JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

Date:	**Tuesday 7 March 2017**	Time	**2.00pm**
Venue	**Quaker Room, Meeting Point House, Southwater Square, Town Centre, Telford, TF3 4HS**		

Enquiries Regarding this Agenda:

Democratic and Scrutiny Services	Jessica Tangye	01952 382061
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Committee Membership:	**Telford & Wrekin**	**Shropshire**
	Councillor Andy Burford (TWC Health Scrutiny Chair)	Councillor Gerald Dakin (SC Health Scrutiny Chair)
	Councillor Veronica Fletcher	Councillor John Cadwallader
	Councillor Rob Sloan	Councillor Heather Kidd
	Ms Carolyn Henniker (Co-optee)	Mr David Beechey (Co-optee)
	Mr Dag Saunders (Co-optee)	Mr Ian Hulme (Co-optee)
	Vacancy (Co-optee)	Mrs Mandy Thorn (Co-optee)

AGENDA

1. **Apologies for Absence**

2. **Declarations of Interest**

3. **Minutes** — Appendix **A**
   To confirm the minutes of the meeting of the Joint Health Overview and Scrutiny Committee held on 1 February 2017.

4. **Update on the Future Fit Programme**
   To receive a verbal update from the Programme Director, Future Fit Programme

5. **0-25 Emotional Health and Wellbeing Service**
   To receive verbal updates on the new service commissioned for child and adolescent mental health in Shropshire, Telford & Wrekin from the Clinical Commissioning Groups and the Provider Organisations

Continued ...

6. Chairs' Update

A

Joint Health Overview and Scrutiny Committee 7 March 2017 2.00 pm	Item **3** Public

MINUTES OF THE JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE MEETING HELD ON 1 FEBRUARY 2017
1.30 PM – 3.40 PM

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

Members Present:
Shropshire Councillors: Gerald Dakin (Chair), John Cadwallader
Telford and Wrekin Councillors: Andy Burford (Co-Chair), Veronica Fletcher and Rob Sloan
Shropshire Co-optees: David Beechey, Ian Hulme, Mandy Thorn
Telford and Wrekin Co-optees: Carolyn Henniker, Dag Saunders

Also Present:
David Evans, Chief Officer Telford and Wrekin CCG &Senior Responsible Officer, Future Fit
Simon Freeman, Interim Accountable Officer, Shropshire CCG
Steve Gregory, Director of Nursing and Operations, Shropshire Community Health Trust
Amanda Holyoak, Committee Officer, Shropshire Council (minutes)
Sheena Khanduri - Consultant
Neil Nisbet, Director of Finance, Shrewsbury and Telford Hospital Trust (SaTH)
Rod Thomson, Director of Public Health, Shropshire Council
Kate Shaw, Associate Director of Service Transformation, SaTH
Jessica Tangye, Telford and Wrekin Council
Debbie Vogler, Future Fit Programme Director
Simon Wright, Chief Executive, Shrewsbury and Telford Hospital Trust

1. Apologies for Absence

Apologies were received from Councillor Heather Kidd.

2. Disclosable Pecuniary Interests

In connection with the item on the Sustainability of Services Provided by SaTH, Mandy Thorn reported that she had just been appointed Chair of the Lingen Davies Cancer Fund.

3. Minutes

Councillor J Cadwallader was added to the list of attendees at the meeting held on 2 December 2016. The minutes were then confirmed as a correct record.

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

STP Update

It was agreed to take the update on the Sustainability and Transformation Plan (STP) first.

Neil Nisbet, Finance Director, Shrewsbury and Telford Hospital Trust (SATH), was welcomed to the meeting. The Chair said that Members of both Councils would very much welcome a seminar at an appropriate time on STP finance.

In response to questions on the STP, Mr Nisbet explained:

The Financial Plan that sat behind the STP was based on a starting point of the underlying surplus and deficit amongst the three main provider organisations, Shropshire and Telford and Wrekin Councils and Shropshire and Telford and Wrekin Clinical Commissioning Groups. It was then necessary to look at the pressures faced by the CCGs including demographic growth and tariff issues which would add to the recurring deficit. The efficiency standard would then be applied with a requirement to deliver 2% Cost Improvement Programmes (CIP) each year alongside QIPP and transformational activities.

The Transformational activities over a five year period were designed so that all providers and both CCGs would record a balanced budget or better. Some schemes were crucial to that programme, the SATH Outline Business Case being one of these. This was designed to reduce spend caused by duplication over two sites, reduce the overall level of activity and generate a recurring saving of £30 million for commissioners.

Programmes of work had been established associated with levels of orthopaedic surgery, and configuration of community services but the biggest change in delivery of the Transformation Programme would be through the Outline Business Case.

Shropshire had received £33m from the 'System and Transformation Fund' and over the STP period it was intended to use this non recurringly to support changes and drive forward developments. It would also be used to support seven day working, digital technology, and improvements in mental health care and maternity services.

In recognition of the sizeable deficit in acute sector, the STP would be used to provide a level of support to Acute Trusts

It was intended that £10.5m of the fund would be used in year one, £10m the next year and £10m the following year. This would start to reduce the cost base and there would be less reliance on that fund.

The Chairman asked about dependence on the plan to develop primary care to reduce the throughput in the acute hospitals and about the funding required for this. Mr Nisbet said that £6m had been earmarked as a contingency to support primary and community care developments and that that this amount was in addition to the £33m. Work was underway looking at how to deploy it to support activity change.

The Chairman asked about the current position of the local authorities in taking forward the STP and support for activities presently delivered through them. Members heard that part of the role of the programme board involved looking at how to use the £33m. There was an expectation that the Programme Board would make available a level of funding to help support social care.

The Co-Chair of the Committee referred to the Shropshire and Telford and Wrekin STP area being one of the worst off in the country in terms of funding per head of the population. He asked if NHS colleagues were making representations about this.

There did not seem to be a clear rationale for receiving less in an area of rural sparsity and also of deprivation in urban areas. The Chief Executive of SATH said he along with local authorities had met with and made representations to Ministers but he was unsure if they were being listened to. He referred to a recent national forum established to highlight the challenges of the rural system. Another was forthcoming. He said that he and colleagues were not lying down and were pursuing this but also needed to make progress at the same time. This lower level of funding made it all the more important that the money available should be targeted to the areas of best return.

The Director of Finance added that other allocations were challenging for commissioners too in the next two to three years. There was growth, but it would accompanied be really challenging pressures.

The Chair reported that the Portfolio Holder for Health, SC, had written to Philip Dunne expressing concerns around the STP

Members commented on what they felt was a very complex picture and asked a series of questions including whether QUIP targets had been achieved in recent years, what priority would be given to assessment of patient services, and to what extent did financial limitation mean that level of service for patients could not be maintained.

Mr Freeman, Accountable Officer, Shropshire CCG, said that a reason Shropshire CCG was in a deficit position was because it had failed to delivery QUIP of any appreciative size. He said that there would not be a wholesale reduction of services, but action would be taken to make better use of the money available. As an example he referred to care of frail elderly people and said that there were potentially enormous savings to be made through improvements in this care and putting in measures which would result in less falls and fractures and consequent demands on social care.

Members asked if patients would have to wait longer for services in future. The Accountable Officer said that the only way it would be possible to save money would

be by making people healthier. This would lead to a reduction in activity and reduction of costs for the whole of the health economy.

The Chief Officer of Telford and Wrekin CCG reported that Telford and Wrekin CCG had over the last 4 – 5 years delivered 70% of its QUIP target but challenges still presented themselves. By developing a more mature approach it would be possible to deliver QUIP across the whole system, rather than just the CCG.

The Director of Finance explained that his use of the term 'activity reduction' meant decreasing the amount of activity which found its way to SATH. Reconfiguration, reducing the costs of duplication and transferring activity that could be undertaken in the community would help to reduce the premium agency costs currently being paid. Around £1.5m a month was currently being paid for agency staff, £500,000 of that being the agency premium.

Members expressed concern that activity would be reduced in acute services before the appropriate investment had been made in community services. There was a lack of awareness of members of the public around work to transfer this activity.

The Chief Executive of SATH explained that SATH already delivered some services in the community. He referred to telephone and tablet applications which could be used by patients to self-manage conditions and reduce the frequency of patient visits to hospital. Attempts were being made to try to convey how technology could be used to deliver care without boundaries, reducing waste and duplication.

In response to a question from Members, Mr Evans, Chief Officer, Telford and Wrekin CCG, explained that from a legal point of view it was not possible for NHS funding to be used for social care, but schemes could be joint funded.

The Chief Executive of SATH added that separate additional funding for social care was an imperative as many problems identified in the media had their roots in inadequacies in social care, he said this was a feature of an ageing population. Partnership working with local authorities was underway to develop schemes marrying together health, wellbeing and social care. Talks were underway with Chief Officers at Shropshire and Telford and Wrekin and there would be visits to Parliament to discuss this.

Members asked about the Shropshire CCG deficit which they understood to be around £26m. Mr Freeman, Interim Accountable Officer for Shropshire CCG explained that it could be viewed as an allowable 'overdraft' of a £26m in year deficit. This had to be reduced to £19.4 m in the following year.

He said that at the next CCG Board meeting clinicians would start talking about how to make those reductions and he encouraged members of the public to attend and speak at that meeting. The Board would look at how to better invest and in a more transparent way.

The Chairman mentioned feedback on the STP which had recently appeared in the media. He asked that all Members of the Committee have sight of this feedback. The Chair of the STP Board reminded Members that these documents represented a snapshot in time. The latest iteration had only just been sent to NHS England – this

would be made public along with any feedback received on it. There would be challenging financial changes to work through and this would be done in the full public gaze. There were still gaps remaining and plans would be built on over time.

Mr Nisbet was thanked for attending the meeting and answering the Committee's questions.

Update on Future Fit Programme

Debbie Vogler, Programme Director, Future Fit, explained the next steps in the Future Fit Programme. Terms of reference for an independent review of the options appraisal process had been drawn up. The initial draft specification on the integrated impact assessment of the potential move of Women's and Children's services had been drawn up. In addition work was underway on the constitution of a Joint Committee to receive the outcome of this work.

Work was also underway to address the recommendations from the Clinical Senate report. An action plan would be provided to a Future Fit Programme Board the following week. Some of this work would not require completion before consultation.

The Gateway first stage review plan would also be going to the Programme Board. This currently remained a report which was confidential to the two Senior Responsible Officers and an action plan would be made public after the Board meeting if it was approved.

The overall impact on the timetable would be discussed at the Programme Board meeting in detail, it looked as if the consultation was likely to start at the end of May subject to what came out of the independent review.

Members referred to the special edition of 'Putting People First' released by SaTH and queried how this had been published ahead of the Future Fit consultation. In his capacity as Senior Responsible Officer for Future Fit, Mr Evans explained that SaTH had conducted a parallel piece of work on how it saw future services, running alongside Future Fit. He expressed his reservations about having a separate process.

Members asked if there had been any more information forthcoming regarding the capital element of Future Fit and if not what the likely timescale would be. They heard that there was no definite information available, but that it had just been confirmed that the case had been included on a priority list and that both NHS England and NHS Improvement were recommending investment in this community.

The Chair asked what would happen if the finance was not available. He also asked if it would be repaid over several years. Mr Wright, Chief Executive of SaTH, said it could be borrowed over 20 – 30 years.

The Co-Chair asked if it was accepted that the issue of capital funding needed to be resolved before the consultation was launched. In response, Mr Wright said the consultation would provide a clear clinical indicator about how services would look but he felt that waiting for a decision on capital would be wrong. He felt that the conversation with the public on how services should look should happen first. In

response to further questions, Mr Wright said that there was confidence in the power of the argument and the case would not be challenged in terms of its validity.

Mr Evans said that the process of designing a clinical model and the issue of process development around an Outline Business Case did nothing to stop engagement proceeding on what a future model could look like. He said it would not pre-determine the consultation process. The SaTH 'Putting Patients First' was one potential version. There would be other options that the public could consider during the formal consultation period. His understanding was that financial sign off would be needed by the time of the consultation.

The Co-Chair said that the content of 'Putting Patients First' appeared to have pre-empted Future Fit, when an independent review had just been launched of the Programme. He added that he did not understand how consultation could happen before capital funding became clear.

Mr Freeman explained that it was not legally possible to consult on a solution that could not be delivered. However it was possible to consult when the capital was not in place and he cited an example of this in Leicester. He said if it was known that the capital was definitely not available, then the issue would be clear. If there was a reasonable opportunity of obtaining it then the CCGs could enter consultation. The definition of reasonable, sure and confident were open to interpretation but no CCG would want to break the law.

Mr Wright said he had only been in post for a year but he understood the reconfiguration debate had now been going on for over 10 years. Future Fit was currently in its third year. His staff believed that configuration should be discussed with the public without impediment, and shape what was going on.

A Member referred to the Putting Patients First publication of last week and felt it had been easy to understand. Another Member queried the existence of a preferred option and said that a role of the Joint HOSC was to ensure the right process had been undertaken. She said she felt the Review should take precedence and it was not known what the outcome would be. Mr Freeman said that the Future Fit Programme Board had met and agreed to recommend a preferred option. Mr Evans said that the Review would look at the process behind determining the recommendation of the preferred option of the Programme Board. At the moment there was a recommended preferred option, subject to an independent review.

5. Update on the Sustainability of Services Provided by Shrewsbury and Telford Hospitals NHS Trust (SaTH)

Dr Khanduri, Consultant Clinical Oncologist, SaTH was invited to outline the risks and concerns around NHS England proposals for changes to radiotherapy services based on population numbers. She explained that the proposals meant that Shropshire and Telford and Wrekin would fall into the lowest tier of satellite coverage as NHS England deemed that fewer than 500,000 people lived in the area covered by the hospitals. This did not include the population of Powys receiving treatment from SaTH.

This meant that patients with less common cancers would be required to travel out of county for radiotherapy for which daily attendance was needed for usually between three to five weeks. This would impact on 4,000 patient journeys.

Mr Wright, Chief Executive, reported that he had written to NHS England to highlight the needs of patients in Powys. The Director of Public Health, Shropshire Council referred to a previous incidence where the half a million population standard had been put aside in relation to aortic aneurysm screening. In that case the rurality of the county had been taken into account on travel times for staff and patients.

Mr Wright welcomed unified representations being made by all partner organisations on this issue. The Committee agreed to write to Philip Dunne MP, and NHS England supporting SaTH on this issue, referring to the population of Powys, the sparsity of Shropshire and the growing demographic projections for Telford.

Steve Gregory, Shropshire Community Health Trust, said that a proactive stance should be taken with NHS England as many documents were currently focused on a population of 500,000 and did not take into account other factors such as rurality or growth.

Dr Khanduri was thanked for attending the meeting.

Mr Wright went on to provide an update on the current position with regard to A&E services. There were currently five substantive consultants in post. This included one who had handed in their notice, meaning the number would fall to four in June, and one of whom did not provide on call services. This meant that in June there would be a 1 in 3 rota which was not tenable.

Currently support to this fragile service was provide by high cost locums who could leave at very short notice. The fragility of the service had been concerning for a number of years and it would be impossible to go into next winter with less resilience than existed currently. The nearest hospitals in Wolverhampton and Stoke were unable to offer any support and an advert for Joint appointments with University Hospital North Midlands had not resulted in any interest at all. The next steps were therefore to discuss with partners, colleagues, stakeholders and the public the options available. The existing workforce were very frustrated as to whether a solution would ever be found to address the problem.

In response to a Member saying that she had heard A&E staff were not being replaced, Mr Wright confirmed that SATH was replacing any member of staff with a permanent replacement, and that there was active recruitment at all levels.

The Committee asked about the nature of the staff who would work in the Urgent Care Centres, and asked if this would involve recruitment of permanent GPs. Members heard that SaTH employed five GPs in hospitals already.

The skill sets needed for urgent care already existed both A&Es. Two A&Es could be retained with an additional emergency centre concentrating on critical care. Members asked if it would be possible to use the urgent care centre model at the present time. Mr Wright said that at the current time pathways and clinical approaches meant that space in Majors cubicles would need to be released and

capacity was not there at the moment. SaTH was exploring options with commissioners but A&Es were currently overwhelmed.

A Member asked about the vulnerability of services other than Accident and Emergency, as they were aware there was a national shortage of Acute Medicine Physicians, Middle Grade doctors and heavy reliance on locums and GPs.

Mr Wright referred to national shortages in care of the elderly, and stroke services. SaTH had recently made successful appointments into intensivist roles and cardiology but more were needed.

A Member asked about the withdrawal of the Walk in Centre and Practice located at the Princess Royal Hospital. In response Mr Evans said the CCG had looked at availability of primary care, the practice list size was 8,000 and there was a capacity of 14,000 across Telford as a whole. A risk mitigation plan was in place to ensure all would have access to primary care post July.

A Member asked if the Walk in Centre had taken pressure off of A&E, and how triage had been managed to ensure people were presenting at the right place. Mr Wright confirmed that some patients had been streamed into the walk in service rather than A&E. Those presenting at the Walk in Service were often seeking urgent treatment rather than attending their own GP practice. It was known that 20% patients nationally in A&E could have been managed by a pharmacy or in primary care. A solution needed to be found which would not add pressure to A&E.

Mr Evans added that attendances at the Walk in Centre had been analysed, and most were from the Malling Health Practice itself. There was a big educational piece of work to be done, messaging was not currently working.

A Member asked if the CCG had modelled the impact on Shropdoc services in anticipation of the Malling Health practice ceasing to exist. Mr Evans reported that the majority of visits were two an hour for the out of hours service and he confirmed that work was underway with Shropdoc to ensure this was covered.

A members said that Healthwatch had found referrals were being made to Shropdoc due to a three week wait for a GP appointment. Mr Evans acknowledged that access to primary care was the biggest issue for the population but that he was not sure if this was genuine or just a perception. It might be that a person thought that they would not be able to get a doctors appointment but GPs did offer emergency appointments and telephone consultations. He said that a three week wait for an appointment was clearly not acceptable.

Returning to issues around A&E, the Co-Chair asked about solutions if the tipping point had been reached. He asked if it was still the view that space restrictions would curtail previously suggested solutions. He also asked about discharge and whether improvements and working with Adult Social Care was still on course. He had received anecdotal reports that it was not always working as it should be.

In response, Mr Wright said that the system was very complicated when it came to discharging patients with complex needs and he acknowledged the system was not always perfect. He said that the relationship between SaTH, the Community Health

Trust, Local Authorities and CCGs had never been as good at it was now, and all were working very hard to achieve the right outcomes.

He said that an underlying problem that no amount of hard work could address was lack of funding in avoiding delays. There were around 80+ patients at one time in SATH who did not need to be there. In response to the comment about anecdotal evidence, he encouraged members to pass any concerns they had through to him. Health and Social care teams met twice a day every day on cases and he had personally observed some of these meetings.

With regard to A&E tipping point decisions would be made in the full gaze of the public and it would be wrong to progress without allowing this to happen. He reiterated that it would not be feasible to move into next winter in such a fragile state and action plans were underway to make the service more resilient. It would not be right to put patients and staff through the same pressures as this winter.

The Chair thanked NHS Colleagues for attending and for the frank answers provided to the Committee.

6. Joint HOSC Work Programme

It was noted that the planned meeting on the Emotional Health and Wellbeing Service was likely to take place on 8 or 9 March 2017. A date would be confirmed as soon as possible.

Chair: _____

Date: _____

Programme Director's Report to Sponsor Boards

March 2017

1. Programme Plan – Progress Update/RAG Rated Delivery Dashboard

The purpose of this report is to provide Board members with an update of progress on programme delivery since the last meeting. The programme timeline has been rebased to assume a consultation start date of earliest June 2017; however, this may be subject to change dependent on the outcome of the independent review which is expected to be known in May 2017.

The table below is a summary RAG rated dashboard of the status of delivery of the key components of the Futurefit Programme Plan. It includes a summary narrative of key risks and/or issues.

		Last updated	20th February 2017
		Overall RAG rating	Key Issues/risks
1	**Programme Governance**	A	Risks relate to needing clear terms of reference and reporting through new STP governance structures for enabling groups and ensuring their terms of reference meet Future Fit programme (FFP) requirements. Current priority is the Workforce Workstream. Programme Board agreed on 30.11.16 that full transition of the FFP governance arrangements to STP governance should not be until the programme moves to project delivery phase. This will be after public consultation and decision making has concluded. Project Execution Plan (PEP) currently being refreshed to reflect current status of the programme within the STP structure and will be submitted for approval to the Programme Board. The opportunity to consolidate PMO functions for the STP and Future Fit are being explored with the secondment coming to an end of the current Programme Manager.
2	**NHS Approvals/ Assurance Gateways**		
	2.1 West Midlands Senate Review	A	Action plan approved by Programme Board on 6.2.17. Implementation update reports will be submitted as standing item to future Programme Board meetings to ensure key milestones are achieved particularly those required pre-consultation. Key areas of focus in the action plan are modelling ambulance and patient transport impact and greater level of detail on the acute workforce development plan, description of the corresponding community model of care particularly in Shropshire, the plan to ensure the required IT infrastructure will be in place to enable a system networked approach and the desired patient outcomes and how these will be measured.

	2.2 NHS Gateway Review		RED/AMBER rating achieved. Action plan approved by Programme Board on 6.2.17. Implementation update reports will be submitted as standing item to future Programme Board meetings to ensure key milestones are achieved particularly those required pre-consultation
	2.3 NHSE Formal Stage 2 Assurance	A	Process delayed post JC meeting; will be rescheduled in May 2017
	2.4 Pre- Consultation Business Case	A	A number of issues remain unresolved particularly the availability of capital, the more granular detail on the community models that will support the acute configuration and its affordability given the moving position of the CCG. SaTH are working with NHSI to clarify what levels of capital are or are not likely to be available before public consultation including potential alternative sources of capital than through the Treasury.
3	**Options Appraisal/ Preferred Option**	R	Independent Review: Terms of reference approved by Programme Board on 6.2.17 (attached to this report). Invitation to Tender published 14.2.17. Awaiting outcome. IIA W&C: Programme Board delegated the design of the detail of the specification to the IIA Workstream which met on 13.2.17, another meeting to be scheduled. The specification requires acute clinical input. Approval of the final specification and the costs delegated to the Joint SROs. Current indications are that this piece of work will take 8 weeks from start to finish which poses a potential risk of further delay to the programme decision making timeline. Joint Committee: Meeting scheduled with NHSE, NHSI and CCGs on 23.2.17 to develop and agree future joint decision making arrangements which will then require formal Board approval.
4	**Formal Consultation**	R	Preparations for consultation continue with the development of the consultation materials including the consultation document, survey questionnaire and a refresh of the programme website. Given the above delay to timelines following Joint Committee decision, the consultation is not likely to be before June 2017. Work has begun to develop clear and unambiguous public messages describing the role and function of the UCCs on each site. Next steps are to share the draft messaging with GP Forum/Locality meetings and patient reps in March for feedback prior to inclusion in any consultation materials.

5	**Developing the supporting community model to support required left shift**	A	Neighbourhoods and pathway development work and associated activity modelling whilst progressing has not to-date delivered the granular level of detail CCG Boards are indicating is required to give assurance the community model will support the required left shift in acute activity in the OBC and that it is affordable. Frailty activity modelling completed, further work planned for other patient/condition groups. STP timeline for Neighbourhood Model completion (March 2017). SCCG have commenced a review of community services and Neighbourhood work to-date for completion by the end of March 2017 which will inform their community model design.
6	**Programme Funding and Budget Management**		Costs pressures have been incurred in recent months associated with the Clinical Reviews and Gateway Review. Further costs pressures for 17/18 relate to the need to do the Independent Review of the option appraisal process and the additional IIA work on W&C impact. Subject to necessary approvals to proceed, the costs of formal consultation will also be a cost pressure in 2017/18. Budgets are currently being agreed and consideration looking to opportunity to integrate some Future Fit functions within the STP programme management office (PMO)
7	**SATH OBC/FBC**	G	Draft OBC approved by SaTH Board in December 2016. Further work required in light of Clinical Senate recommendations for inclusion in final OBC for CCG approval

Action Status RAG Rating definition	
	Complete
	Delayed - recovery actions planned or in place. Low risk of materially affecting programme delivery and/or timeline
	Delayed - recovery actions planned or in place. Medium to high risk of materially affecting programme delivery and/or timeline
	Deadline not yet reached, delivery on target

2. For Information - Independent Review of Option Appraisal Process – Terms of Reference

The Future Fit Programme Board and CCG Governing Bodies approved the Terms of Reference and proposed approach to procurement of the independent auditors for the review of the option appraisal process at its meeting on 6th February 2017. The final terms of reference are provided for information at Appendix 1.

APPENDIX 1

Independent Review of Appraisal Process Terms of Reference

February 2017

1 AIM

The Joint Senior Responsible Officers of NHS Future Fit seeks independent external assurance in relation to the robustness of the financial and non-financial processes used to appraise the programme's shortlist of options.

2 OBJECTIVES

The appointed independent body shall via a desktop review of programme and related documents, and discussions with the Future Fit Programme Team:

a) Review the methodology for the shortlisting process
b) Review the design of the financial and non-financial evaluation was appropriate for discriminating between the short-listed options for acute services reconfiguration;
c) Review as far as is possible whether the actual methodology deployed in the financial and non-financial evaluation was appropriate both in design and enactment;

3 KEY EVIDENCE SOURCES

The independent body shall have regard to relevant national guidance including (but not limited to):

- HM Treasury's Green Book and the 2013 Supplementary Guidance on Delivering Public Value from Spending Proposals;
- The Department of Health's Capital Investment Manual;
- HM Government's Impact Assessment Toolkit; and
- NHS England's guidance of Planning and delivering service changes for patients (2013) and Planning, assuring and delivering service change for patients (2015).
- Relevant NHS Wales legislation and guidance

Local documentation to be consulted shall include:

- The Programme Board's approved approach to appraisal;
- All Evidence supplied against the non-financial appraisal criteria
- Non-financial scoring and weighting data;
- Financial appraisal data from Shrewsbury and Telford Hospitals NHS Trust and any existing external assurance the Trust can provide in relation to that data (including the independent audit performed by Dolomites);
- Appraisal outcome report;
- Health Gateway Review and West Midlands Senate Reports in relation to the programme;
- Integrated Impact Assessment;
- All documents concerning the appraisal process submitted by Telford and Wrekin Council along with any formal responses to those documents made by the Programme Board and/or its sponsors.

In addition, it is expected that the supplier shall engage directly with the Programme Director and those members of the Programme Team involved in the design and implementation of the appraisal process (including CSU Strategy Unit, Provex Consulting).

The successful Provider will also have the opportunity to engage directly with the Chairs of Shropshire and Telford & Wrekin CCGs and Powys Teaching Health Board (sponsor organisations) and a nominated officer each from Shropshire, Telford & Wrekin and Powys Local Authorities (stakeholder organisations).

4 QUALIFYING REQUIREMENTS

In order to provide the assurance required, it is essential that potential suppliers can assert and evidence where possible that they have:

a) Extensive experience in undertaking reviews of this level of political and service reconfiguration complexity within an NHS environment;
b) Capacity to complete the review by the 6th April 2017;

No pecuniary or other interest in the findings of the review, specifically that it has not, and does not expect to be, contracted for any related purpose by an organisation that is a sponsor or stakeholder member of the Programme Board or that has declared a position in relation to outcome of the appraisal process.

5 OTHER MATTERS

In determining appropriateness or otherwise in 2(a) we are asking for an overall opinion as to whether the process was in line with other evaluations of this nature. Shortcomings in the process should only be identified where in the opinion and experience of the supplier they were material and substantial in terms of the outcome of that process.

NHS
The Shrewsbury and Telford Hospital
NHS Trust

Reporting to:	**JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE** **Tuesday 7 March 2017**
Title	Fragile Clinical Services - Briefing
Sponsoring Director	Debbie Kadum, Chief Operating Officer
Author(s)	Carol McInnes - Assistant COO, Unscheduled Care Carolynne Scott – Assistant COO, Scheduled Care
Previously considered by	
Executive Summary	This briefing paper provides an update to the Health Overview and Scrutiny Committee on fragile Clinical Services at the Shrewsbury and Telford NHS Trust and actions being taken to ensure long term fundraising.
Strategic Priorities 1. Quality and Safety	☐ Reduce harm, deliver best clinical outcomes and improve patient experience. ☐ Address the existing capacity shortfall and process issues to consistently deliver national healthcare standards ☐ Develop a clinical strategy that ensures the safety and short term sustainability of our clinical services pending the outcome of the Future Fit Programme ☐ To undertake a review of all current services at specialty level to inform future service and business decisions ☐ Develop a sustainable long term clinical services strategy for the Trust to deliver our vision of future healthcare services through our Future Fit Programme
2. People	☐ Through our People Strategy develop, support and engage with our workforce to make our organisation a great place to work
3. Innovation	☐ Support service transformation and increased productivity through technology and continuous improvement strategies
4 Community and Partnership	☐ Develop the principle of 'agency' in our community to support a prevention agenda and improve the health and well-being of the population ☐ Embed a customer focussed approach and improve relationships through our stakeholder engagement strategies
5 Financial Strength: Sustainable Future	☐ Develop a transition plan that ensures financial sustainability and addresses liquidity issues pending the outcome of the Future Fit Programme
Board Assurance Framework (BAF) Risks	☐ If we do not deliver **safe care** then patients may suffer avoidable harm and poor clinical outcomes and experience ☐ If we do not work with our partners to reduce the number of patients on the **Delayed Transfer of Care** (DTOC) lists, and streamline our internal processes we will not improve our 'simple' discharges. ☐ Risk to **sustainability** of clinical services due to potential shortages of key clinical staff ☐ If we do not achieve safe and efficient **patient flow** and improve our processes and capacity and demand planning then we will fail the national quality and performance standards ☐ If we do not get good levels of **staff engagement** to get a culture of continuous improvement then staff morale and patient outcomes may not improve ☐ If we do not have a clear **clinical service vision** then we may not deliver the best services to patients ☐ If we are unable to resolve our (historic) shortfall in **liquidity** and the structural imbalance in the Trust's **Income & Expenditure** position then we will not be able to fulfil our financial duties and address the modernisation of our ageing estate and equipment

Care Quality Commission (CQC) Domains	☐ Safe ☐ Effective ☐ Caring ☐ Responsive ☐ Well led
☐ **Receive** ☐ **Review** ☐ **Note** ☐ **Approve**	**Recommendation**

UPDATE ON THE SUSTAINABILITY OF SERVICES PROVIDED BY SHREWSBURY AND TELFORD HOSPTIALS NHS TRUST (SaTH)

1. Emergency Department Update

There are 5 Substantive Consultants for both Emergency Departments at RSH and PRH and 4 Locum Consultants. Across the substantive and locum staff a 1:5 on call is worked (1:4 = tipping point). One of the Locum Consultants leaves 1 April 2017 and the Trust is advertising for a replacement.

2. Ophthalmology

A Stakeholder Workshop is being held on 14 March 2017 to discuss and review options for the long term sustainability of this service. The service remains closed to new referrals for glaucoma, general surgery and Adult surgical squint surgery.

Due to short notice sickness the Trust is unable to offer glaucoma surgery. Alternative providers have been sought for approximately 12 patients waiting for surgery.

Following the engagement exercise on 14 March 2017 an option paper will be presented at the Public Session of the Trust Board on 30 March 2017 for a decision on the preferred option for long term sustainability. Depending on the decision this may need to come back to HOSC with a recommendation to consider formal consultation.

3. Neurology Outpatient Service

Commissioners have been informed of a proposed temporary change to the Neurology Outpatient Services provided by SaTH. The service has consistently been flagged to commissioners and NHS Improvement as being a particularly challenged speciality with constraints in delivering national access targets due to consultant workforce gaps.

Currently, SaTH employs 2 wte Consultant Neurologists. This is supported by 1 wte locum post. The national average is 1 Neurologist per 80,000 people. This would equate to 6 wte for our local population. Despite our best efforts, we are unable to secure additional locum capacity to fill the gap.

This workforce position has led to increasing delays in patients waiting to be seen. On average, new routine patients are waiting 30 weeks for their first appointment and 9 weeks for an urgent referral. In order to deliver the RTT standard this should be 7-9 weeks for routine patients and 2-4 weeks for urgent referrals.

Clearly, there is a potential risk to patients waiting excessively to be seen and/or reviewed. We have, as you would expect, undertaken a series of actions to mitigate against this risk.

These actions include:

- Providing detail to both RAS & TRACS TRAQS for Shropshire & Telford CCGs on a weekly basis highlighting the average waiting times for new referrals, so this information can be shared with patients prior to them making their choice of provider alongside the details of other provider services who have shorter waiting times.
- If patients do choose SaTH as their provider, they are asked to contact the booking team should their condition resolve itself prior to their appointment to avoid missed appointments which can be reallocated (our current DNA position = 10%).
- Referrals are assessed by the consultants with some patients being advised to choose an alternative provider with shorter waiting times where possible. There is however an element of patient choice to be considered in this scenario as patients can still choose to wait for a SaTH appointment.

Despite these actions, we are concerned that a significant residual risk to patient safety remains in place. Consequently, we have recently undertaken a piece of work to identify possible short term options to reduce this identified risk.

The options included:

- Do nothing - this option would include maintaining the current level of service delivery alongside acceptance of new referrals while continuing to try and recruit.
- Hold an Executive to Executive discussion with neighbouring trusts regarding clinical support to alleviate the backlog.
- Suspend all routine referrals to the service for 6 months.
- Suspend all referrals to the service for 6 months.

These options alongside the identified risks and benefits of each option have been presented to SaTH executives for consideration. It was determined that option 1 (do nothing) is not viable as SaTH has held this position for some time without success. Option 2 has been attempted previously without success. It was agreed however that this discussion would be progressed alongside option 4, the suspension of all referrals to the service for 6 months.

In response to the level of clinical risk that has been identified, SaTH has formally advised commissioners of our intention to temporary close the Neurology Outpatient Service to all new referrals for a 6 month period with effect from 20 March 2017. We are working with commissioners to work through the necessary steps and detail to put this into effect, including communication with patients. All current patients on the waiting list will be seen with an expected reduction in waiting times from 30 weeks to 12 weeks within 3 months.

During the next 6 months the Unscheduled Care Group team will be developing an options paper for the long term sustainability of this Service.

4. Dermatology Outpatient Service

The Dermatology Outpatient Service is provided by SaTH and St Michaels Street Clinic. The SaTH current substantive workforce is;

- Consultant x 1
- Locum Consultant x 1
- GP's with Special Interests x 5
- Cancer Nurse Specialists x 3
- RGN's x 2

The Locum resigned week commencing 22 February 2017 with immediate effect. Several options are being pursued to maintain service delivery. A single Consultant led service is not viable due to the need for all Cancer 2 week referrals to be supervised by a Consultant. During periods of annual leave without alternative Consultant presence all clinics would have to be cancelled (10 weeks per year – 950 new/2WW patients and 850 follow up patients). Failure to appoint into either a substantive or Trust Locum Consultant post will leave the service in a very fragile position with only a single Consultant to deliver and oversee all aspects of the service. During Consultant annual leave the service would require an alternative provider to be secured to accommodate Acute Dermatology in-patient activity. An options paper for the long term sustainability of this service is being developed.

5. Spinal Service

SaTH has 1 Consultant who specialises in spinal surgery. This Consultant went on long term sick with no notice week commencing 13 February 2017. Commissioners have been informed that with immediate effect the Trust cannot take referrals for spinal problems. SaTH is in discussions with the Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust regarding their capacity to support this service for the County.