



Telford & Wrekin
COUNCIL

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

Date: 6 December 2019

Committee:
Joint Health Overview and Scrutiny Committee

Date: Monday, 16 December 2019
Time: 10.00 am
Venue: Quaker Room - Meeting Point House, Southwater Square,
Town Centre, Telford, TF3 4HS

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

Cllr Karen Calder (Co-Chair)
Cllr Madge Shingleton
Cllr Heather Kidd
Co-optees:
David Beechey
Paul Cronin
Ian Hulme

Telford

Cllr Derek White
Cllr Stephen Burrell
Cllr Kelly Middleton
Co-optees:
Janet O'Loughlin
Hilary Knight
Dag Saunders

Your Officers are:

Josef Galkowski Democratic Services and Scrutiny Officer,
Telford and Wrekin Council 01952 388356
Email: josef.galkowski@telford.gov.uk

Amanda Holyoak Committee Officer, Shropshire Council 01743 252718
Email: amanda.holyoak@shropshire.gov.uk

AGENDA

1 Apologies for Absence

2 Declarations of Interest

Members are 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 Previous Meeting (Pages 1 - 8)

To confirm the minutes of the meeting held on 2 October 2019

4 Hospital Transformation Programme Update

To receive a verbal update on Hospital Transformation Programme

David Evans, Chief Officer of Telford and Wrekin Clinical Commissioning Group will present the update and answer questions

5 Transforming Midwifery Care Update

To receive a verbal update on Transforming Midwifery Care

David Evans, Chief Officer of Telford and Wrekin Clinical Commissioning Group will present the update and answer questions

6 Sustainability and Transformation Plan - Long Term Plan Update

To receive an update on the Sustainability and Transformation Plan Long Term Plan – TO FOLLOW

David Stout, Interim Accountable Officer, Shropshire CCG will present the update and answer questions

7 Shrewsbury and Telford Hospital Trust - Winter Pressures Planning (Pages 9 - 14)

Claire Old, Urgent Care Director for Shropshire Clinical Commissioning Group and Sara Biffen, Deputy Chief Operating Officer for the Shrewsbury and Telford Hospital, will attend the meeting to give the presentation and answer questions

8 Shrewsbury and Telford Hospital Progress Update Against Care Quality Commission Recommendations

To receive an update on Shrewsbury and Telford Hospital's progress against the Care Quality Commission recommendations – TO FOLLOW

Barbara Beal, Executive Director of Nursing and Midwifery will present the update and answer questions

9 Co-Chairs Update

This page is intentionally left blank

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 2 October 2019 3.00 pm – 4.27 pm in the
Shrewsbury Room, Shirehall, Shrewsbury**

Members Present:

Shropshire Councillors: Karen Calder (Chair), Heather Kidd, Madge Shingleton
Telford & Wrekin Councillors: Derek White (Co-Chair)
Shropshire Co-optees: David Beechey,
Telford and Wrekin Co-optees: Hilary Knight, Dag Saunders

Others Present:

Tom Dodds, Statutory Scrutiny Officer, Shropshire Council
Fiona Ellis, Commissioning and Redesign Lead, Women and Children's Services,
David Evans, Chief Officer, Telford and Wrekin CCG
Amanda Holyoak, Committee Officer, Shropshire Council (minutes)
Deborah Moseley, Democratic and Scrutiny Services Team Leader, T&W Council
Dr Julian Povey, Chair of Shropshire CCG
Rachel Robinson, Director of Public Health, Shropshire Council
Pam Schreier, Head of Communications and Engagement, STP
Jess Sokolov, Medical Director, Shropshire CCG
Debbie Vogler, CCG Associate Director

1. Apologies for Absence

Apologies were received from Councillor Stephen Burrell (Telford and Wrekin Council), Councillor Paul Watling (Telford and Wrekin Council), Ian Hulme and Paul Cronin (both Shropshire Council co-optees)

2. Disposable Pecuniary Interests

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

3. Minutes of the last Meeting

An updated version of the minutes originally circulated with the agenda had been circulated on 1 October 2019 and Members were asked to approve this version. This version of the minutes was confirmed as a correct record.

