JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

Date	**Monday 28th September 2015**	Time	**12.30pm**
Venue	**Castle Farm Community Centre, High Street, Hadley, Telford TF1 5NL**		

Enquiries Regarding this Agenda:

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Membership

TELFORD & WREKIN	**SHROPSHIRE**
Cllr Andy Burford (TWC Health Scrutiny Chair)	Cllr Gerald Dakin (SC Health Scrutiny Chair)
Cllr Veronica Fletcher	Cllr Tracey Huffer
Cllr Rob Sloan	Cllr John Cadwallader
Dag Saunders (Co-optee)	David Beechey (Co-optee)
Barry Parnaby (Co-optee)	Ian Hulme (Co-optee)
Vacancy (Co-optee)	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 JHOSC held on 12th February 2015.

4. **Hospital Transfer** — Appendix **B** (To follow)
   To update the Committee on the current position on delayed discharge, delayed transfer and patient fit for

discharge, and consider the commissioning strategy to manage this.

5. **Future Fit** — Appendix **C**

   The Joint Committee will consider the draft consultation process and agree comments to be submitted to the Future Fit Programme Board.

6. **Joint HOSC Terms of Reference - Update** — Appendix **D**

7. **Joint HOSC Work Programme 2015/16**

8. **Chairs' Updates**

   To receive verbal updates from the Health Scrutiny Chairs on progress since the previous meeting and any issues arising.

SHROPSHIRE COUNCIL/TELFORD & WREKIN COUNCIL

JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Minutes of a meeting of the Joint Health Overview and Scrutiny Committee held on 28 September 2015 at Castle Farm Community Centre, Hadley, Telford at 12.30pm

PRESENT – Cllr A Burford (TWC Health Scrutiny Chair) (Chairman), Cllr G Dakin (SC Health Scrutiny Chair), Mr D Beechey (SC co-optee), Cllr J Cadwallader (SC), Cllr V Fletcher (TWC), Mr I Hulme (SC Co-optee), Ms D Price (substitute for Mrs M Thorn – SC Co-optee), Mr D. Saunders (TWC Co-optee), Cllr R Sloan (TWC), Ms G Stewart (substitute for Mr B Parnaby -TWC Co-optee)

Also Present –

K Allward (Integrated Community Services Lead, SC/Community Health Trust)
F Bottrill (Scrutiny Group Specialist, TWC)
S Chandler (Director Adult Social Care, SC)
Cllr L Chapman (Portfolio Holder, Adult Social Care, SC)
J Ditheridge (Chief Executive, Community Health Trust)
I Donnelly (Assistant Chief Operating Officer, SaTH)
D Evans (Accountable Officer, Telford & Wrekin CCG)
W Greenwood (SaTH)
A Hammond (Deputy Executive, Telford & Wrekin CCG)
A Holyoak (Committee Officer, Shropshire Council)
N Nisbet (Finance Director, SaTH)
A Osborne (Communications Director, SaTH)
J Smith (Access and Assessment Manager, TWC)
P Taylor (Director of Health, Wellbeing and Care, TWC)
P Tulley (Chief Operating Officer, Shropshire CCG)
S Wright (Chief Executive, SaTH)

JHOSC-1 APOLOGIES FOR ABSENCE

Apologies were received from Cllr T Huffer (SC), Mr B Parnaby (TWC Co-optee) and Mrs M Thorn (SC Co-optee)

JHOSC-2 DECLARATION OF INTERESTS

None

JHOSC-3 MINUTES

RESOLVED – that the minutes of the meeting of the Joint Health Overview and Scrutiny Committee held on 12 February 2015 be confirmed as a correct record and signed by the Chairman.

JHOSC-4 HOSPITAL TRANSFER

The Chairman stated that the Joint Committee had asked for an update on the current position on delayed discharge and transfer of care of patients from hospital. The Joint Committee was mindful of the huge spike in patient admissions last winter, which led to a lot of cancelled operations, and wanted reassurances that the various health and social care bodies were working together to address capacity issues before the onset of the winter period.

Anna Hammond (Deputy Executive: Integrated Care, Telford & Wrekin CCG) gave a presentation, which provided information on:

- Definitions of terms – it was added that a change in the Department of Health's guidance/terminology was expected soon;
- Targets for each defined area of delayed transfer of care (DTOC) and medically fit for discharge (MFFD);
- Performance against key targets – for acute care, there had been a growth over the summer period of the proportion of beds being occupied by patients waiting to be transferred from hospital – up to 5.4% against a target of 3.5%. Delayed days in Shropshire community hospital beds had fallen since April but were still above target. There was an improving trend for reducing the number of FTT patients but the total remained above target. For Better Care Fund patients, the Telford & Wrekin health economy had achieved their target in months 1-3, but the Shropshire health economy was above target.
- Key challenges - these included different interpretations locally of definitions and targets for DTOC and MFFD, and access to domiciliary care particularly in the most rural parts of the county.
- Commissioning Strategies – there were three key plans in development based around admission avoidance, improving patient flow and early supported discharge schemes. Winter planning was built into this.

Julie Smith (Access and Assessment Manager, TWC) explained the Telford & Wrekin approach, which meant that from 12 October 2015 there would no longer be a hospital social work team. It was realised that assessing people in a hospital setting was not the right thing, and that the way forward was to provide information and assistance to help people to stay at home. This would involve working with partners and key professionals, with a joint hub of intermediate care services based at the PRH site to receive referrals/contacts. It was planned that people would be seen initially within an hour. In terms of the discharge of more complex cases who had been admitted to an acute hospital, a fact finding assessment would be carried out by SaTH staff on the ward. If a patient was identified for discharge, a senior social worker would co-ordinate the discharge and the support package that was required for the patient, with the aim of the patient leaving an acute bed within 24 hours.

Kerrie Allward (Integrated Community Services Lead, SC/Community Health Trust) explained Shropshire's approach to commissioning, which was similar to Telford & Wrekin's. A model of Integrated Community Services (ICS) had been developed, bringing together a number of different Council and health

services with voluntary/independent sector providers. ICS would be the default service for Shropshire in terms of patient discharge from hospital, and there were similar patient pathways as the Telford & Wrekin model. ICS had been trialled in the Shrewsbury area from November 2013, and rolled out in phases to the rest of the county. The final phase (for the north and south of the county) was due to be launched shortly.

Ian Donnelly (Assistant Chief Operating Officer, SaTH) gave a presentation which provided information on:

- SaTH definitions of and targets for MFFD and DTOC;
- Performance against key targets – for DTOC there had been a continued rise in delays over the period April 2014 to August 2015. On average the DTOC figure was currently running at 8% (equivalent to 53 beds) against a national target of 3.5%, with an agreed stretch target of 2.5%.
- Weekly discharge pattern and quarterly discharges;
- Cancelled operations – last winter's spike had returned to normal levels. It was stressed that urgent operations were not cancelled;
- Comparison and percentage of delays by site (RSH and PRH) across the last two years;
- Increase in over 70s admissions – there had been a marked increase in over 70s admitted to both hospitals, with a significant rise over the last winter period.

The Committee then went on to ask questions of NHS and Local Authority representatives regarding delayed transfer of care and discharge, and highlighted particular issues:

With the new strategy of having a joint/integrated team to assess patients for discharge etc, to what extent were family and/or primary carers involved in the assessment process?

And how would self-funders be looked after to ensure they were safe after discharge from hospital?

The Access & Assessment Manager, TWC explained that the first assessment of a patient for hospital discharge would take place on the ward and be relatively quick. Depending on the likely pathway, there would then be further discussions with other professionals and the family/carer. Any domiciliary care/rehabilitation required would be funded free for up to six weeks. Self-funders would not be treated any differently, and would be covered by re-enablement funding for the first 6 weeks. Voluntary sector partners (eg Red Cross) were being used to ensure people were safe when they went home. The Assistant Chief Operating Officer, SaTH added that the 'fact-finding' document from the initial assessment provided enough information about the patient to determine discharge.

There were still concerns that patients were being discharged from hospital late at night. Was this practice still continuing?

The Assistant Chief Operating Officer, SaTH advised that this may still happen following discussions with the patient's family and/or with a care home that was admitting the patient. However, if necessary, discharge would be delayed until the next morning.

Was there a reduction in the amount of elective surgery as a result of the sort of increase in cancelled operations seen last winter?

The Deputy Executive: Integrated Care, Telford & Wrekin CCG reported that there was a planned reduction in elective surgery during the third quarter to take account of the likely increase in admissions. The Assistant Chief Operating Officer, SaTH added that occasionally temporary additional resources had been put in to address demand and keep cancellations to a minimum.

Within the independent care sector, it was felt that more practical assistance from the health services was needed to allow patients to be admitted to a care home and for their needs to be met. To what extent were communications between SaTH and the independent care home sector taking place?

The Assistant Chief Operating Officer, SaTH stated that the capacity teams at each hospital site did discuss daily discharges with the independent sector.

Clarification was sought as to the main cause for delayed transfer of care within the ICS model in Shropshire.

There was some disagreement as to whether this primarily related to the Hospital Trust or to other health services. The Accountable Officer, Telford & Wrekin CCG advised that a significant proportion of the health element would be related to intermediate care and its availability. Some would relate to social care. However, all sectors were committed to reducing the number of DTOCs.

Mr I Hulme provided an example of a case where he believed the transfer of care had not been handled properly, and that the elderly patient had been sent home without proper care in place. It was felt that the system was understaffed and overstretched, that family and friends needed to be part of the discharge planning process, and that the quality of care needed to be higher.

The Chief Executive, Community Health Trust expressed regret for any such failures. Patient safety always came first, and elderly patients were not treated any differently.

The Joint Chairs stated that it was clear that the JHOSC still had concerns about the continued rise in DTOCs above the target figure, and the missing of key targets. While acknowledging the measures being put in place, regular monitoring was needed in order to see the direction of travel. The Committee wished to have a regular single report submitted by all partners in the health economy, with a greater explanation of the reasons for delays in the system, and how this was impacting on admissions. The Chief Executive, SaTH

suggested that such a report could be produced within the next month, and agreed that a single version agreed by all partners would be preferable. SaTH would be committed to trying to reduce the numbers of people coming into hospital, and that the report to Members would include the Trust's plans for dealing with any increases in demand over the winter period while maintaining patient safety and standards of care.

The Committee welcomed the offer of a further report within the next month, which would be circulated to Members for information.

JHOSC-5 FUTURE FIT

Simon Wright, Chief Executive, and Adrian Osbourne, Communications Director, Shrewsbury & Telford Hospital NHS Trust presented a paper setting out the framework for developing a Consultation Plan for formal consultation on the Future Fit proposals for safe and sustainable acute and community hospital services..

The Chair welcomed Simon Wright, who had just started his role as Chief Executive of SaTH, to his first meeting of the JHOSC.

In the context of the overall Future Fit programme, the Chief Executive, SaTH explained the challenges facing the Trust in terms of the numbers of consultants and other specialists, and being able to put together staff rotas for both hospital sites. He confirmed that the services are safe however, rotas are difficult and services are frail. Decisions needed to be made in a timely and measured way to produce a resilient solution, rather than have to introduce emergency measures in the event of one consultant leaving.

The Communications Director, SaTH reported that the Framework had been agreed by the Future Fit Programme Board on 13 August 2015. Further work had taken place since then on developing the Consultation Plan, which would be submitted to the Programme Board on 1 October for approval. The Framework document included details on Consultation Principles, the Consultation Plan timetable, key requirements, resources and risks. The formal consultation period on the Future Fit proposals would take place between December 2015 and March 2016. All communities and stakeholders would be able to have their input into the process and make their views known, but it was not a public vote or opinion poll. The pre-election period for Welsh Assembly elections in the Spring gave a window for the review and analysis of the comments received, with a decision being made in late Spring 2016. A detailed consultation plan/programme would be worked on during October 2015, and any comments/views from the JHOSC could be fed into that final Plan.

Members of the JHOSC then expressed views on, and asked a number of questions about, the Future Fit Programme and the Framework for the Consultation Plan.

Concern that the Programme is just focussing on acute hospital services and their reconfiguration, and not addressing issues of an ageing population, preventative care, and new ways of working etc.

The Communications Director, SaTH stated that Future Fit was one part of a wider approach to addressing all the issues in the health economy, and it needed to be linked to those other things. The Accountable Officer, Telford & Wrekin CCG added that ensuring safe clinical services in hospitals had always been a key part of Future Fit, but it was recognised that it was linked to wider health and care issues within Shropshire and Telford & Wrekin. The Chief Executive, SaTH agreed that there needed to be wider solutions in the long term, but at the same time solutions needed to be in place to protect services against current fragilities in the system.

Concern that there might be a misunderstanding as to what this consultation was about, and that it needed to be made clear what was being consulted on and what changes in service were being proposed. Acute services could not be divorced from all other sectors of the health economy, and all the implications needed to be understood.

The Accountable Officer, Telford & Wrekin CCG advised that a lot of the work that had been carried out previously had been clinically-led and looked at a whole range of care pathways/outcomes and models of care. While much of the public focus had been on emergency care, it should be clear that the Programme was also about other issues such as long term conditions, planned care etc.

During the consultation it was important that the public were engaged directly, and that the consultation goes to them rather than the other way round.

The Communications Director, SaTH stated that there would be a lot of consultation activities and events, and these would be outlined in the detailed Consultation Plan.

