Dear Secretary of State,

We are writing to you as the Co-Chairs of the Shropshire and Telford and Wrekin Joint Health Overview and Scrutiny Committee (Joint HOSC) on behalf of the members of this Committee.

We would like to request a meeting with you and representatives from our Health and Care system to discuss the concerns we set out in this letter in more detail and seek your assistance in working with the appropriate agencies to realise the availability of the help and resources that Shrewsbury and Telford Hospital Trust (SaTH) and the system locally require to attain sustained, continuous improvement and ensure good care and outcomes, including patient experience, for our communities. We also want SaTH to be recognised as a great place to work, in order to attract and retain the best talent. The timing of this request seems to us to be optimum given the recent change in leadership at SaTH and the opportunities this presents to move forward together.

As a committee, we work apolitically and effectively to provide robust critical friend challenge to improve health and care services for our communities. We amplify their voices and raise their concerns to local bodies. The Joint HOSC has been in place for 20 years, maintaining a clear and consistent view of health and care services across both local authority areas.

Our recent focus areas include:

- Winter planning (regular annual review of learning, impact and plans)
- Urgent and Emergency Care
- Shrewsbury and Telford Hospital Trust (SaTH) Quality and Performance
- Maintaining a view of the Hospital Transformation, including concern over the number of acute beds and the relationship with the Local Care Transformation Programme.

The Committee is deeply concerned about the ongoing poor performance at SaTH and the impact this is having on patients, their friends, family and staff. The most recent CQC report and the Channel 4 ‘Dispatches’ programme, which aired in May, highlighted issues that we have been scrutinising for the past two years (and raising concerns about for more than a decade.) The programme vividly depicted the reality of the data and issues we have been challenging locally since before the pandemic and as part of the more recent NHS recovery work.

The Committee have also been working with the local health system to understand more about what appears to be a higher-than-expected number of excess deaths in the SaTH UEC departments. Although no conclusions have yet been drawn there is data to suggest excess death rates at SaTH run A&E services are significantly higher than they are expected to be and appear to be at higher levels in comparison with other Trusts. All the issues above, as well as the well-documented historic issues of inadequate care, poor outcomes, and distressing experiences for patients and their families within the Trusts maternity department risk a loss of confidence in the services provided by the Trust and

there is evidence of this occurring with patients already seeking care elsewhere. Just this week the media locally have shared reports that the acute hospitals were the second worst in the country for the number of emergency patients waiting more than 12 hours for a bed last month. The local press also reported the concerns of Donna Ockenden that the previous leadership of SaTH had failed to communicate effectively with families:

> *"The reason I am back here in Shrewsbury, meeting some of the affected and harmed families, is because families were really clear that the trust wasted two years in not communicating with them"*

Following the airing of the Dispatches documentary we initially considered writing to you in July 2024 but decided that we needed to ensure we had fully explored the matter at a local level first. Therefore, in August 2024 we held a formal meeting of the Committee where we met with representatives of SaTH and the ICB. The Committee were concerned when informed by the local NHS officers present that they were not surprised by the outcomes of the CQC report or the findings of the Dispatches programme. At this meeting we took up the offer extended by the NHS Shropshire Telford and Wrekin Chief Executive to create a working group alongside Members of the JHOSC, to delve into those must do's and should do's of the CQC report in greater detail and understand the improvement plans which would deliver them. However, following this work due to the ongoing performance at the Trust especially its UEC departments we felt that we needed to write to you.

Over the years that the Committee have been working with the NHS locally on these and related issues there have been numerous changes to leadership in the organisations. Whilst change to senior staffing is not unusual, it is the experience of the Committee that despite their best efforts this churn has not resulted in changes discussed and expected, and that despite these efforts, ongoing performance issues at SaTH compel us to write to you.

Our respective local authority HOSCs have investigated contributory factors such as what is provided in communities including Primary Care. Shropshire Council conducted a system-wide investigation to understand issues and opportunities from prevention and primary care through UEC to discharge.

This investigation has informed the Joint HOSC's work programme for the past 18 months. We highlight our effective collaboration on these important matters and our understanding of the system's response to address the issues, including the roles of CQC and NHSE, while emphasising SaTH's responsibility and accountability.

