Joint Health Overview and Scrutiny Committee 7 August 2024 2.00 pm	Item Public

MINUTES OF THE JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE MEETING HELD ON 7 AUGUST 2024
2.00 - 5.00 PM

Responsible Officer: Emily Marshall
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Members Present
Cllr Geoff Elner (SC Co-Chair), Cllr Edward Towers (SC), Cllr Fiona Doran (T&W Co-Chair), Simon Fogell (T&W Co-optee), Anne Mitchell (SC Co-optee), David Sandbach (SC Co-optee), Cllr Derek White (T&W)

Also Present

Tom Dodds, Scrutiny Manager, Shropshire Council
Hayley Flavell – Director of Nursing, Shrewsbury &Telford NHS Hospital Trust (SaTH)
Sophie Foster, Overview and Scrutiny Officer, Shropshire Council
Simon Froud, Director of Adult Social Care, Telford and Wrekin Council
Lorna Gordon, Democracy Officer, Telford and Wrekin Council
John Jones - Medical Director, Shrewsbury and Telford NHS Trust (SaTH)
Emily Marshall, Committee Officer, Shropshire Council (minutes)
Helen Onions, Interim Director of ASC, Telford and Wrekin Council
Paige Starkey, Senior Democracy Officer, Telford and Wrekin Council
Cllr Paul Watling, Cabinet Member Adult Social Care and Health, Telford and Wrekin Council
Vanessa Whatley – Chief Nursing Officer, NHS Shropshire Telford and Wrekin
Simon Whitehouse – Chief Executive NHS Shropshire Telford and Wrekin

1 Apologies for Absence

Apologies for absence were received from Cllr Nigel Dugmore (T&W), Cllr Heather Kidd (SC) Hilary Knight, Cllr Heather Kidd, and Cllr Nigel Dugmore.

2 Declarations of Interest

None declared.

3 Minutes of the Meeting held on 16 May 2024

RESOLVED:
That the minutes of the meeting held on 16th May 2024 be confirmed as a correct record.

4 Shrewsbury and Telford Hospital Trust

The Co-Chairmen welcomed all present to the meeting and reminded the Committee of their role. The Chairman began by welcoming those present to the meeting and providing background to the purpose and role of the Joint Committee. The focus of this meeting was the CQC report but also the Dispatches Programme which aired recently.

Following brief introductions, the Committee posed the following questions to Dr John Jones – Medical Director for the Shrewsbury and Telford NHS Trust (SaTH), Hayley Flavell, Director of Nursing, SaTH, Simon Whitehouse, Chief Executive – NHS Shropshire, Telford and Wrekin Integrated Care Board and Vanessa Whatley, Chief Nursing Officer, NHS Shropshire, Telford and Wrekin ICB :-

Do you accept the contents of the CQC report and the recommendations within it?

Yes

Can you explain or provide an analysis of why ever since 2014 the CQC reports for SaTH have never been better than Needs Improvement?

Dr Jones responded by agreeing with what had been said during the Chairman's introduction and confirmed that he understood the alarming nature of what was seen on the Channel 4 Documentary, Dispatches and the impact that it would have had on residents of Shropshire and Telford and Wrekin and current and future patients. Dr Jones stated that he wanted to make it clear from the beginning that they did not consider what was shown on the programme acceptable either.

The Trust had always required improvement during that period and the focus of that improvement had changed during over time. The main focus had always been on how we manage people who need urgent or emergency care. It was added that there has always been the need to improve care particularly with regards to urgent and emergency care. The particular challenges of an increasingly frail population were outlined. It was acknowledged and accepted that in the past the SaTH had not reached out and worked closely enough with some of their partner organisations e.g. social care, primary care and other providers.

Recruitment in some areas had also been a theme, it had been particularly difficult to recruit into emergency medicine. Dr Jones acknowledged that on the whole SaTH had been behind with a rapidly changing way in which health care was delivered and along the way hadn't been joined up enough.

Hayley Flavell commented that although the CQC report was reflective of the organisation and the improvements that needed to be made in urgent and emergency care, which had been prioritised, Hayley also highlighted that the CQC report did also reflect many improvements that had been made since the 2014 report. Improvements in other areas, such as maternity services, children and young people's services and palliative end of life care were highlighted. The focus of improvement work since the CQC report had been urgent and emergency care. The

importance of ensuring the emergency care pathway was working efficiently was explained and there was work to be done on all aspects of that pathway into urgent and emergency care.

