JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

Minutes of a meeting of the Joint Health Overview & Scrutiny Committee held on Monday, 16 December 2019 at 10.00 am in Walker Room, Meeting Point House, Southwater Square, Telford TF3 4HS

Present:

Shropshire Councillors: Karen Calder (Chair), Heather Kidd,
Telford & Wrekin Councillors: Cllr Kelly Middleton
Shropshire Co-optees: David Beechey, Paul Cronin, Ian Hulme
Telford and Wrekin Co-optees: Hilary Knight, Janet O'Loughlin, Dag Saunders

Also Present:

Sarah Biffen, Deputy Chief Operating Officer, SaTH
Tom Dodds, Statutory Scrutiny Officer, Shropshire Council
David Evans, Joint Accountable Officer, NHS Telford & Wrekin CCG and NHS Shropshire CCG
Josef Galkowski, Democratic Services and Scrutiny Officer, T&WC
Deborah Moseley, Democratic Services and Scrutiny Team Leader, T&WC
Claire Old, Urgent Care Director for Shropshire, Telford & Wrekin
Rachel Robinson, Director of Public Health, Shropshire Council
David Stout, Interim Transformation Director, Sustainability and Transformation Partnership
Bev Tabernacle, Interim Deputy Chief Executive for SaTH

JHSOC14 Declarations of Interest

None.

JHOSC15 Minutes of the Previous Meeting

RESOLVED – that the minutes of the meeting held on the 2 October 2019 be confirmed and signed by the Chair.

JHOSC16 Apologies for Absence

Councillor Derek White & Councillor Madge Shineton.

JHOSC17 Hospital Transformation Programme Update

The Joint Health Overview Scrutiny Committee received a verbal update on the Hospital Transformation Programme by David Evans, Joint Accountable Officer for NHS Shropshire Clinical Commissioning Group (CCG) and NHS Telford & Wrekin CCG. The Chair noted the Committee's dissatisfaction about the paucity of information or reports presented to the Committee. The Committee heard from Mr Evans that a draft strategic outline case had been written and seen by

the Trust Board as well as both CCG's, and that the document would be published early in the New Year. Further to this, Bev Tabernacle, Director of Transformation and Strategy at Shropshire and Telford Hospital was in the process of organising timelines. Members of the Committee asked questions and received responses as follows:

What is an A&E Local? Is it part of the Future Fit development? And if not, will there be further consultation for it?

Mr. Evans explained that some aspects were clear; in that it would be consultant led. However, what this meant in terms of how long it would be open and what other services could operate from it had not been determined. Likewise, Mr Evans explained that it was not clear how much would be determined locally and nationally, but this was being discussed with NHS policy advisors across the country. Mr Evans clarified that there were no plans to make the change until building work had been completed at both sites and that a change from an Urgent Care Centre (UCC) to an A&E Local would be an enhancement of service, not a reduction. If the A&E Local was only open for a period of time during the day, there would still be a 24 hour UCC provision.

Was Future Fit now known as the Hospital Transformation Plan?

Mr. Evans confirmed that upon submission and approval of the pre-consultation business case, the programme became a capital programme and not a development of a clinical model and business case. The implementation of the clinical model transferred to the NHS Trust, and the oversight group had provided assurance to commissioners and stakeholders that it was on track.

Can Future Fit/Hospital Transformation Plan be financially delivered as set out in the proposals?

Mr. Evans responded to this by confirming that the £312 million designated to the Future Fit could deliver the clinical model that was laid out in the original proposals.

JHOSC18 Transforming Midwifery Care Update

David Evans, Joint Accountable Officer for NHS Shropshire Clinical Commissioning Group (CCG) and NHS Telford & Wrekin CCG provided a verbal update to the Committee on Transforming Midwifery Care (TMC). He communicated that similarly to Hospital Transformation Plan, TMC reports and recommendations were going through NHSi assurance processes and that he expected to hear by January as to whether the proposals were acceptable to go out for consultation. Following on from this, the Committee asked a number of questions and received the following answers:

The recent Ockenden Report leak was contrary to what had been heard previously by this Committee. What was the view of the CCG on the leaks?

Mr. Evans responded that the CCGs had not seen the leaked document nor trusted the accuracy of it. It was conjecture as to where the leak came from, but it had been said publically by Ms Ockenden that the report would be ready towards the end of 2020. The CCGs would like to see it completed as quickly as possible, but it was important that women and families had the opportunity to raise concerns and that they were appropriately reviewed. Likewise, Mr Evans mentioned that he welcomed the findings of the latest Care Quality Commission (CQC) report about Maternity Care in SaTH, but did not want to convey complacency in recognising the work that was still needed to be done.

The Ockenden report leak had led to local action and the public encouraged to use Ockenden process.

Mr. Evans echoed that individuals should use the Ockenden process if they felt it relevant to them and that he understood that some individuals wanted some recourse.

Was there certainty that what had gone forward to NHSi was flexible enough to take account of any report recommendations?

Mr. Evans responded that he believed there was flexibility to incorporate any Ockenden recommendations into the final model. For example, some cases related to births in standalone birthing units in smaller market towns and that was not a continued offered in the proposals which recommended midwifery led births only in free standing birth centres. He stated that the Team was cognisant about the model being the right one from a safety point of view for pregnant women and their children.

There was a review 5 years ago, and it felt like nothing was learned from this. The public wanted assurance that it would not happen again moving forward.

Mr. Evans emphasized that he didn't want to come across as complacent or minimizing what had happened but that the Trust had delivered roughly 5,000 babies per year for the last 40 years, and that cases in the Ockenden Report were therefore relatively small numbers in real terms. If the leak was correct, then a cause for concern was the approach the staff took in dealing with women and families that went through traumatic episodes.

The discussion concluded that more evidence was needed in terms of comparative statistics and human factors on the topic of midwifery care in Telford, Wrekin and Shropshire, and NHS colleagues and Healthwatch could be invited to help provide this information.

JHSOC19 <u>Sustainability and Transformation Plan - Long Term Plan Update</u>

David Stout, Interim Transformation Director for the Sustainability and Transformation Plan (STP) made a presentation which summarized the 11 chapters of the draft version of the STP Long Term Plan (STP LTP).:-

- Chapter 1: System Structure and Governance to support delivery of change - Building on previous plan, system & clinical leadership, governance, quality, ICS development, vision and narrative
- Chapter 2: Shropshire, Telford & Wrekin at a glance - Demographics, deprivation & inequalities, life expectancy, premature deaths and mortality
- Chapter 3: Population Health Management - How data, evidence and insight was used to drive transformation priorities, population need and future demand
- Chapter 4: Delivering a new service model for Prevention and Place based integrated Care - Overall approach to out of Hospital Care, Prevention, Place based care, Primary Care, Frailty & End of Life Care
- Chapter 5: Mental Health Prevention and Wellbeing including Learning Disability and Autism
- Chapter 6: Acute Care Development - Hospital Transformation Programme, focus on Urgent & emergency care, maternity & neonatal services, Elective Care & Cancer
- Chapter 7: Support Services - Non clinical (back office support) and Clinical: Pharmacy, Pathology & Imaging programme to be fully worked up
- Chapter 8: Our People - Workforce understanding, development of new roles to meet future need Transformation to support individual Clusters / Programmes
- Chapter 9: Digital Enabled Care - Electronic records, information Governance, infrastructure & security Analysis, artificial intelligence
- Chapter 10: Estates - Estate utilisation, building maintenance, energy efficiency, future estate requirement and estate efficiencies
- Chapter 11: Financial Sustainability & Productivity - Setting out our financial position, efficiencies and expected financial trajectories

Mr. Stout emphasised that the key point to be taken away from chapter four was that there was the presumption that over time, healthcare would move to a preventative model and less reactive in admissions to A&E, concentrating on keeping people in the comfort of their own home. In relation to mental health summarised in chapter 5, he understood that there had been low investment in the mental health economy compared to comparators across the country, and that efforts were being made to change this. Chapter seven related to ambitious plans for recruitment and the issues that were being faced, not only in recruitment but retaining staff. Bev Tabernacle, Interim Deputy Chief Executive for SaTH, added that there was a 95% fill rate for registered staff and that an additional 8-10 nurse associates had been recruited. Mr. Stout stated that chapters eleven and twelve, described how there had been a significant financial growth of £850million into the healthcare economy, but this was not to undermine that social care still remained under pressure and the wider systematic economic stress. The starting point for the current year, was based

on the overspend for the previous year and therefore there was a need to balance the budget. Chapter twelve focused on the steps moving forward to deliver the plan.

Following on from what they had heard, Members of the Committee asked questions as follows:

What were the board arrangements for the Integrated Care System (ICS)? Who was it accountable to?

Mr. Stout responded that there was currently no statutory board that the ICS was accountable to but there was legislation in planned form for this. The ICS brought collective oversight from chairs and political leads round the table, and therefore was accountable to different boards and organisations in the meantime.

How did the ICS link with the LTP and the Single Strategic Commissioner (SSC)?

Mr. Stout responded that it made sense for the SSC structure to reflect that of the ICS and STP footprint, as per the direction of the national policy.

Members reflected on the plan to integrate provider organisations, and questioned how it differed to the way organisations work collaboratively now.

David Stout replied that the establishment of ICS solutions was to allow ways for partners to work together more collaboratively than was currently provided for.

Primary Care Networks (PCN's) were described as emergent. Reflecting on the Committee's experience that a PCN had taken 2 and half years to be working comfortably, what assurance was there that they would be in a state of maturity by April 2021? The Committee was particularly interested to see how would will deliver care in rural communities.

Mr. Stout said that the PCN's were not underdeveloped, and that there was a need for them to be ready by this point. Part of the GP practice was paid into PCNs and there was a financial incentive policy on a national scale to do this. All local practices were signed up to PCNs and participated.

West Midland Ambulance Service (WMAS) didn't appear to be part of STP, were they engaged and how did they participate?

Mr. Stout responded that WMAS was not a formal organisation within the STP but they were key partners in delivery of services. David Evans added to this, by saying that it was difficult for WMAS as their resource requirement was challenging. However work actively continued with WMAS, including at a recent meeting of regulators to coordinate ambulance services within the Winter Plan.

What was the current level of maintenance backlog on the estate?

The Committee were advised that there was a substantial backlog of maintenance work required for the hospitals and that the Estate Directors were working together to generate improvement.

Was the STP LTP supported fully by both Local Authorities?

Mr. Stout responded by saying that it was challenging to receive formal sign off from local authorities as the STP LTP was not at the time of the meeting in publishable form, however the local authorities were involved in the process.

One of the chapters mentioned the use of community service as a source of healthcare access, how would the public be informed and kept up to date on the best places for them to access healthcare? Could this be subject to scrutiny at a future meeting?

Mr. Stout replied saying that one of the chapters of the STP LTP set out the communication and engagement strategy, which would be used to inform as much of the public as possible and that he was happy to bring this back to the Committee on a separate occasion.

JHOSC20 Shrewsbury and Telford Hospital - Winter Pressures Planning

Clare Old, Urgent Care Director at Shropshire Telford and Wrekin and Sarah Biffen, Deputy Chief Operating Officer for the Shrewsbury and Telford Hospital provided a presentation and update to the Committee on Winter Pressure plans for Shrewsbury and Telford Hospital NHS Trust in 2019/2020. The Committee heard the progress that had been made;

- Regional winter conference on the 12th of September 2019
- Regional template submitted on the 17th of October 2019
- Winter Plan's updated monthly rather than on historic data
- Approval of Winter Plan by all organisations and Commissioning boards
- Only schemes which had high or medium confidence delivered
- Bed deficit of 4, offset by Day Surgery Unit (DSU) beds to deliver near balanced plan.
- Shropshire/Telford & Wrekin amongst best at placing patients who were medically fit for transfer within 48 hours. Reduction in long stays – exemplar in national scheme.

Likewise, the Committee heard the challenges faced by the hospitals;

- Workforce shortages (however all approved scheme owners assured A&E delivery group that they were fully staffed)
- West Midlands Ambulance Service in Winter Planning redesign. Escalated to NSEI/NHSE.
- Rise in age and acuity of patients in November/December – NHSI/NSHE allocated more funds.

- Powys experiencing acute lack of domiciliary of care provision. Offset patients in Shropshire/Powys border provision.

Finally, the Committee heard the demand and capacity modelling that was being used, which had been overseen by the A&E Delivery Group. In response to the information that they had heard, the Committee asked a number of questions: and received the below answers;

Was it possible to breakdown the figures in terms of types of patients, as used in the demand and capacity model?

The Committee were informed that the figures shown in the demand and capacity model related to adults only, and that a demand and capacity model had not been done for paediatrics. Likewise, the Committee were told that the Winter Pressure planning team would work with the Children's assessment unit to understand their modelling.

