Shropshire Council

Telford & Wrekin COUNCIL

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

Date: 24 January 2017

Committee:
Joint Health Overview and Scrutiny Committee

Date: **Wednesday, 1 February 2017**
Time: **1.30 pm**
Venue: **Shrewsbury Room, Shirehall, Abbey Foregate, Shrewsbury, Shropshire, SY2 6ND**

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

Cllr Gerald Dakin (Co-Chair)	Cllr Andy Burford (Co-Chair)
John Cadwallader	Veronica Fletcher
Heather Kidd	Rob Sloan
David Beechey (Co-optee)	Carolyn Henniker (Co-optee)
Ian Hulme (Co-optee)	Dag Saunders (Co-optee)
Mandy Thorn (Co-optee)	tbc

Your Committee Officer is:

Amanda Holyoak Scrutiny Committee Officer
Tel: 01743 252718
Email: amanda.holyoak@shropshire.gov.uk

AGENDA

1 Apologies for Absence

2 Disclosable Pecuniary Interests

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 (Pages 1 - 8)

To confirm the minutes of the meeting held on 2 December 2016, attached marked: 3

4 Update on the Sustainability of Services Provided by Shrewsbury and Telford Hospitals NHS Trust (SATH)

To receive a verbal update from the Chief Executive of SaTH on the current position regarding sustainability of services at the Princess Royal Hospital and the Royal Shrewsbury Hospital.

Members of the Cancer Team will also be present to explain the risks associated with NHS England proposals for Modernising Radiotherapy Services.

5 Updates on the Sustainability and Transformation Plan (STP) and Future Fit Programme

Review of funding and allocation of STP – from the Executive Lead, STP Funding

Verbal update on the STP – from the Chair of the STP Board

Verbal update on the Future Fit Programme – from the Accountable Officer of the Future Fit Programme

6 Joint HOSC Work Programme

To consider the work programme for the Joint HOSC

7 Chairs' Update

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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 Friday 2 December 2016 in Meeting Room G3-G4, Addenbrooke House, Telford 3.00 pm

PRESENT – Cllr G Dakin (SC Health Scrutiny Chair), Cllr A Burford (TWC Health Scrutiny Chair) (Chairman), Mr D Beechey (SC Co-optee), Cllr V Fletcher (TWC), Mr I Hulme (SC Co-optee) Cllr H Kidd (SC), Mrs C Henniker (TWC Co-optee), Mr D Saunders (TWC Co-optee), Cllr R Sloan (TWC)

Also Present –

C Wright, Chief Executive
J Davies, Shropshire CCG (representing S Freeman)
J Ditheridge, Shropshire Community Health Trust
F Bottrill (Scrutiny Group Specialist, TWC)
D Evans (Accountable Officer, Telford & Wrekin CCG)
I Ghani (Consultant in Public Health, SC)
S Gregory (Shropshire Community Health Trust)
A Holyoak (Committee Officer, Shropshire Council)
L Noakes (Director of Public Health, TWC)
J Tangye (Senior Democratic and Scrutiny Services Officer) (Minutes)
M Taylor (Shropshire Local Pharmaceutical Committee)
V Taylor (Locality Director, NHS England)
S Wright (Chief Executive, SaTH)

Observing the Meeting
Cllr K Calder (Porfolio Holder Health, SC)
Cllr A England (Portfolio Holder Adult Social Care, TWC)
Cllr L Chapman (Portfolio Holder for Adults, SC)

1. Apologies for Absence

Apologies were received from Mr R Mehta (T&W co-optee), Mrs T Thorn (SC Co-optee)

2. Declarations of Interest

There were no declarations of interest.

3. Minutes

RESOLVED: that the minutes of the meeting of the Joint Health Overview and Scrutiny Committee held on 18 October 2016 be confirmed as a correct record and signed by the Chairman.

4. Update on the Sustainability of Services and the Shrewsbury and Telford Hospital NHS Trust

The Chair introduced the agenda item and asked the Chief Executive of SATH a standing question about the level of confidence he had in the sustainability of acute and urgent care services at present; and the provision of adult care with the onset of winter pressures. It was reported that a winter plan had been drawn up late this year and a meeting of the stakeholders was scheduled for the following week. There had been unprecedented demand in late November/ beginning of December, which would normally be seen in January, therefore the Trust was seeking to do more than initially planned, although winter funding was not forthcoming from Shropshire CCG. The Chair noted the pressure on staff working in the service and expressed his appreciation on behalf of the Committee for their hard work in difficult circumstances.

One of the main difficulties highlighted was the potential risk to services due to the low number of four Accident and Emergency consultants, following a recent resignation. Requests for mutual aid from other Trusts had been unsuccessful, however a joint appointment was being considered with the University Hospitals of North Midlands Trust; which provided a more attractive offer because of the trauma unit status at Stoke Hospital. The Committee noted the impact of potential night-time closure of Princess Royal Hospital (PRH) Accident and Emergency unit, which Members recalled had been reported by SATH as the only viable option due to service interdependencies at the Shrewsbury Royal Hospital (RSH). It was reported that current service demand on average per month was 490 ambulance cases, 700 patients attending hospital, 500 ambulatory hospital admissions and 350 admissions into beds. If the A&E unit closed overnight, RSH would have to find additional capacity of 42 beds and 18 short–stay beds to keep up with demand.

Providing the level of capacity and workforce to do this would take 6 – 9 months to deliver. In the interim it was therefore necessary for the Trust to appoint two locum consultants at high rates, which presented a risk as they could leave with just a week's notice. It was highlighted that the consultant in post at present had agreed to support the rota for an additional month in the event of the resignation of one of the locum consultants.

The Trust was hopeful that the current arrangements would only have to be in place for six months; once the reconfiguration of the service was certain, vacancies would be more attractive to consultants. Despite the drive to reduce reliance on locum services, which had recently been reported in the media, the frailty of the situation meant such measures were being supported to assure patient safety. A question was asked about NHS England's (NHSE) support for the Trust and whether it was possible for it to apply some degree of influence on other Trusts to share consultants. It was noted that the NHSE provided the national direction of travel and ensured CCGs were delivering safe and effective services whereas the role of NHS Improvement (NHSI) was related to providers delivering safe and effective provision. It was noted that NHSE could not instruct Trusts to support each other as there was often already significant pressure being dealt with by those Trusts; such was the case in Staffordshire.

It was reported that there had been a successful pilot of a rapid response unit in Shrewsbury where two physicians had been employed full time to undertake home-visits, which intercepted the initial request for an ambulance. It had provided some alleviation for ambulance services and acute services but had been temporarily halted due to a

governance issue. It was reported that the impact of the pilot had become clear on the day that the pilot was suspended, and to date, figures showed that the pilot rapid response unit had resulted in a 63% non-conveyance to hospital.

The Committee agreed to support the reinstatement of the pilot and request that data be shared on the outcome of the pilot.

In response to a question, it was reported that when capacity was reached in the specialist paediatric unit, that children could be transferred to Wrexham or other locations until control was regained.

The Committee noted measures in place and asked how the Joint HOSC would be kept updated on risks It was suggested that it would be valuable to have sight of the risk register on a regular basis to understand how the process was being managed. In response, S. Wright agreed that SATH supported transparency and the Joint HOSC would be kept informed.

5. Sustainability and Transformation Plan (STP) and Future Fit Programme (FFP)

D. Evans confirmed that he was acting in the capacity of Senior Responsible Officer of the Future Fit Programme and that he would make it clear when he addressed the meeting as Chief Officer of Telford and Wrekin CCG. The potential conflict of roles was noted.

The late receipt of the documentation was acknowledged; the Committee expressed their concern that in receiving the STP and FFP integrated impact assessment, non –financial appraisal and appraisal of options pack so late; the ability to scrutinise effectively was put at risk when dealing with such a complex area. It was explained that the FFP integrated impact assessment and the options appraisal could not be released earlier because the content described the advantages and disadvantages, benefits and dis-benefits of the options and they had been unable to hold a FFP Board meeting before the STP had been published. The Committee accepted that the late circulation of the documentation had not been deliberate but due to circumstances; it was recognised that the Joint HOSC had been given a difficult job and it was therefore suggested that it would be preferable to have a further meeting to review the documentation in more detail. A meeting date had been provisionally scheduled for 21st December to receive the consultation plan and at this point Committee members' questions could be considered. It was noted that the consultation plan would be required five days ahead of the proposed meeting for publication to provide members with the requisite time to consider the plan in sufficient detail.

In terms of the STP, it was noted that it was a live document that would change as it required more granularity and that there would be improvements to transparency with updated versions of the STP published on the web on a monthly basis. It was commented that the STP would have to be revisited in light of the worsening financial position of Shropshire CCG.

The next stage for all STPs was to determine capital requirements which would take a number of months. This in turn would influence the Outline Business Case and FFP and work was underway with NHS England to clarify the position. Work had been undertaken on the delivery of the five year forward view of primary care including mental health

services with the aim of ensuring patient safety across the model. It was reported that more detail on workforce and education would be available from 23 December 2016. An important component of the programme of change was engaging with the public, for which more work needed to be done. NHSE had indicated that more granularity was required particularly to reflect clearly and substantially how the present day conditions were being managed and in particular the conditions around hospital visits.

The position of Shropshire and Telford and Wrekin Authorities in relation to the STP was queried. S Wright said that there had been commitment and support from the local authorities but acknowledged that there was a very different governance structure in place and the inability to scrutinise the process had been a source of concern. The Chief Executive of Shropshire Council highlighted the development of the document within an NHS timeframe which had not allowed the level of engagement which would have been undertaken by local government. The Neighbourhood work was not developed enough to go before elected members for any sort of decision and it would be important to get all partners on board. The Director of Public Health Telford and Wrekin Council said that Neighbourhood work should be bottom up which would take time. This difference had not been addressed in the timeline and process.

In terms of funding issues:

- it was acknowledged that capital funding was constrained, however, two values had been outlined in the appraisal of options for the FFP
- a question was raised about the adequacy of funding within the STP for the transition of services/ activity directly from acute services to community and primary care. £5-6 million had been set aside but this also had to meet other priorities and there was a lack of clarity around management of the deficit, the deficit reduction plan.

It was acknowledged that the aim of the STP and FFP was a total transformation of healthcare and shift of activity from acute to primary and community care. The new model would deliver radically new services, including access to urgent care which would replace the need for people to travel to hospital.

In terms of the financial starting point the Committee continued to be concerned about the scale and cost of the ambitious changes required and questioned whether it was possible that new models eg in cancer and ophthalmology could realistically improve the starting position. In response, it was suggested that the current organisation of health and social care regionally meant that significant funding was being diverted to prevention programmes for the short – medium term whereas a full transformation of services would see short-medium term programmes become unnecessary.

The Committee raised the issue of plans for rural areas such as South Shropshire; it was felt that the plans would have a major impact on accessibility for rural communities but they did not meet the broad requirements of rural communities, a one size fits all approach would not work. The difficulty in accurately measuring rural deprivation was highlighted; rural areas were often sparsely populated with poor living standards and a lack of carers. The Committee commented that the integration of work in the plans for all communities, particularly rural communities, was not clear and that the transformation of services was not as yet comprehensive. There was a need for a bottom up approach involving local elected

members to ensure the greatest possible understanding. There was also a need for GPs located on the other side of county and national borders to be involved in preventive work. The Joint HOSC remained to be convinced that the plans for transformation stacked up before they could be supported.