If we take the Must Do's as CQC's most recent red flags how have the actions been developed and collated to address them?

Hayley Flavell reported that there had been a two day onsite inspection of all the core services and immediately following that inspection, the Trust received a letter which outlined the areas of improvement and the areas that were found to be working well. Following this, conversations within the CQC were had as significant problems within the Princess Royal Hospital (PRH) site had been identified. Specifically, patients were being cared for in corridors but the Joint Committee were informed that this was as a result of balancing risks associated with waiting in ambulances and other parts of the hospital. Immediate actions were taken to address this specific issue, which then fed into the transformation work undertaken. All of the urgent and emergency care transformation work was being overseen by the SaTH Assistant Chief Operating Officer, Sara Biffen and all work challenged through a committee which included existing workstreams, immediate actions from the CQC and the actions arising following the publication of the report. A robust action plan was in place with 33 'must' and 'should do's' in total.

Are there any Must Do's that haven't been implemented?

Hayley Flavell responded by explaining that the 'must' and 'should do's' were a work in progress and were part of the overall transformation work. It was confirmed that additional information could be provided outside of the meeting forum if required. We have had support from regional colleagues. The focus of the work had been in the Trust's Emergency Departments which were extremely busy and overcrowded.

When would the actions be ticked off, are they sustainable actions and how can we track the actions?

The Joint Committee were informed that each 'must' and 'should do' had an action and a set of requirements to demonstrate that the action was in progress or completed, using reverse RAG rating system. When delivered the action is implemented and it doesn't turn green until there is evidence through an audit that it is embedded within the organisation. These are monitored and scrutinised by the Urgent and Emergency Care Transformation Committee. There are external attendees on that committee, so it is a robust committee which tests the evidence put forward. The tracking around the actions and progress was robust.

In response to a further related question, Simon Whitehouse confirmed that he was aware of the Academy of Fabulous Stuff and this was one way of sharing and learning. Work with regional and national colleagues was ongoing. A 'must do' was not a simple yes or no, it was vitally important that what was delivered against these action points was sustainable and robust and goes through the appropriate governance processes to demonstrate that improvements were embedded into the organisation.

What feedback did you get during and immediately after the CQC Inspection so that in the 6 months from the Inspection until when the covert filming took place, what actually were you able to address and do?

Hayley Flavell responded that the Inspection took place in October over a period of two days and feedback was shared immediately after the inspection with the Executive Team and this was followed up with a letter which went to the public board. Treating patients in the main corridor of the Princess Royal Hospital was immediately highlighted as a specific issue. As an organisation, treating patients in corridors was not what anyone wanted but it was about lowering the risk of patients waiting in ambulances and in response to an extremely busy and overcrowded emergency department. This standard of patient care was unacceptable, and the Trust could only apologies to their communities. Since the publication of the CQC report we included all the findings within our transformation workstreams, for example we no longer care for patients in corridors. Following Inspection our hospital fall programme was reviewed as one example. The review of the fit to sit area at both sites was outlined.

The suggestion was put forward that establishing a Task and Finish Group to report on actions completed and in progress would be a way forward with ongoing reports to the Joint HOSC.

The Chairman commented that it was clear during the Dispatches Programme that staff were clearly upset and distressed in response to their working conditions and questioned what was being done to improve staff morale?

Dr John Jones, responded by confirming that it was made clear to staff that although there were conversations that needed to be had with some members of staff it was senior leaders who had overall responsibility to provide good care. It was a recognition that on particular days that filming took place the Trust were not able to provide the level of care they should have done. The Trust learnt a lot during the review of maternity services and as a result had developed a strong psychology service and various responsive ways of dealing with staffing issues as they arose. The Trust recognised that staff were doing their best in extremely difficult circumstances. Staff were also supported by the Trust while the programme was aired. The importance of learning from mistakes rather than allocating blame was stressed.

How were the situations depicted in the Dispatches Programme occurring if there was a focus on making the improvements that were highlighted in the earlier CQC Report? Did the Dispatches Programme tell the Trust anything they did not already know?

Hayley Flavell explained that the Dispatches Programme did not tell the Trust anything they did not already know. What Dispatches showed was the challenges the Trust has and the challenges they were working hard to address, for example and overcrowded Emergency Department, areas where improvements were needed and an opportunity to review the fit to sit areas. The ‘must do’s’ in the report were all complex areas of regulation and were all part of the complex transformation work.