In October 2023, we met with the Chief Executives of SaTH, the Integrated Care Board, and Shropshire Community Health Trust to understand SaTH's performance. While NHSE and CQC were invited, the CQC immediately declined with the NHSE deciding not to attend, as they believed system leads were best placed to answer our questions. However, the most recent CQC report, the Dispatches programme and our own findings indicate that the issues remain unresolved.

We believe the challenges of demography and geography in the Shropshire, Telford and Wrekin system need better national funding and support. For example, NHSE Midlands

identified our local system as the most challenged for UEC in the East and West Midlands. We are unable to see how this evidence has shaped action to deliver better, sustainable health and care provision needed to meet current and forecast local needs.

Following our meeting on the 16th of December 2024, we remain very concerned and have therefore decided to write to you.

In addition to the other points set out in this letter, the Committee are particularly concerned about the following issues that have been identified through their work, raised in the CQC report and shown in vivid reality and stark relief in the Channel 4 'Dispatches' programme.

We would be very keen to discuss these, and other matters related to improving our local acute hospitals with you.

- We were shocked to see the practice where a patient is left in the ambulance reception area at SaTH without any handover to the A&E staff in the Dispatches programme which was referred to as "Drop and Go". Surely this is not best practice, or even good practice. We believe it is high risk for the patient's safety and it also creates additional stress and pressure for those who are working in those areas. The Shropshire Healthwatch report into patient experiences of calling for an ambulance in an emergency provides an insight into this. Appendix 2

- The Dispatches programme highlighted concerns over leadership and the delivery of sustainable improvements. The CQC report highlighted that staff in the ED at RSH were not aware of the escalation level that they were working at. There is also the question over mandatory training not being completed, and the adequate staffing to deliver acceptable levels of care and safety.

  The Committee would like SaTH to be recognised as a great place to work, but this may be more of a challenge given the following data included in Appendix 1.

  The Committee is conscious that since the CQC report was published a number of new senior officers have joined both SaTH and the ICB. We see this as an opportunity to support them in making the sustainable changes required to improve performance.

- Suitability and appropriateness of 'fit to sit' in general and especially in relation to people with significant health concerns including heart conditions and suspected strokes.

- Regarding the NHSE statement at the end of the Dispatches programme. Prof Julian Redhead, NHS England's National Clinical Director for Urgent and Emergency Care, said what was seen at the Shropshire NHS trust in the programme:

  > *"not commonplace in A&Es across the country" and was "not acceptable"*

  We were both confused and somewhat perturbed by this NHSE statement at the end of the Dispatches programme which suggested that the issues raised at the Royal Shrewsbury Hospital A&E were not usual in other hospitals. This runs counter to the statements and opinions shared in the programme by Dr Adrian Boyle, President of the Royal College of Emergency Medicine who told Dispatches:

  > *"I don't think this is unique to this hospital by any stretch of the imagination. The things we've seen here today are clearly not just confined to winter. It was a year-round crisis in emergency care."*

  The findings of the Darzi report, as well as in many stories covered in national, regional and local media across England would suggest that these issues are a national challenge, but we are concerned that data in Appendix 3 shows that according to the Telegraph's NHS Trust Performance Tracker at the time of writing this letter SaTH is the worst performing acute hospital in England.

- We have extrapolated from information visible in the filming that the Dispatches programme appears to have been filmed during May 2024. This is over six months after we understand that the CQC inspection of SaTH took place in November 2023. We assume that CQC would have provided immediate feedback to SaTH on any concerns they had based on what they had witnessed? On this basis we do not understand what happened in those six months to deliver improvement. What was seen in the Dispatches programme could, in no way, be viewed as an improved/good service, or more worryingly was it an improvement on what CQC observed in November 2023? We would therefore suggest that the CQC return to SaTH to check whether improvements have been made and provide a baseline to the incoming senior team of the challenges they face to achieve true sustainable improvements.

- With the Dispatches focus on UEC, and considering the CQC report, the CQC rated the UEC at Royal Shrewsbury Hospital as 'requires improvement. Worryingly for our communities, they rated the UEC at the Princess Royal Hospital in Telford as 'Inadequate'.

