakes. A Leadership Academy had recently been launched and the Virginia Mason work had supported 2,000 staff into a programme which had led to 57,000 safer patient journeys. Retention figures were actually quite good and feedback from medical trainees was very good.

The Committee asked about the promotion of the 111 service which had appeared to have increased demand on ambulances and the accident and emergency service. Members also referred to the growing demand from the increasing population and very high bed occupancy of 98.3%. It appeared that decision on Future Fit and reconfiguration would not alleviate these issues. The Director of Nursing, Midwifery and Quality said that SaTH was not waiting for Future Fit to address these issues. SaTH was working closely with West Midlands Ambulance Service on a joint action

plan and this would be released as soon as possible. From 1 October 2017 there would be a GP presence at PRH to help stream patients and a Fit to Sit Pilot involved an assessment of patients to see if they could be taken off of a trolley.

The Committee thanked the Director and Chief Executive for the update and praised the sterling efforts of all SaTH staff.

6. Shropdoc

The Committee was aware that Shropdoc was facing financial challenges and asked for an update on the current situation.

The Chief Officer, Telford and Wrekin CCG reported that Shropshire CCG, Telford and Wrekin CCG and Powys Teaching Health Board were working together to consider how to support Shropdoc going forward. A recovery plan was due to be presented in the next few weeks.

Members asked what would happen in the meantime, particularly with regard to coverage in rural areas. The Chief Officer said that support was guaranteed by commissioners whilst the situation was under review and there should not be a diminution of out of hours service to the population served by Shropdoc during this period.

A Member asked for clarity on how the service would be delivered in rural areas and emphasised the need to be transparent and clear so that people would know what to expect. The Chief Officer said that reduction of Shropdoc bases would not necessarily mean a reduction in out of hours provision. A telephone service would be available as well as GP home visits. Retention of bases was an issue for Shropdoc and the Community Health Trust rather than Commissioners.

The Committee agreed that a future report from both Shropdoc and Commissioners would be needed.

6. Future Fit Pre-Consultation Business Case

David Evans, Senior Responsible Officer, Future Fit Programme, outlined the work on Future Fit up to the current time. Shropshire and Telford and Wrekin CCGs had agreed to proceed to consultation on all deliverable options, the preferred option and the 'do nothing' option. The Programme was currently moving through the NHS England process and it was intended the consultation period would start in October, and last for 14 weeks to allow extra time for the Christmas and New Year period. This would be followed by a period for the two CCGs to assimilate feedback and it was unlikely that a decision would be made before March 2018.

The Committee identified the main areas of questioning it wished to pursue in relation to the Pre-Consultation Business Plan – these included finance, repatriation of services and community services.

Finance

The Committee observed that it was not possible to establish whether the £311m needed was or was not affordable. They asked whether the anticipated £126m of

Public Dividend Capital would definitely be available to finance the preferred option, and assuming this amount was available, how much commercial operations would reduce the overall capital cost by. They asked about the level of confidence in raising the money needed.

The Senior Responsible Officer added that it had been indicated that this amount would be available, but the NHS England process needed to be completed before this could be confirmed. The Chief Executive, SaTH, said he believed it was an entirely affordable scheme for the system. It was intended to remove capital from build costs in £50m chunks and consideration was being given to opportunities including car parking as a commercial entity and estates management options. Once the lump sum had been obtained from the Treasury, it would then be possible to access further capital from other partners through the Phoenix Programme, this detail was still being progressed with commissioners and regulators. This was not private finance in the way PFI was normally understood, but funding from a commercial entity linked to the Treasury.

Members asked if this meant that repayments would be made at a higher rate than public money. The Chief Executive said that there could be a differential but that detail still needed to be considered fully. He explained that the full £311m would not be available immediately but in phases, starting with £100m covering the initial groundwork. NHS England approval was needed before this could be signed off by the Treasury and no commercial entity would invest without this approval. Greater levels of detail would emerge at that point.

Members expressed concern that the consultation would proceed without the public knowing how much money would be available. The Chief Executive said that he thought the public was aware of this issue but the Co-Chair said he did not think the public were aware at all. The Chief Executive said that once the NHS England Level Two scrutiny was completed, this would become clearer.

The Committee reiterated that proper information about finance was required in the consultation.

Repatriation

The Chair asked about the repatriation assumptions made in the Business Case and how the sum of £6m had been arrived at. She asked why once services had left the county providers would want to give them back and how they could be encouraged to do so.

The Chief Executive, SaTH, said that there was not currently the capacity to manage some services at the moment but there would be in future. It would be irrelevant if other providers wished to retain those patients, if it was possible to provide the services safely and affordably so that patients would not have to travel, they would be delivered locally. Commissioners would be attracted by locality and this was not a false aspiration. The Chair observed that it was reassuring that there was confidence in the repatriation assumptions.

Community

The Chair referred to £6m of funds set aside for Community services. However, the KPMG report had pointed out that significant recruitment would be needed at a community level and the Committee asked where this would be funded from.

The Chief Executive of SaTH said there would be a number of funding streams available. As SaTH moved forward out of its deficit there would be more funds available to invest in increasing the resilience of primary and community care, particularly through the use of technology. Funding would be available from the STP funding bridge and it was hoped to invest more than the £6m which had already been identified.

Members commented that Community Fit appeared to have been subsumed into the STP. The Joint HOSC had not felt cited on the work of the STP and wanted more involvement in future.

The Future Fit SRO reported that the Shropshire and Telford and Wrekin CCGs and Powys Teaching Health Board were carrying out a significant amount of work in partnership with local authority colleagues. Powys had made significant progress on reducing emergency admissions, the model of locality working in Telford was advanced and was also progressing in Shropshire. The Future Fit Assurance process would cover this aspect.

The Co-Chair referred to the KPMG report's comments on local community services and the need for rapid description and costing. The Committee questioned whether the activity would be sufficient to make an impact on acute flows so that the Future Fit model could function. The Future Fit SRO stated that as activity moved out of the acute sector into the community sector, the way patient services were delivered would change. For example, consultants would provide outreach to primary and community care. Some of this care would be from re-aligned existing resources, and some would require a step up in resource, this was currently difficult to quantify. He acknowledged that it was not easy to recruit GPs and that only six had been trained across the whole of Shropshire in the past year.

Members felt that the Committee and public were being asked to accept that things would come right in the end, but the SRO could not definitely say whether the model would stand up and in time for Future Fit implementation. This was not in line with the Gunning principles as the consultation was being initiated without this assurance.

The Future Fit SRO said since the KPMG report had been published, significant work had been undertaken in Telford & Wrekin and Shropshire, but there was further to do including the public consultation phase. He was confident that commissioners would have robust plans in place and be able to instil confidence in the public and JHOSC in future. NHS England would be looking at where beds could be placed over the next few years. Pilot projects were working well but he acknowledged that these needed to be developed at a greater pace to give the public and politicians confidence that this was the right thing to do.

A Member commented on the heavy dependence on this work stream and expressed concern that the pilots were not encompassing the really rural areas. Delivery in very rural areas appeared to be reliant on digital transformation and

mobile and agile working, but with poor mobile phone signals and lack of broadband provision there were concerns about roll out of these pilots. Concern was expressed that neighbourhood working was progressing on a one size fits all basis and this simply would not work for a large part of very rural Shropshire.

The Future Fit SRO said that the three main commissioning organisations did not think there was a one size fits all solution. Neighbourhood schemes in Telford were based on health needs for each locality. It would be more difficult to deliver a comprehensive service to a widely dispersed population and it was clear not withstanding infrastructure issues that technology would have a significant role to play.

The Director of Performance and Delivery, Shropshire CCG also acknowledged that one size would not fit all. The timeline would be presented to the Shropshire CCG Governing Body meeting and would be modelled in January 2018. There was a need to engage and identify outcomes for patients in the North, South and in Shrewsbury and balance these with implementation on a locality basis. Equity to access was not currently available in the county and the intention was to improve this and focus on outcomes, not models.

Members asked for information around funding frailty in community proposals and how 80% of savings from hospital being reinvested in the community would work. The Future Fit SRO said there were significant plans for transformation and some investment would be made through STP transition funding to enable people to be cared for closer to home. Long term conditions should not have to be admitted into a hospital bed – this should be regarded as a failure of the system. The challenge would be to keep patients at home and he expressed confidence that neighbourhood work will help that aspiration, there was a commitment from all to make that work.

In referring to the non-financial appraisal, a member asked why it was thought that there had been such a large variance between the two options for quality, and how the Trust felt about such a difference between the two hospital sites. The Future Fit SRO said that these were simply the scores recorded following the Panel's assessment on the day.

Returning to the theme of finance, a members asked whether local authorities would be approached for capital funding. The SaTH Chief Executive said that all partners in the system had been approached with the question to see if they could help or not.

A Member commented on the visit to two Urgent Care Centres in the North West by the Committee, both of which were closed from 10.00 pm at night. He asked about the demand for urgent care after 10.00 pm and whether the PRH and RSH Urgent Care Centres might reduce 24 hour care if another financial crisis were to occur in five years' time.

The SATH Chief Executive said this was difficult to predict but that services were driven by need as the population increased. In Telford the younger population were likely to access services at a different time, later in the day and less likely to be admitted. Activity numbers currently supported the need for 24/7 Urgent Care provision, the need was there so the service would meet it.

The Co-Chair referred to the KPMG report which drew attention to the recommendation for a 50% reduction in delayed transfers of care which was 97 beds equating three wards. This appeared to be an enormous drop in bed provision and would increase demand on primary services. He asked how this compared with the cost of alternative provision in the community. The Committee asked for assurance that local authorities had endorsed both the financial and practical solutions for that approach.

The Chief Executive reported that working with partners and the voluntary sector had achieved significant improvement, down to 2 – 3% from 8 – 10% year ago. There was now just one assessment process now rather than four and partnership working was achieving change. It was expensive and wrong for a patient to be in a bed when this was not the right environment for them.

The Future Fit SRO said that if the right care was being provided in the right place at the right time then a delayed transfer of care should be avoided in the first place. The Co-Chair said that it was agreed that it was best to try and keep people close to their communities but that home was not always the best place and sometimes a bed was needed. He was aware of good work in relation to delayed transfers of care but the question was around the scale of the step change in the Future Fit model – equivalent to 3 acute wards when there was a growing elderly population and the care sector was on a knife edge.

The Chief Executive of SaTH said that if a patient needed to be in a bed clinically this would still be the case but it could be managed differently. Since the frailty unit had been introduced admissions had reduced by 3 elderly people a day which represented significant progress. It was an ambitious aspiration, but the alternative would be to build bigger hospitals with more staff. The work in Powys was more mature and had achieved an 11% reduction in emergency admissions from that community – this provided good evidence that working differently would make a difference.

The Chair asked about the next stage of tests for the Programme. There remained questions in the PCBC in relation to sensitivity analysis, how the evaluation had been scored, she asked if these questions would be answered and if there was any contingency planning if the Programme fell at the next hurdle.

The SATH Chief Executive explained that the NHS England assurance process had been used for many years. It was important to point out that the process was on-going. The Outline Business Case would not be signed before spring 2018, then there would be a further 12 months to get to complete a full business case. In terms of contingency, he emphasised that all as a system were committed to the journey, there was a need to retain hospitals and more integrated delivery would happen and is happening whether Future Fit happened or not. The Future Fit capital would allow modifications to hospitals at both sites.

The Chair thanked NHS colleagues for answering questions and said the Committee appreciated that the PCBC was a working document.

7. Future Fit Programme – Consultation Plans and Consultation Document

Phil Evans, STP Programme Director and new Future Fit Programme Director introduced himself to the Committee.

The Chair referred to an e-mail sent to Mr Evans on 12 September 2017 setting out how the Committee would like to work and with some questions, to which a response had not yet been made. It had been very helpful to receive the PCBC on a timely basis but answers to the questions were needed as soon as possible to allow the Committee to plan its timetable and work programme. This would help avoid the difficulties which arose when meetings had to be arranged at short notice.

She went on to refer to the KPMG report which had identified that it was clear in the original Future Fit remit that regard would be paid to the Gunning Principles.

Questions, comments and observations made by the Committee regarding the consultation document covered:

- the delays and time taken to reach this stage which had left the public weary. What would be done to address the feeling of 'yet another consultation'

- Public disbelief and difficulty in understanding the proposals to move Women and Children's Services to RSH. The reasons for this were not clearly set out in the consultation document.

- The new descriptors for the options C1 and B1 which changed them to 1 and 2 were confusing (page 35 of consultation document).

- Major users to acute hospital services were older people, but it was more likely that younger people would respond. Work would be needed to obtain the view of patients in their 70s, 80s and above.

- Page 40 stated 'we are working with patients, carers, members of the public and the voluntary sector to look at ways in which we can improve our local health Services'- an expansion of this paragraph was needed.

- Where would the 10 meetings referred to in the document be held.

- There was lack of clear explanation of the reasons for the preferred option in the consultation document. The reason for the choice was needed.

- The consultation document did not talk about who would miss out once changes were made, for example, vulnerable pregnant woman in Telford needing a consultant led service, or vulnerable people living in very rural areas. It needed to make clear that there would be 'losers' – and that there was no ideal solution that would meet the needs of everyone.

In response to these questions and comments, the Future Fit SRO apologised that the original date for the Joint HOSC meeting had needed to be rescheduled, but that he had had no choice about attending a meeting with regulators in London on that day. He emphasised that the Programme was keen to maintain an honest, open and transparent dialogue with JHOSC.

He acknowledged that the case for Women and Children's Services was not clearly articulated but emphasised that it was not about the wholesale transfer of the Women and Children's Service. The consultant element would transfer but 75% - 80% activity would continue to be delivered at PRH – including outpatients, diagnostics, day services, paediatric Urgent Care Centre, antenatal, postnatal and deliveries. The Committee's observations around mitigation for obstetric led births and paediatric inpatients would be taken forward.

It was correct to say that older people were more likely to use the service but that younger people were more likely to respond to the consultation. The consultation period would be heavily reliant on a mixed approach to talking to people – there would not just be 10 meetings. Interested groups and parish and town councils would be able to request Future Fit representation at meetings.

He said he understood the weariness around 'another consultation' but the Programme had worked hard on engagement over the past four years and at this stage of the process 'consultation' took on a very specific meaning. In terms of the preferred option he said he would look at how information could be made clearer, but he was unable to explain why individual Panel Members had voted in a certain way during the non-financial appraisal. He also acknowledged that changes would not be to the advantage of everyone. The Joint CCG Committee had given very serious consideration in agreeing the preferred option. He said he would look into providing more explanation on this into the consultation document.

Members asked and how alternative thoughts and proposals would be elicited through the consultation, or were there really just these options that could be conceived of. They asked for more information on the evaluation process.

The Committee heard that at the seven week stage an assessment would be made on feedback received from seldom heard and minority groups. The Committee asked to contribute to this assessment. The seven week point would be in mid-December and the Programme would welcome an opportunity at that point to discuss with the JHOSC how the consultation was going. The Programme Director pointed out that the Programme was working with the Consultation Institute.

The Future Fit SRO emphasised that reshaping service provision would never be easy. The Future Fit proposals were based on a clinical model developed by acute, community, primary care, mental health and ambulance service clinicians who all had a common view that one single Emergency Centre was the right way to obtain best clinical outcomes. The location of the Emergency Centre would always be controversial as some people would have to travel further, some of whom would be in disadvantaged groups, but it was important to provide the best solution possible. Equality of provision was not available now and there needed to be a care offer that every member of the public could understand and expect. Patients were already sent out of county to major trauma centres in Stoke and Birmingham and all trauma in the county had been directed to RSH for four years already.

The SRO said that if the consultation document was not clear about the disadvantages for some than this would be looked at. Journey times would increase

substantially for some seeking elective care and there was a need to get balance right around where the disadvantage lies.

He confirmed that if a clinically sustainable proposal was identified through the consultation process this would be taken into account during the stage following the consultation and an explanation would be provided as to why it was discounted or accepted. He also confirmed that the 'five tests' would apply to all work within the programme. Transport would always be an issue but the correct clinical location for a patient should always be top priority.

He added that said there would always be some out of county provision for good clinical reasons. However, there was a need improve how patients were seen and assessed, for example, avoiding the need to travel long distances for pre-med checks. If elective care was moved further away there would be a need to work with providers to minimise unnecessary travel and mitigate this – so patients only had to go to the elective centre when they really needed to.

He said that the explanation in the consultation document for the preferred option in terms of value for money would be improved. The narrative around the move of Women and Children's Services would also be added within the next few days.

The Chair concluded the meeting by emphasising that the consultation document needed sufficient quality and content to allow the public to make a reasonable and informed response. The Committee had identified a number of ways in which it needed to improve.

There would be more comments, questions, and recommendations from the Committee in the weeks and months ahead. She thanked NHS officers for their attendance and for answering questions. She thanked Members of the Committee and members of the public for attending. She encouraged members of the public to let the Committee have any relevant points, concerns, information and questions in the coming weeks.

The meeting closed at 6.02 pm

Chair: _____ Date:_____