The consultation should do more to promote Urgent Care Centres so that the public could understand the role they would play if A&E services were confined to one hospital site.

The Accountable Officer, Telford & Wrekin CCG stated that roughly 75% of patients currently seen in A&E could be more appropriately treated in Urgent Care Centres or other settings. Urgent care centres in Telford and Shrewsbury, but not rural urgent care centres, would be part of this consultation.

What were the timescales and what would happen if the timetable slipped?

The Accountable Officer, Telford & Wrekin CCG explained that if the formal consultation did not start in December 2015, it would then be delayed to May 2016, after the Welsh Assembly elections.

The Co-Chair said that the issue of A&E is an emotive subject and often people see A&E as the hospital. However, more should be done to promote the Urgent Care Centres on both sites so they are in a position to do much of what an A&E currently does. Members of the public should be advised of this.

The Chair explained that one of the roles of the Joint HOSC is to make sure that people understand the facts and that the process for Future Fit is clear. He asked who will be carrying out the consultation? Will it be each CCG or a Joint CCG Committee?

The Accountable Officer, Telford & Wrekin CCG responded that the consultation will be the responsibility of the Commissioners. The consultation in July will be run by both CCGs.

It was agreed that comments and feedback summarised above be considered by the Future Fit Engagement and Communications team in the construction of the final Consultation Plan.

JHOSC-6 JOINT HOSC TERMS OF REFERENCE – UPDATE

The report of the Scrutiny Group Specialist, TWC was received. Appended to the report were proposed amendments to the Joint Committee's terms of reference in order to reflect more recent guidance from the Department of Health in relation to health scrutiny. In particular, guidance published in 2014 provided greater detail on the specific powers of delegation of health scrutiny issues. If any consequent changes were required to each Authority's Constitution, these would be dealt considered through the appropriate process operating within each Council.

In response to a question, the Scrutiny Specialist added that there would be no changes to the voting scheme for the JHOSC, but she would circulate the scheme to members for information.

RESOLVED – that the draft terms of reference, as shown at Appendix 1 of the report, be endorsed.

JHOSC-7 JOINT HOSC WORK PROGRAMME 2015/16

The Scrutiny Group Specialist, TWC reported that the two main agenda items at this meeting would continue to be the focus of the current year's work programme. Members had also agreed to look at mental health services for children, and this needed scoping.

Reference was made to any follow up work relating to the scrutiny of wider mental health services. The Scrutiny Group Specialist and the Director of Health, Wellbeing & Care, TWC advised that the issue about the future of the Castle Lodge facility had been picked up by Telford & Wrekin's Health & Adult Care Scrutiny Committee, and that Shropshire might want to look separately at anything of specific concern to them. It was reported that a commissioning review of mental health services would be discussed at a meeting the

following week, and the Chair advised that any developments would be monitored in case any joint issues arose.

JHOSC-8 CHAIRS' UPDATE

Cllr Burford advised that he would circulate the current TWC Health & Adult Care Scrutiny Committee work programme to JHOSC members.

The meeting closed at 2.52 pm.

Chairman……………..………………………

Date………..…………………………………

SHROPSHIRE COUNCIL/TELFORD & WREKIN COUNCIL

JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Minutes of a meeting of the Joint Health Overview and Scrutiny Committee held on 12 February 2015 in The Council Chamber, Shirehall, Shrewsbury from 2.10 pm – 4.20 pm

PRESENT – Councillor D White (TWC Health Scrutiny Chair) (Chairman), Councillor G Dakin (SC Health Scrutiny Chair), Mr D Beechey (SC co-optee), Ms D Davis (TWC Health Co-optee), Mrs V Fletcher, Mr I Hulme (SC Co-optee), Cllr S Jones (SC), Mr J Minor (TW), Mr B Parnaby (TW Co-optee) Mrs M Thorn (SC Co-optee).

Also Present –

F Bottrill (Scrutiny Group Specialist, TWC)
S Chandler (Director Adult Social Care, SC)
L Chapman (Portfolio Holder, Adult Social Care, Shropshire Council)
K Calder (Portfolio Holder Health, Shropshire Council)
J Ditheridge (Chief Executive, Community Health Trust)
A England (Cabinet Member for Adult Social Care, Telford & Wrekin Council)
D Evans, (Accountable Officer, Telford & Wrekin CCG)
A Holyoak (Committee Officer, Shropshire Council)
M Innes (Chair, Telford & Wrekin CCG)
C Morton (Accountable Officer, Shropshire CCG)
A Osborne (Communications Director, SATH)
M Sharon (Future Fit Programme Director)
P Taylor (Director of Health, Wellbeing and Care, Telford & Wrekin Council)
R Thomson, (Director of Public Health, Shropshire Council)
I Winstanley (Chief Executive ShropDoc/GP Federation)

The Chairman informed those present of the recent death of two co-opted Members of the Committee, Mr Richard Shaw, from the Senior Citizen's Forum, Telford and Wrekin and Mr Martin Withnall, from Telford and Wrekin Healthwatch. It was agreed that a letter be sent from the Committee expressing condolences to their families and expressing gratitude for their valued contribution to its work.

JHOSC-10 APOLOGIES FOR ABSENCE

Apologies were received from Cllr Tracey Huffer (SC)

Mr Barry Parnaby, Telford & Wrekin Healthwatch, was welcomed to the meeting as a co-optee of Telford and Wrekin Council.

JHOSC-11 DISCLOSABLE PECUNIARY INTERESTS

Members were reminded that they must not participate in the discussion or voting on any matter in which they had a disclosable pecuniary interest and should leave the room prior to the commencement of the debate.

JHOSC-12 MINUTES

RESOLVED – that the minutes of meeting of the Joint Health Overview and Scrutiny Committee held on 29 September 2014 be confirmed as a correct record and signed by the Chairman, subject to the addition of Mr I Hulme and Mrs V Fletcher being added to the list of attendees

JHOSC-13 FUTURE FIT

The Chairman reminded those present of the role of the Joint Health Overview and Scrutiny Committee relating to proposals for substantial developments in service. He also referred to the important role of Overview and Scrutiny Committees in looking at safety and quality issues affecting their community.

The Future Fit Programme Director gave a brief presentation on the Programme which covered: what the Programme wished to achieve; progress to date; details of the recommended shortlist; details of the women's and children's variants; proposals for developing urgent care centres, and next steps, including the proposals for two strands relating to community offer. A copy of the presentation is attached to the signed minutes.

The Committee then went on to ask questions of NHS and Local Authority Representatives regarding the Future Fit Programme.

1 How are organisations working together to address the challenged services at the Acute Trust, for example, Accident and Emergency, and ensure they are safe until changes are made.

The Accountable Officer, Shropshire CCG, explained that the CCG and provider organisations worked together to ensure services were safe, through a Strategic Resilience Group, chaired by herself. Representatives from Shrewsbury and Telford Hospital Trust (SATH), West Midlands Ambulance Service (WMAS) and Shropdoc sat on this Group.

2 How will you work together to resolve the wider capacity issues and reduce the number of patients fit for discharge at SATH? How will you work together to identify the extent of this problem and the underlying issues?

Those present acknowledged the well known recent difficulties related to patients who were medically fit for discharge. All were working towards the

target set which had been set by the NHS Trust Development Authority (TDA) and NHS England.

3 *If there is a problem to address and Integrated Community Service (ICS) is not the answer, does the Acute Trust have any other suggestions? What are the other pressure points in freeing up beds?*

It was felt that the Integrated Community Service was a significant part of the answer but it was acknowledged that this was not the only solution. The level of discharges from the Acute Trust were higher during week days and lower at weekends and work was underway to investigate how to obtain a more even distribution across the week. Weekend activity often resulted in a difficult Monday which could lead to 12 hour trolley breaches.

The Communications Director, Shrewsbury and Telford Hospital NHS Trust (SATH), reported on a 'discharge to assess' pilot currently underway and the need for expansion in availability of domicillary care. A package of support to the voluntary sector had been made available through the British Red Cross and SATH was looking to support this to facilitate more of a 7 day process. A lot of good work was underway but there was more to do.

4 How will SaTH's financial position affect the viability of the Future Fit Programme.

The Communications Director, SaTH, referred to the drivers of quality, outcome and safety which needed to be addressed through Future Fit but needed to be affordable. Ending duplication at two sites of costs, services, equipment and infrastructure would allow improvement of viability. The financial assessment of all options would be critical. A new offer with care closer to home would be more affordable and better for patients.

The Co-Chairman referred to staff shortages, difficulties in recruiting and reliance on agency nurses and the Communications Director confirmed that one of the big drivers for Future Fit was challenges around recruitment. These were challenges that were faced nationally and there was a need to attract the brightest and best otherwise agency costs would continue to increase.

5 How many Urgent Care Centres/Local planned care facilities / Community Units / Health Hubs and diagnostic and Treatment Centres will there be as part of the Future Fit programme and where will they be located?

The Future Fit Programme Director explained that the development of a rural urgent care centre offer was underway. At this stage it was not possible to say how many rural urgent care centres there would be. It was confirmed that there would be a minimum level of care and opening times offered from urgent care centres which would help address the current challenge of people not knowing where to go.

6 How affordable is the Future Fit Programme? How is the programme taking into account utilising existing buildings, facilities and equipment and including the costs of the maintenance backlog at RSH? (We understand that only co-location with paediatrics is a must)

The Future Fit Programme Director explained that the assumptions in the feasibility study aligned with College of Emergency Medicine Guidance regarding the 'seven key specialities': Critical Care, Acute Medicine, Imaging, Laboratories, paediatrics, orthopaedics and general surgery.

Existing buildings would be utilised to the greatest extent possible. If an Emergency Centre and Diagnostic and Treatment Centre were to be located on a Greenfield site, the existing estate would be used less. An Urgent Care Centre offer was likely to start with utilising existing community facilities. The Programme would be clearer about affordability in around May or June.

7 What is the outcome of the Care Quality Commission (CQC) inspection? Does this affect the Future Fit Programme?

The Communications Director, SATH, reported that the overall CQC inspection rating had been 'requires improvement'. The report had recognised staff care as good and it was felt by the Trust to be a fair and balanced report which had not contained anything unexpected. A big theme of the report had been challenges around speciality care. An action plan was being drawn up by the Trust Board.

8 What is the clinical view on the co-location of A&E with Women's and Children's Services?

The Committee was referred to the 'Acute Services' template completed by SATH clinicians for the Evaluation Panel (copy attached to signed minutes) which summarised the clinical quality and safety advantages and disadvantages of co-locating consultant led obstetrics and neonatal care with emergency care.

9 How will you work together to reach a realistic consensus on the number of beds needed in the acute sector? How does this affect the affordability of the Future Fit Programme and what are the long term consequences for the sustainability of services.

The Accountable Officer, Shropshire CCG, said the Project Management Office had been set up to focus on delivery. Part of the work was to consider bed capacity in the acute and community sectors and Future Fit modelling. However expensive an acute bed was, it was very expensive to do things twice and it was essential to ensure that a patient would reach the right bed at the right time.

A Member referred to a public consultation event she had attended in relation to Future Fit where it had been stated that financial aspects had not yet been taken into account.

The Chairman of Telford and Wrekin CCG explained the Future Fit response to the Call to Action in November 2013 had been designed to address the population needs of Shropshire. There had been agreement that these should be driven from a truly clinical point of view designed from the bottom up, not top down. Costing the options and managing capital and recurring costs would be part of that process.

Other Members queried financial viability issues as the two cheapest options on paper were not included on the short list and that which was highest in cost was. Members asked what would happen if funding was not obtainable for a greenfield site, and if that was discounted, whether the long list would then be re-visited for a more affordable option.

The Accountable Officer, Shropshire CCG, emphasised that clinical care was the central focus and nationally more investment was needed for prevention. Money spent on buildings could not be spent elsewhere and the evaluation panel members had weighed up the evaluation criteria quality and safety, access and delivery. A solution needed to be found which balanced with financial viability.

The Programme Director stated that the final option would need to be affordable to both commissioners and providers. If some options on the short list were removed because they were not viable, it would be possible to re-visit other options.

In response to further questions from Members, it was confirmed that the preferred option would have to be determined as affordable before consultation began.

Members also raised issues around investment in primary and community care and the need to know who should be making this investment and leading on this.

10 How are you ensuring that the current services are delivered with care, compassion, competence, communication, courage and commitment while planning and delivering the Future Fit Programme?

The Communications Director, SATH, said the CQC rating of caring in current services at SATH had been very reassuring. All were thankful to public service colleagues for doing a good job under difficult circumstances.

11 How are transfers between hospitals being managed? What are the performance measures for the current contract and how is the provider performing?

A member of the Committee had heard that there had been some inappropriate use of West Midlands Ambulance Service ambulances on occasions for transfer of patients between hospitals. The Committee heard

that there had been problems with inter-site transfer previously but a new contract was now in place.

12 What arrangements have been put in place to build on the success of the GP service at the A&E at PRH?

Members heard that there was strong clinical evidence both nationally and from local schemes and pilot studies that co-location of general practice within A&E provided better patient outcomes, and also helped avoid admissions and overcrowding. The walk in service had now located at Royal Shrewsbury Hospital and the Pilot Study at the PRH was being evaluated.

13 How well is the Welsh Ambulance Service engaging in the Future Fit Programme and working to resolve the cross border pressures on the WMAS?

It was confirmed that Welsh Ambulance Service was represented on the Programme Board and had attended the evaluation panel. They had been asked to enter into the data sharing agreement.

14 How well has Future Fit communicated the current provision of services at PRH and RSH? e.g. that patients with some acute illnesses / injuries are currently treated out of county?

It was acknowledged that there was always more that could be done in terms of communication. Members commented that the public did not generally realise that the regional trauma centre was Stafford or Stoke, rather than Shrewsbury or Telford. They were informed that this would be addressed as progress was made in the next Future Fit phase, from May onwards.

PRIMARY AND COMMUNITY CARE

15 How are you working together to develop the capacity and model of care in Primary and Community Services (Future Fit 2)? How will you ensure that this work takes place alongside the current Future Fit Programme? What is the timetable for Future Fit 2 and do you have the capacity to deliver on this in time? What is the risk that resources will be directed towards increasing capacity at SaTH at the expense of primary and community services?

The Accountable Officer, Shropshire CCG reported on willingness from GP surgeries, the Community Health Trust, voluntary organisations and Shropshire Partners in Care (SPIC) to start shaping work. Change would involve developing new integrated ways of working.

16 What are the local plans for 7 day working in primary care? How can this be used to encourage integration of primary and community health services and are doctors and the GP Federation engaged?

Members heard about work underway in Shropshire with some practices already offering weekend working. However the current capacity of General

Practice was limited and the solution was likely to incorporate Nurse Practitioners, Pharmacies and clusters of practices across weekends.

The Chief Executive of the GP Federation explained that the number of GPs would fall short of demand for several years yet. However, he reported that the GP Federation was fully engaged and a visionary event was planned for 24th February to develop 'Future Fit 2' – the community offering.

Reference was also made to planned development of 'Team around the Practice' Schemes.

A Member of the Committee referred to a scheme in Telford and Wrekin involving Pharmacies which had been designed to divert patients where appropriate from making a GP appointment. He commented that it had been inconsistently promoted by chemists and the scheme had not appeared to have been well monitored. It was agreed that consistency of offer was extremely important so that people knew how to navigate themselves to the appropriate point.

The Accountable Officer, Telford and Wrekin CCG pointed out that both CCGs now had delegated commissioning responsibility for GPs which would give them more influence.

17 How many Urgent Care Centres / Local planned care facilities/ Community units /Health hubs and Diagnostic and Treatment Centres will there be as part of the Future Fit programme and where will they be located?

The Committee had already heard that this was a work in progress.

18 How will GPs be supported to work together / federate? How will this be managed particularly in rural areas? What is the role of the Community Health Trust to support this?

Other discussion during the meeting addressed these points.

19 How will you ensure that GPs are fully engaged in Future Fit? It is recognised that there are several channels to do this through the CCG, GP Federation and Shrop DoC. How will this work be co-ordinated to recognise the role of GPs as commissioners and providers? How will you enable GPs to develop a clear vision for how their sector relates to the wider NHS and care services?

Other discussion during the meeting addressed these points.

20 Is there an enhanced role of the GP Federation to work with GPs to develop new services and business models? How robust is the current model of primary care and how is the shortage of GPs being addressed?

The Chief Executive of the GP Forum referred to earlier responses and reiterated that Primary Care was keen to play a role in finding solutions. All GP Forum meetings were extremely well attended.

21 How will you ensure that the Future Fit Programme and the Better Care Fund work is co-ordinated?

All emphasised that the Better Care Fund would be a very important means to drive change and the Future Fit solution.

22 What is the future of the Community Health Trust?

The Chief Executive of the Community Health Trust said Shropshire needed an organisation to manage a wide range of community services. The future was bright, and it had been agreed with the TDA that the Trust would aim to become a Foundation Trust.

23 How are you ensuring that the current services are delivered with compassion, competence, communication, courage and commitment while managing change?

The Chief Executive of the Community Health Trust emphasised that the primary purpose for any NHS organisation was to create an environment to deliver high quality care to people within the service. It was essential to establish sound values and culture and engage well with staff. Staff were caring about patients and felt they could speak up when something was not right, or if something went wrong. When any change was introduced, the reason it would make a difference for patients was always emphasised. External scrutiny included audits and peer reviews.

24 What are the financial implications of the installation and running costs of diagnostic equipment in primary and community care locations?

Members were informed that there were costs to installing diagnostic equipment in community locations, but that this was not the biggest issue which was one of recruiting a flexible workforce to operate it. If this could be addressed, there was enormous potential to improve the quality of customer service closer to home and avoid unnecessary A&E visits.

25 What is meant by the term 'prevention' - is this preventing people getting ill or preventing ill people going to hospital or both?

Members heard that early intervention in lifestyle, health and education and preventing ill health in the first place was a key concern of Future Fit.
The Director of Public Health, Shropshire Council, commented on three key areas – keeping well, getting better and helping patients with long term conditions to cope, eg with diabetes. He also referred to efforts in addressing smoking cessation and obesity, and in increasing uptake of healthcheck screening programmes. He reported on variations in uptake of these across sections of the population. He also referred to making healthcare in rural

areas as accessible as possible, citing examples of use of telecare in Australia, Finland and Canada.

27 How can the different health and social care systems and regulators be aligned to deliver the Future Fit Programme?
28 How far is integration between health and social care a joint programme? What capacity is there within the local authorities to jointly lead this work?
29 How can you jointly manage and share the risk of the perverse incentives that the payment by result system creates?

Members asked if the Community Health Trust experienced any issues working with the Acute Trust and Social Care services and how issues were communicated if there were any problems. Practitioners on the ground worked closely together to solve problems and when problems were part of a larger pathway issue these were addressed together. Time had been released to allow opportunities for people to talk to each other.

The Chief Executive of the Community Health Trust commented that issues did exist but that these should be easy to address, for example, people changing care locations having to undergo multiple assessments.

The Director of Health, Wellbeing and Care, Telford and Wrekin Council, and Director of Adult Social Care, Shropshire Council, confirmed Social Care engagement in the Future Fit process and membership of the Programme Board. The need for the Health and Wellbeing Boards to demonstrate leadership was emphasised, particularly for Future Fit 2, discharge pathways and admission avoidance. The Care Act further cemented requirements and intervention.

Seven day working would have implications for social care and purchasing from the independent sector and social care was wedded to these principles. An integrated way of working was needed throughout Shropshire and Telford and Wrekin. However, in Local Government, finances were being reduced year by year until at least until 2018 and this would be very challenging.

The Director of Adult Social Care, Shropshire Council emphasised that prevention was very important and there was more that communities could do to keep themselves healthy and well, and more that could be done to support this.

He said that Social Care would need to step forward and contribute to Future Fit 2 but was concerned that it sounded like a follow on to Future Fit, when Future Fit itself needed to look across the whole system

Members were informed that NHS tariffs encouraged activity that did not assist the whole system and created perverse incentives. The Director commented on a professional, positive and constructively challenging relationship between social care and the NHS, both before and during Future Fit. Enhancements would only be made by communities, the NHS, volunteers and social services working together.

The Accountable Officer, Telford and Wrekin CCG said the working assumption was that CCG cash allocation would be as expected over the next 3 – 4 years. He commented on the social care budget pressures and the need to work with providers to establish a system that worked. He was comforted by the commitment of all organisations in trying to address this.

30 How well are Welsh commissioners and providers of health and social care engaging in the Future Fit Programme? If the Welsh commissioning arrangements change so Welsh patients are treated at Welsh hospitals what are the implications for the Future Fit programme?

It was reported that Powys Local Health Board was an integral partner in the Future Fit Programme with Clinical and Managerial Colleagues sitting on the Programme Board, along with the Welsh Ambulance Service. It was not expected that commissioning intentions in Wales would change and there was not enough capacity in the North Wales system to treat all patients.

31 How will the change to co-commissioning affect the decisions about the Future Fit programme?

The Accountable Officer, Telford and Wrekin CCG said that both CCGs saw the change to co-commissioning as an opportunity which could help develop solutions, for example, federations between groups of practices.

The Chief Executive of the GP Forum said it should help ultimately in moving some primary care into times when people could access it more freely, and also help with sharing of practice sites and records.

PUBLIC EXPECTATIONS

32 How are patient and political expectations being managed?

The Programme aimed to be both transparent and to create a clear dialogue with politicians and the public. The forthcoming election period would however mean reduction in levels of communication activity. Members emphasised the need to present clear, simple and jargon free messages to the public.

33 How can people be helped to understand that when seeking primary care you do not always have to see a GP often primary care clinician would be sufficient?

The Chair of Telford and Wrekin CCG said that this would emerge through Future Fit Communications. There was clear evidence that people needed as early an appointment as possible and a quick explanation of how they could get their needs addressed and at the right level, not necessarily a GP. This was both for planned care and urgent care.

34 How can patients be supported to understand that they do not always need continuity of care from the same GP?

This would eventually be achieved through patient experience and the sharing of records and information would be essential to this. However, continuity of care would remain important in some cases although not necessarily from a GP.

35 How can patients be supported to manage their own health more effectively? ie Smoking and obesity – are these measureable and being tracked?

Question addressed in previous discussions.

A Member of the Committee emphasised the need for a different way of supporting people in the community and the incredible pressure on Adult Social Care budgets. She highlighted the lack of discussion around a joined up approach to workforce development and felt that training was needed for a new kind of worker able to support people in their own home.

The Better Care Fund was seen as the right vehicle for this and the Accountable Officer, Telford and Wrekin CCG said there was potential for CCGs to put commissioning budgets into the Better Care Fund. This would need careful governance to limit risk and ensure that providers were not being put at risk.

It was also reported that Health Education England was involved in clinical design and reconfiguration of workforce challenges, and discussion was ongoing. The Accountable Officer, Telford and Wrekin CCG reported that he was a Board Member of the National Skills Academy for Health and would be taking this suggestion forward.

The Chairman thanked all those in attendance for their time and for responding to the Committee's questions.

The meeting closed at 4.30 pm.

Chairman……………………………………………

Date……………………………………………….

The Shrewsbury and Telford Hospital NHS
NHS Trust

HOSC Meeting 28th September 2015

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Ian Donnelly
ACOO USC
SaTH

Definitions

“Medically Fit for Discharge”

- Determined as the point at which acute medical intervention ends, where the patient would not benefit from remaining in an acute bed;
- This is decided by the ward multi-disciplinary team at the morning board round – this team includes a senior medic (SPR or Consultant), ward sister / coordinator, member(s) of the therapy team, discharge liaison nurse;
- The target set by the health and social economy was 40 across two sites for all providers.

Definitions

Delayed Transfer of Care “(DTOC)”

- A delayed transfer of care from acute or non-acute (including community and mental health) care occurs when a patient is ready to depart from such care and is still occupying a bed. A patient is ready for transfer when;
- A clinical decision has been made that patient is ready for transfer AND;
- A multi-disciplinary team decision has been made that patient is ready for transfer AND;
- The patient is safe to discharge/transfer;
- A multi-disciplinary team in this context includes nursing and other health and social care professionals, caring for that patient in an acute setting.

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Definitions

DTOC Cont'd

- This is determined by the Discharge Hub on each hospital site meeting every morning and agreeing whether a patient on the fit to transfer list is DTOC reportable in line with national guidance and number of days they are reportable;
- Members of the Discharge Hub include SaTH Head of Capacity, discharge liaison nurses, CCG observer, ICS link worker, Powys care transfer coordinator and ad hoc membership from relevant parties (eg CHC team / mental health team);
- The national target is 3.5% (23 Beds) of the acute bed base with an agreed stretch target of 2.5%; on average we are currently running at 8%, this equates to 53 beds.