Taking these ratings for the two acute hospitals into account, Members were particularly concerned to see that CQC had evaluated the UEC departments at both hospitals as 'requires improvement' for Caring. We are struggling to comprehend how a service with a primary purpose of providing care to those at their most vulnerable, in the vast majority of cases, when they need to access UEC services, can be rated as anything lower than 'Good', which appears to be the rating that most other UECs across the country receive.

- The pattern of CQC ratings for overall performance at SaTH shows that there has never been a rating of good or outstanding since the CQC introduced inspections in 2014 Appendix 4.

We look forward to receiving your response to our letter and hope to be able to discuss the issues and opportunities to help our communities have access to health and care services that are consistently good.

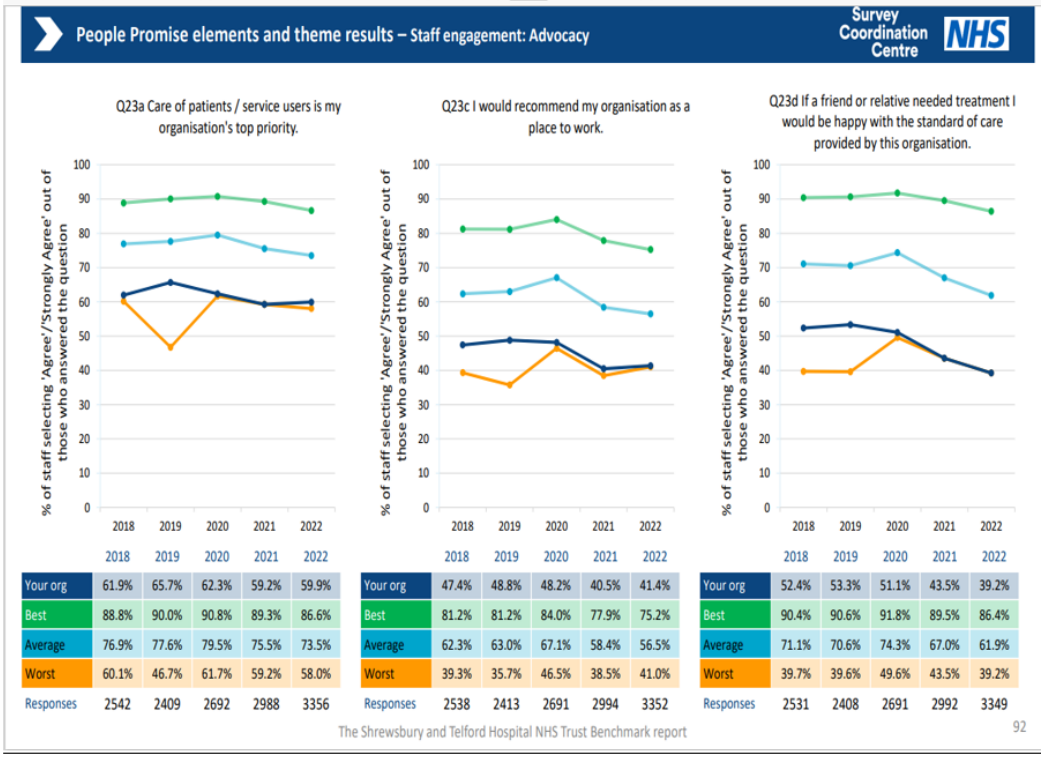
Yours sincerely,

Cllr Fiona Doran Co-Chair, Joint Health Overview and Scrutiny Committee

Cllr Geoff Elner Co-Chair, Joint Health Overview and Scrutiny Committee

Appendices

Appendix 1



Appendix 2

[Calling for an ambulance in an emergency | Healthwatch Shropshire]

Appendix 3

[NHS tracker: England's best and worst hospitals ranked]

Appendix 4

[All inspections: Shrewsbury and Telford Hospital NHS Trust - Care Quality Commission]

2024

Overview

Latest inspection: 10, 11 October 2023 and 12,13 November 2023 Report published: 15 May 2024

Safe	Requires improvement
Effective	Requires improvement
Caring	Good
Responsive	Requires improvement
Well-led	Requires improvement
Use of resources	Requires improvement
Combined Rating	Inadequate

