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 2 November 2017 2pm in The Wakes, Theatre Square, Oakengates, Telford

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

Also Present:
Tom Dodds, Statutory Scrutiny Officer, Shropshire Council
David Evans, Chief Officer Telford & Wrekin CCG; Senior Responsible Officer, Future Fit
Phil Evans, Future Fit Programme Director
Amanda Holyoak, Committee Officer, Shropshire Council (minutes)
Julian Povey, Chair Shropshire CCG
Pam Schreier, STP Communications & Engagement Lead Shropshire, Telford & Wrekin NHS
Jessica Tangye, Senior Democratic and Scrutiny Services Officer, Telford & Wrekin Council
Simon Wright, Chief Executive, Shrewsbury and Telford Hospital Trust

1. Apologies for Absence

Apologies were received from Telford Co-optee Hilary Knight and Shropshire Co-optees Mandy Thorn and David Beechey. Apologies were also received from Simon Freeman, Shropshire CCG

2. Disclosable Pecuniary Interests

None

3. Minutes

The minutes of the meeting of the Joint Health Overview and Scrutiny Committee held on 25 September 2017 were agreed as an accurate record.

4.

The Co-chair, Cllr Andy Burford introduced the meeting and reported that the Committee was considering how it would take evidence from the public on the Future Fit Programme (FFP) and wished to involve the public in its determinations.

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

The Co-chair welcomed the Chief Executive of SaTH to the meeting and invited him to provide a verbal update on the fragility of services since the update to the Joint HOSC meeting on 25 September 2017. He acknowledged the pressures that all health trusts were currently under. Simon Wright stated that the position of the Accident and Emergency service had been strengthened by SaTH securing two locum consultations starting in a week's time. This would provide some additional support but the Consultants were not prepared to go on the rota. He reported that this was the first time in a number of years that the Trust had been able to secure professionals in this way and at this level. Another hospital had been invited to provide consultant services and he had approached Health Education England expressing frustration at medical rotations especially compared to the numbers of doctors training at hospitals in Stoke and Birmingham. He had requested that the rate be increased, at the moment it was only at 40% which presented pressures where middle grade doctors were concerned.

He stated that some changes had been introduced in the Accident and Emergency departments which included a clinical decision unit and GP streaming. A Practice Educator had been appointed at PRH and RSH to help retain the nursing workforce and support the demands of the service. He wished to make it clear that having a business continuity plan was necessary but that both PRH and RSH Accident and Emergency departments would continue to be strengthened as far as possible until a strategic solution was in place for the future.

A question was raised about GP streaming and when SaTH would expect to see some progress. Simon Wright said he would be happy to share the evaluation with the Joint HOSC once a suitable point had been agreed with the CCG.

Expanding on the winter pressures, he said that in order to avoid admissions, a number of other initiatives had been introduced in addition to GP streaming. These included the frailty service which would improve the treatment, planning and timely discharge of patients. Discharges would be supported during weekends with support from social care staff, consultants and pharmacists and a small number of additional beds would be made available for fractures and falls. SaTH was supporting patients with complex needs to go home and working closely with the Local Authorities to meet a target of 58 per week across the system. A number of these schemes had been brought forward as hospitals were currently full whereas the winter period usually started at the beginning of December. He added that social care colleagues did an excellent job in supporting discharge and the aim was to bring down the average six day wait to 48 hours. If the discharge rate fell from the current 3.3% to 2-2.5%, performance would be amongst the best in the country.

A question was asked about the take up of flu vaccinations. The Chair of Shropshire CCG reported that the vaccination programme was co-ordinated through Public Health England and that monitoring information was not expected before December. Members noted that 2000 staff at SaTH had been inoculated.

A question was raised about whether SaTH was experiencing delays discharging patients to Powys. The Chief Executive said there had been delays with some patients but these

had been relatively small in number and work was underway to address hurdles where differences in the English and Welsh systems caused unnecessary delays.