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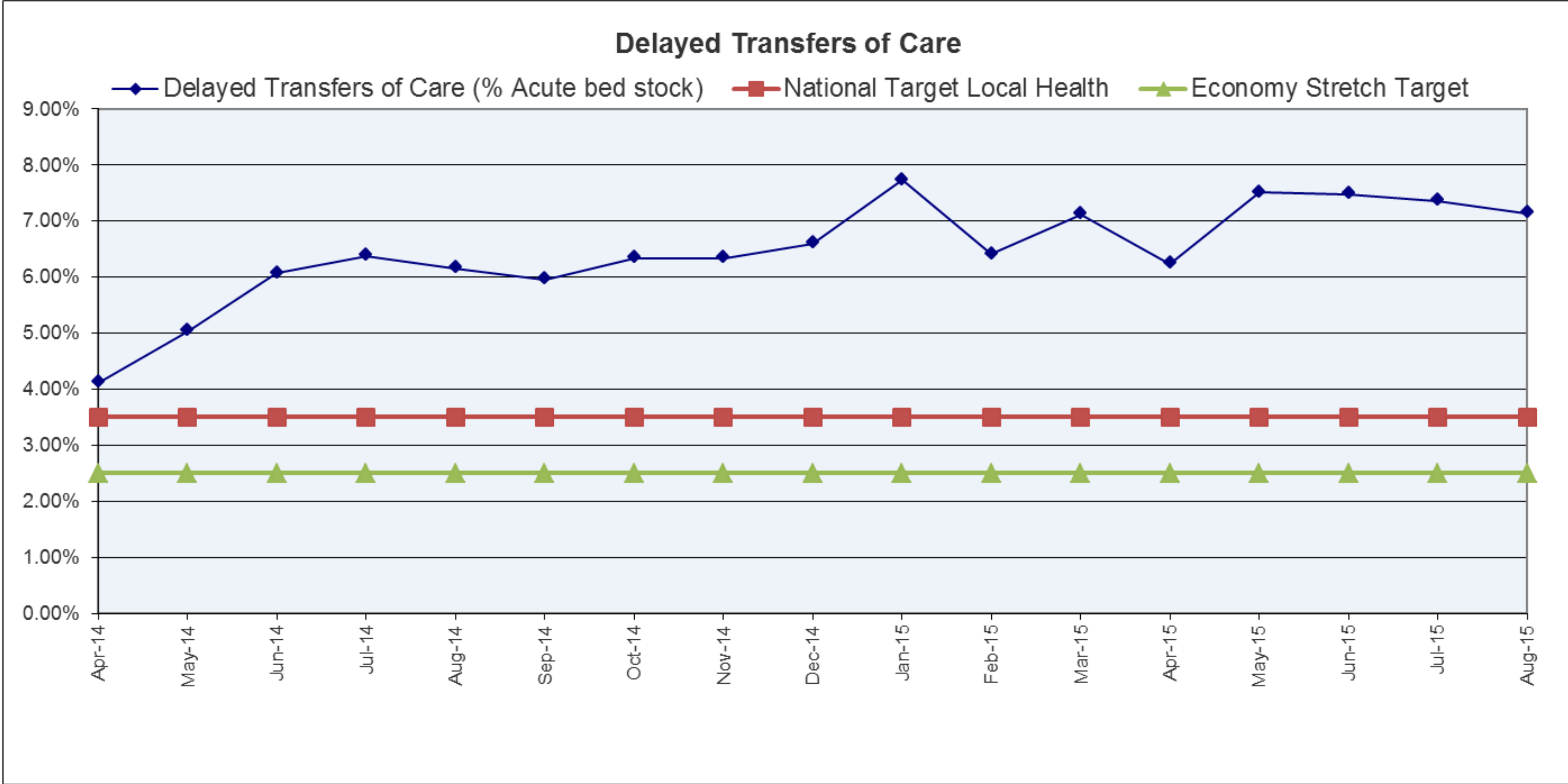
Monthly DTOC Report



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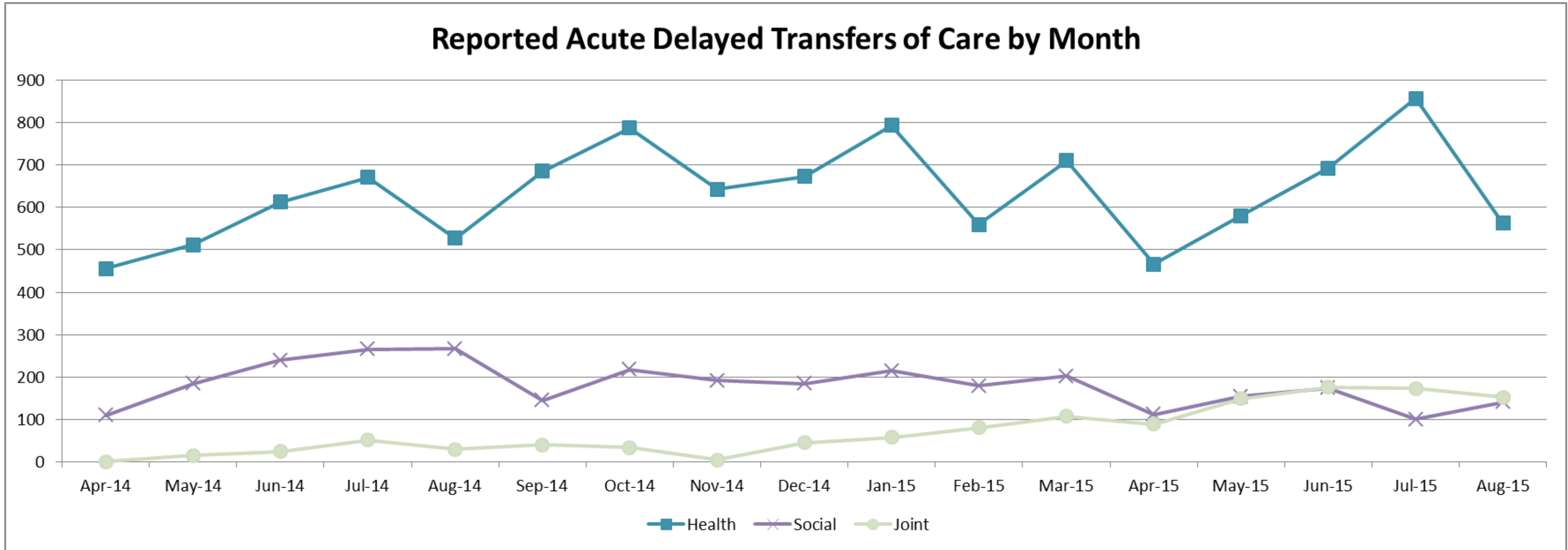
Apr 14 – Aug 15 DTOC by Month



Continued rise in overall delays

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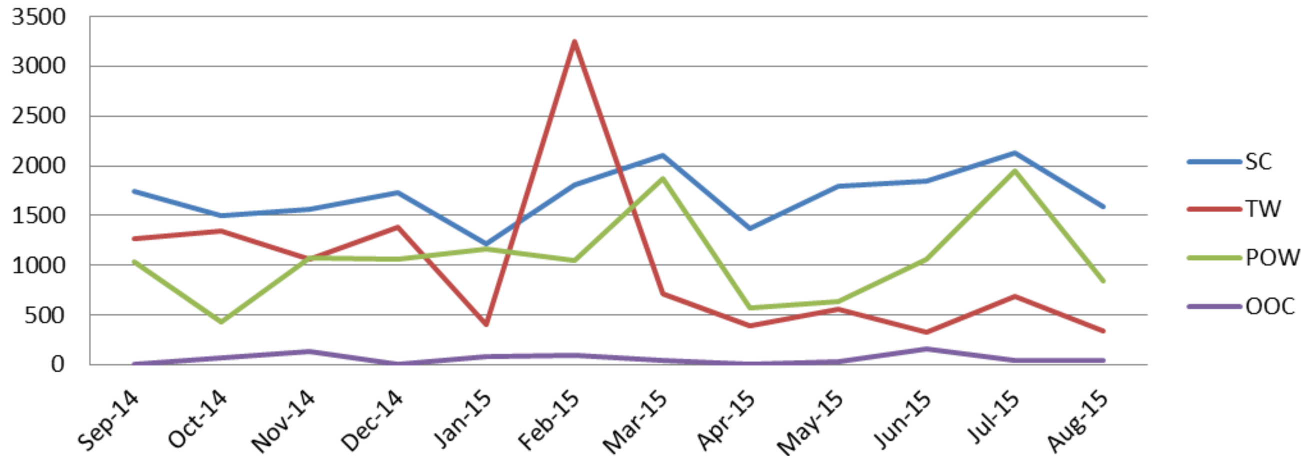
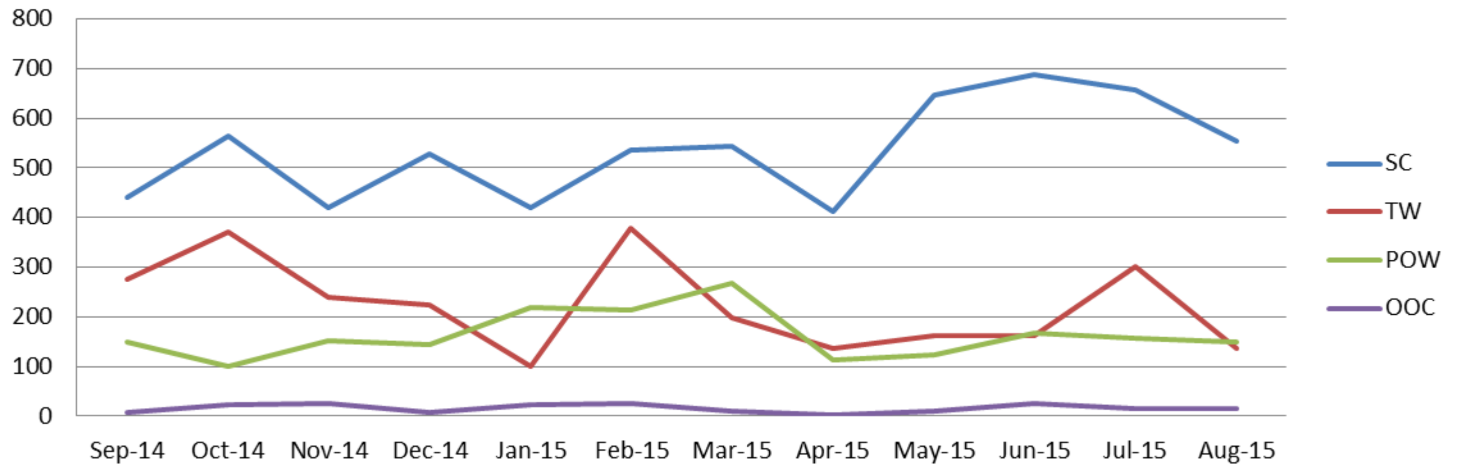
DTOC - Overview





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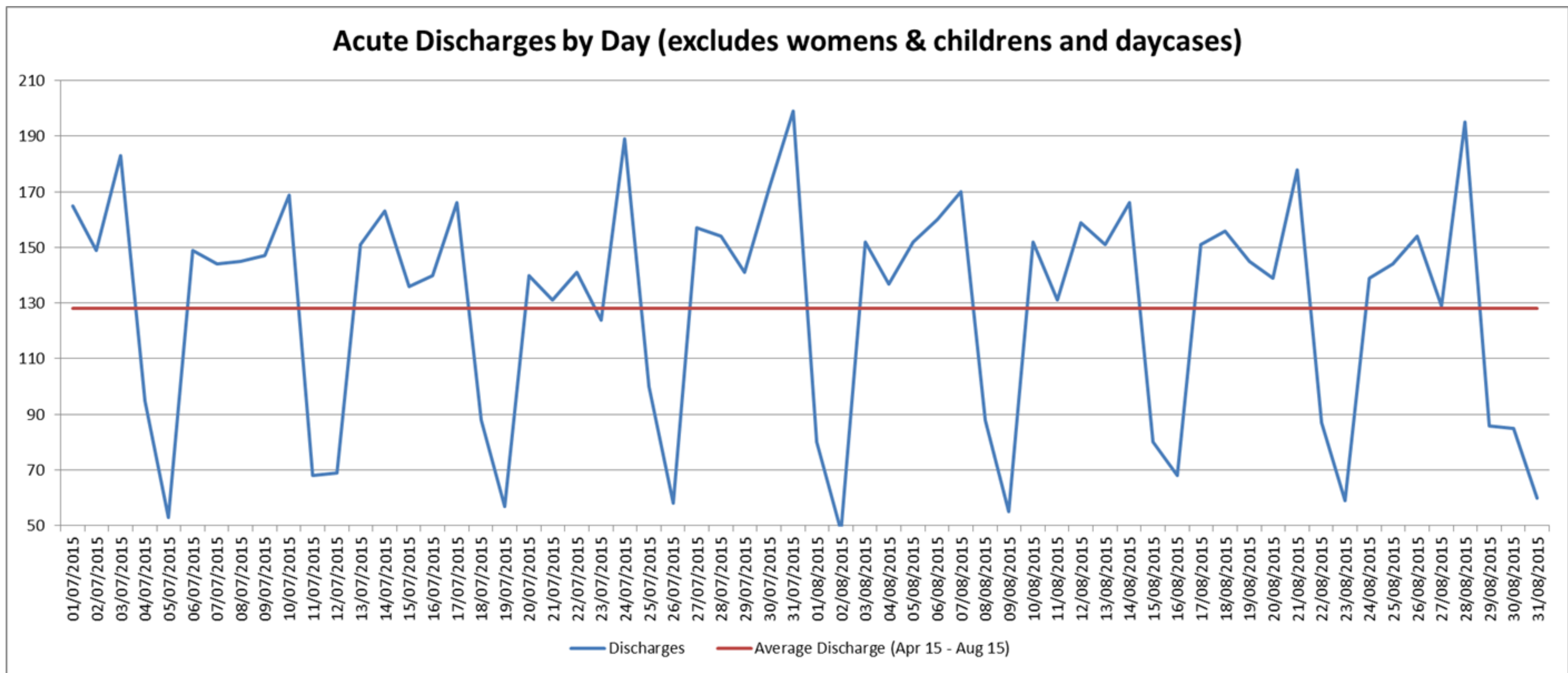
Weekly Discharge Pattern



Standard variation between weekend and weekday

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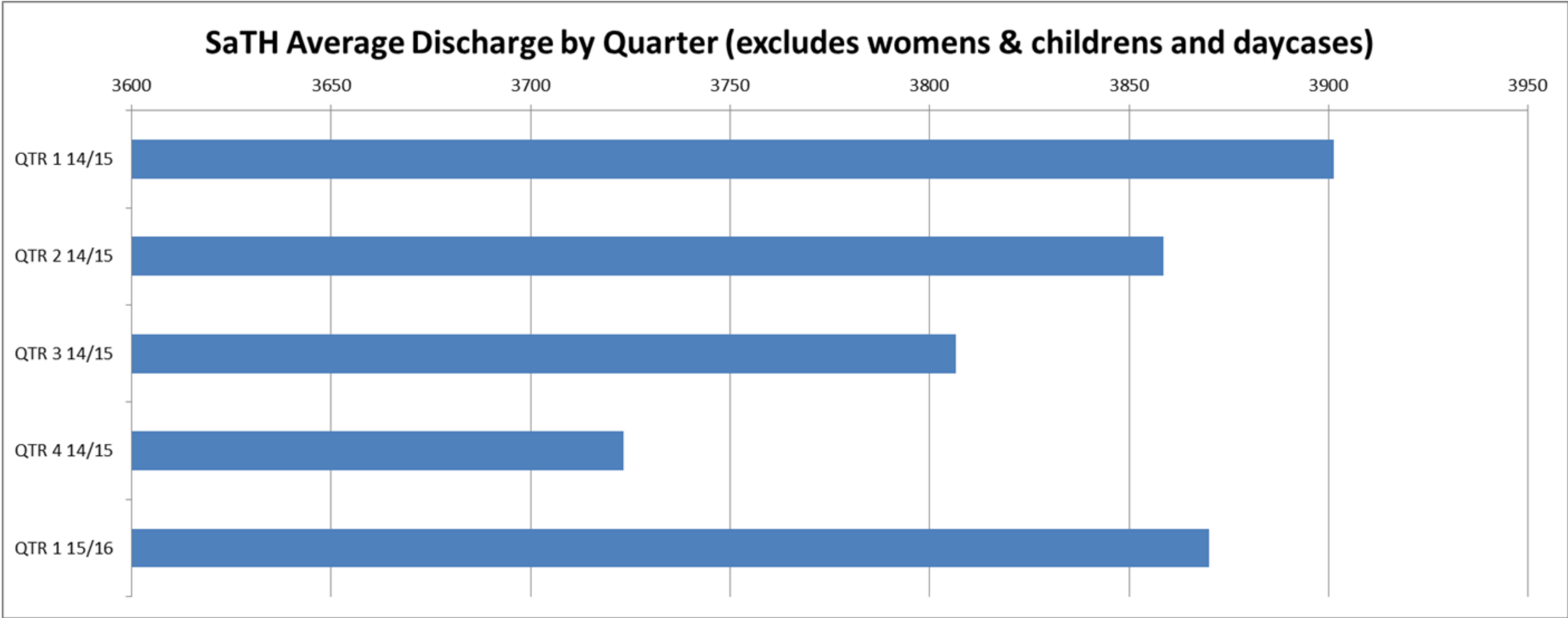
Discharges by Quarter



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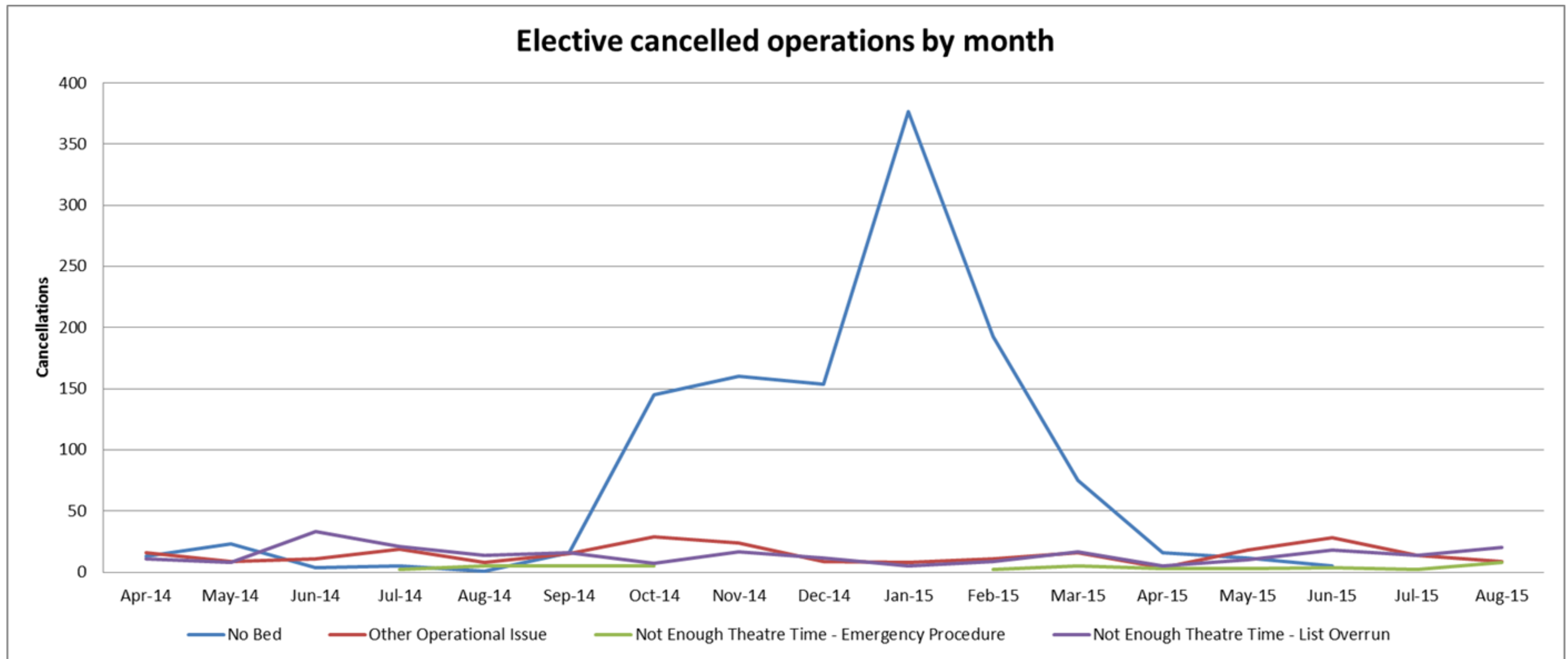
Cancelled Operations



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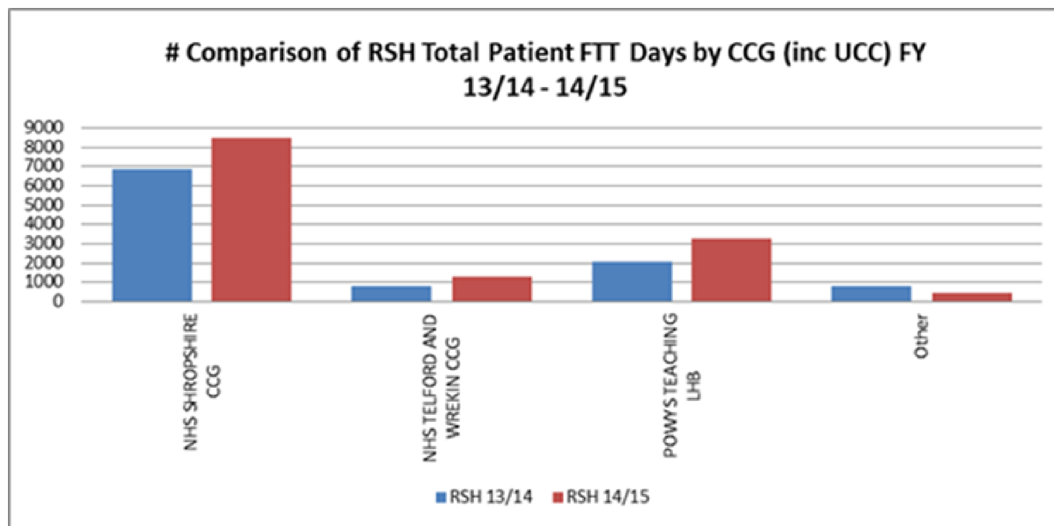
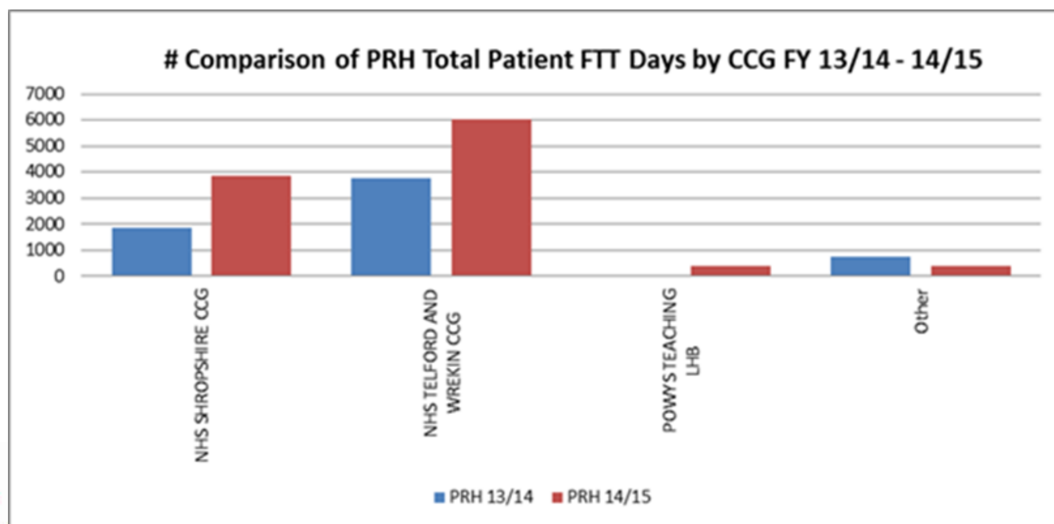
Comparison by site





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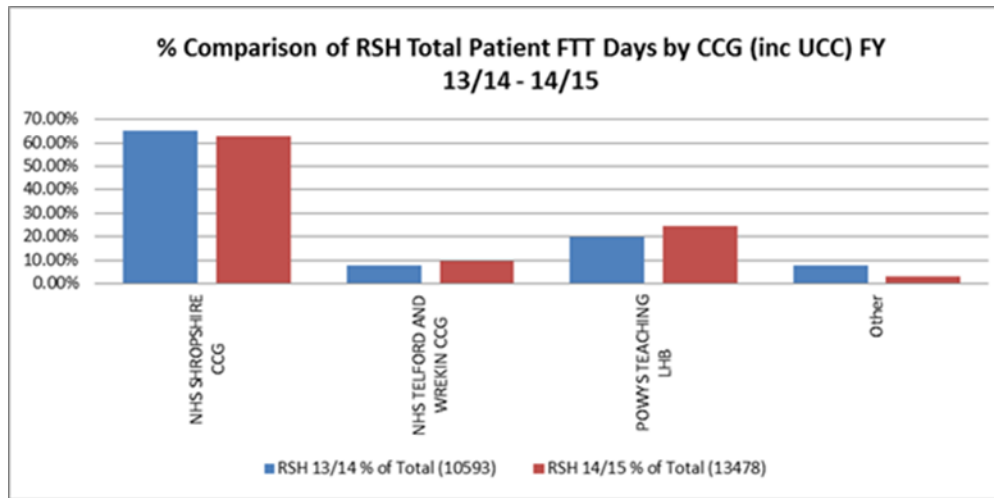
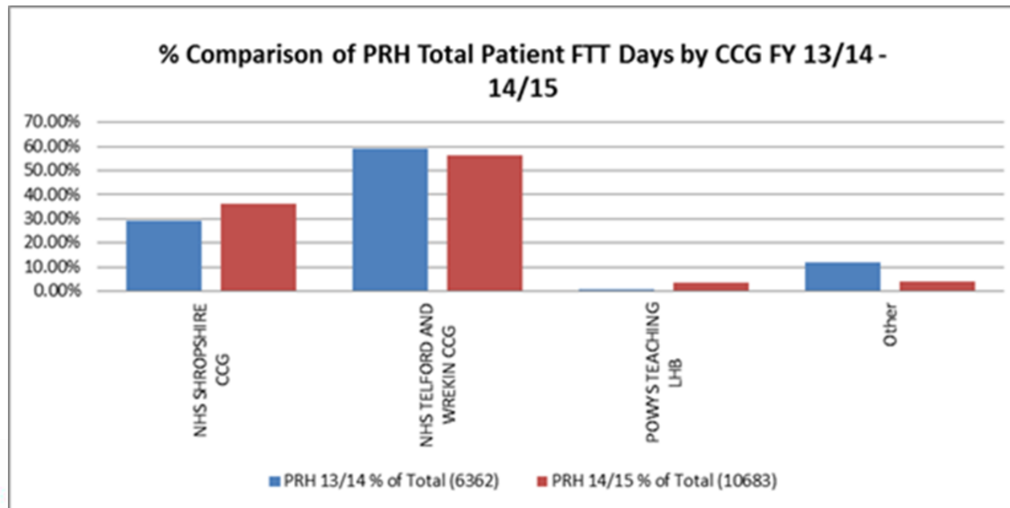
Percentage of Delays by Site





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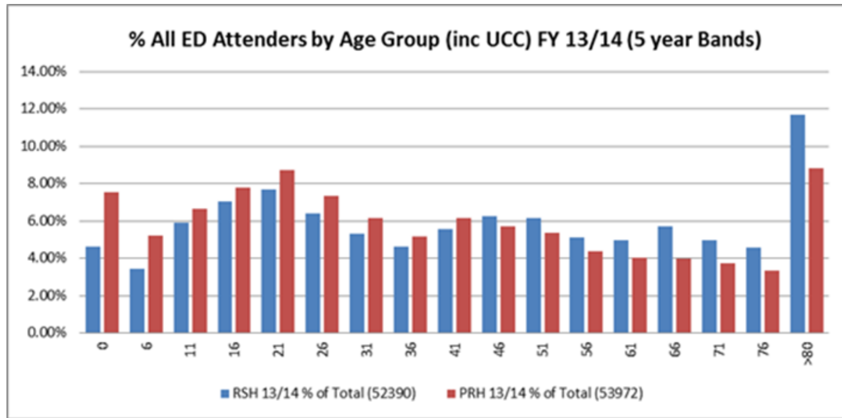
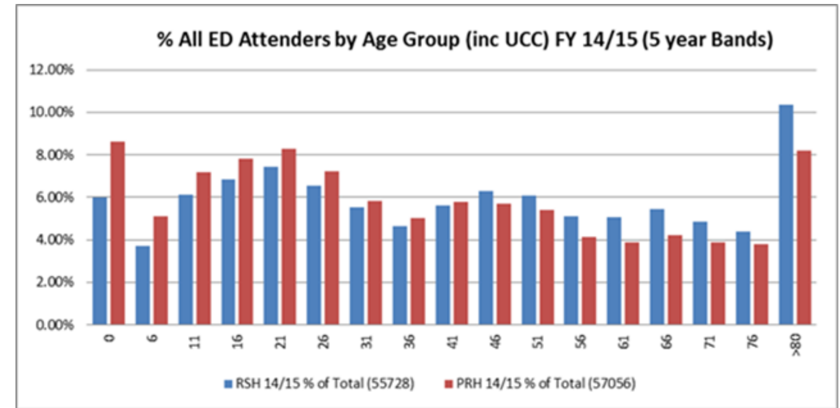
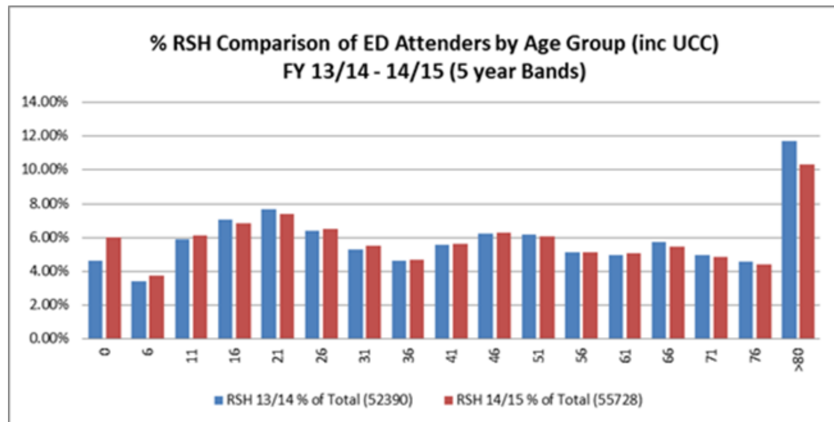
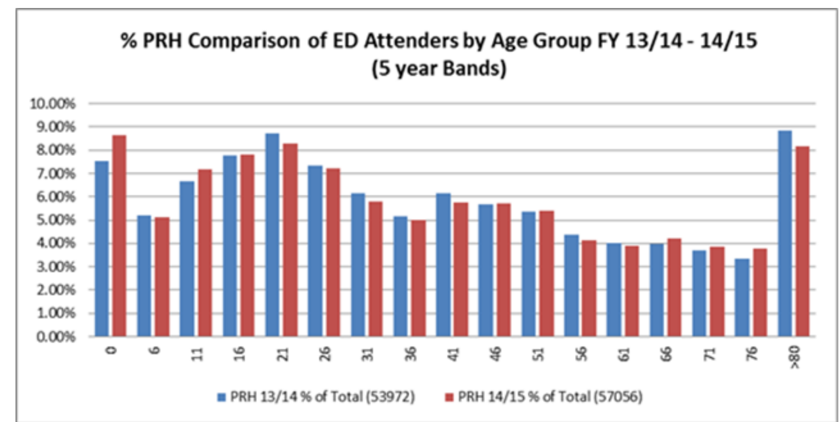
ED Attenders by Site









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Increase in over 70s Admissions

	PRH	RSH
Nov 13 to Feb 14	2437	3318
Nov 14 to Feb 15	2625	3499
% Difference	7.16%	5.17%
Difference	188	181
Number of days for winter period	121	121
Number of weeks in winter period	17	17
Number per day	1.6	1.5
Number per week	11.1	10.6

Marked increase in over 70s admitted to SaTH

Significant shift between Summer and Winter

	RSH	PRH	Trust
Summer Period Apr -14 to Sep- 14	4838	3442	8280
Winter Period Oct-14 to Mar 15	5151	3751	8903
Difference	313	309	623
% Difference	6.1%	8.2%	7.0%
Number of days for summer period	182	182	182
Number of weeks in summer period	26	26	26
Number per day	1.7	1.7	3.4
Number per week	12.0	11.9	24.0

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Delayed Hospital Discharge

Structure of the presentation

1. Definitions of the terms
2. Targets for each area
3. Performance against the key targets
4. Key Challenges (including those relating to those definitions)
5. Known consequences of not meeting targets
6. Commissioning strategies: Shared areas of work, Shropshire health economy specific work and Telford and Wrekin specific work

Monday 28th September 2015

1. Definitions of the terms

Delayed Transfer Of Care (DTOC)

The CCG's, Shropshire Council and Telford and Wrekin Council both promote and apply, **The Department of Health DTOC** definitions:

"A delayed transfer of care from acute or non-acute (including community and mental health) care occurs when a patient is ready to depart from such care and is still occupying a bed. A patient is ready for transfer when:

a. A clinical decision has been made that patient is ready for transfer AND

b. A multi-disciplinary team decision has been made that patient is ready for transfer AND

c. The patient is safe to discharge/transfer.

Medically Fit For Discharge (MFFD)

- As soon as a patient is declared 'clinically fit' they are presented on the MFFD daily report 'list.' This is prior to multi disciplinary team input and triggers the start of discharge planning for the most complex patients.
- There is no clear definition owned by the whole system of what constitutes MFFD.

2. Targets for each area

DTOC Acute

- The local standard DTOC target of delays is to achieve no more than 3.5% of occupied bed days at our acute provider for NHS responsible, Social Care responsible and jointly responsible delays.

DTOC Community

- The local standard DTOC target of delays is to also achieve no more than 3.5% of occupied bed days at our community provider for NHS responsible, Social Care responsible and jointly responsible delays.

Medically Fit For Discharge

- The local target who will present on the Medically Fit for Discharge (MFFD) list per day is a total of 26 for Shropshire and 12 for Telford and Wrekin.

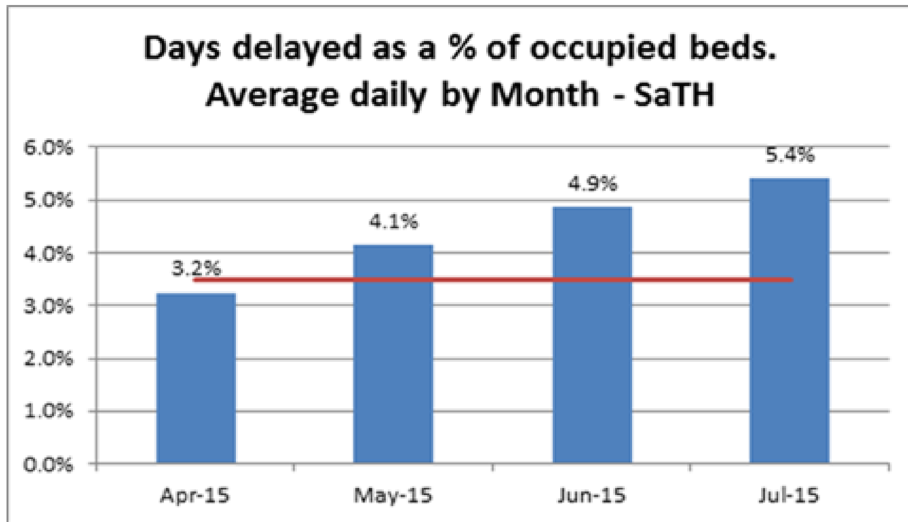
Better Care Fund

- Shropshire: For the purposes of the Better Care Fund (BCF), the measure is based on all Shropshire residents wherever they are occupying a bed standardized by 100,000 of population. Telford and Wrekin: This measure is similar although it is not limited to NHS responsibility.

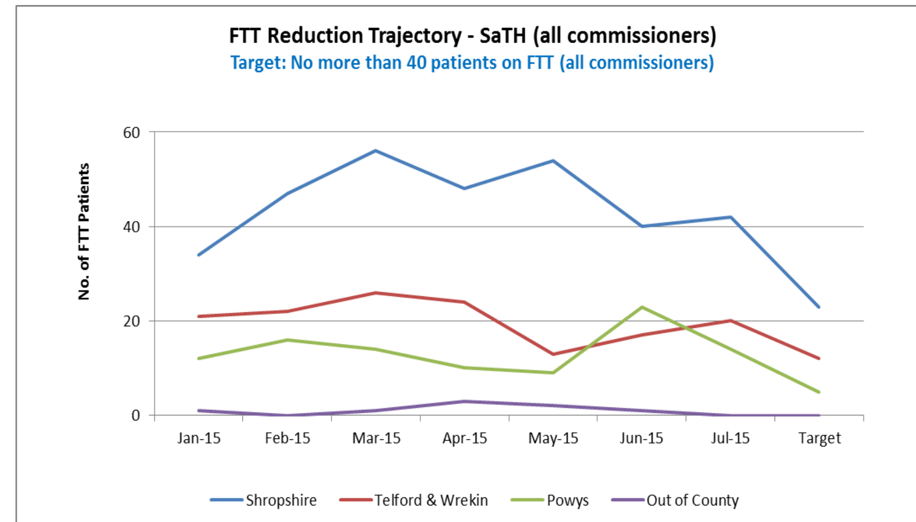
- There is also a Quality Premium Indicator attached to the BCF metric which sets a target for a reduction in DTOCs attributable to NHS responsibility of 3.6% from 2014/15 levels. For Shropshire this target is to reduce from 6225 to 5999 and for Telford this is to reduce from 2746 to 2647 days.

3. Performance against key targets

DTOC Acute

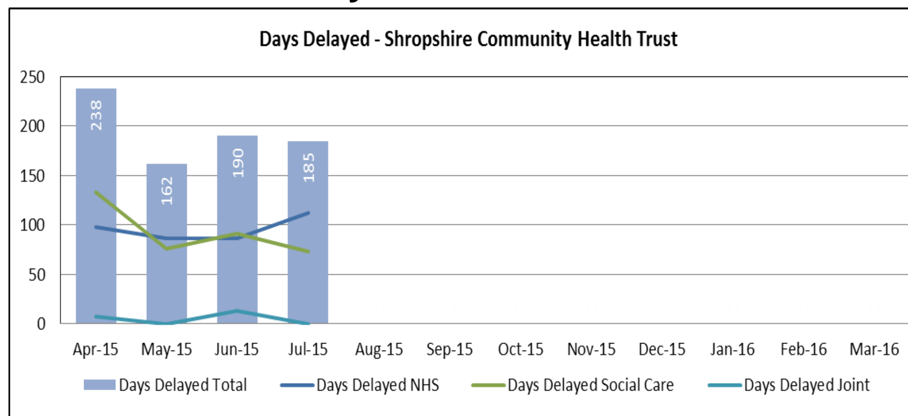


The proportion of delays has grown during summer & is above target



There is an improving trend of FTT but the total remains above target

DTOC Community



Delayed days in Shropshire community hospital beds have fallen since April but remain above target

Telford and Wrekin health economy achieved their BCF target in months 1-3 (actual rate of 146 versus the target of 176) This represents a reduction of a third from the same time period last year

Shropshire health economy have not achieved the BCF target of 307. In accordance with the rise in DTOC delays through the summer this is now reflected in the BCF target and position in June was 393.4.

4. Key Challenges

- The Complexity of the different targets can create confusion and hinder a joined up approach and direction.

- Definitions of DTOC are well defined nationally but tend to be interpreted by each partner differently at a local level.

- Although DTOC as defined in the Act should be a subset of the MFFD report; The Trust tend to quote MFFD numbers to indicate levels of delays.

- A particular challenge in Shropshire over the last 12 months has been access to domiciliary care particularly in the most rural areas of the county.
    - Shropshire Council are in the process of addressing this with the implementation of zone contracts and also recruitment programmes led by Shropshire Partners

5. Known consequences for not meeting targets around DTOC

- If patients are in hospital longer than necessary they will decompensate as a result
- Tensions between partners increases which does not help to resolve issues and reduce delays for patients.
- Delays in discharge can create further capacity challenges to The Trust
- Delays can increase costs associated with funding private sector beds to manage ‘flow’
- Negative impact upon morale, retention and recruitment of staff across the health economy.
- Challenges with patient flow across the entire patient journey

6. Commissioning Strategies

There are three key plans which are in development: Recovery Plan (centring around the achievement of the A&E '4 hour target'); the 'Surge' plan and the winter plan

Admission Avoidance

- Integrated Intermediate Care Service
- Development of Mental Health services (e.g. RAID, crisis support and the helpline)
- Paramedics additional coaching support for frequent callers of 999
- Each CCG has a range of works teams within the respective Better Care Funds
- Long Term Conditions (COPD and Diabetes) 'help line'
- There is a move from both Council and CCG to centre teams around GP practices

Improving Patient Flow

- Winter Planning – Frailty works streams
- Complex Discharge Commissioning Manager to support and monitor DTOC across the system
- Flexible 7 day working

Early Supported Discharge Schemes

- Pilot and potential roll out of 'Discharge to Access'
- Domiciliary care 'zone contracts' to block purchase care in advance.
- Integrated health and social care teams
- SPIC have re-launched the Care Ladder
- CHC pilot to ensure all complex assessments take place outside of the acute setting

Key messages

- Complex patients experience delays in the transfer of their care from the acute and community hospitals and there is an agreement across all partners that there is work to be done to improve this.
- The definitions of DTOC will be reviewed in partnership following the release of the national guidance at the end of September.
- All partners are accountable to resolving issues with the process to help reduce delays for patients.
- There are a number of services now in place different to last year for example integrated teams, admission avoidance schemes and discharge to assess. These are expected to have a positive impact on reducing delays and improving care.
- Additional focus is being given as part of the joint plan for recovering urgent care performance as we head into winter.
- Improvements will be embedded through the hospitals plan to roll out its intended improvement programme.

Report to:	JHOSC, Monday 28th September

Title	Developing the framework for our Consultation Plan: December 2015 to March 2016
Sponsor	Adrian Osborne, Chair, NHS Future Fit, Engagement & Communications Workstream
Author	Adrian Osborne, Chair, NHS Future Fit, Engagement & Communications Workstream
Purpose	This paper sets out the overarching Consultation Framework within which a detailed consultation plan will be developed for review and approval by the NHS Future Fit Programme Board. The development of this framework seeks to ensure a shared understanding of the core principles, requirements and risks for the development of the detailed plan.
Previously considered by	NHS Future Fit Core Group, Programme Team, Engagement & Communications Workstream members, Programme Board.

Executive Summary

This document sets out the framework for developing our Consultation Plan for formal consultation on NHS Future Fit proposals for safe and sustainable acute and community hospital services from December 2015 to March 2016. As approved by the NHS Future Fit Programme Board on 13 August 2015, this framework will be used to develop a Consultation Plan for agreement by Programme Board. This framework assumes the delivery of the Critical Path approved by the NHS Future Fit Programme Board on 24 June 2015.

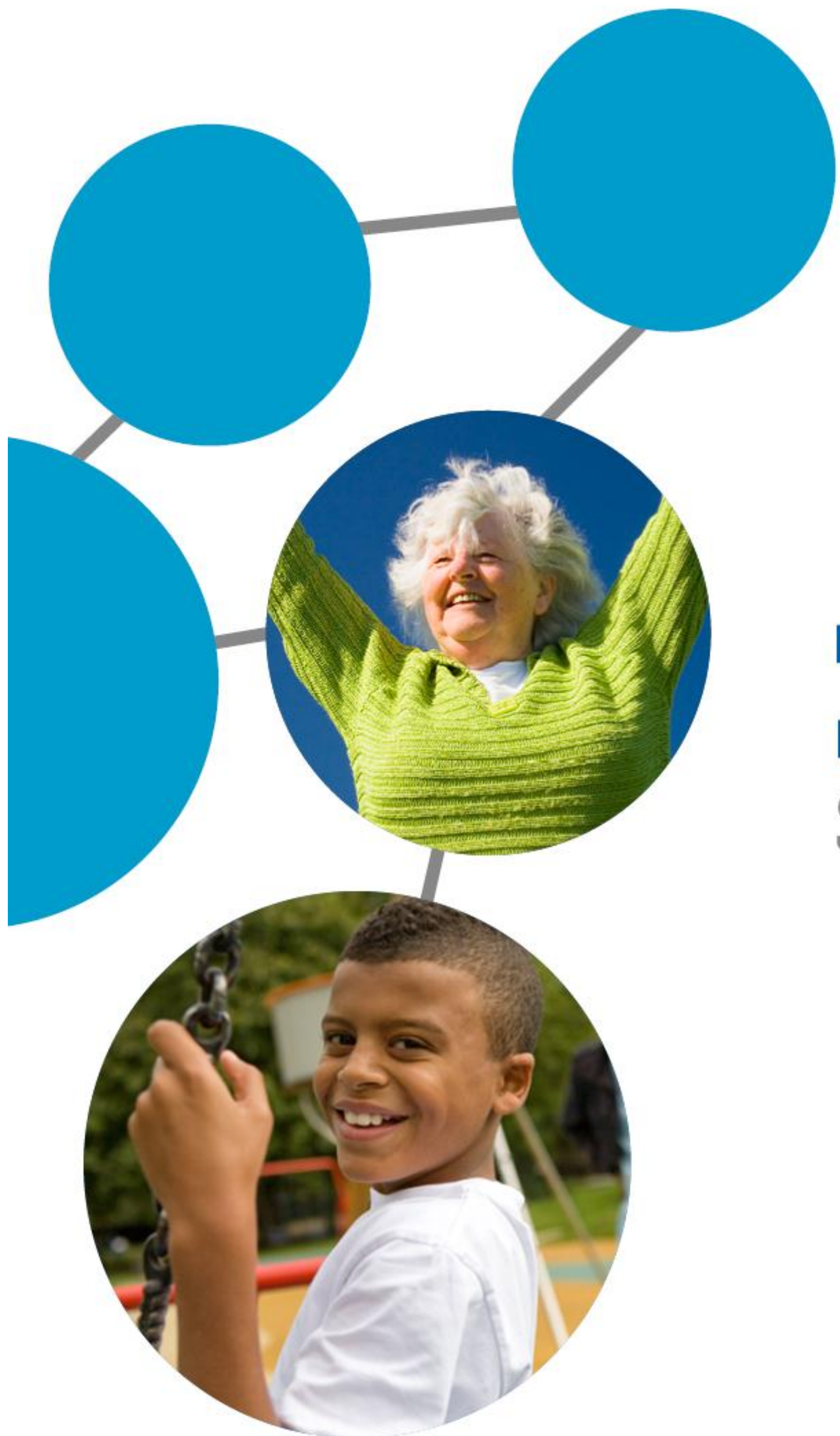
Development of this document: A draft of this framework (version 1.1) was developed based on the work to establish and review the Engagement and Communications Strategy, advice from the Consultation Institute and other guidance and best practice. This was shared on 6 July 2015 with the NHS Future Fit Core Group, Programme Team and Engagement and Communications Workstream for feedback by 31 July 2015. This version (version 2) fully incorporates all feedback received from Core Group, Programme Team, the Engagement & Communications Workstream and Programme Board.

Process moving forward: This paper will be the base used to create a Consultation Plan for Board approval. Discussions to inform the specific content and nature of the Plan will take place with the Engagement and Communications Workstream on 22 September 2015, and subsequently, a development workshop with the latter workstream, members of the IIA workstream and members of JHOSC on Thursday 24 September. Outcomes from the workshop and meeting will inform the creation of the Consultation Plan for Programme Board approval ahead of the proposed formal Consultation in December.

A verbal update/presentation will be delivered at the JHOSC meeting on Monday 28th September.

Risk and Assurance Issues	The development of a clear framework for our Consultation Plan supports the Programme to ensure that statutory and mandatory requirements will be met through the development and implementation of the Plan.

Action required by the JHOSC
The JHOSC is asked to REVIEW the Consultation Framework and AGREE any oral feedback for the NHS Future Fit Engagement and Communications team to utilise in the construction of the final Consultation Plan.



NHS

futurefit

Shaping healthcare together

Developing the framework for our Consultation Plan December 2015 to March 2016

Version Control				Contents
Version	**Date**	**File Name**	**Status**	
Version 1	2 July 2015	1507-ConsultationFramework	Initial draft prepared based on Engagement and Communications Strategy, specialist advice from Consultation Institute and further development work during 2015.	
Version 1.1	6 July 2015	1507-ConsultationFramework	Additional sections on Resources and Risks added. Version 1.1 issued for review and feedback to NHS Future Fit Core Group, Engagement & Communications Workstream and Programme Team	
Version 2	**31 July 2015**	150731-ConsultationFramework	Updated for presentation to NHS Future Fit Programme Board on 13 August 2015, with all feedback fully incorporated.	

Contents

1. **Introduction**
2. **Consultation Principles**
3. **Consultation Plan Framework**
4. **Key Requirements**
5. **Resources**
6. **Risks**
7. **Next Steps**

1 Introduction

This document sets out the framework for developing our detailed Consultation Plan for formal consultation on NHS Future Fit proposals for safe and sustainable acute and community hospital services from December 2015 to March 2016.

Subject to discussion and approval by the NHS Future Fit Programme Board on 13 August 2015, this framework will be used to develop a detailed Consultation Plan for agreement by Programme Board on 1 October 2015.

This framework assumes the delivery of the Critical Path approved by the NHS Future Fit Programme Board on 24 June 2015.

Development of this document

A draft of this framework (version 1.1) was developed based on the work to establish and review the Engagement and Communications Strategy, advice from the Consultation Institute and other guidance and best practice. This was shared on 6 July 2015 with the NHS Future Fit Core Group, Programme Team and Engagement and Communications Workstream for feedback by 31 July 2015. Engagement in the development of this framework focused on the following questions:

- Are we content with the Consultation Principles in Section 2? Is anything missing?
- Does the Consultation Plan Framework in Section 3 encompass the main elements we will need to consider? What other key dependencies would you add?
- Have we identified the Key Requirements in Section 4? Is there anything to add or change?
- Are the assumptions around Resources and Risks in Sections 5 and 6 appropriate?

This version (version 2) fully incorporates all feedback received from Core Group, Programme Team and the Engagement & Communications Workstream.

2 Consultation Principles

During the Call To Action in 2013, the development of the NHS Future Fit Engagement and Communications Strategy, the pilot work on the integrated impact assessment and the ongoing delivery of the Engagement and Communications Workstream, the following principles have been identified which will be used as the basis for developing the Consultation Plan:

a. The future plan for services, whilst clinician-led, needs to be the result of genuine consultation. All those affected need to be able to understand the process and the reasons for the outcomes and so have the **opportunity to feed into the debate**

b. Some people believe that decisions have already been taken, so ongoing action must be taken to counteract this by offering the public a **wide range of ways to be involved**.

c. **All groups and individuals** must be targeted e.g. all age groups, ethnic groups, those without internet access, isolated communities, NHS staff, politicians, clinicians, carers, vulnerable groups, the working well etc.

d. **Genuine consultation** must be undertaken, not a paper exercise in order to tick boxes

e. Need to **go to where people are** e.g. Shrewsbury Flower Show, schools, GP surgeries etc.

f. Keep **politics out of the debate**

g. Work with organisations that have **existing networks** e.g. Patient Groups, Healthwatch, Young Health Champions, voluntary groups, community and religious leaders, etc.

h. The impact on **populations across Shropshire, Telford and Wrekin and mid Wales** should be taken into account at all stages

i. **All media** to be utilised, e.g. internet, social media, traditional media, newsletters, etc.

j. Prepare **information** for distribution at regular intervals to involved groups

k. Avoid jargon in all communications, ensure language is **clear and easy to understand**

l. Provide regular updates and feedback to let people know that their input is being taken into account – **close the loop**

m. Communications should **be accurate and honest**; acknowledging shortcomings, providing the facts

n. Varying, appropriate approaches to engagement and communication to be employed including **specific approaches** for those with learning difficulties, disabilities and English as a second language

3 Consultation Plan Framework

The Consultation Institute provides specialist advice and consultancy to ensure good practice in engagement and consultation. They have identified key elements for formal consultation. These are summarised below and will be considered in the development of the consultation plan:

Aspect	Key Dependencies include:
July 2015 to November 2015	
Agree the project timeline	Delivery of NHS Future Fit Programme critical path
Confirm what can and cannot be influenced • Clarify Preferred Option or Options?	Option Appraisal Process
Agree the critical questions to be asked as part of the formal consultation	Workshop needed in early Autumn to agree the critical consultation questions
Agree consultation processes	Financial and Human resources available to support the process
Identify risks to deliver of effective consultation and agree a strategy to mitigate risks	Risk identification and management process already in place through the Engagement and Communications Workstream with further assurance through Assurance Workstream and Programme Board
Undertake stakeholder mapping	Review and update existing Stakeholder Mapping within the Engagement and Communications Strategy
Develop a communications plan	Review and update existing Stakeholder Mapping within the Engagement and Communications Strategy
Undertake Integrated Impact Analysis	Build on experience of pilot Integrated Impact Analysis
Develop the consultation engagement plan • Quantitative • Qualitative • Participatory • Online > Social Media • Agree appropriate venues	Driven by the critical questions, agreed above Engagement will be dependent on the financial and human resources available to support the process – all organisations will need to ensure that senior individuals can be released for the period of the formal consultation (and for training and development prior to consultation)