4. Transforming Midwifery Care in Shropshire, Telford and Wrekin

Jessica Sokolov, Fiona Ellis and Debbie Vogler gave a presentation (copy available on the web and attached to the signed minutes) which provided a recap

of the reason for change and the proposed model of care; the outcome of the option appraisal; location of hubs needs analysis; differential need; access to hubs and the consideration of access and needs analysis and targeted support.

All proposals were subject to the NHSE/assurance process with a Regional Stage 2 Panel Date due imminently, followed by progression to national sign off, although it was not known when this might be. Feedback from NHSE/I on the proposed model to date had been positive and the PCBC and final proposals including consultation documentation would need to go to CCG Boards after the NHSE Assurance process was concluded and the consultation process began. These would also be shared with the Committee.

Members of the Committee asked the following questions :

Please clarify your expectations of the role of the Committee, are timelines clear and when will a response from the Committee be expected

An early draft of the consultation document had already been shared with Healthwatch and other groups. Joint HOSC would also be asked to comment and comment on how the consultation should run. It was hoped to share this sometime in November after the Stage 2 Assurance Panel process and presentation to the CCG Boards. If the consultation started before Christmas an extra period to the planned eight weeks would be added in light of the holiday period. In the meantime comments on pre-consultation engagement would be welcome.

Why was the consultation period intended to be 8 weeks, rather than 12?

Time period for the consultation was negotiable but it was felt that a focus targeted consultation in eight weeks would achieve an effective response and was within the legal requirements .

Please clarify what is meant by 'targeted support'

Dr Sokolov explained that the midwifery team in Hanley Castle had identified some issues in relation to cultural barriers to access, rather than geographical barriers to access. A closer relationship with midwives would help address these barriers. Another example of targeted support could be provision of remote scanning in the Oswestry area.

Is there any plans to encourage use of facilities just across the border, for example, there are scanning facilities at Welshpool hospital which is just 10 mins across the border and many Shropshire residents were registered with GP Practices in Wales.

The access impact assessment only looked at those residents who were registered with a Practice in Shropshire and Telford and Wrekin but the CCGs were aware that people crossed borders when it was more convenient to them to do so. Women who already moved out of area for services would be able to continue to do this. Discussion was underway with partners to explore streamlining the processes involved with this.

Would consultation responses influence decisions, and if so what sort of decisions?

Feedback from the public would be used in influencing what type of services would be available and influence decisions around a fourth hub. It was intended to be as clear as possible in the consultation document about the needs assessment and access issues, whilst also explaining the need to provide value for money. There would be opportunities to influence the type of targeted outreach.

Can the decision to have two birthing hubs be influenced.

There was a requirement to consult on financially and clinically deliverable options as tested by NHS England, and it was not believed that births in other units would be deliverable. The consultation would help the public express how that would affect them. Dr Povey emphasised that all views would be considered but the key options would not include births in any other units..

Would demand on PRH be too excessive without a unit in the Bridgnorth area, and is the hospital the right place for the Telford Midwife Led Unit to be located – as access and parking is difficult ? Transport is a significant issue.

Dr Sokolov explained that the Midwife Led Unit had to be co-located with the Consultant Led Unit at PRH as access to consultants could be needed. It was proposed that there would be a hub in South Telford which was community based. It was accepted that Hadley had needs where targeted activity could help and this had been suggested.

The current configuration was not operating currently, the smaller rural units had not been open to births or postnatal stays for 12 months, and the RSH had been closed too. This situation had been managed at Telford.

It was not possible for the Programme to change transport links but they could be considered and conscientious consideration had been given to the access data which had been gathered independently.

Where does the Ockenden Review sit with the Transformation Programme. Could it have implications for the Transformation Proposals and would there be the capacity to react the Review recommendations? Was it known when the Ockenden Report would be available?

It was non known when the Ockenden Report would be published but it was anticipated that recommendations within it would relate to safety. There was confidence that the model represented safe care and proposals were flexible.

Shropshire and Telford and Wrekin had been waiting for a very long time to get to this point. How confident was the Programme that NHSE/I would turn this around quickly so that the consultation could be launched as soon as possible?

Committee members agreed that a letter be written to the NHS England/NHS Improvement Regional Assurance Panel asking for a quick resolution and decision to

be made on the proposals so that the consultation could start as soon as possible with local stakeholders and residents.

Birth Before Arrival date since the MLUs had been closed had been an area of concern

Dr Sokolov said that the BBA rate was monitored routinely, there was a 0.5% - 1% regional BBA rate. Shropshire was not an outlier before the Units had closed and was not an outlier with units closed.

What was happening in terms of digital transformation?

Consideration was being given to the needs of midwives, whether they were working in the home or elsewhere. This was all happening through the Local Maternity System and the broadband issue was being addressed through the STP Digital Workstream.

Were the 29 extra Midwives going to be in post as anticipated in October

The Programme understood that these midwives would be in place by early October.

The Chair reported that a member of the Committee who was unable to be present had sent her comments on the proposals and had felt that they were sensible and evidenced based. He had emphasised the importance of moving forward quickly to give certainty to beleaguered staff and help recruitment.

It was noted that the NHS E/I Regional Assurance Panel was due to take place on 7 October 2019 and so the letter from the Committee would need to be dispatched as quickly as possible.

The Chair thanked the Transformation Team for attending the meeting and answering questions and looked forward to receiving the consultation documentation at a future meeting.

5. Single Strategic Commissioner

The Chair welcomed David Evans, Chief Officer, Telford and Wrekin CCG who was asked to provide an update on work undertaken following the decision of the Shropshire and Telford and Wrekin CCG Boards to create a single organisation.

Mr Evans referred to the report before members which explained that the CCGs had set up a programme management office to oversee the project and had created a Joint Executive Group to act as the project board. This met weekly supported by Deloittes with five workstreams reporting to it. It was hoped that the Accountable Officer would be appointed imminently at which point the management of change with staff could get underway.

The draft Communications and Engagement Strategy had been appended to the report before the Committee and feedback on this would be welcomed in relation to areas not covered or that could be strengthened.

In acknowledging the central drive for merger of CCGs, members asked a number of questions including:

- Was it thought that the proposal would satisfy central government in its desire to reduce CCGs across the country.
- Would the outcome result in a levelling up of services commissioned, and not down.
- Would the new structure ensure that best practice could be spread effectively to all GP Practices across Shropshire and Telford and Wrekin
- Had the risks related to loss of organisational memory been identified and would they be addressed.

In responding to these and other questions, Mr Evans said that the restructure had been encouraged centrally and the new CCG would still be one of the smaller ones nationally. It was an uncertain time but there was confidence that this was the right way forward. Extensive discussions would be held across both Shropshire and Telford and Wrekin to ensure that commissioning and delivery of services for the whole population. He acknowledged the concerns of members but the development of Primary Care networks based around Shropshire Health needs would ensure a more consistent approach across primary care as a whole. The new CCG would plan and commission the right services for the future, although time would be needed to achieve consistency across the whole geography. Both CCGs currently had out of hospital models and worked closely with the local authorities and the new organisation would continue to do this. It was important to remember that individual practices were individual businesses and persuasion would be required to undertake change in some cases.

Members observed that Primary Care Networks were not yet a clearly defined entity. Mr Evans acknowledged that they were in their infancy but there was significant enthusiasm in the primary care to establish them to drive forward improvement.

The Co-Chair of the Committee reported on a letter sent by Telford and Wrekin Council expressing concern around the financial differential of the two organisations and fears that the restructure would be detrimental to the Telford and Wrekin area. It was understood that 20% savings were expected from the reorganisation and proposals to achieve this saving would be scrutinised carefully. More accountability was desired, with fit for purpose services serving communities. Primary care was in crisis with nearly every practice experiencing long waiting times.

Mr Evans said that one of the advantages of the STP Long Term Plan was that it began to remove the Purchaser/Provider split, and established a more system focused basis to deal with the significant challenges faced. He pointed out that both CCGs and one provider were in a deficit position this year, and the development of

an integrated care system and strategic clinical commissioner would play an important part in addressing it. There were challenges in Primary Care with most practices facing increased demands, as well as accident and emergency services and other elements of the health service. There was a need to ensure access was available to people who needed it at the right time, and this was equally true of primary care, mental health services and acute care.