Neurology - there was collaboration with the Commissioners to increase the nursing element to three nurses to stabilise the service, which would make a big difference. Simon Wright was in dialogue with three providers including the Walton Centre, Stoke and Birmingham. All were interested in developing a hub and spoke model which would enable services to be supported in the hospital. He noted that there was no history of this type of provision in Shropshire. He was meeting with the Walton Centre to discuss their contribution then the right relationship for the service going forward would be determined with the Commissioners. It was moving towards a conclusion.

A question was raised about the 6 months closure of the service to new referrals. Simon Wright confirmed that new referrals were being managed through other providers and some of these were out of county. The service only had two neurologists and they needed five. A further questions was asked about the process of the out of county service as Healthwatch had received feedback that there was a breakdown in communication with patients. Simon Wright stated that the out of county service provider which was Wolverhampton, should manage the pathway if the provision was at a tertiary centre. It was the service provider's responsibility to communicate to the patients from the initial assessment onwards. He suggested that anyone with difficulties with out of area providers should let SaTH or the CCG know.

Ophthalmology - since the creation of a new department two consultants had been successfully recruited which meant SaTH would be fully staffed with 8.5 Ophthalmologists, the most SaTH had had in a decade. A private clinic at Shrewsbury was being used to make services more accessible for welsh patients.

SaTH wanted to ensure the provision of services would meet the needs of the public and a further proposal would come to Joint HOSC for the next phase. The aim was to resolve the service issues permanently to provide a high quality service and it was hoped to fill a further two posts and secure more training doctors.

Spinal Service – the service level agreement was being finalised with the Robert Jones Agnes Hunt hospital. The spinal service would be provided with Sath as they had eight spinal surgeons so they were not looking to provide an alternative at SaTH but through RJAH which would include the teams already employed at SaTH.

Dermatology – another locum had been secured; there was now one substantive role and one locum supporting the service. It was largely a nurse led service but consultants were needed for cancer referrals. A network agreement with two other hospitals with similar vulnerabilities was being developed to support the cancer component of dermatology. Negotiations were also underway to develop a service level agreement with the Skin Clinic.

The Co-chair stated that the Committee would look forward to receiving the Winter Plan once it had been signed off and acknowledged that work had been done on the construction of the plan with Shropshire and Telford & Wrekin Local Authorities.

The Committee acknowledged that it was good to hear some better news.

6. Update on the Future Fit Consultation Plans and Consultation Documentation

The Co-chair welcomed David Evans, Chief Officer of Telford & Wrekin CCG and Dr Julian Povey, Chair of Shropshire CCG standing in for Chief Officer Simon Freeman. It was acknowledged that the NHS assurance process had been delayed. The Chief Officer and the Chair were asked whether the delay was significant. David Evans indicated that NHS England had recommended that the consultation document was more readable and had asked for some points of further clarification before resubmission on 6th November. The NHS Assurance Panel would then reconvene but he felt that it did not materially impact on decision making. One of the criteria that NHS England required was that the final versions of the documentation be talked through with both CCG Boards. Dates for the next CCG Boards and Future Fit Board meetings were confirmed as 13 November, 14 November and 15 November. He confirmed that the CCG Boards would also be considering the end of consultation decision making process.

The Committee raised concerns about the NHS response to the Joint HOSC informal recommendations, which had been submitted shortly after the meeting on 25th September. The Committee felt that the response lacked detail and the CCG Officers were asked whether they wished to add anything further to their response. It was noted that the Committee had intended to make the recommendations formal but due to the recommendations being formalised at an informal meeting after the public meeting on the 25th September, they had been submitted as informal recommendations. It was acknowledged that the Committee wished to make the recommendations formal and the CCG Officers were asked whether they were content that this was their final response to the recommendations. David Evans stated that he was confident with the responses as Senior Responsible Officer for Future Fit Programme and the responses were agreed on behalf of both CCGs.