Commenting that there had been 10 years of failure, and that during the election the number one concern of local electors had been the state of their local health services, the question was raised - What happens if this failure continues, where do you go from here?

A member commented that it seemed that the was an easy target for the programme and that's why it was chosen. The SATH representatives were reminded that the Joint Hosc were here **as** a critical friend and could make valuable contributions to progressing improvements within the Trust.

Simon Whitehouse responded by acknowledging that everyone in the room wants to improve services across Shropshire and Telford and he fully recognised the importance of consultation and engagement with partners and recognised the value and positive difference that Scrutiny would bring. It was added that those representing the Trust today and their colleagues recognised the supportive role of Scrutiny and they all recognised that there were areas within which they could do better.

The Chairman commented that it seemed apparent that communication was lacking, it had been three months since the program aired and it seemed that the Trust were not actively publicising the actions that were being done to address the issues raised in the CQC report and the Dispatches Programme. Hayley Flavell commented that she and Dr Jones were happy to meet on a regular basis with council's and colleagues.

In response to comments made in relation to funding, Simon Whitehouse highlighted a report recently published by the National Audit Office which detailed the limitations of the national funding programme and how issues such as rurality, low population, high geographic area and impact on the national funding formula.

The Trust had been required to give several million pounds back to pay off historic debt, and this had an impact on the available resources for this year.

The workforce piece of transformation work was fundamental, making sure the Trust could recruit staff into challenging conditions was difficult and needed work. There were various stands or work to be done and the messaging around why working in Shropshire, Telford and Wrekin was positive and attractive.

In response to comments made by a Committee Member, Vanessa Whatley explained that a report had been prepared into why the Emergency Department was so congested. It identified that there were too many people coming into the system and what could be done about it. Vanessa outlined various workstreams that were ongoing to address the issues identified, working with public health colleagues and local communities.

As a patient having contact with ground level hospital staff, how will you provide me with the confidence that the situation is improving?

In terms of saying how do we get the communication right, so wherever your point of contact you get the message that we are on the right direction in terms of change.

Simon Whitehouse confirmed that this was an important point and he would take it away.

How can we address the CQC issues, address issues that came out of the television programme with the background of the financial problem we have?

Simon Whitehouse explained that ongoing investment nationally was required if to ensure that the NHS is delivered in the way that people expected it to be and that was a decision at national government level. As a system, we are some 9% deficit versus turnover, which was significantly higher than other integrated care systems in that space. 9% was too high but it was lower than it had been last year. Therefore in terms of percentages and reducing that figure, the Trust was in a better place than it was last year, but it was not where we would want it to be.

In terms of cuts to community services, that is not something that has happened locally. The Integrated Care Board, has invested in Community services locally and invested in in additional services to support some of the challenges that had been talked about,

Shropshire, Telford and Wrekin were actually one of the few areas that had continued to invest in community services. In terms of supporting those services and looking to make progress in that area whilst continuing to meet funding obligations.

Funding commitments had been maintained but that was not the case across other parts of the country. Going forward, the Trust needed to keep bringing that percentage down next year to be less than 9% but confirmed that would not happen at the expense of community provision.

We were interested to note that CQC rated the UEC at RSH as Requires Improvement, but the same service at PRH was rated as Inadequate. How could the same service operated by the same trust on two sites achieve such different ratings?

The challenges on the PRH site related to safe and responsive and as had been explained earlier it was felt that the CQC report was reflective of the organisation and the challenges that exist.

In terms of the Royal Shrewsbury Hospital (RSH) site was rated as required improvement. The safe rating was with regards to the corridor being used for caring for patients and I've also said that none of us think that is acceptable. But at the time it was about balancing risk, the risk of people waiting in ambulances.

SATH was one organisation, with one executive team and four divisional teams, in terms of the urgent and emergency care and medicine, it was one team and the systems, processes, policies, and workforce were across the whole organisation. The challenges of the two emergency departments were quite different. The RSH emergency department was slightly bigger and more tricky to get around because it had various sections built on, the PRH emergency department was a smaller footprint. It was explained that there were commonalities but also significant differences. But the main rating change was the safe rating and that was down to the care of patients in the corridor. It was confirmed that patients were no longer cared for in corridors and this was unacceptable.

The Trust were aware that there were challenges with demand and capacity. It was acknowledged that there were challenges with the bed gap and so it was vital to ensure that processes were right.