Was the use of DSU beds to offset the bed shortage resulting in the cancellation of surgeries?

Ms. Biffen replied by saying that further staff had been recruited and some permanent beds had been made available for short stay surgical beds. However, some routine day surgeries had been cancelled.

Were there people sitting unnecessarily in the A&E?

Ms. Old responded that there was a new programme in Telford which resulted in more weekend appointments, therefore more people were receiving acute care appointments on the day. This was done by enhanced services up to 8pm at night and on the weekend but was constrained by the workforce. From 6 January 2020, GPs would work on admission avoidance by using the Rockwood score to determine necessity of admission. However there were some people who were unable to get appointments in A&E.

To what extent was this an extract from the annual capacity plan? Were there other key topics which would transform the winter pressures plan?

Ms. Old responded that the winter plan was a separate capacity plan required by NHSI/E, as additional money was received to deal with increased cases in winter. The Winter Plan was part of a five year planning process, which included an emphasis on same day emergency care so that patients could be discharged as quickly as possible, and returned to their own home because research suggested that helped patients feel independent. This 'getting it right first time' approach had received a "green" in its feedback. Alongside this, the five year process concentrated on improving access in different ways including respiratory, cardiology, stroke, trauma and orthopaedic pathways.

The discussion concluded with a discussion on flu vaccinations in the area. Ms. Biffen reported that there was a 95% staff target in place and that it was at 75%. David Evans added to this, by saying that there had been a 50% uptake by staff

at SaTH compared to the same period in the previous year. Claire Old said that the public were still being advised that vaccines were available.

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

Bev Tabernacle, Interim Deputy Chief Executive for SaTH updated the Committee on the Care Quality Commission's (CQC) report and recommendations for SaTH.

- Since the report was published in November 2018, there had been a number of unannounced visits on both sites and two letters of intent from the CQC which outlined areas of improvement.
- Feedback was mixed with some acknowledgement of improvement such as maternity care.
- Letters of intent had meant enhanced regulation requirement from CQC in relation to Section 29-31 of the Health and Adult Social Care Act.
- Themes reported: care and treatment for mental health patients, emergency services, acute medicine and management of deteriorating patients.
- Emergency Services Risk Summit – December 2019 – looked at how system could escalate support.
- Final report was due in April 2020.
- Virginia Mason rapid improvement events had been used to improve areas that performed badly.
- Responding to regulatory requirements in a timely and appropriate manner.

Did the Risk Summit put forward solutions and support? What was the outcome?

Mr. Evans replied that the risk summit was focused on how the system could help the NHS trust to reduce demand in hospital, and that it was recognised there was a workforce challenge. Likewise, he added that there was work to be done as there had been a significant increase in ambulance conveyances in the last two years, as well as a rate of increase in semi-rural areas.

The CQC report from November 2018 rated SaTH "inadequate"… what would the rating be if they were inspected now?

Ms. Tabernacle responded that SaTH had just been inspected and that she hoped that it would be seen that improvements had been made; this was reflected in feedback but she was unsure if the level of improvement would lift the Trust above the "inadequate" rating.

Had there been any board member resignations?

Ms. Tabernacle said that there had been a substantial turnover in trust board, particularly from June this year from an executive perspective. New interim executives had been appointed such as Paula Clarke and Louise Barnett who were trying hard to influence culture.

It was unsurprising that there were workforce challenges when staff were still charged for parking - were there any retention methods around conditions?

Ms. Tabernacle confirmed that parking charges still applied for staff but said that the focus of retention was more to do with creating a better general health and wellbeing offer for staff, with particular emphasis on filling vacancies to improve conditions for staff.

Had the CQC finished their inspections of the hospitals?

Ms. Tabernacle responded that process was still at the unannounced stage, and that the CQC could continue to turn up to the hospitals unannounced for an inspection.

Members suggested that improvements were needed to be made in the paediatrics pathways.

Ms. Tabernacle responded that they were working on paediatrics areas to get expertise shared across the Emergency Department, as well as chief operating officers making changes to respond to issues in the system to make them more effective.

What was the timeline for the final report from the CQC?

The Committee were advised that it was hoped the report would be published in spring time.

22 Co-Chairs Update

None.

The meeting ended at 12.30 pm

Chairman: .....

Date: 2 March 2020