A question was raised about the funding underpinning the Future Fit Programme, as outlined in the Joint HOSC recommendations. The Committee wished to challenge the assertion that the funding solution should not be part of the consultation and pressed for initial funding information to be made available as soon as possible in order for the public to make an informed decision as per the Gunning Principles. It was felt that the ability of the NHS to carry out the reconfiguration of acute services was highly dependent on the financial package. A question was asked about the capital funding; whether £126 million of the £311 million capital required would be made available from public sources. David Evans stated that the CCGs were required to submit the Pre-Consultation Business Case (PCBC) before capital funding could be confirmed. The PCBC was in fact the CCG's case for public capital and the proposals would not be considered without it. He reported that there was an indication that the level of funding, £126 or £150 million, was available from the Regulators although it could not be confirmed from public dividend. He went on to confirm that the PCBC was an application for funds and that if it was signed off there would be no reason why the funding should not be received. If it was signed off by NHS England, an amendment could be made to the consultation document to indicate how the funds would be made available.

The Chief Officer was asked how the CCGs proposed to pay the £161 million short fall. The Committee was concerned that the consultation was unnecessarily opaque and that the residents of Telford & Wrekin and Shropshire would in effect indirectly pay for the shortfall.

It was suggested this would be a recurring issue that the public would want to know the answer to, whatever the figures provided in the consultation document.

David Evans responded that until it was known whether the public dividend would be available, the CCGs could not be certain how much additional capital was needed but it was circa £155-160 million; he stated that they were not trying to be un-transparent. The Chief Executive of SaTH added that they had to be assured that other sources of funding were robust before the Treasury figure was declared. David Evans agreed with the sentiments of the Committee, that it was equally frustrating for the CCGs that the funding could not be nailed down nor would they know until the assurance process had been completed.

Members asked if the revenue calculations took into account debt repayment charges for non-governmental sources of funding. David Evans explained that interest would also be payable on public dividend capital. He confirmed that the revenue assumptions took into account interest payable on all borrowing. There was also a clear statement in the Business Plan that this would not impact on tariff pricing for both CCGs and the current tariff operated with SaTH.

More information on the LIFT and Phoenix scheme had been requested from the Chief Executive of SaTH following the Joint HOSC meeting on 25th September. Simon Wright said that he was unable to provide more detail at this time and that there might be commercial sensitivities involved. In general terms the Department of Health Model placed capital investment in regions together in order to secure best possible terms.

David Evans was asked to reconfirm that greater detail about funding would be included in the consultation if and when NHS assurance was received or was this aspirational. He said that if the timescales allowed it, something could be put in around the public dividend. It would not be in any great detail as there were commercial sensitivities to consider but there were elements that could be included. The Committee urged the CCGs to explain the finances and make it as clear as it possibly could be.

A question was raised about repatriation benefits and how they had been calculated as it was implied that the best prospect of gaining benefit through repatriation was through the preferred option but there did not appear to be any justification for this. Simon Wright gave an example of percutaneous coronary intervention being made available in Telford, rather than at Stoke. Conversations with commissioners had been held around planned care activity where other hospitals were struggling to meet obligations in terms of referral to treatment. Access time as well as choice were significant factors for patients.

A question was raised about the proposals to increase car parking charges and the request by the Joint HOSC to defer the proposals prior to recommendations being received from the Joint HOSC. The Joint HOSC had not heard back about this issue. Simon Wright confirmed that a full reply would be forthcoming. He said that SaTH had recently met with Councillors to explain the proposals and the contractual circumstances that the previous Board had put in place which allowed for the increase in charges.

It was suggested by the Committee that the trauma unit was the lynch pin of the consultation and a Member referenced p.29 which described Option 1 as the preferred option for the location of the trauma unit. The CCGs were asked to clarify whether this was the advice of the National Trauma

Network (NTN) and whether the Network would support Option 2 for the trauma unit if this was selected. David Evans confirmed that the NTN's view was that due to geography and population RSH would be a better solution. However, this did not mean that an application could not be submitted for PRH. As there was no emergency surgery currently at PRH it wold not be possible to apply currently to find out but if the outcome of Future Fit was an emergency centre at PRH, it would need a Trauma Centre and an application would be made on that basis.