The Chief Executive of Shropshire Council said that real transformation would involve housing and employment which the NHS was looking at local authorities to deliver. The Local Authorities felt that the STP was focused on making the acute sector sustainable, but and the resources identified would not be enough to enable transformation in prevention and other areas.

There was a discussion about work in progress in analysing the various specialist services across Shropshire, Telford and Wrekin, such as ophthalmology and orthopaedic services. It was noted that overall, a disproportionate amount of money was being spent on orthopaedic services through multiple providers. Obesity was a particular problem; it provided an example of how a transformed service could tackle such issues by making changes across the local economy in leisure, transport and education. It was an example of a long term aspiration and illustrated that the STP set out the ambition for working differently and that models such as Neighbourhood working would take years to come into effect. In ophthalmology, services were being transformed in partnership with the Virginia Mason Hospital in Seattle. The Trust had been selected for this partnership via a national process and this had helped to convey confidence in change. It was anticipated that the new approach would remove waste and duplication, improve efficiency with savings of £80k a year expected through efficiencies such as reducing multiple appointments.

A question was asked about the current concerns of GPs and it was reported that there were mixed views on clinical models and proposals for some of the work in acute services to be redirected to primary care. It was uncertain what this would mean for primary care and the point at which radical changes could be made was unclear, it would depend on whether capacity could be freed up and a knock-on effect was inevitable on other parts of the service.

Next steps were discussed; it was advised that the Joint CCG Committee would make a decision on going out to public consultation on 12th December. D Evans said that he would not sit on the committee but would be in attendance as Senior Responsible Officer to provide advice. Following the Joint CCG Committee meeting, the NHS Stage 2 assurance process would start but this would not be before 9th January 2017 which meant that the public consultation could not commence until after this time, at the earliest the 16th January. It was suggested that there could be a split consultation which meant consultation prior to and then following the Shropshire pre-election period. It was noted that the Joint HOSC would require time to consider the consultation plan and anticipated responding to the consultation late February/ early March if the public consultation went ahead in January. There were a number of concerns about a split consultation including the Joint HOSC membership; there was a possibility that a reconstitution of the committee could fall within the consultation period. It was also noted that Shropshire and Telford and Wrekin authorities had the option to refer to the Secretary of State, and this needed to be factored into the programme timescale.

The Committee had requested that the CCG response to the points raised by Telford and Wrekin Council be shared with the Joint HOSC. A summary had been tabled at the

meeting. There were further concerns that had been raised by Telford and Wrekin Council and the Committee highlighted that it was seeking factual answers for the purposes of independent scrutiny consideration, not for political reasons. D. Evans was reminded that he did not have to comment at this point.

Questions raised by Telford and Wrekin Council and by the Joint HOSC remained outstanding on:

- the weighting of the financial and non-financial appraisal
- lack of training of the CCG panel members
- the statutory representation on the Joint CCG Board of Shropshire, Telford and Wrekin but not of Powys
- the lack of scope in the integrated impact assessment of the Women's and Children's Unit at PRH, particularly in terms of access for the deprived and young population of Telford and Wrekin.

The Committee reiterated the request for information and supporting evidence on the 80% modelling for urgent care centres; and requested sight of the option appraisal process and the outline business case that contained elements of the financial case.

D Evans responded to the point about the Women's and Children's Unit, recognised that on a demographic basis, it did appear that the unit should be located at the PRH. In terms of the £28 million investment in setting up the Women's and Children's unit, the facility would be used for other services in the event that the unit was relocated to RSH. It was confirmed that there would be a range of outpatient services at PRH including a children's urgent care centre, with diagnostics, antenatal care and maternity and possibly paediatric oncology.

It was agreed that clarity was urgently needed around the scope of the Women's and Children's Unit.

The Committee highlighted the difficult job that the CCG/ NHS faced in winning the public vote, particularly in relation to proposals for the Women's and Children's unit. This was also true for Neighbourhood working, the Committee felt that the public needed to understand how the their communities healthcare needs would be delivered now and in the future, including services moving from hospital to the community. J Ditheridge reported that work was being done on identifying estates and buildings for delivery of Neighbourhood services; community hospitals were well placed to deliver healthcare in the future. The Committee indicated that there were no community hospitals in Telford and Wrekin, they had been closed even though they were a big asset and well-loved. In response it suggested that services could be delivered in a variety of different buildings but costs and staffing had to be addressed. Facilities in general practice was also an option being considered. In terms of general practice, further consolidation of primary care practices was intended; which would entail the merger of 40 – 50,000 practices in Telford and Wrekin; therefore clarity was needed in how this would be delivered.

It was reinforced that the Joint HOSC had a duty to consider substantial changes to public health services and that an early indication was essential for the committee to scrutinise effectively. The Committee requested early notice of services known to the CCG that were going to be decommissioned and/or new services that would be commissioned.

It was agreed that the CCG would provide a timeline for the FFP and public consultation following the Joint CCG Board meeting on 12th December.

An agenda would be put together for the Joint HOSC with any outstanding issues following the meeting today.

Simon Wright, Liz Noakes, and Clive Wright left the meeting 4.30pm.

6. Funding for Community Pharmacy Services

M. Taylor, Shropshire Local Pharmacy Committee reported that the budget for pharmaceutical services was normally agreed by the Pharmaceutical Services Negotiating Committee (PSNC) and the Department of Health (DoH); however, this year no agreement could be reached on funding needs for pharmacy services and a 7% cut had been directed by the DoH. An access scheme was made available to support vulnerable pharmacies or where demographically the closure of a pharmacy would have a significant impact. Cuts had been reduced to 3% for pharmacies in deprived areas. There was widespread concern in the pharmacy profession about closures particularly to pharmacies serving small communities which would most likely be affected. These were the types of pharmacies that provided extra supportive tailored services to their communities, such as making up books of medication for elderly residents. It was noted that the cuts were in contrast to central government's aim to shift activity into the community.

The Committee considered the current landscape; it was commented that there had been considerable growth in the numbers of pharmacies in recent years; this was partly due to the Government removing exemptions that prohibited pharmacies from establishing premises in retail parks. It was noted that pharmacies in retail parks, often in large supermarket chains, were supported by the additional over-the-counter product sales. It was also noted that there were no geographical guidelines or criteria for establishing where pharmacies should be located.

The Committee agreed that accurate data would be useful to identify which pharmacies were most at risk in Shropshire, Telford and Wrekin, particularly where they provided essential services in smaller and rural communities. The LPC agreed to keep the Joint HOSC informed and to provide early warning of local implications.

7. Joint HOSC Work Programme

The Committee agreed that the principle items on the work programme remained the FFP and STP. It was suggested that:

- the FFP consultation was a priority, particularly in light of the Shropshire pre-election period beginning in March 2017
- a seminar delivered by the CCG on the financial business case supporting the STP would be valuable when the timing was appropriate
- another visit to an urgent care centre would be informative and provide a useful insight

Emotional Health and Wellbeing was on the agenda for the meeting on 20 February 2017. The Committee agreed that they would consider methods of scrutiny for further work on this, particularly the opportunity to gain an understanding from service users, through voluntary bodies as well as providers. The Chair thanked the Committee members for their considered input.

8. Chairs's Updates

The Committee welcomed the update on the commissioning arrangements for the Emotional Health and Wellbeing 0-25 years' service that had been provided by Deputy Executive for Commissioning and Planning (Integrated Care) at Telford and Wrekin CCG to the Co-Chairs on 30 November 2016.

The Chair also expressed his thanks on behalf of the Committee for the hard work, dedication, commitment and professionalism of the Scrutiny Specialist, as this was her last meeting of the Joint HOSC.

The meeting ended at 5.54pm

Chair: …… Date: ……..

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 Friday 2 December 2016 in Meeting Room G3-G4, Addenbrooke House, Telford 3.00 pm

PRESENT – Cllr G Dakin (SC Health Scrutiny Chair), Cllr A Burford (TWC Health Scrutiny Chair) (Chairman), Mr D Beechey (SC Co-optee), Cllr V Fletcher (TWC), Mr I Hulme (SC Co-optee) Cllr H Kidd (SC), Mrs C Henniker (TWC Co-optee), Mr D Saunders (TWC Co-optee), Cllr R Sloan (TWC)

Also Present –

C Wright, Chief Executive
J Davies, Shropshire CCG (representing S Freeman)
J Ditheridge, Shropshire Community Health Trust
F Bottrill (Scrutiny Group Specialist, TWC)
D Evans (Accountable Officer, Telford & Wrekin CCG)
I Ghani (Consultant in Public Health, SC)
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M Taylor (Shropshire Local Pharmaceutical Committee)
V Taylor (Locality Director, NHS England)
S Wright (Chief Executive, SaTH)

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Cllr K Calder (Porfolio Holder Health, SC)
Cllr A England (Portfolio Holder Adult Social Care, TWC)
Cllr L Chapman (Portfolio Holder for Adults, SC)

1. Apologies for Absence

Apologies were received from Mr R Mehta (T&W co-optee), Mrs T Thorn (SC Co-optee)

2. Declarations of Interest

There were no declarations of interest.

3. Minutes

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governance issue. It was reported that the impact of the pilot had become clear on the day that the pilot was suspended, and to date, figures showed that the pilot rapid response unit had resulted in a 63% non-conveyance to hospital.

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The Committee raised the issue of plans for rural areas such as South Shropshire; it was felt that the plans would have a major impact on accessibility for rural communities but they did not meet the broad requirements of rural communities, a one size fits all approach would not work. The difficulty in accurately measuring rural deprivation was highlighted; rural areas were often sparsely populated with poor living standards and a lack of carers. The Committee commented that the integration of work in the plans for all communities, particularly rural communities, was not clear and that the transformation of services was not as yet comprehensive. There was a need for a bottom up approach involving local elected

members to ensure the greatest possible understanding. There was also a need for GPs located on the other side of county and national borders to be involved in preventive work. The Joint HOSC remained to be convinced that the plans for transformation stacked up before they could be supported.

The Chief Executive of Shropshire Council said that real transformation would involve housing and employment which the NHS was looking at local authorities to deliver. The Local Authorities felt that the STP was focused on making the acute sector sustainable, but and the resources identified would not be enough to enable transformation in prevention and other areas.

There was a discussion about work in progress in analysing the various specialist services across Shropshire, Telford and Wrekin, such as ophthalmology and orthopaedic services. It was noted that overall, a disproportionate amount of money was being spent on orthopaedic services through multiple providers. Obesity was a particular problem; it provided an example of how a transformed service could tackle such issues by making changes across the local economy in leisure, transport and education. It was an example of a long term aspiration and illustrated that the STP set out the ambition for working differently and that models such as Neighbourhood working would take years to come into effect. In ophthalmology, services were being transformed in partnership with the Virginia Mason Hospital in Seattle. The Trust had been selected for this partnership via a national process and this had helped to convey confidence in change. It was anticipated that the new approach would remove waste and duplication, improve efficiency with savings of £80k a year expected through efficiencies such as reducing multiple appointments.

A question was asked about the current concerns of GPs and it was reported that there were mixed views on clinical models and proposals for some of the work in acute services to be redirected to primary care. It was uncertain what this would mean for primary care and the point at which radical changes could be made was unclear, it would depend on whether capacity could be freed up and a knock-on effect was inevitable on other parts of the service.

Next steps were discussed; it was advised that the Joint CCG Committee would make a decision on going out to public consultation on 12th December. D Evans said that he would not sit on the committee but would be in attendance as Senior Responsible Officer to provide advice. Following the Joint CCG Committee meeting, the NHS Stage 2 assurance process would start but this would not be before 9th January 2017 which meant that the public consultation could not commence until after this time, at the earliest the 16th January. It was suggested that there could be a split consultation which meant consultation prior to and then following the Shropshire pre-election period. It was noted that the Joint HOSC would require time to consider the consultation plan and anticipated responding to the consultation late February/ early March if the public consultation went ahead in January. There were a number of concerns about a split consultation including the Joint HOSC membership; there was a possibility that a reconstitution of the committee could fall within the consultation period. It was also noted that Shropshire and Telford and Wrekin authorities had the option to refer to the Secretary of State, and this needed to be factored into the programme timescale.

The Committee had requested that the CCG response to the points raised by Telford and Wrekin Council be shared with the Joint HOSC. A summary had been tabled at the

meeting. There were further concerns that had been raised by Telford and Wrekin Council and the Committee highlighted that it was seeking factual answers for the purposes of independent scrutiny consideration, not for political reasons. D. Evans was reminded that he did not have to comment at this point.

Questions raised by Telford and Wrekin Council and by the Joint HOSC remained outstanding on:

- the weighting of the financial and non-financial appraisal
- lack of training of the CCG panel members
- the statutory representation on the Joint CCG Board of Shropshire, Telford and Wrekin but not of Powys
- the lack of scope in the integrated impact assessment of the Women's and Children's Unit at PRH, particularly in terms of access for the deprived and young population of Telford and Wrekin.

The Committee reiterated the request for information and supporting evidence on the 80% modelling for urgent care centres; and requested sight of the option appraisal process and the outline business case that contained elements of the financial case.

D Evans responded to the point about the Women's and Children's Unit, recognised that on a demographic basis, it did appear that the unit should be located at the PRH. In terms of the £28 million investment in setting up the Women's and Children's unit, the facility would be used for other services in the event that the unit was relocated to RSH. It was confirmed that there would be a range of outpatient services at PRH including a children's urgent care centre, with diagnostics, antenatal care and maternity and possibly paediatric oncology.

It was agreed that clarity was urgently needed around the scope of the Women's and Children's Unit.

The Committee highlighted the difficult job that the CCG/ NHS faced in winning the public vote, particularly in relation to proposals for the Women's and Children's unit. This was also true for Neighbourhood working, the Committee felt that the public needed to understand how the their communities healthcare needs would be delivered now and in the future, including services moving from hospital to the community. J Ditheridge reported that work was being done on identifying estates and buildings for delivery of Neighbourhood services; community hospitals were well placed to deliver healthcare in the future. The Committee indicated that there were no community hospitals in Telford and Wrekin, they had been closed even though they were a big asset and well-loved. In response it suggested that services could be delivered in a variety of different buildings but costs and staffing had to be addressed. Facilities in general practice was also an option being considered. In terms of general practice, further consolidation of primary care practices was intended; which would entail the merger of 40 – 50,000 practices in Telford and Wrekin; therefore clarity was needed in how this would be delivered.

It was reinforced that the Joint HOSC had a duty to consider substantial changes to public health services and that an early indication was essential for the committee to scrutinise effectively. The Committee requested early notice of services known to the CCG that were going to be decommissioned and/or new services that would be commissioned.

It was agreed that the CCG would provide a timeline for the FFP and public consultation following the Joint CCG Board meeting on 12th December.

An agenda would be put together for the Joint HOSC with any outstanding issues following the meeting today.

Simon Wright, Liz Noakes, and Clive Wright left the meeting 4.30pm.

6. Funding for Community Pharmacy Services

M. Taylor, Shropshire Local Pharmacy Committee reported that the budget for pharmaceutical services was normally agreed by the Pharmaceutical Services Negotiating Committee (PSNC) and the Department of Health (DoH); however, this year no agreement could be reached on funding needs for pharmacy services and a 7% cut had been directed by the DoH. An access scheme was made available to support vulnerable pharmacies or where demographically the closure of a pharmacy would have a significant impact. Cuts had been reduced to 3% for pharmacies in deprived areas. There was widespread concern in the pharmacy profession about closures particularly to pharmacies serving small communities which would most likely be affected. These were the types of pharmacies that provided extra supportive tailored services to their communities, such as making up books of medication for elderly residents. It was noted that the cuts were in contrast to central government's aim to shift activity into the community.

The Committee considered the current landscape; it was commented that there had been considerable growth in the numbers of pharmacies in recent years; this was partly due to the Government removing exemptions that prohibited pharmacies from establishing premises in retail parks. It was noted that pharmacies in retail parks, often in large supermarket chains, were supported by the additional over-the-counter product sales. It was also noted that there were no geographical guidelines or criteria for establishing where pharmacies should be located.

The Committee agreed that accurate data would be useful to identify which pharmacies were most at risk in Shropshire, Telford and Wrekin, particularly where they provided essential services in smaller and rural communities. The LPC agreed to keep the Joint HOSC informed and to provide early warning of local implications.

7. Joint HOSC Work Programme

The Committee agreed that the principle items on the work programme remained the FFP and STP. It was suggested that:

- the FFP consultation was a priority, particularly in light of the Shropshire pre-election period beginning in March 2017
- a seminar delivered by the CCG on the financial business case supporting the STP would be valuable when the timing was appropriate
- another visit to an urgent care centre would be informative and provide a useful insight

Emotional Health and Wellbeing was on the agenda for the meeting on 20 February 2017. The Committee agreed that they would consider methods of scrutiny for further work on this, particularly the opportunity to gain an understanding from service users, through voluntary bodies as well as providers. The Chair thanked the Committee members for their considered input.

8. Chairs's Updates

The Committee welcomed the update on the commissioning arrangements for the Emotional Health and Wellbeing 0-25 years' service that had been provided by Deputy Executive for Commissioning and Planning (Integrated Care) at Telford and Wrekin CCG to the Co-Chairs on 30 November 2016.

The Chair also expressed his thanks on behalf of the Committee for the hard work, dedication, commitment and professionalism of the Scrutiny Specialist, as this was her last meeting of the Joint HOSC.

The meeting ended at 5.54pm

Chair: …… Date: ……..

The Shrewsbury and Telford Hospital NHS
NHS Trust

Information pack for the Joint Health Overview & Scrutiny Committee

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Aims of this presentation

To provide:

- Overview of the services on each site
- Proposed UCC model as described in the OBC

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Emergency Site

B PRH

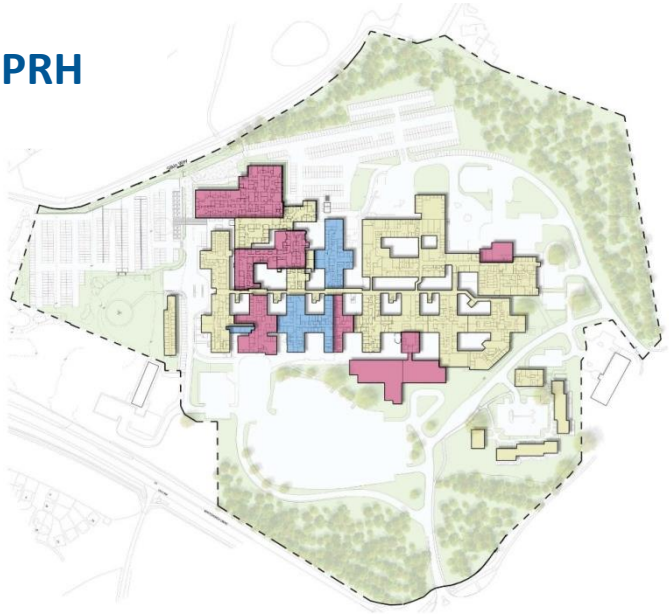
C RSH

- Emergency Department
- Urgent Care Centre
- Critical Care Unit (ICA, HDU, ITU)
- Ambulatory Emergency Centre (AEC)
- Approximately 510 inpatient beds including:
  - Acute Stroke Unit
  - Coronary Care Unit
  - Women and Children's
  - Orthopaedic Trauma
  - Acute medicine
  - Complex planned surgery
- Outpatients
- Diagnostics
- Day Case Renal Unit
- Oncology/Haematology – chemotherapy

Planned Care Site

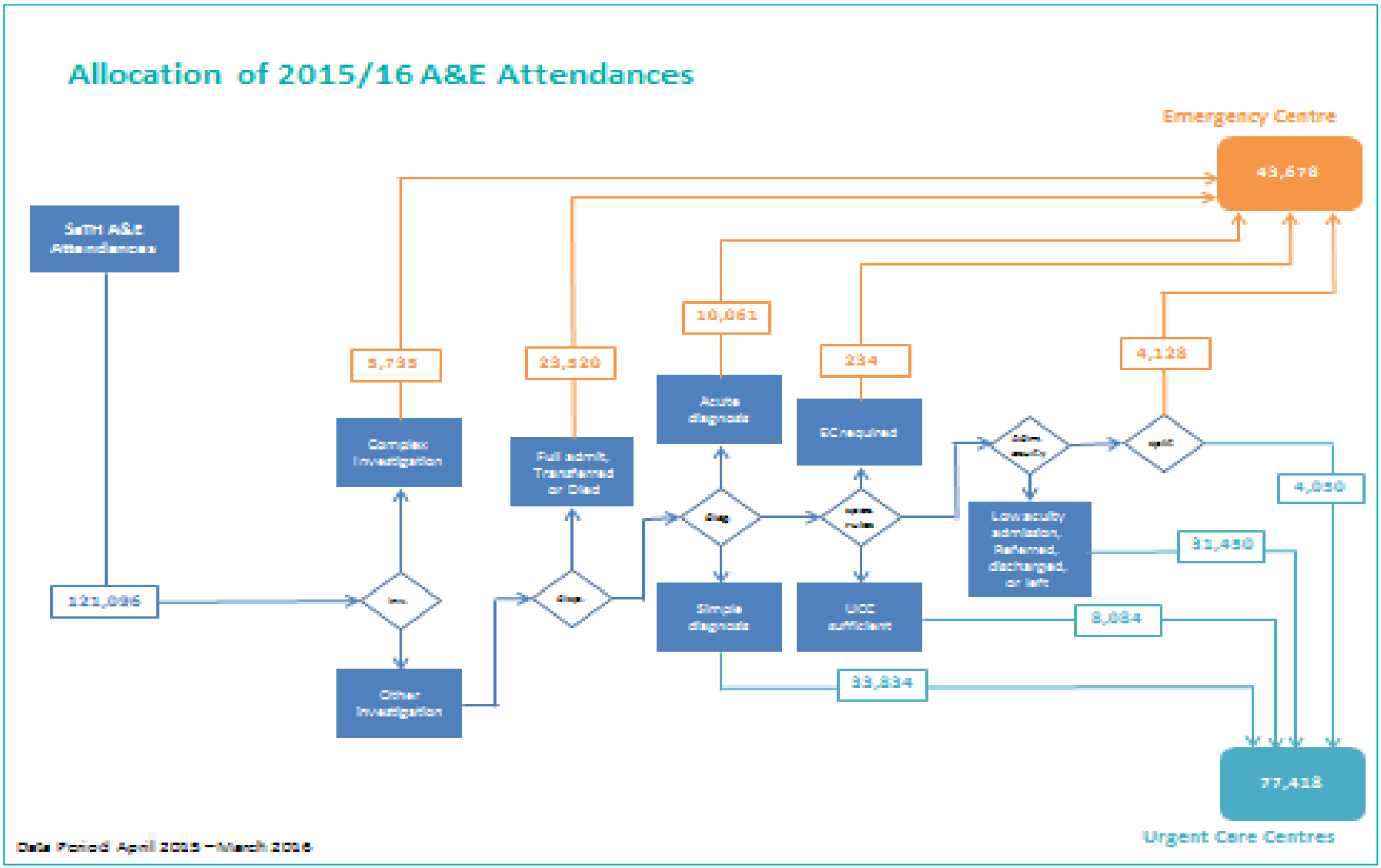
B RSH

C PRH



- Diagnostic and Treatment Centre
- Urgent Care Centre
- Elective and Day Case Surgery
- Endoscopy
- Approximately 350 beds (240 inpatient beds and 110 day case beds) including:
  - Elective Orthopaedics
  - Breast Service
  - Frailty and Elderly Care
  - Rehabilitation
- Outpatients
- Diagnostics
- Day Case Renal Unit
- Oncology/Haematology – chemotherapy

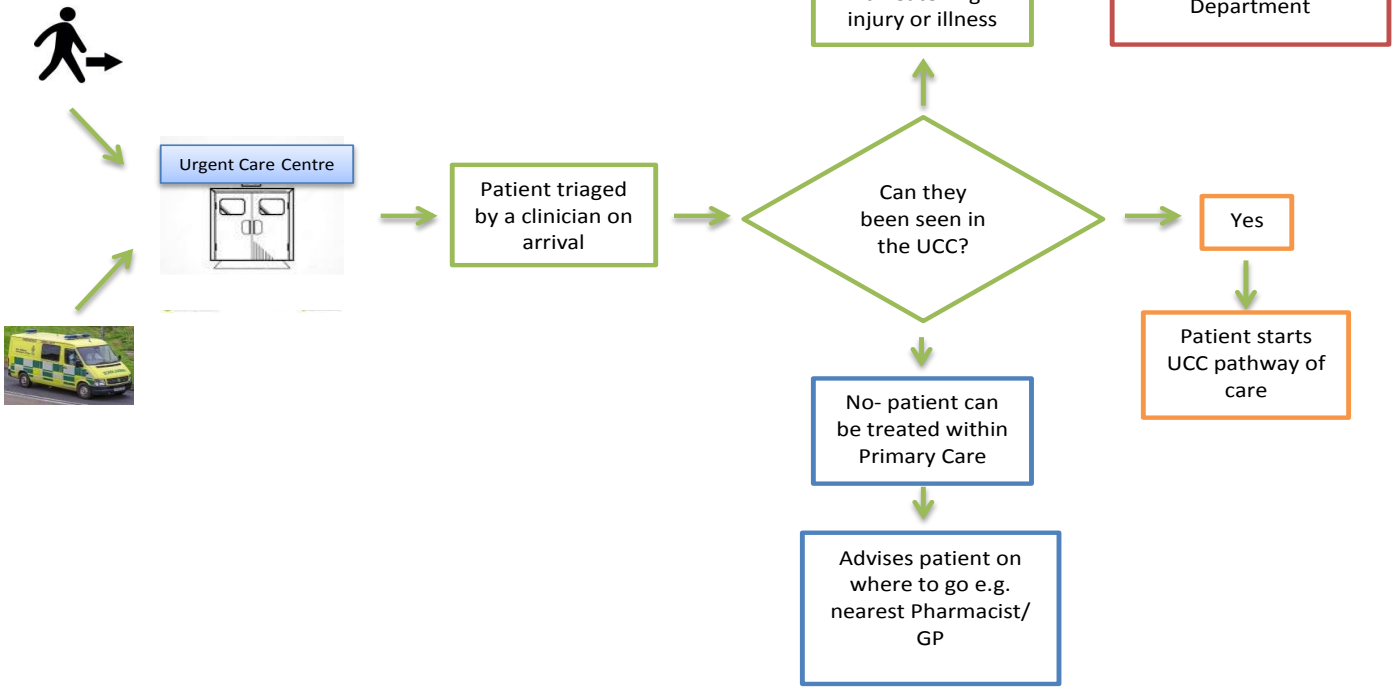
Future Fit algorithm applied to 2015/2016 SaTH activity



Urgent Care Centre

- The original Future Fit algorithm has been applied to the Trust's activity data for 2015/16 to determine whether patients need emergency or urgent care services
- Complaints/conditions to be treated at the Emergency Department include:
  - anaphylaxis
  - stroke
  - severe chest pain
  - multiple trauma
  - compound fractures
  - moderate burns
  - poisoning
- Complaints/conditions to be treated within Urgent Care services are:
  - sprains and simple fractures
  - cuts and scrapes
  - asthma
  - ENT conditions
  - scalds
  - bites and stings

Urgent Care Centre Pathway



Facilities

	RSH	PRH	Total
UCC Adult cubicles	7	7	14
UCC Children's cubicles	4	4	8
UCC Adult waiting places	30	30	60
UCC Children's waiting places	15	15	30

- Dedicated quiet areas
- Facilities for vulnerable patients
- Separate pathways for children and adults

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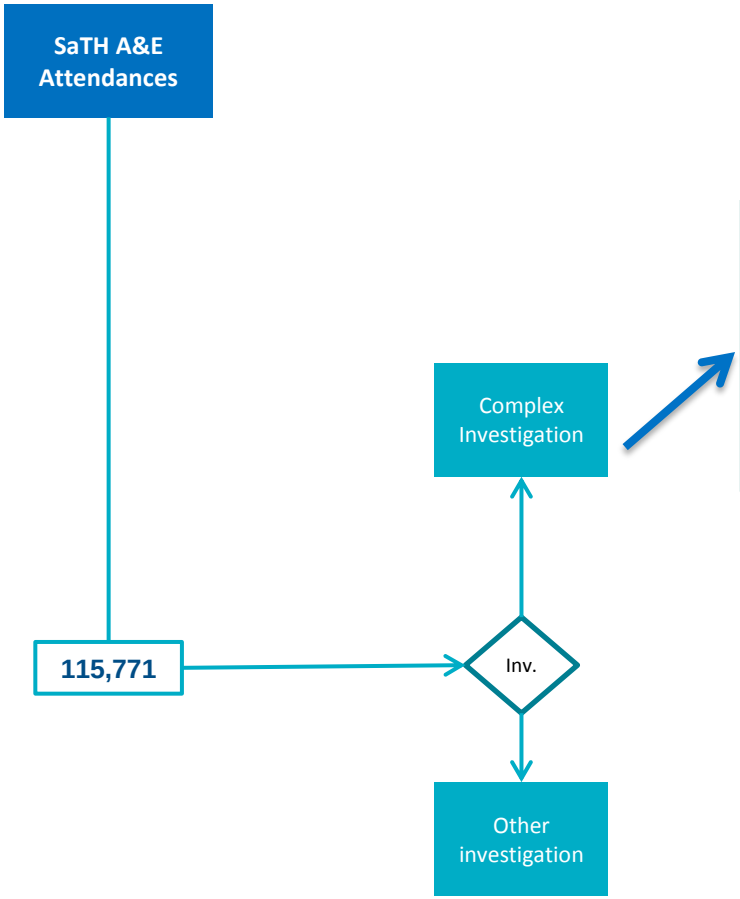
Additional information on ED/UCC algorithm

Allocation of A&E Attendances – SaTH View



Inv.	Incudes one of more of the following investigations >> **Emergency Centre** • x-match blood grp • MRI Scan • CT Scan • GU contrast exam / tomography • Toxicology • Dental Exam • Refraction, orthoptic tests etc

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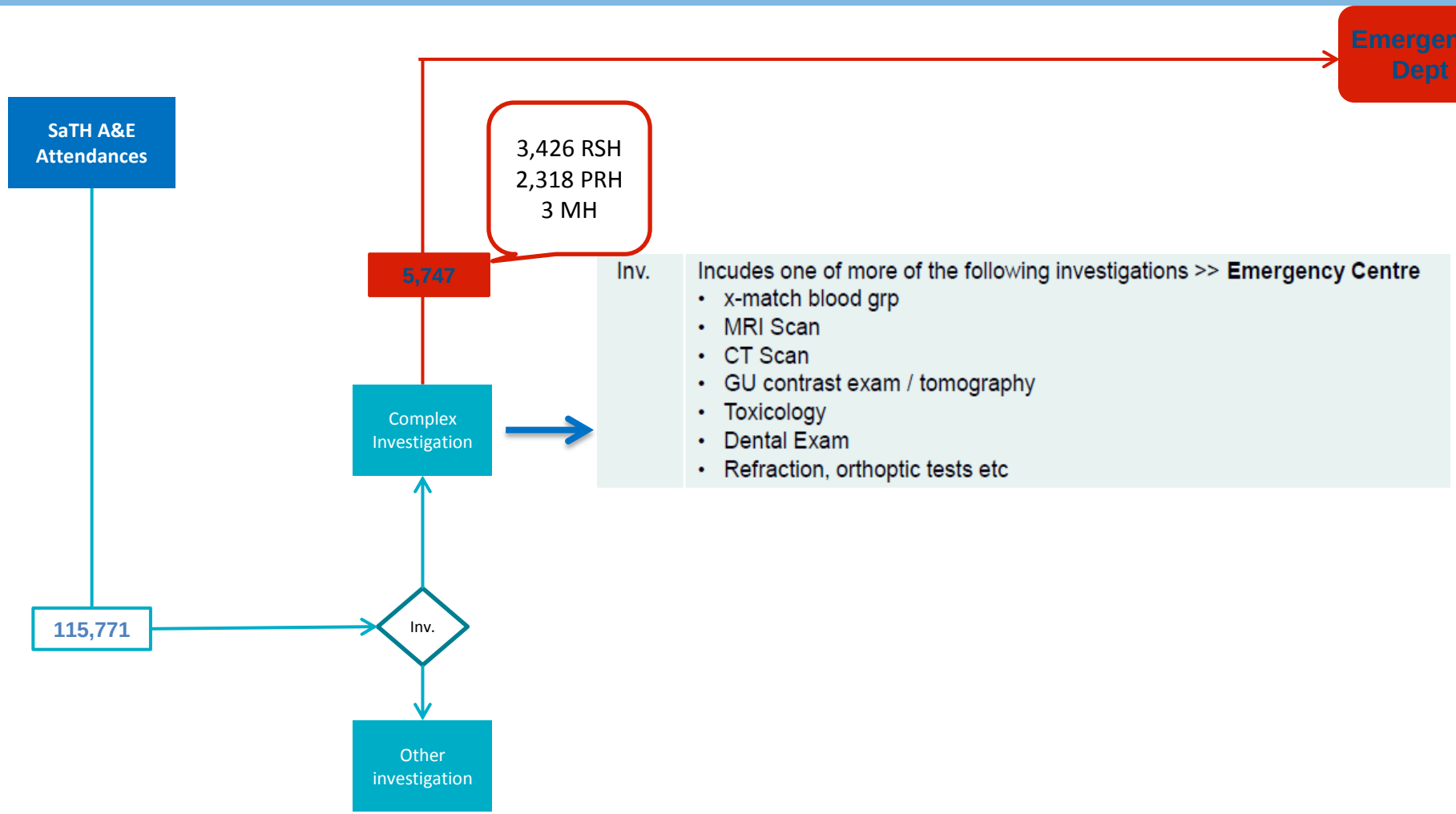
Please note that the above assumes a FYE of the RSH UCC
Data Period October 2014 – September 2015

Allocation of A&E Attendances – SaTH View



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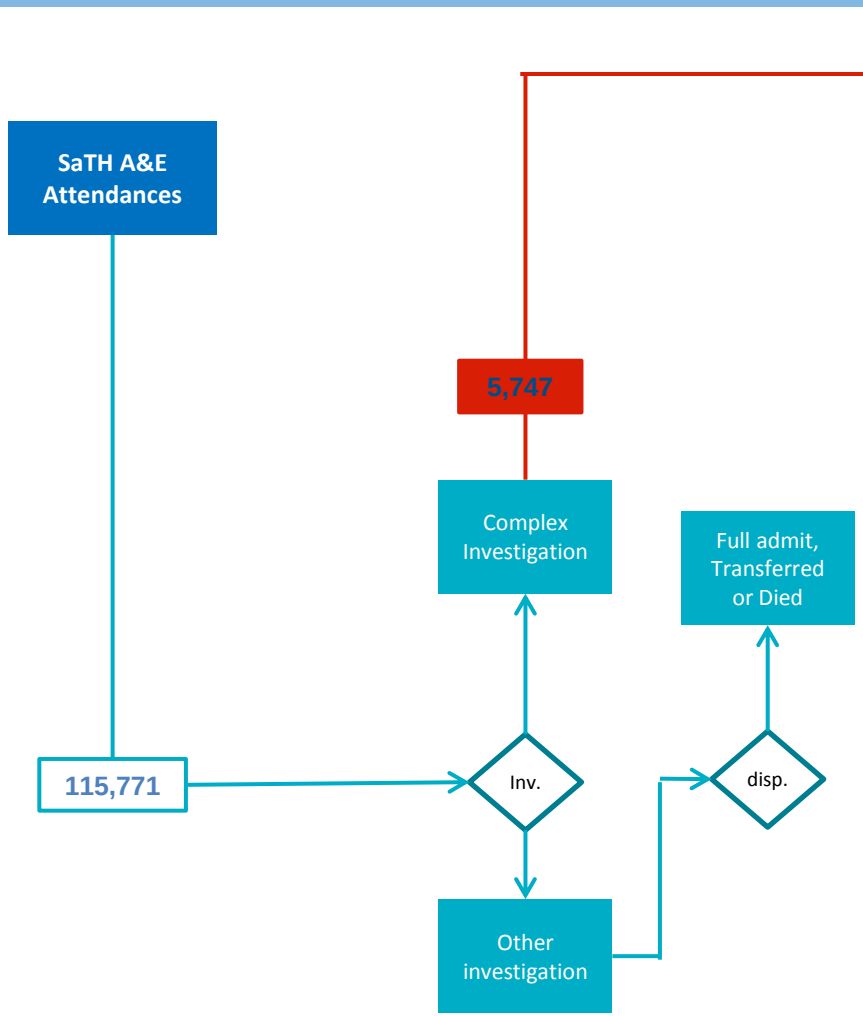

Disp.	Disposal code one of >> **Emergency Centre** • Admitted • Transferred • Died in Department Disposal code one of >> **Urgent Care Centre** • Discharged for GP follow-up • Discharged no follow-up • Referred to Outpatient Clinic • Referred to healthcare professional • Left before being seen • Left refused treatment

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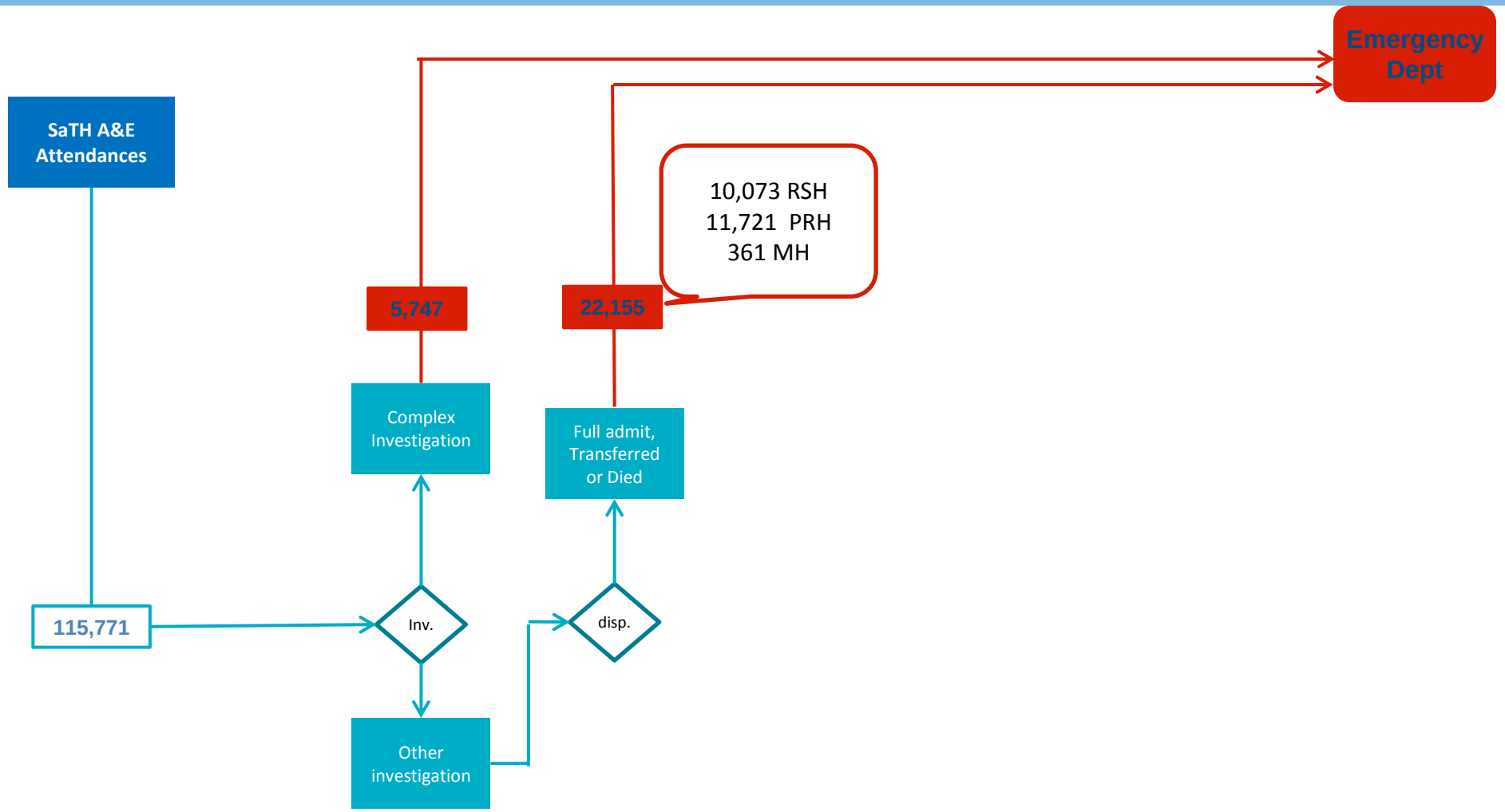
Data Period October 2014 – September 2015

Allocation of A&E Attendances – SaTH View



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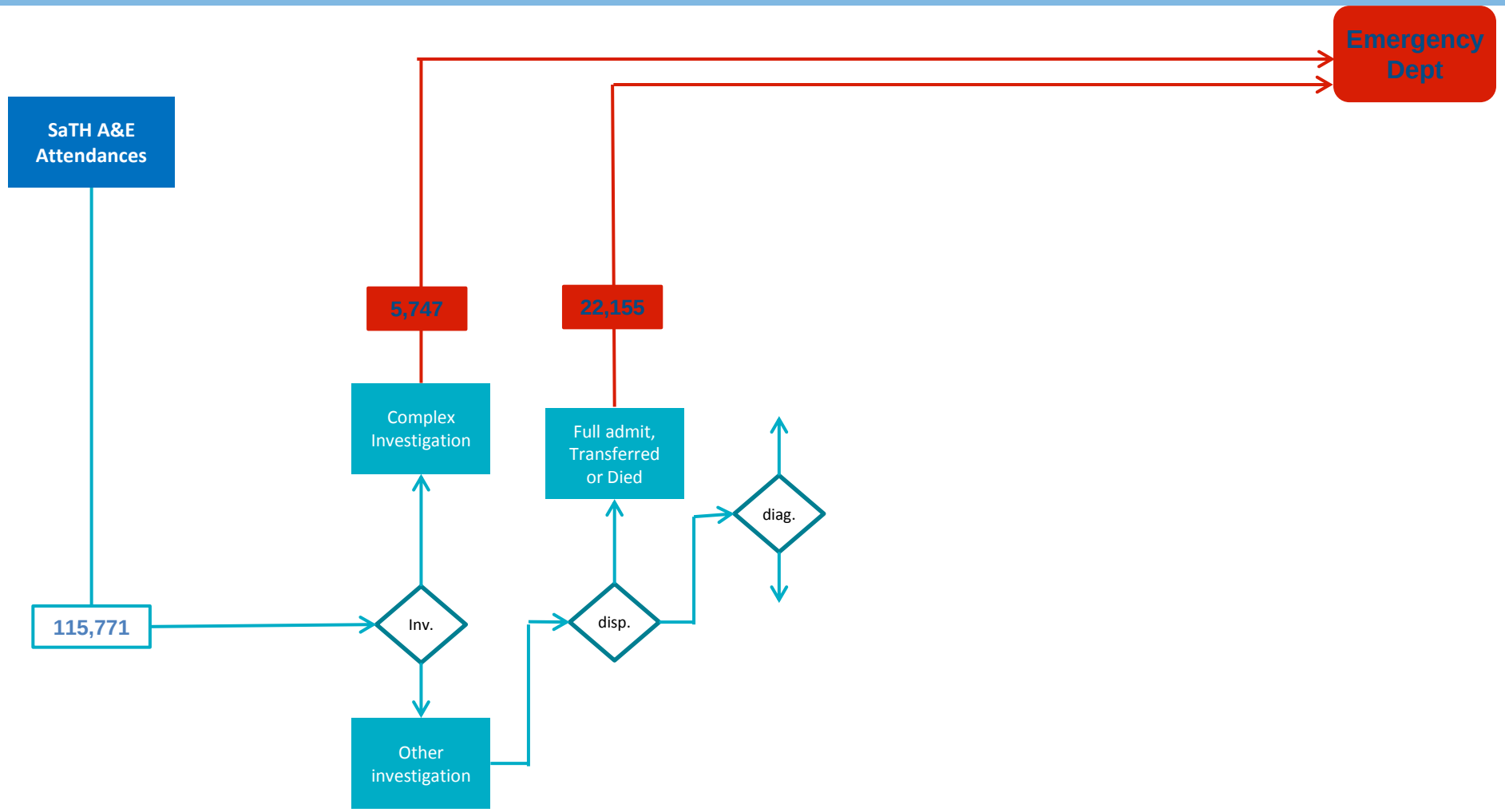

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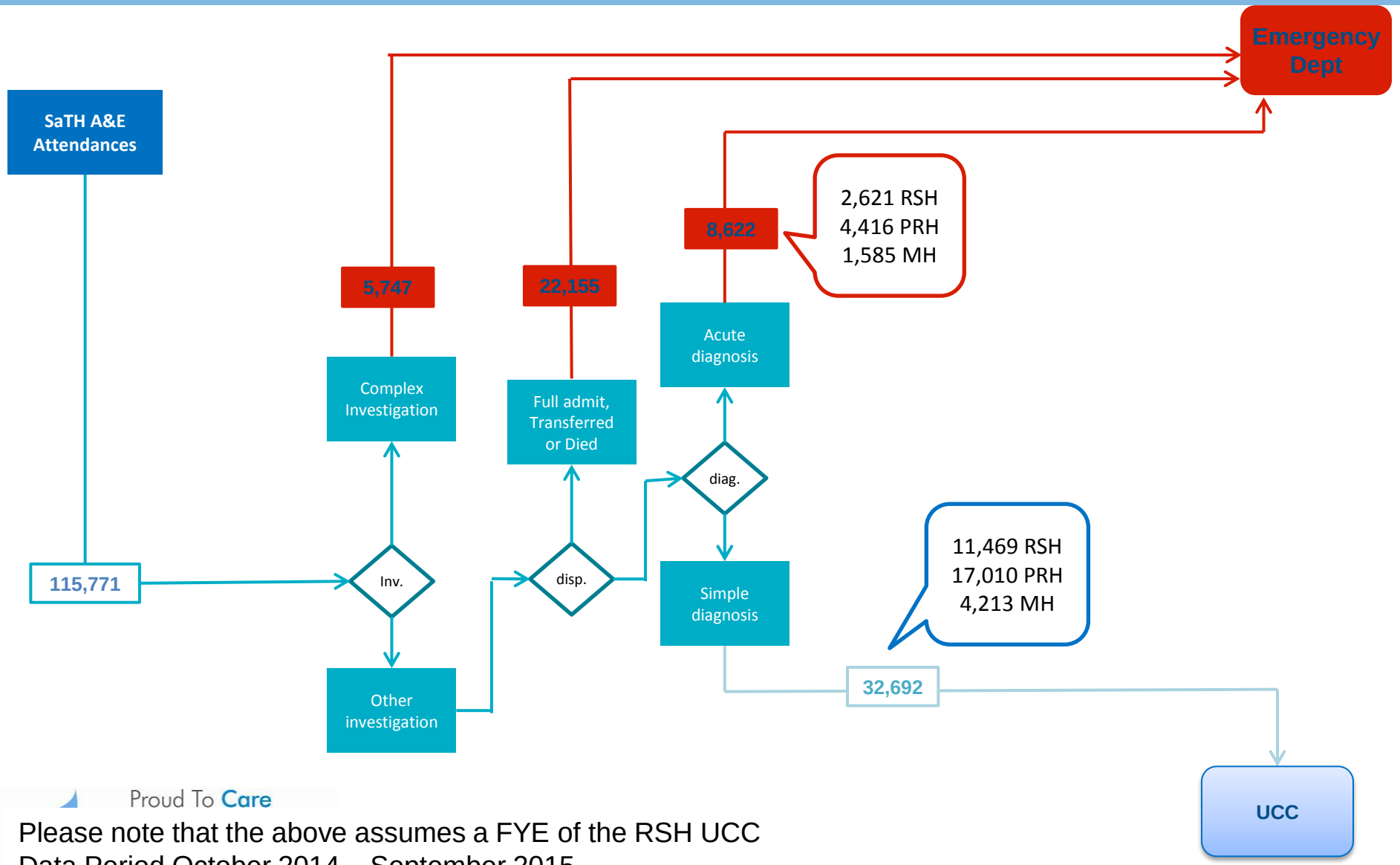
Data Period October 2014 – September 2015

Step	Rule
Diag.	Primary Diagnosis in one of the following >> **Emergency Centre** • Nerve inj. • Vascular inj. • Electric Shock • Poisoning (inc OD) • Near Drowning • Septicaemia • Cerebro-Vascular • Other vascular conditions • Haematological • Obstetric • Gynaecological • Allergy (inc anaphylaxis) • Facio-maxillary • Ophthalmic Primary Diagnosis in one of the following >> **Urgent Care Centres** • Contusion / abrasion • Soft tissue inflammation • Sprain / ligament • CNS (exc stroke) • Respiratory • Urological • Diabetes & Endo • Dermatological • Psychiatric • Social • Nothing abnormal

Allocation of A&E Attendances – SaTH View



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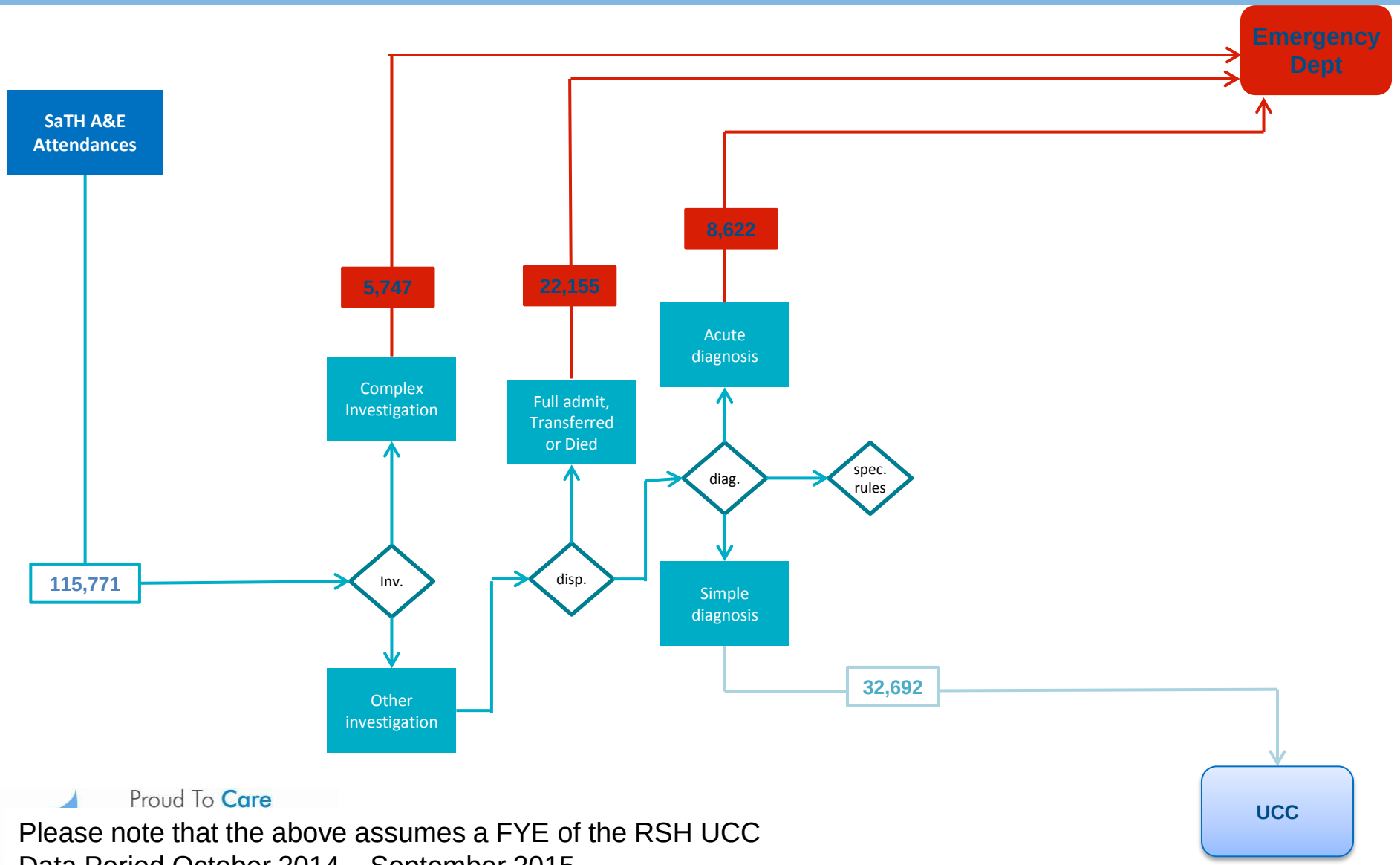

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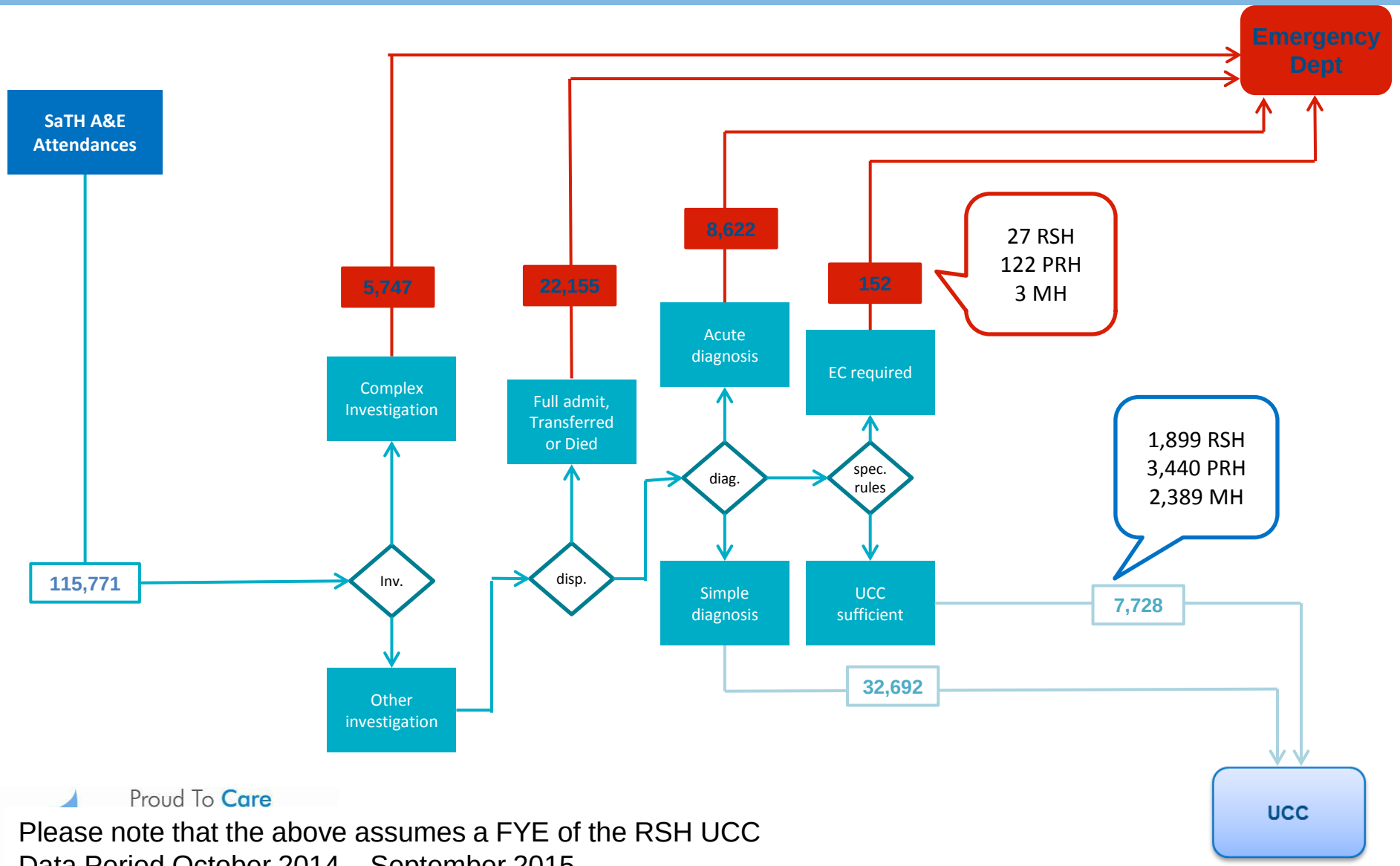
Please note that the above assumes a FYE of the RSH UCC
Data Period October 2014 – September 2015

Step	Rule
Spec. Rules	Primary diagnosis ENT Conditions and any treatment >> **Emergency Centre** Primary diagnosis Bites/Stings and any secondary diagnosis Allergy (inc anaphalaxis) >> **Emergency Centre** Primary diagnosis cardiac conditions and any investigation cardiac enzymes and disposal not in one of the following >> **Urgent Care Centre** • Admitted • Transferred • Died in Department Primary diagnosis ENT conditions and no treatment >> **Urgent Care Centre**

Allocation of A&E Attendances – SaTH View



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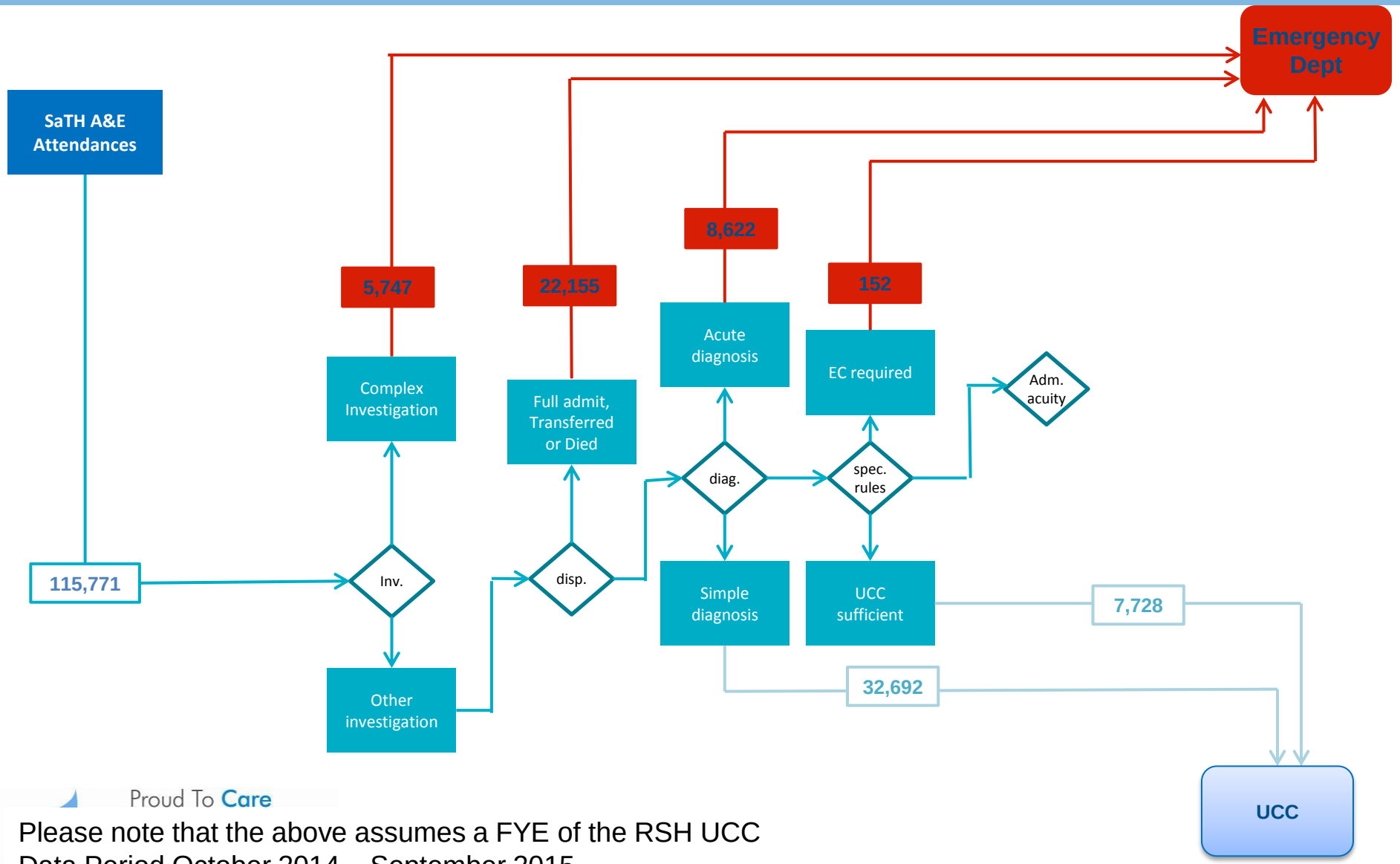
Allocation of A&E Attendances – SaTH View



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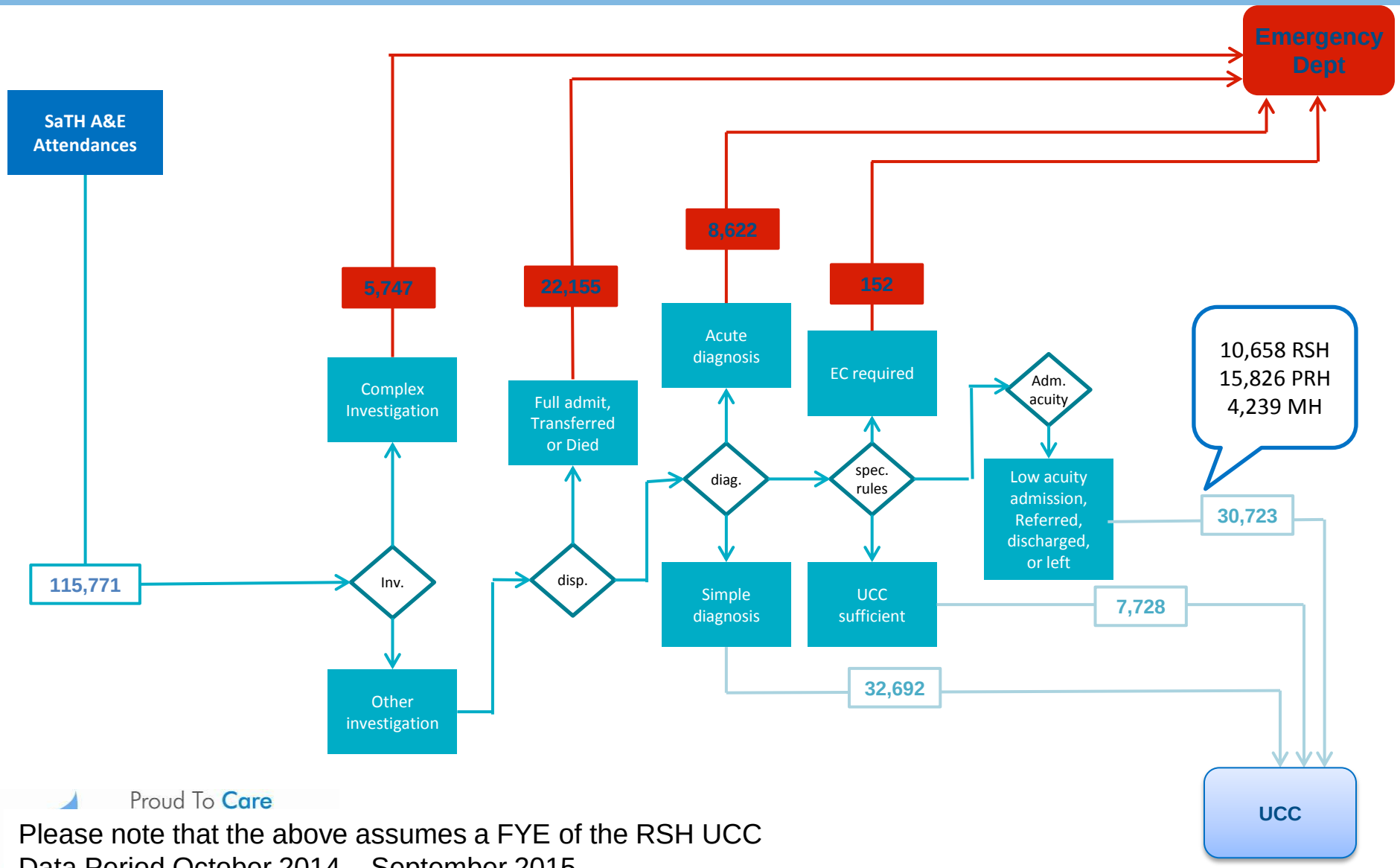
Adm. Acuity	Admitted and discharged alive the same day and no procedure

Allocation of A&E Attendances – SaTH View



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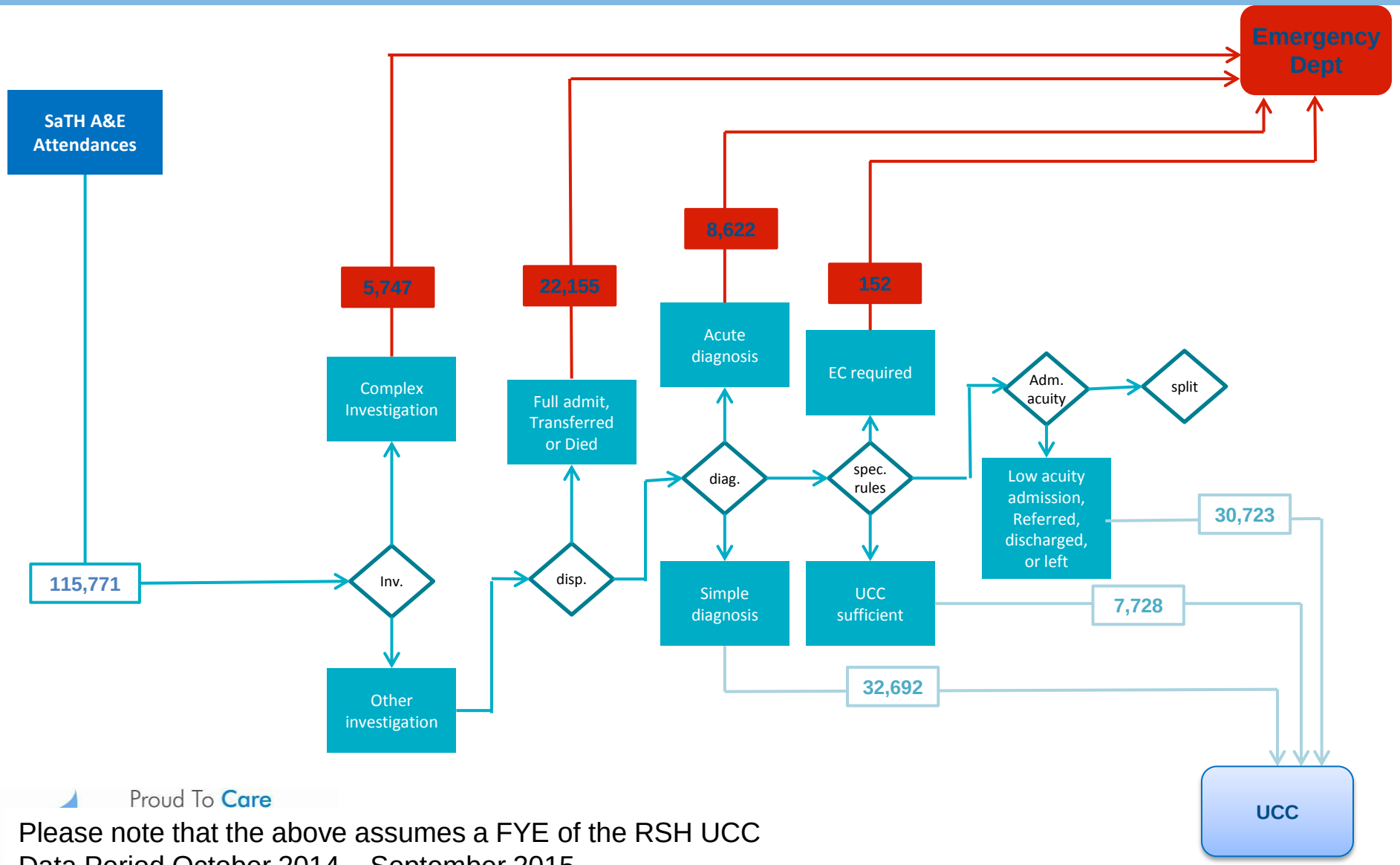

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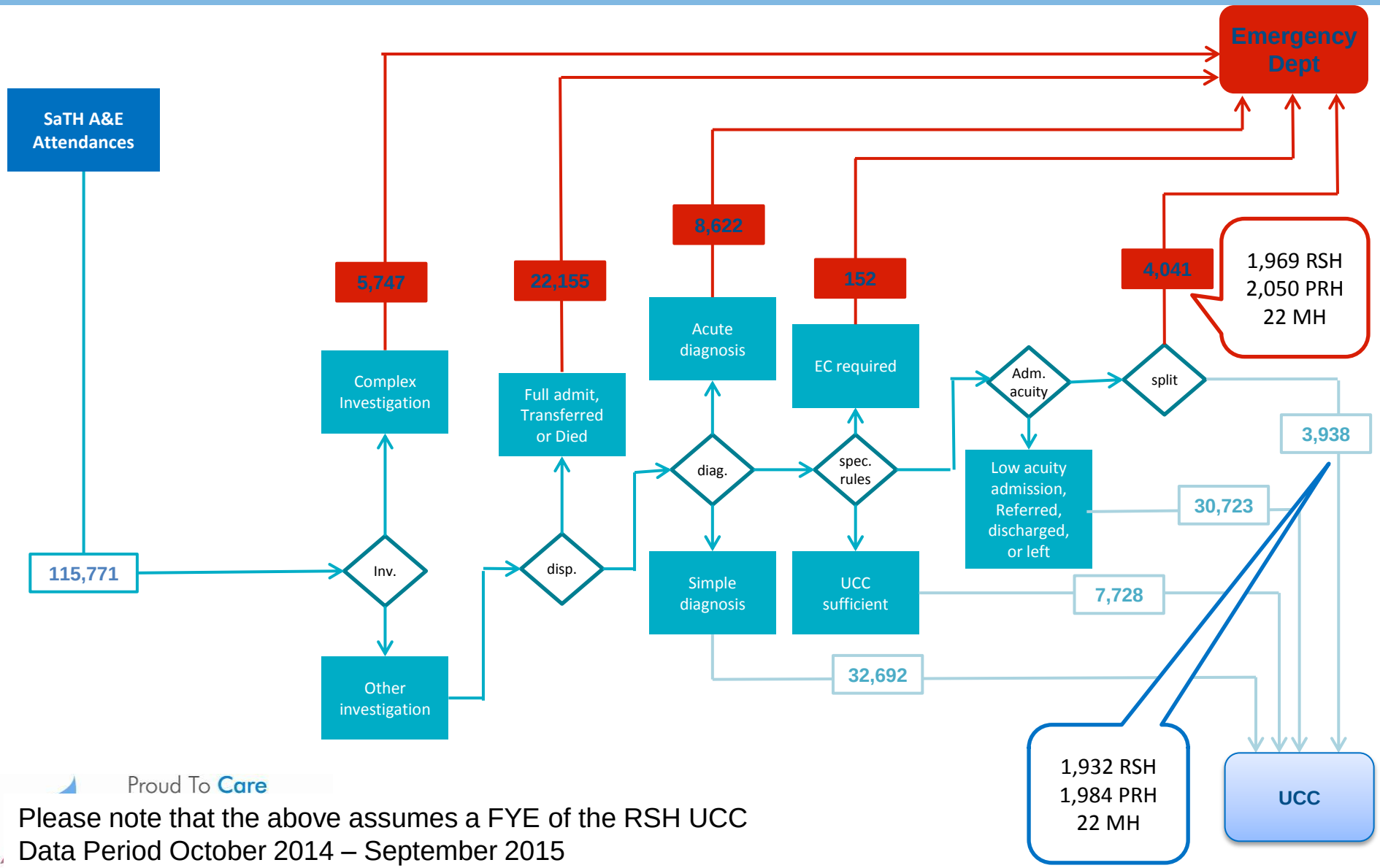

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Data Period October 2014 – September 2015

The Shrewsbury and Telford Hospital NHS Trust

NHS ENGLAND MODERNISING RADIOTHERAPY SERVICES PROPOSALS - IMPACT ON SATH

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PROPOSED PROVIDER MODEL

Population	Cancer Sites Treated	Infrastructure
< 0.5 million	Common cancers: Breast, Urology, Colorectal, Lung	Satellite with services from larger provider
> 0.5 < 1.0 million	Common + less common cancers	Larger provider with subspecialist sites
Network population 3 – 6 million	+ Rare cancers	Lead provider with comprehensive services

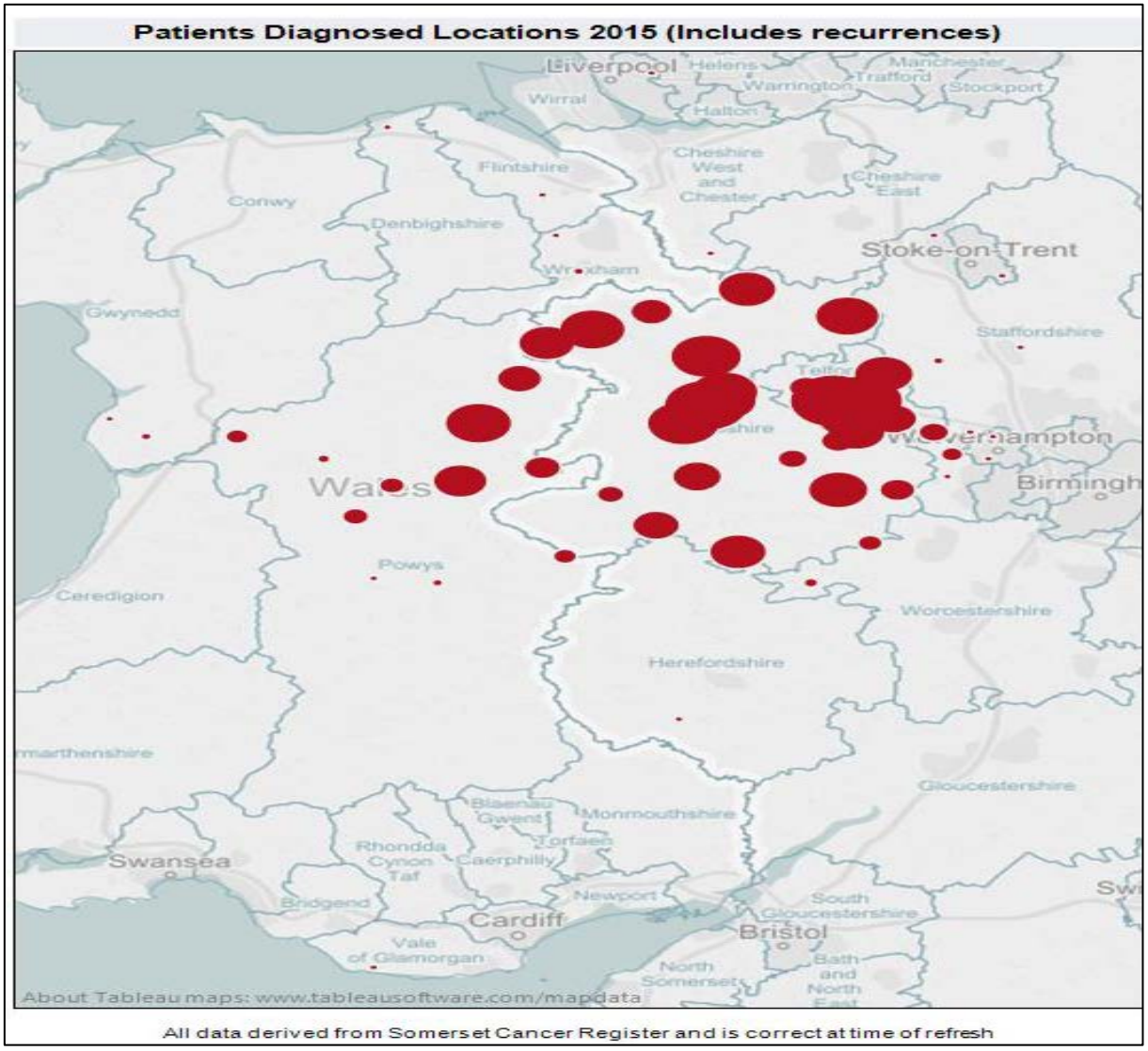
POPULATION

- SaTH's Radiotherapy population is **535,790**
  - 452,790 in England
  - 83,000 in Powys

- **NHS England's figures only include the radiotherapy catchment population in England**

- Unless the Powys population is taken into account SaTH would be down-graded to a satellite unit

LOCATIONS



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LOCAL IMPACT

- SATH would lose less common cancers:
  - Increasing distance for patients to travel
  - Loss of expertise
  - Serious problems retaining and recruiting staff
  - Loss of activity of 4077* fractions per annum
  - Loss of income of £659,209* per annum
  - Loss of excellent reputation
  - Loss of clinical trials

  - **Data provided by Radiotherapy services*

- Engagement with NHSE to ensure that SATH is recognised in the appropriate tier group to ensure provision of essential services locally.

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