2021

Mytton Oak Road
Shrewsbury
SY3 8XQ
Tel: 01743261000
www.sath.nhs.uk

Date of inspection visit: 6 July, 7 July, 13 July, 14 July, 19 July, 20 July 2021, 17 August, 18 August and 19 August 2021
Date of publication: 18/11/2021

Ratings

Overall trust quality rating	Inadequate
Are services safe?	**Inadequate**
Are services effective?	**Requires Improvement**
Are services caring?	**Requires Improvement**
Are services responsive?	**Inadequate**
Are services well-led?	**Requires Improvement**

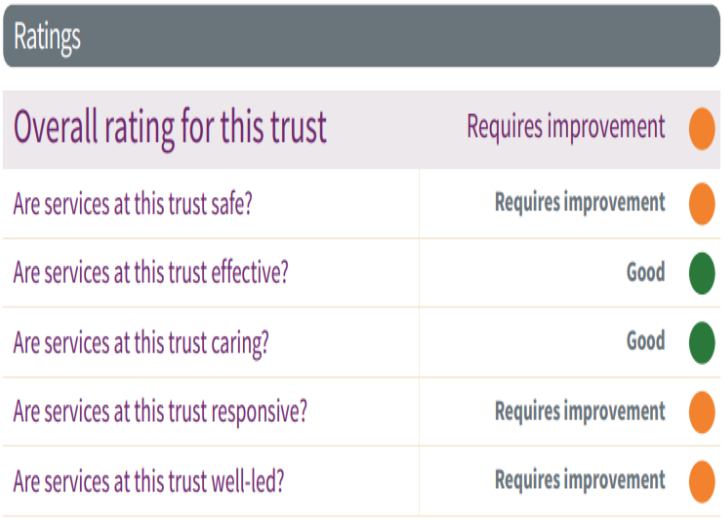
2020

Ratings	
Overall trust quality rating	**Inadequate**
Are services safe?	**Inadequate**
Are services effective?	**Inadequate**
Are services caring?	**Requires improvement**
Are services responsive?	**Inadequate**
Are services well-led?	**Inadequate**

2018

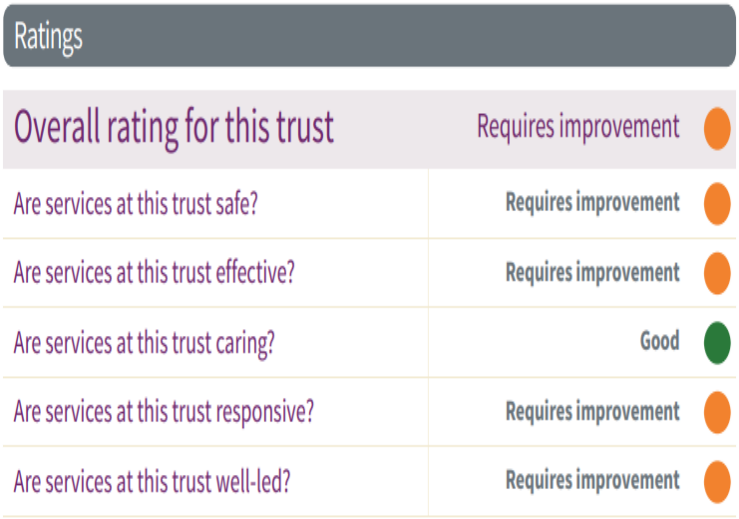
Ratings	
Overall rating for this trust	**Inadequate**
Are services safe?	**Inadequate**
Are services effective?	**Requires improvement**
Are services caring?	**Good**
Are services responsive?	**Requires improvement**
Are services well-led?	**Inadequate**
Are resources used productively?	**Requires improvement**
Combined quality and resource rating	**Inadequate**

2017



Ratings	
Overall rating for this trust	Requires improvement
Are services at this trust safe?	Requires improvement
Are services at this trust effective?	Good
Are services at this trust caring?	Good
Are services at this trust responsive?	Requires improvement
Are services at this trust well-led?	Requires improvement

2015



Ratings	
Overall rating for this trust	Requires improvement
Are services at this trust safe?	Requires improvement
Are services at this trust effective?	Requires improvement
Are services at this trust caring?	Good
Are services at this trust responsive?	Requires improvement
Are services at this trust well-led?	Requires improvement