The Committee expressed concerns about the development of community services and suggested that the community services model could not be considered independently of the acute services reconfiguration. The funding, resources and staffing requirements for primary care and community services remained unclear. It was felt that a lot of the work was aspirational; a proper understanding and analysis was not available. The CCG Officers and the Chair were asked for the rationale behind this. Dr Julian Povey clarified that the Future Fit Programme was about the redesign of acute services and therefore some assumptions had to be made, the review of Out of Hospital Services would be the next stage. He reported that the CCGs and LMC felt that enough work had been done on the assumptions to know they were achievable. There was a lengthy timescale for the model to be built up, to 2021-22. David Evans stated that the vast majority of activity taken out of SaTH as a consequence of Future Fit Programme would be covered by community and primary care and a level of money would come out of acute services to finance community and primary care. It was not clear at the moment whether an infrastructure was needed, both had a number of schemes to develop.

The Committee felt that detail about community and primary care was crucial but that due to financial constraints and the savings that were intended it was difficult to understand what the balance would be between the new investment and what was going to be taken away. The difficulty was apparent but this did not give the public confidence that it has been thought through and worked up.

David Evans said that an assumption could be made quite easily as the average cost of an emergency admission was £2,500 but the detail still needed to be worked up. Primary care had to be managed differently to stop beds being used unnecessarily. A radical change was needed in terms of prevention of admissions and early discharge.

It was possible to save money where there was a duplication of services. Telford & Wrekin CCG had identified that savings could be made in the diabetic network without detrimental impact to the patient. Through these sorts of initiatives change could be made and capacity would be freed up to assist primary care in looking at patients differently with long term conditions. Both CCGs through the governmental process had assured themselves of this approach.

The closure of cottage hospitals especially in Shropshire generated a great amount of public involvement in wider issues and this had generated a lot of interest in accountable care. The reconfiguration of services was a tremendous opportunity to include the public in wider issues where social care and primary care were coming together.

Dr Povey pointed out that Future Fit had started with a Call to Action in 2013 about the redesign of acute services, as a result of the fragility of services. Community and hospital plans had to be split into chunks as not everything could be covered at the same time, it was too complex and difficult. It was acknowledged that the hospitals and social services were under significant strain and would continue to be in the future, for example with the high child obesity rate in Telford & Wrekin. Investment was needed in community and primary care. The Committee reinforced the need for greater detail and asked at what point it would become available. It was noted that spring 2018 was

the point of the Decision Making Business Case, autumn 2018 was the stage at which the Full Business Case would be put together. In the PCBC, section 12 assumptions were clear and at this point the CCGs had confidence. They could not wait any longer to find a solution for acute services.

The Committee pressed for proper engagement with the public in all plans. There was a concern about the lack of public involvement in Sustainability and Transformation Plans (STP). The CCGs confirmed that the STP was changing how health care was delivered in the community and by the time of the Full Business Case the CCGs would have a huge amount of input from the public through consultation engagement about community and primary care provision. It was noted that the public would not have the confidence in healthcare in the future if the CCGs were not transparent. The Committee stressed that clarity would be required on what was not being consulted on and felt strongly that it would be good practice to scrutinise the STP in more depth. The Committee agreed to come back to the STP and look at how scrutiny could be involved. It was acknowledged that Shropshire, Telford & Wrekin Councils were involved in the STP.

A question was raised about the number of services that would be lost – 70-80 % bed bases and the workforce plan showed that there were 4051 full time equivalent staff to be reduced by 330. The Committee felt that the CCGs were asking the public to take a lot on trust; reduced numbers of beds, reduced numbers of posts, and this would happen smoothly, integrated with community and primary care. David Evans confirmed that the PCBC presented reductions in staff in the acute sector but this meant the movement of staff, for example where there was greater demand for therapists in the community than in hospital, the therapists would be redeployed in the community. It was not about saying less clinical staff would be needed. He confirmed that the CCGs expected the majority of savings would be achieved through the reduction in locum staff.

Looking at delayed transfer of care, the Committee asked whether year by year modelling had been carried out. The CCG Officers confirmed that year on year bed numbers would go to NHS England on 6th November, reassurance would be given on bed bases in line with increased capacity. The performance and utilisation of beds needed to be understood and this would be shown in the Year on year data. The Committee felt that assurance was needed on the reduction in beds and this needed to be embedded in the PCBC and consultation documents in order to show the impact.

Debbie Vogler said that there was no reduction in current beds, critical care or ambulatory, and there was an increase in capacity. Supplementary information would be provided on this as and when it became available at all engagement events throughout the consultation.

The Committee felt that communication was vital, the information had to be described in a simple effective way. At Bishops Castle / or / at Community Hospitals in rural Shropshire, General Practitioners on the whole were persuaded by the concept that health services could be delivered differently under Future Fit but there should be less confusion about the way services would be delivered. Despite this buy-in there were still concerns about the rural issues, community care and engaging GPs. The CCGs were clear that GPs had been engaged with acute service reconfiguration over the last four years, and they were all involved through the STP Neighbourhood work. Community services was part of the solution, removing activity out of acute care. The vast majority of GPs had signed up to this and were agreed on upon it as far as the CCGs were concerned.

It was agreed that the Committee understood the direction of travel; care closer to home, but capacity in the system and transparency of how resources would be shifted to enable this model to work was a serious concern. The Committee suggested that the CCGs give assurance and detail where possible to assist the consultation process about show how the model could be made to work. At this time, the

Committee could not endorse that the Future Fit plans were robust. Members expressed their concern that the public consultation document did not allow for cross-referencing, there was discontinuity and it was intentionally opaque. The Committee cautioned that the only thing that the public would take away from the consultation was the location of the Accident and Emergency service.
In terms of the options it was felt that more information was required on what the outcomes would be for options A & B. The Committee also asked what the outcome of the process of consultation would be.

David Evans said that the two CCGs would need to demonstrate that all responses from the public consultation would be taken into account. It would not be helpful if responses gave only a preference for where the A&E should be situated, instead responses that described the services that the public wanted and why would be more valuable, The CCGs would have to consider alternative proposals and ideas, and demonstrate why solutions were rejected. It was felt that it would come as a shock to the public that the consultation was not a democratic vote. The CCG Officers were asked how they would show the public that their views were being taken into account. Even if there was an overwhelming public vote it would not necessarily lead to the CCGs determination. The CCGS would be very transparent about taking the public views into account giving the reasons why they agreed or disagreed with proposals.

In terms of redeployment of staff, existing locum staff all carried out necessary duties and functions, the Committee wanted to know if locum jobs were cut as proposed how the duties and functions would be covered. It was noted that A&E locums made up five consultants which the CCGs envisaged would become substantive roles. A locum was counted as full time equivalent.

In the description of Women's and Children's services, there was no mention of maternity, nor the growing number of people with dementia. There is no information as to how Future Fit would improve services. Users of healthcare services were often people that came from more isolated positions in society, they were the critical users of services and they needed to be engaged with as one of the more significant harder to reach groups. The Chief Officer said he would welcome Members' suggestions in reaching these groups.

At the meeting on 25th September, there had been a discussion on the benefits and dis-benefits of the Options and this had been articulated in the informal Joint HOSC recommendations submitted to the Future Fit Programme Director. It was felt that the dis-benefits had not been sufficiently addressed within the revised consultation document and that an admission of what the downsides were should be included. David Evans agreed to re-look at this.

The Committee raised concerns about the significant impact on the proposals affordability of the sensitivity analysis on the ambulatory modelling and asked the CCGs when this would be addressed. The Chief Officer explained that the Ambulance service was commissioned externally within and as part of the West Midlands, which made it challenging to provide the detail. However in addition to number crunching, activity and pathway analysis, the CCGs were looking at how the risks would be mitigated. It was noted that the first part of the consultation would happen without this being included but it would be available for Full Business Case. A suggestion that a shuttle bus between the two sites hourly for patients attending the hospitals would be welcome.

The Co-Chair asked that the Joint HOSC be kept informed of progress of the NHS assurance process and that a meeting could be arranged at short notice. The Joint HOSC intended to engage the public which is why early sight of the consultation would be appreciated. It was pointed out that sight of the

consultation plan/ communications plan would have been useful but it was understood that NHS England had to sign it off.

Chairs Update
A brief update was given on recent activity; a stakeholder letter had been received from the NHS regarding changes to the Renal Psychology Services. Further information had been requested to identify whether it was a substantial variation in service.

The meeting ended at 4.04pm

Chair: …… Date: ……..