Dr Povey, Chair of Shropshire CCG, said it was right to challenge demand and waiting times. He referred to challenges in the workforce, the declining number of GPs, and GPs wanting to work in different ways. Demographics and demand had changed and primary care needed support in addressing these changes as most people had expectations of a GP led primary care model. Reducing two CCGs to one would not result in immediate change but would allow a more co-ordinated approach to the whole of the footprint. There were a lot of good ideas in the GP Forward View and the Primary Care Networks would result in more joined up working.

A Member referred to the need to retain staff and drew attention to the Milton Keynes University Hospital Acute Trust programme designed to improve staff well being and retention. He understood that this had reduced agency staff costs by 50%.

In response to questions about the engagement of GP Practices Dr Povey reported that attendance at workshops held on the matter had been good, and all had attended meetings prior to the vote. Individual meetings were available to any practice that requested one. Mr Evans said that in Telford and Wrekin a monthly meeting was held with members with approximately 80% attendance and he had attended around 50% of practices in Telford and Wrekin and held some evening meetings with an open discussion.

The Chair asked how it had been demonstrated in the submission that the two local authorities had participated. Mr Evans said that participation had mostly been with senior officers up until this point, through SLG. The Committee felt that it would be useful to find a date to provide a briefing for the elected members of both local authorities and asked that arrangements be made to this. Mr Evans agreed that this would be helpful

In noting the report, the Committee felt that on the basis of the information provided, it was not yet in a position to indicate support for the proposals as requested in the report. Mr Evans was thanked for attending and was asked to return to a future meeting when more information and assurances were available, particularly in relation to services being levelled up and not down.

9. STP Long Term Plan

Pam Schreier, Head of Communications and Engagement, STP gave the presentation as the STP Director was unable to attend.

She outlined the background and timescales around the Plan with a final submission being due 15 November 2019.

The Committee asked when the Joint HOSC could input and comment on the Plan and when this would be. Members were concerned that the timeline in the presentation indicated participation by JHOSC when it had not seen the content of the Plan. Although members did not wish to see the entirety of the document, they would wish to see a summary, the priorities within it and any major highlights or problems. They asked that the STP Director attend a future meeting so that he could be questioned on these areas.

In the meantime, Members queried the absence of sections on Primary Care and Social Care and asked whether there had been any indication from the Treasury regarding financial commitment. They heard that Primary Care and Social Care were woven throughout all sections and cross cut all workstreams and therefore did not require separate sections. The Head of Communications said she was not in position to answer the question about finance.

The Chair commented that the Shropshire Health and Wellbeing Board had felt for the first time that there was traction and buy in from providers and directors sitting around the table, however as a scrutiny committee more detail was needed.

10. Co-Chairs Update and Work Programme

A number of areas had been suggested for the work programme and the Chairs agreed to meet to look at these and bring back proposals to a future meeting.

The meeting concluded at 4.27 pm

This page is intentionally left blank

Shropshire, Telford and Wrekin Winter Planning

06.12.2019

NHS England and NHS Improvement



Progress so far

- Regional winter conference 12th of September
- Regional template submitted on the 17th of October
- Plan remains iterative based on our dynamic bed modelling which is now updated on a monthly basis according to actual activity rather than historical activity.
- A&E Delivery Board requested further information from the A&E Delivery Group on proposed schemes in September and recommended that the full winter plan is submitted to all boards in November after approval at the October A&E Delivery Board. All organisation and commissioning Boards have approved the winter plan.
- Only schemes that have a high and medium confidence of being delivered have been recommended for approval.
- At present there is a bed gap of minus 4 beds for December. The unexpected delay in the Ward 35 scheme is a major contributor to this gap which will be mitigated by the use of DSU beds at both sites. Schemes to be implemented going forward from November will deliver a near balanced demand and capacity plan, however it must be noted that if a surge in demand occurs, the system escalation plan is triggered including the use of the full capacity protocol.

Challenges

- Whilst workforce remains a challenge, all approved scheme owners have assured the A&E Delivery Group of their ability to staff the approved schemes
- Engagement of the West Midlands Ambulance Service in winter planning and the process of redesign has been a challenge. This has been escalated to NHSI/E, and a summit led by the A&E Delivery Board Chair has been arranged.
- Given the sustained challenges due to the rise in demand and the age and acuity of patients admitted during November and the first week of December, NHSI/NHSE have allocated further funding to the system and further capacity has been purchased out of hospital and in hospital and is represented in the demand and capacity numbers in this presentation.
- Powys have been experiencing an acute lack of domiciliary care provision and nursing and residential home provision. They have plans to enhance the provision but this will not bring extra capacity into the system until next year. Because of this, NHSI/E have allocated funds to place Powys patients in Shropshire/Powys border provision, and Shropshire Local Authority have been supporting Powys with the transformation of their services.
- Shropshire and Telford and Wrekin Local Authorities are amongst the best in the country at placing patients who are medically fit for transfer within 48 hours of referral. This, coupled with our reduction in the long length of stays in hospital, has made the system an exemplar in the national scheme to reduce long lengths of stay.

Winter Plan 2019/20 – demand and capacity modelling

- The development of the winter plan demand and capacity modelling has been overseen by the A&E Delivery Group.
- Phase 1** – SATH undertook bed modelling to identify the bed gap between their core bed stock and the predicted winter demand. The table below reflects the position in light of September actual demand. Calculated based on average length of stay and 95% bed occupancy.

	Sept	Oct	Nov	Dec	Jan	Feb	March
PRH	-6	-41	-21	-18	-58	-35	-19
RSH	-16	-43	-47	-50	-56	-63	-26
SATH Total	-22	-84	-68	-68	-114	-98	-45

- Phase 2** – system partners developed a schedule of schemes to create acute bed capacity (or equivalent) in order to bridge the above gap.
- A total of 29 schemes comprise the system winter capacity plan covering the 4 categories of:
 - Additional acute bed capacity
 - Demand reduction
 - Internal flow
 - Complex discharge
- 22 of the schemes are assessed as being high confidence of delivery and 7 schemes as being medium confidence. The key risks associated with the medium confidence schemes relate to workforce availability, however, system partners are actively working to ensure that these risks are mitigated

Winter Plan 2019/20 – demand and capacity modelling

The summary table shows the acute bed impact for each of the categories of winter capacity schemes. The boxes highlighted in red indicate where a bed gap remains.

Winter 2019/20	Sept		Oct		Nov		Dec		Jan		Feb		March	
	PRH	RSH	PRH	RSH	PRH	RSH	PRH	RSH	PRH	RSH	PRH	RSH	PRH	RSH
SATH Bed Gap By Site (last update Sept 19 actual)	-6	-16	-41	-43	-21	-47	-18	-50	-58	-56	-35	-63	-19	-26
Additional acute beds	0	12	0	12	0	12	17	17	18	47	38	47	38	47
Complex discharge	0	0	0	1	2	4	3	6	5	6	5	6	3	6
Acute demand reduction	3	0	3	0	8	5	9	5	12	20	12	20	12	20
Acute flow	0	0	4.5	0.5	6	1	12	6	13	6	14	6	15	6
Total acute bed impact	3	12	7.5	13.5	16	22	41	34	48	79	69	79	68	79
Variance +/- acute bed gap vs mitigating schemes	-3	-4	-33.5	-29.5	-5	-25	23	-16	-10	23	34	16	49	53
Use of DSU as Planned Escalation	3	4	16	12	5	12	0	12	10	0	0	0	0	0
Acute bed gap with use of DSU above	0	0	-17.5	-17.5	0	-13	23	-4	0	24	32	17	49	54
Remaining Unplanned Surge Escalation Capacity														
DSU	13	8	0	0	11	0	16	0	6	12	16	12	16	12

Next Steps

- The demand and capacity modelling is reviewed by the A&E Delivery Group and Board on a fortnightly basis.