Hayley Flavell provided an update on some of the changes already implemented including moving the Emergency and Urgent Care Treatment centre, which was located within the Emergency Department footprint to the Malins Building which was still within the PRH site. This had allowed for a designated space for children and young people with designated waiting rooms, more treatment rooms and this has had a positive impact on triage times for children.

There had been lots of work at the PRH site, including the creation of an elective hub that had been created on the first floor, which has created more space in the Emergency Department. Hayley confirmed that there were no main corridors being used to treat patients, however there were ED corridors that could be used when the hospital was at capacity. The meaning of a hospital full policy was explained.

We understand that the normal process for a CQC inspection would include a Use of Resources evaluation and that this report would accompany the related inspection report.
Did you get a copy of the Use of Resources Report and can you tell the Committee what it said?

Simon Whitehouse responded by confirming that he was unsure and would report back to the committee. The Chairman confirmed he was happy with this approach.

The Committee are concerned to see the frequency that equalities, safety and safeguarding came up in the Must Do's in the CQC report what actions are going to be taken, by when to ensure that the issues which resulted in these judgements will be addressed and no longer be a concern.

Dr Jones asked if this question could be taken up outside of the meeting and a further discussion take place. Vanessa Watley provided an update on safeguarding within the Trust and the way that safeguarding worked within the Trust. It was explained that an improved and rigorous system was in place. Every team had a designated safeguarding lead and they worked across children's and adults services, the Trust were confident that they were very visible and mobile on the wards. Two visits had been made to the two ED since Dispatches, and safeguarding has been a focus on these visits. They checked with staff and asked them to explain policies, procedures and processes to report safeguarding issues. All of this work provided assurance that good practice was in place. With regards to children who visit the ED but leave before being seen by a clinician, robust follow up systems were in place to check on children, checks were made with those parents/guardians the following day.

In response to a question regarding the prioritisation of the 'must do' list and whether this list could be shared with the Joint Committee, Hayley Flavell confirmed that this could be considered and she would find a way to share with the Committee. It was added that the key theme was also the governance around the actions.

In response to the question raised early in the meeting about the separate use of resources report in the main CQC report, Simon Whitehouse confirmed that there was **not** a separate use of resources report.

Simon Whitehouse also asked the committee to note that the number of 'must do's' in 2023 had decreased from the original figure in 2018. It was an important point to note that this was a significant change and progress was being made but it was also stressed that this did not diminish the work that was still ongoing.

With regards to timescales against each action, Hayley Flavell reported that there were timescales and a reverse RAG rating was used since 2021. A RAG rating system had proven to be a very successful methodology and had been used in the transformation of maternity services and was being used throughout the transformation work. The process of reporting and feeding through committee's was outlined, progress was monitored vigorously by independent boards and by local authorities.

The Chairman asked if there could be a system in place for the Joint Committee to monitor and review progress on a regular basis. This suggestion was agreed, and a key action was to consider how to proactively share the right information in a timely manner.

Simon Whitehouse thanked the Committee for the opportunity to open the dialogue and for handling the difficult nature of the topics discussed in a professional way. He hoped the Joint Committee felt that open and honest conversation exchange had taken place. The offer and commitment to continue to work together was confirmed.

Simon explained that he had identified that there was a theme around communication to take away and further consideration needed to be given to how information was shared in a timely way and a staff piece, and how does every single member of the health and care workforce understand the improvements that were taking place and be able to talk about this and build confidence and the messaging of the importance of the NHS locally.

In terms of the CQC report, he was committed to establishing a Task and Finish Group to review the 'must do's and should do's'. There is value in establishing a group to do this in more details. There was also a theme around improvement and establishing change, this was important, and it was acknowledged that more of this needed to be done.

The final theme was around a genuine commitment to ongoing dialogue and discussion in a way that adds value to local people.

Mr David Sandbach raised a question in relation to the number of cardiologists employed by SaTH, Dr Jones responded by outlining the cardiology services currently provided and confirmed that cardiology was a difficult area to recruit and the service was dependent on locums.

The Chairman thanked Simon Whitehouse, Dr Jones, Hayley Flavell and Vanessa Whatley their attendance. Members commented that they felt encouraged at the

prospect of a task and finish group and confirmed that they were happy to work in that way going forward.

It was agreed that a way forward and action points would be discussed and agreed at the next informal meeting of the Joint Committee.

5 Co-Chairs Update

There was no Co-Chairs update for this meeting.

Signed …… (Chairman)

Date: