Shropshire, Telford and Wrekin Defend Our NHS
26th September 2018

To Board Members at Shrewsbury and Telford Hospital NHS Trust (SaTH)

Dear Board Member

We hope that you will spend a few minutes reading this letter, and considering its content carefully. The issues here are important ones.

"It's all fine. Steady as she goes. Business as usual."

This will be the position put to Board members in your pre-Board discussions. This is probably the decision that you will feel compelled to support. This will be your mind-set as you vote through the overnight closure of the A&E at Princess Royal Hospital.

We ask you to think hard before you do this. Think about where SaTH is now. Think about the maternity crisis, and about the shocking care that your staff revealed to hospital inspectors a matter of weeks ago. Think about the very real risks to patients of poor care. And, if you wish to see this in business terms, think about the severe damage being caused to SaTH's reputation and the ongoing consequences of this.

Are you confident in the skills of the Senior Management Team that got you into this situation? Are you confident that, as a Board, you have been robust enough in holding SaTH's Executive to account? Do you think it is possible that SaTH's SMT has come to put the perceived business interests of the organisation *before* the needs of patients?

If you have doubts about any of these things, this is not a time for 'business as usual'. It's a time for asking questions and for a sharp refocusing of SaTH's priorities.

This letter is aimed at NEDs and SaTH Chair Ben Reid, although we are sharing it with the Executive Team on the Board (and sharing this also as a public document). For NEDs, you will of course know that your role includes a responsibility to *'Hold the executive to account for the delivery of strategy*'; *'Ensure that patients and service users are treated with dignity and respect at all times, and that the patient is central to trust decision-making'*; and *'Ensure the directors of the board are 'fit and proper' for the role and champion an open, honest and transparent culture within the organisation'*[1].

And as Chair, Ben, your role will include those things, but will go further. You have a leadership role in making SaTH's vision of *'safest kindest care'* a reality. An important strand of your leadership role is of course to facilitate the work of the wider Board and ensure that NEDs are enabled to fulfil their own role of 'holding to account'. SaTH's own guidance on the role of the Board of course includes financial monitoring and control – but stresses that the main focus of the Board is '*providing high standards of healthcare'.*

[1] NHS Improvement. 2017. Non-executive appointments: about the non-executive director role

Candour and trust need to be part and parcel of working relationships between Executive members and NEDs. And all Board members must, as a matter of course, have the information necessary to allow them to identify key risks and respond appropriately.

Maternity

Do a quick Google search on 'Morecambe Bay maternity' if you're so minded. The 2015 investigation found that failures of clinical care resulted in the deaths of 11 babies and one mother. Quite rightly, Morecambe Bay is remembered. Each death – a human life lost just as it began – was an individual tragedy. Put together, those deaths were a disgrace.

The Ockenden Review, in our own locality, is investigating possible death or significant harm to well over 100 babies and four mothers now. Every scrap of publicity leads to more families coming forward. Bad things happen in childbirth, of course. Babies occasionally die. Sometimes it genuinely is 'just one of those things'. It is looking increasingly likely, though, that what we have at SaTH is a scandal at least on a par with Morecambe Bay, and quite possibly a scandal that far, far exceeds it. SaTH is going to be remembered, for all the wrong reasons.

A number of people have contacted Defend Our NHS about deaths in the maternity service, and we have referred them to the Ockenden Review. Some of what we've been told has been very, very hard to listen to. As a Board, have you been sighted on this unfolding situation? Those of you who have been on the Board for several years, are you confident with what has been done in SaTH's name in the past? When bereaved parents speak of 'cover up', of being 'fobbed off' – are they automatically and necessarily wrong?

This is not just a historic issue. The new CQC enforcement notice on maternity suggests that at least some of those problems with the maternity service are ongoing. We also note that the treatment of expectant mothers at rural MLUs earlier this year was deplorable, with closures sometimes planned weeks in advance but routinely announced with a few hours' notice.

In June this year, **MBRRACE-UK** maternity data were released. The data related to 2016 births, because of the detailed analysis that goes into production of the data set.

SaTH was the fourth worst performing Trust, out of 47 comparable organisations[2] [3], for 'extended perinatal mortality' – that is for stillbirths and neonatal mortality combined. This was for adjusted data, allowing for random quirks and correcting for factors such as social deprivation and maternal age. This means that the data are likely to reflect something 'real' rather than a random variation. We believe this should have been brought to the Board's attention in 2016, as those deaths were occurring. Did this happen? We also believe that your Medical Director, Care Group Director or Head of Midwifery should have brought SaTH's poor performance to your attention when the MBRRACE report was published in June 2018. Again, did it happen?

Did you know that **Shropshire babies are more affected by neonatal deaths** than Telford and Wrekin babies? This applies to both unadjusted crude data and adjusted data. We assume you didn't

[2] The applicable group was for Trusts (or comparable organisations in other UK countries) with over 4000 births a year and without a Level 3 NICU. Maternity services with a Level 3 NICU are more likely to care for women with very complex pregnancies and for the very sickest babies. This increases mortality rates for these organisations.

[3] Last year's 2017 report on 2015 data **also** showed SaTH to be the 4th worst trust in its group for perinatal mortality. An improvement took place across the group as a whole in that year; 2016 data show less variability; & SaTH's neonatal mortality rate improved but stillbirths did not.

know – but why not? Should you have been told? What might the reasons be for Shropshire babies being more at risk of dying than Telford babies? What active steps is SaTH currently taking to identify those reasons and, if it can be done, take corrective action? And if you don't know, why not? Is it appropriate to take far-reaching decisions on MLU closure before a postcode analysis of neonatal deaths and the reasons for these? Our view is that you are being let down by the senior staff in SaTH who have professional responsibility for the safety of the maternity service. You are not being given the information you need to do your job effectively.

Dr Bill Kirkup led the Morecambe Bay review. His comment when the report was released was, *"Our conclusion is that these events represent a major failure at almost every level … [There were] repeated failures to be honest and open with patients, relatives and others raising concerns. The trust was not honest and open with external bodies or the public."*

We do not believe that SaTH has been open and honest with a key external body – with the **Joint HOSC of 19th September**. The Joint HOSC was told of 51 'legacy' cases – a number repeated several times. There was no mention at all of the 100 cases then under consideration by the Ockenden Review. The figure of 51 was repeated when a Councillor queried it. The Joint HOSC was also NOT told of CQC concerns about the safety of the service, nor about the CQC's enforcement notice on maternity. Why not? Councillors heard this information **not** from your Chief Executive or Director of Nursing and Midwifery, but from a member of the public who was sent a text during the meeting.

On the numbers, we have seen Simon Wright's letter to Councillor Karen Calder stating that he and Deirdre Fowler did not know of the scale of the independent review at the time of the Joint HOSC, and found out immediately after the meeting ended. We have seen evidence that suggests Deirdre will have known of the significant extension of the review.

Irrespective of this, WHY did Simon and Deirdre take a decision that they would not tell the Joint HOSC of the CQC's concern about the maternity service and the CQC's issuing of an enforcement notice on maternity? Simon of course knew of the CQC's concern; the CQC had written to him a week before. Whether Deirdre knew of this or not, it is entirely unacceptable that Simon as Chief Executive chose not to share this information with the Joint HOSC.

The maternity crisis was the lead story on the national BBC news that evening. What was Simon's logic here? Did he make an assumption that there would not be a second leak of CQC information, that the maternity story could be kept under wraps for a few weeks? This is speculation, of course, and there may be another explanation, but it would be nice to know. At the Joint HOSC meeting, Simon Wright made strong commitments to openness and transparency – but at that same meeting, he failed to share the information that the Joint HOSC needed to do its job.

HOSCs are statutory bodies. They have the power to *'Require information to be provided by certain NHS bodies about the planning, provision and operation of health services that is reasonably needed to carry out health scrutiny'*. The NHS has a corresponding statutory **duty** to *'Provide information about the planning, provision and operation of health services as reasonably required by local authorities to enable them to carry out health scrutiny'*.[4]

Did your Chief Executive decide this didn't apply to SaTH? Are you comfortable with his decision? The Joint HOSC was not meeting for fun. This was an 'extraordinary' meeting called in response to crisis. Part of the crisis is that a lot of babies have died, and some of those babies died unnecessarily.

[4] DOH. Local Authority Health Scrutiny. 2014

We do not believe that putting a positive gloss on things is a remotely acceptable response to human lives being lost. What on earth has happened here?

The Kirkup report on the Morecambe Bay deaths highlighted, too, **a culture of denial**. Is it possible that this has existed at SaTH?

You will be probably be told on Thursday of 'legacy families' (rather than babies) and of 'opportunities for learning' (rather than deaths). This was the language used by your Director of Nursing and Midwifery at the Joint HOSC last Wednesday. Denial might be one way of describing this.

That same instinct of denial can be seen in the SaTH statements issued on 31st August and 19th September. The news release of 31st August is remarkable, read a few weeks on. Simon Wright insists in this that there are not as many as 40 cases, and that *'to suggest that there are more cases which have not been revealed when this is simply untrue is irresponsible and scaremongering'*. This is simply at odds with reality. Did the Senior Management Team really have no idea at all of the extent of this crisis? Why not?

An instinct of cover up can arguably be seen in the decision by SaTH's Senior Management Team to withhold the damning Royal College of Obstetricians and Gynaecologists report – a review that took place in July 2017; the review report received by SaTH in January 2018; that report not released to the Board or the public until July 2018. Was it delayed so it could be issued with a positive addendum reporting progress? Bad news or good, it should have been shared promptly with the Board.

We are concerned that there may be little regard for candour here.

As Board members, you need to trust the information you are given. This example is a small thing, but important in context. We came across this by chance this morning. On 3rd May this year, the 'Maternity Metrics' sent to the SaTH Board reported on neonatal mortality rates at SaTH and nationally. The national figure was accurately reported at 0.17%. The SaTH figure is reported in that document as 0.14%. This is **not** accurate. We have looked at the same source, the 2017 MBRRACE-UK report of 2015 data. SaTH's neonatal mortality rate was 0.318% on crude data, and 0.203 on statistically adjusted data. You were told your neonatal mortality rate was below the national average; in reality it was above the national average. What happened there? Has it happened before, or since?

We have given you a lot of detail around maternity here. This is deliberate, and we have two reasons for doing this. Behind every statistic on perinatal mortality is a human being. Not a legacy case, but a life lost. And our second reason is that we wish to impress upon you the gravity of this situation. Remember Morecambe Bay. Remember Mid-Staffs. We do not believe that the escalating crisis around SaTH's maternity service is going to go away any time soon.

And there's another crisis

None of you will have been able to miss the HSJ stories about the standard of patient care at SaTH. Presumably you – unlike the public – will also have seen the CQC letter about last month's inspection.

The information is genuinely shocking. It genuinely isn't acceptable to have a diabetic patient left for 15 hours without food or water, despite multiple requests by them. It is not acceptable either for a high dependency area to be left unstaffed for 15 minutes, or for a patient with signs of sepsis and deterioration to be placed in a corridor. It is extraordinary that 'on multiple occasions', patients had

to ask hospital inspectors for help because of staff shortages. The woeful shortage of staff and beds emerges with stark clarity. No patient, anywhere in the NHS, should ever be treated like an animal; no staff member should ever be left feeling that their working environment forces them to treat patients like animals or cattle.

There is something else just as shocking. The CQC letter says, *"Staff across all areas and grades raised concerns with us about this practice ('boarding') and told us they felt it was unsafe, demeaning, undignified, and disgusting".*

Three things emerge from this. One is that there are not enough nurses, HCAs and beds. (This of course raises serious questions about Future Fit proposals). A second and crucial issue is that grossly inadequate care had become normalised. And a third is that reporting mechanisms within SaTH seem to have failed. There is a strong sense here of caring and committed staff desperate to get things put right – but resorting to giving information to hospital inspectors because they either did not trust or did not feel safe with internal avenues for raising concerns.

We do not believe that these horror stories represent a 'little blip', perhaps attributable to temporarily reduced capacity while fire safety work was completed. Boarding is a long-established practice at SaTH. Those of you who have been around a few years will recall the bland assurances to the Board that although the practice is not ideal, no patient has ever come to any harm. Staff shortages are also nothing new. We talk to staff, and we know the terrible pressure that frontline staff work under. We know that experienced nurses are getting out because SaTH is not a good place to work. We know that SaTH – unsurprisingly – is acquiring a reputation as a place to avoid. One important point: staffing problems are not just about recruitment difficulties. They are about management decisions on what level of staffing is necessary. Those decisions are not always correct ones.

You may wish to listen to a patient perspective from a recent Shropshire Radio phone in: https://www.bbc.co.uk/programmes/p06hm9hw . You will find stories you really should listen to at 21.50 and 29.20. Other shorter accounts are at 21.58 and 44.50. The stories are from both Telford and Shrewsbury, of incidents that occurred across time. The CQC did not pitch up during an exceptionally bad week. They saw SaTH doing what SaTH does, at a time of year when pressures were not particularly great. Undoubtedly they will have seen a great deal of good care. They also saw care that was inexcusably bad.

Failure on the scale identified by the CQC is systemic. It's about problems with accountability, honesty, learning, a culture where staff are valued and feel safe in voicing concerns. It's about leadership that takes an organisation the wrong way. It's about a process of forgetting that the job of the NHS is to start from the needs of patients and work backwards from those.

There are no quick fixes to the levels of difficulty that SaTH now has. What we absolutely believe is that an approach of *'Business as usual, let's deny there's a problem'* is a simple catastrophe. Local people deserve better.

The Francis Report

Councillor Karen Calder, Chair of Shropshire Council's Health Overview and Scrutiny Committee, spoke of the Francis Report at the Joint HOSC meeting on 19th September. Her view was plainly that the tragedies of Mid-Staffs and the Francis Report analysis of those are relevant to SaTH.

We agree.

We include here a few strands from the Executive Summary of the Francis Report, focusing particularly on Robert Francis' findings on the Mid-Staffs Trust and the Trust Board:

> *…the Board and other leaders within the Trust, failed to appreciate the enormity of what was happening, reacted too slowly, if at all, to some matters of concern of which they were aware, and downplayed the significance of others. (1.6)*
>
> *Trust management had no culture of listening to patients. There were inadequate processes for dealing with complaints and serious untoward incidents (SUIs). Staff and patient surveys continually gave signs of dissatisfaction with the way the Trust was run, and yet no effective action was taken and the Board lacked an awareness of the reality of the care being provided to patients. The failure to respond to these warning signs indicating poor care could be due to inattention, but is more likely due to the lack of importance accorded to these sources of information. (1.9)*
>
> *It is clear from the evidence at both inquiries that the Trust was operating in an environment in which its leadership was expected to focus on financial issues, and there is little doubt that this is what it did. Sadly, it paid insufficient attention to the risks in relation to the quality of service delivery this entailed. (1.11)*
>
> *Throughout the period with which this Inquiry is concerned, the Trust suffered financial challenges… I have no doubt that the economies imposed by the Trust Board, year after year, had a profound effect on the organisation's ability to deliver a safe and effective service. (1.12)*
>
> *The Board of the time must collectively bear responsibility for allowing the mismatch between the resources allocated and the needs of the services to be delivered to persist without protest or warning of the consequences. However, they were able to fail in this way because of deficiencies in the system around them. (1.16)*

Are there parallels here? We believe there are. The finances of SaTH have come to dominate the leadership's agenda. And belief in Future Fit as the solution to all problems - financial, staffing and clinical - has become a shibboleth. The support for Future Fit has strayed into total dishonesty quite regularly, on claims that the stroke service improved following centralisation, and that SaTH's centralised services do not experience staffing problems. Neither claim is true – but facts are no longer allowed to spoil a good narrative.

Future Fit of course is about reducing the bed base by 110 beds. This is spelled out in the Pre-Consultation Business Case. It is also about reducing staff numbers, including a reduction in nursing posts. It is hard to know the scale of those reductions with certainty, as SaTH has disagreed with our estimates but refused to publish its own.

Think back though to those hideous problems identified by the CQC in August: the patient suffering that was directly attributable to staff shortages and bed shortages. Simon Wright argued passionately at the Joint HOSC that Future Fit is the strategic solution here. We wonder if reducing the bed base and nurse numbers is really the answer to terrible problems caused by too few beds and too few nurses.

There is an alternative vision for change. We refer you to the Defend Our NHS response to the Future Fit consultation.

Overnight A&E Closure

There are some obvious points to be made here:

1. Releasing a 62 page document at the end of the working day, for a Board decision to be taken the following day, is discourteous. There is no respect shown here for Board members or for the public.

2. There is no suggestion in this document that there is an immediate patient safety crisis. It is therefore a given that the Section 242 'Duty to Involve' applies. It seems to be an established practice these days from SaTH to close services first and do a wee spot of token engagement later; we've seen it with phlebotomy and with rural MLUs. For a change of this magnitude, the approach is unlikely to go unchallenged.

3. There is perhaps an alternative. At the Joint HOSC last week, Simon Wright said that in August, SaTH had asked for 5 to 7 middle-grade doctors to stabilise the situation – but had been turned down. This will have been the 14th August Risk Review chaired by NHS Improvement and NHS England.

   Let's think about this. There is a simple enough solution. SaTH has a duty to provide the acute healthcare that local people need. NHSI and NHSE as regulators have a duty to provide SaTH with the resources it needs to do this. It cannot be beyond the powers of NHSI and NHSE to identify five middle-grade doctors to enable SaTH to meet the clinical needs of over half a million people.

The plans themselves need more careful scrutiny – but what stands out on a preliminary reading is just how shoddy they are.

Let's look at it in business terms, just for a moment.

The risks for the three options are not greatly dissimilar[5]. Option 1 (maintaining both EDs overnight) is given a Total Risk Score of 150. Option 2 (closure of PRH ED overnight) has a Total Risk Score of 126. For Option 3 (closure of RSH ED overnight), the Total Risk Score has been omitted – but a calculator confirms it works out at 155. The difference between running both EDs and overnight closure of PRH is therefore small, while maintaining both EDs is **less** risky than closing RSH overnight.

The financial case is concerning. This is summarised on page 12 of the ED report to be considered by the Board.

We are told that Option 1, the existing situation, is costing SaTH an additional **£2.3m** due to the reliance on agency staff.

Option 2, the overnight closure of PRH ED, would cost SaTH **£3.4m**, due to loss of income.

Option 3, the overnight closure of RSH ED, would cost SaTH **£3.3m**, again due to loss of income.

With these overnight A&E closure plans, there is a worst case scenario given here. The cost to SaTH in a worst case scenario will rise to **between £5.4m and £6.6m**. There will also be additional costs incurred through additional ambulance capacity (unquantified, and presumably to be borne by the CCGs) and through inter-site transfers (again unquantified, but with the costs to be borne by SaTH).

SaTH is not exactly a trust with a positive reputation just now. Wolverhampton has a reputation as being a 'predatory' trust that will be seeking business. We strongly suspect that SaTH's new policy of

[5] SaTH. Emergency Department Contingency Plan. Appendix 6. September 2018

outsourcing its work to neighbouring trusts will lead to a significant loss of income, not just in acute work, but also in subsequent planned care for those same patients. The likelihood is 'worst case scenario' here.

SaTH effectively fell off a financial cliff edge last year, and is continuing to run at a significant loss. We think the answer is lobbying for adequate resourcing; SaTH thinks the answer is reconfiguration leading to a smaller bed base and fewer staff. Either way, **to voluntarily incur new losses of £5m or £6m seems really quite bizarre.**

We are also told cheerily that there will be an impact on social care pathways and that commissioners will be paying more to purchase services from neighbouring trusts. Where is the evidence that our local authorities can afford increased spending on social care? Shropshire CCG's financial situation is as bad as SaTH's. And have our CCGs committed to picking up an unquantified tab for additional ambulance provision? If you as a Board member are not confident that this money is there in the system, you should not support these proposals.

More importantly, what about the human costs here?

The default plan seems to be that ambulances that would now go to PRH will instead be diverted to New Cross at Wolverhampton. Some ambulances may travel instead to the Royal Stoke or to Wrexham Maelor. Children may be diverted to New Cross, Wrexham or Birmingham Children's Hospital. These scraps of information are scattered around in the report.

Telford and Wrekin people will lose local overnight access to emergency care **and** to urgent care. The UCC will be open only to 8pm. (Shropdoc, the Out Of Hours GP service, is of course currently facing its own cuts, and will not be able to fill the gaps).

Stroke patients will, in theory, be admitted directly to the Stroke Unit at PRH. Cardiac patients will be directly admitted to the appropriate ward. Otherwise, we seem to be looking at long journeys for very sick people.

The numbers involved are considerable. Figure 11 shows that Option 2, overnight closure of PRH A&E, will affect an average of 13 children per night (10 brought by carers and 3 by ambulance) and 41 adults a night (24 who self-present and 17 brought by ambulance).

The impact on children will be particularly significant. A sick child in Telford would, at the moment, most often be taken by a parent or carer to A&E at PRH. In the future, their parent/carer will take them to Shrewsbury instead. And if the child is sufficiently unwell that admission is required, he/she will then be transferred back to Telford. Children requiring an ambulance in the first place will automatically travel out of county, to Wolverhampton, Birmingham or Wrexham. That's a long ambulance journey from South Shropshire. And imagine just for a second how a parent without their own transport will make that journey from rural Shropshire to visit a sick child in Wolverhampton or Birmingham.

These are not trivial changes.

We are told: *'WMAS have advised that longer conveyance times does not **necessarily** equate to increased patient safety risks due to them having qualified paramedics on each ambulance'. [Our emphasis].* This is not hugely reassuring.

Again on ambulance provision, *'The Welsh ambulance service are more concerned about the increased conveyance times due to the rurality of the county and the already long conveyance times experienced by patients'.* So, tough if you're Welsh or rural, then.

For both ambulance services, WMAS and Wales, we are advised, *'Additional ambulances will be required to maintain the level of performance and access to paramedic ambulance crews in the local area whilst the crews are conveying patients to neighbouring Trusts'.*

Will we get those additional ambulances? And have neighbouring trusts actually got the capacity? This is really very unclear.

Without absolute guarantees that our ambulance services and neighbouring trusts have the capacity to care for displaced patients, there should be no pretence that this is about patient safety. Simon Wright told last month's Board that this was about *'spreading the risk to other parties'*. It's fancy language for saying 'Not our problem, guv'.

The words 'mitigate' and 'mitigation' appear liberally, but with little or no indication of how this will happen. The report notes, for example, the plans '*will require an action plan to mitigate the risks that have been identified'*. The risks are there – but the action plan is not. This is a long document – but those 62 pages raise very many questions and contain very few answers.

In their current form, these are dangerous proposals. Lives will be put at risk. The business case is weak; the case in human terms is frighteningly poor. Most Board members will not have had time to give this paper the detailed scrutiny it deserves. If you have not read it, or if you have read it and you've noticed the shocking levels of unmitigated risk to local people, then **please** do not support it.

You will know of course that SaTH has lost the support of the local community on this. Telford and Wrekin people are, quite rightly, angry and frightened. The plans have also – quite rightly – been condemned by Shaun Davies and other representatives of Telford and Wrekin Council, and by local MPs Mark Pritchard and Lucy Allan.

There are other issues in this document that should be picked up. We've spoken to a retired Consultant who is unimpressed by the recruitment activities that are listed here. We've spoken to an Emergency Department Consultant who has commented that the problems in our A&Es are multi-factorial, and include patient flow and local environmental issues (as well as more complex challenges around workplace culture). We can do no more analysis with a document received so very late. We invite you to ask your own questions – and to hold to account those who are putting this forward.

One last concern

And quite a major concern, at that.

The first of the core principles in the NHS constitution is:

The NHS provides a comprehensive service, available to all

And the second core principle is:

Access to NHS services is based on clinical need, not an individual's ability to pay

At the Joint HOSC, Deirdre Fowler and Simon Wright proposed something really quite unexpected. They argued that *'We have to scale our capacity to suit our workforce'*. This is a direct quote. There was some discussion around this theme. A Councillor expressed strong disquiet at the concept of organising patients to meet the needs of the trust. The new SaTH philosophy marks a sharp break with an approach to healthcare provision that most members of the public take for granted: that it is simply the job of a District General Hospital to meet the health needs of local people. Apparently that is no longer to be the case.

The new vision fits with the philosophy that underpins overnight A&E closure: that apparent desire to make patient care someone else's problem if it has become an inconvenience to provide. It is perhaps a convenient shift for a trust that is seeking to reduce its deficit by cutting agency costs. A service is essential to patients but it has become costly to provide it? No problem. Just don't provide it any more.

This does of course fundamentally undermine those core NHS principles. The cheapest return train far from Ludlow to Wolverhampton is £23.70. An 'Anytime' return from Ludlow to Birmingham will cost £31.30. The distances are too great to expect voluntary car schemes to meet people's needs. The time taken may be prohibitive for those who will lose pay. These longer journeys may simply be impossible for people who are elderly or disabled or who have small children to care for.

A policy that is convenient to SaTH will, without question, remove access to healthcare from a significant proportion of local people. Telford's social deprivation and Shropshire's rurality exacerbate the problem. The impact of this policy shift is one of taking away comprehensive healthcare, and making access to that care contingent at least in part on ability to pay.

It is a far-reaching policy change, and one that seems to be supported by Shropshire CCG. We believe that this needs more thought – and public consultation.

So where now?

In a time when the NHS is thriving, and in an organisation that is thriving, there is perhaps less of a need for Non-Executive Directors to scrutinise the detail, ask the awkward questions, and challenge hard when that is necessary.

SaTH is not thriving. We ask you to hold the Executive to account.

Gill George

Julia Evans

for Shropshire, Telford and Wrekin Defend Our NHS

(We are both clinicians by background; Gill a Principal Speech and Language Therapist and Julia an A&E Sister)