Developing the Framework for our Consultation Plan –Version 2, 31 July 2015	
Aspect	**Key Dependencies include:**
Agree post consultation processes, including how the outcome of consultation will influence decision-makers and how decisions will be made	Dependent on how the decisions will be made following consultation – clarity on decision-making process needed by end August Decision on whether to commission independent analysis
Review and approval	Review and approval of draft consultation plan by NHS Future Fit Programme Board on 1 October 2015
Develop the consultation documents (including online resources) • The story so far • Explain why change is necessary and provide clear evidence • Explain any external drivers for change • This is what you have told us • What has been considered at the different stages (scenarios > options) [demonstrate that this is not a fait accompli] • Provide a clear vision of the future services • Explain the consequences of change VS maintaining the status quo on quality, safety, accessibility, and proximity of services • In the case of hospitals, demonstrate how services will in future be provided within an integrated service model • Set out clearly evidence for any proposal to concentrate on a single site • Include the evidence of support from clinicians/GPs for any proposed change • Set out how sustainable staffing levels are to be achieved • In the case of changes prompted by clinical governance issues show how these have been tested (through independent revue) • Explain any risks and how they will be managed • Give a clear picture of the financial implications of the different proposals • Spell out who will be affected by the proposals and how their interests will be protected • Explain how any change and benefit will be evaluated after implementation	Need to clarify approval process for the document and how differences of opinion will be addressed Availability of key individuals to provide expert input during the development period

Developing the Framework for our Consultation Plan –Version 2, 31 July 2015

Aspect	Key Dependencies include:
• Be available in appropriate formats – easy read, Braille, BSL, audio, etc • Get it signed off by the board • Invitation to propose alternative solutions	
Populate the website • Put all relevant information in the public domain	
December 2015 to March 2016	
Publish the opening equalities analysis	
Launch the consultation	
Engage	
Hold a mid-Consultation review Update equalities analysis Make changes to the plan	Undertake by late-January Agree scope
March 2016 to June 2016	
Hold a closing date review	At end of consultation
Analyse the feedback (consider whether you wish to commission independent analysis) • Put into useful formats that support decision making • Make all info available to decision makers	Budget and timescale for independent analysis Contingencies for scale of response
Re-confirm and publicise how the consultation will be analysed	Learning from mid-Consultation and Closing Date reviews – has anything changed in terms of how the consultation will be analysed and how decision-makers will be influenced) since the beginning of consultation
Re-confirm and publicise how decision makers will be influenced	
Update media, web and stakeholders of processes	NB recognise the impact of the pre-election period in Wales on the information that can be communicated, when and how
Update integrated impact analysis and publish	
Conduct decision making meetings	
Publish the outcomes/decisions	
Tackle process issues	
Tackle any challenges	

Developing the Framework for our Consultation Plan –Version 2, 31 July 2015	
Aspect	**Key Dependencies include:**
July 2016 onwards	
Develop/complete an implementation plan	
Agree on-going engagement plan	
Timescales	

4 Key Requirements

This section summarises the main statutory and mandatory guidance relating to formal consultation. It focuses on legislation and guidance that specifically relates to consultation and engagement, rather than the wider policy framework that influences how this is conducted (e.g. Equalities Act 2010):

4.1 Legislation and guidance relating to communities and NHS services in Wales

The Welsh Government sets policy and legislation for engagement and consultation in relation to NHS services provided for people living in Wales.

This includes the Community Health Councils (Constitution, Membership and Procedures) Regulations 2010 which place a duty on specified English NHS bodies which provide services to persons resident within the district of a Community Health Council to consult the Council when developing and considering proposals for changes in the way services are provided, and in decisions that will affect the operation of services.

Legislation is supplemented by guidance from NHS Wales, including NHS Wales Guidance on Engagement and Consultation (2011). This expects:

- Strong continuous engagement and formal consultation
- NHS bodies and Community Health Councils must work together to develop methods of continuous engagement which promote and deliver service transformation for their population
- In cases where substantial change or an issue requiring consultation is identified, the NHS should use a two-stage process where extensive discussions with citizens, staff, staff representative and professional bodies, stakeholders, third sector and partner organisations is followed by a focused formal consultation on any fully evaluated proposals emerging from the extensive discussion phase.

4.2 Legislation and guidance relating to communities and NHS services in England

The UK Government sets policy and legislation for engagement and consultation in relation to NHS services provided for people living in England.

This includes the Health and Social Care Act 2012 which places legal duties on CCGs to involve and consult, and the NHS Act 2006 which places legal duties to consult and involve patients and public and for consultation with Health Overview and Scrutiny Committees.

The Health and Social Care Act 2012 introduced significant amendments to the NHS Act 2006, especially with regard to how NHS commissioners function. These amendments include two complementary duties for clinical commissioning groups with respect to patient and public participation. The second duty places a requirement on CCGs and NHS England to ensure public involvement and consultation in commissioning processes and decisions. It includes involvement of the public, patients and carers in proposed changes to services which may impact on patients.

4.3 CCG Constitutional Commitments

Both Shropshire CCG and Telford and Wrekin CCG have set out in their constitutions how they intend to deliver these statutory requirements at a local level. These constitutional commitments will need to be reflected through the programme:

Shropshire CCG – extract from Constitution	**Telford and Wrekin CCG** – extract from Constitution
5.2. General duties - in discharging its functions the group will: 5.2.1. Make arrangements to ***secure public involvement*** in the planning, development and consideration of proposals for changes and decisions affecting the operation of commissioning arrangements by: a) Ensuring that patients and the public are fully consulted and involved in every aspect of the commissioning cycle in line with the Duty to Involve. Promoting among its members and service providers the requirements of the Duty of Candour. b) Developing and publishing an engagement strategy and consultation policy. c) Ensuring compliance with the 'Code of Conduct' which was jointly developed by the Shropshire Patients' Group and the group. d) Publishing an annual consultation report at the AGM describing all the consultations it has undertaken and the findings and actions resulting. e) Embedding lay representation on all clinical pathway or service reform project teams. f) Creating and establishing a public reference group that will	**5.2. General Duties -** in discharging its functions the group will: 5.2.1. Make arrangements to secure public involvement in the planning, development and consideration of proposals for changes and decisions affecting the operation of commissioning arrangements by: a) delegating the responsibility to discharge this duty to the Clinical Commissioning Group Governance Board, to prepare and approve a communications and engagement plan. b) the Clinical Commissioning Group Governance Board will have regard to the following statement of principles in the discharge of the duty outlined in paragraph (a) above: i) working in partnership with patients and the local community to secure the best care for them; ii) adapting engagement activities to meet the specific needs of the different patient groups and communities where possible and affordable; iii) publishing information about health services on the group's website and through other media; iv) encouraging and acting on feedback.

monitor and report the group's compliance against this statement of principles. **3.3. Petitions** 3.3.1. Where a petition has been received by the group, the Chair of the Governing Body shall include the petition as an item for the agenda of the next meeting of the Governing Body.	**3.4 Petitions** 3.4.1 Where a petition has been received by the group the Chair of the Clinical Commissioning Group Governance Board shall include the petition as an item for the agenda of the next meeting of the Clinical Commissioning Group Governance Board.

4.4 Cabinet Office Consultation Principles
The Cabinet Office has published the following guidance on the principles that Government departments and other public bodies should adopt for engaging stakeholders:

This guidance sets out the principles that Government departments and other public bodies should adopt for engaging stakeholders when developing policy and legislation. It replaces the Code of Practice on Consultation issued in July 2008. It is not a 'how to' guide but aims to help policy makers make the right judgments about when, with whom and how to consult. The governing principle is proportionality of the type and scale of consultation to the potential impacts of the proposal or decision being taken, and thought should be given to achieving real engagement rather than merely following bureaucratic process. Consultation forms part of wider engagement and decisions on whether and how to consult should in part depend on the wider scheme of engagement.

Policy makers should bear in mind the Civil Service Reform principles of open policy making throughout the process and not just at set points of consultation, and should use real discussion with affected parties and experts as well as the expertise of civil service learning to make well informed decisions. Modern communications technologies enable policy makers to engage in such discussions more quickly and in a more targeted way than before, and mean that the traditional written consultation is not always the best way of getting those who know most and care most about a particular issue to engage in fruitful dialogue.

Subjects of consultation

There may be a number of reasons to consult: to garner views and preferences, to understand possible unintended consequences of a policy

or to get views on implementation. Increasing the level of transparency and increasing engagement with interested parties improves the quality of policy making by bringing to bear expertise and alternative perspectives, and identifying unintended effects and practical problems. The objectives of any consultation should be clear, and will depend to a great extent on the type of issue and the stage in the policy-making process – from gathering new ideas to testing options.

There may be circumstances where formal consultation is not appropriate, for example, where the measure is necessary to deal with a court judgment or where adequate consultation has taken place at an earlier stage for minor or technical amendments to regulation or existing policy frameworks. However, longer and more detailed consultation will be needed in situations where smaller, more vulnerable organisations such as small charities could be affected. The principles of the Compact between government and the voluntary and community sector must continue to be respected.

Timing of consultation

Engagement should begin early in policy development when the policy is still under consideration and views can genuinely be taken into account. There are several stages of policy development, and it may be appropriate to engage in different ways at different stages. As part of this, there can be different reasons for, and types of consultation, some radically different from simply inviting response to a document. Every effort should be made to make available the Government's evidence base at an early stage to enable contestability and challenge.

Timeframes for consultation should be proportionate and realistic to allow stakeholders sufficient time to provide a considered response and where the consultation spans all or part of a holiday period policy makers should consider what if any impact there may be and take appropriate mitigating action. The amount of time required will depend on the nature and impact of the proposal (for example, the diversity of interested parties or the complexity of the issue, or even external events), and might typically vary between two and 12 weeks. The timing and length of a consultation should be decided on a case-by-case basis; there is no set formula for establishing the right length. In some cases there will be no requirement for consultation, depending on the issue and whether interested groups have already been engaged in the policy making process. For a new and contentious policy, 12 weeks or more may still be appropriate. When deciding on the timescale for a given consultation the capacity of the groups being consulted to respond should be taken into consideration.

Making information useful and accessible

Policy makers should be able to demonstrate that they have considered who needs to be consulted and ensure that the consultation

captures the full range of stakeholders affected. In particular, if the policy will affect hard to reach or vulnerable groups, policy makers should take the necessary actions to engage effectively with these groups. Information should be disseminated and presented in a way likely to be accessible and useful to the stakeholders with a substantial interest in the subject matter. The choice of the form of consultation will largely depend on: the issues under consideration, who needs to be consulted, and the available time and resources.

Information provided to stakeholders should be easy to comprehend – it should be in an easily understandable format, use plain language and clarify the key issues, particularly where the consultation deals with complex subject matter. Consideration should be given to more informal forms of consultation that may be appropriate – for example, email or webbased forums, public meetings, working groups, focus groups, and surveys – rather than always reverting to a written consultation. Policy-makers should avoid disproportionate cost to the Government or the stakeholders concerned.

Transparency and feedback

The purpose of the consultation process should be clearly stated as should the stage of the development that the policy has reached. Also, to avoid creating unrealistic expectations, it should be apparent what aspects of the policy being consulted on are open to change and what decisions have already been taken. Being clear about the areas of policy on which views are sought will increase the usefulness of responses.

Sufficient information should be made available to stakeholders to enable them to make informed comments. Relevant documentation should be posted online to enhance accessibility and opportunities for reuse. To ensure transparency and consistency of approach, all consultations should be housed on the Government’s single web platform (GOV.UK).

To encourage active participation, policy makers should explain what responses they have received and how these have been used in formulating the policy. The number of responses received should also be indicated. Consultation responses should usually be published within 12 weeks of the consultation closing. Where Departments do not publish a response within 12 weeks, they should provide a brief statement on why they have not done so. Departments should make clear at least in broad terms what future plans (if any) they have for engagement.

Practical considerations

Consultation exercises should not generally be launched during local or national election periods. If exceptional circumstances make a

consultation absolutely essential (for example, for safeguarding public health), departments should seek advice from the Propriety and Ethics team in the Cabinet Office

Departments should be clear how they have come to the decision to consult in a particular way, and senior officials and ministers should be sighted on the considerations taken into account in order to enable them to ensure the quality of consultations.

Departments should seek collective ministerial agreement before any public engagement that might be seen as committing the Government to a particular approach. Ministers are obliged to seek the views of colleagues early in the policy making process and the documents supporting formal consultations should be cleared collectively with ministerial colleagues. If departments are intending to use more informal methods of consultation, they should think about at what point, and with what supporting documentation, collective agreement should be sought. The Cabinet Secretariat will be able to advise on particular cases.

This guidance does not have legal force and does not prevail over statutory or mandatory requirements.

(Source: Consultation Principles, Cabinet Office, 2012)

4.5 NHS Four Tests for Consultation and Involvement

The Department of Health's Mandate to the NHS England for 2015/16 identifies four tests for strengthened public involvement:

Where local clinicians are proposing significant change to services, we want to see better informed local decision-making about services, in which the public are fully consulted and involved. NHS England's objective is to ensure that proposed changes meet four tests: (i) strong public and patient engagement; ii) consistency with current and prospective need for patient choice; iii) a clear clinical evidence base; and iv) support for proposals from clinical commissioners.

(Source: A mandate from the Government to NHS England: April 2015 to March 2016, Department of Health, December 2015)

5 Resources

The delivery of the Consultation Plan will include:

- NHS Future Fit Programme Team, NHS Future Fit Engagement and Communications Team (e.g. developing the consultation plan and associated collateral)
- Support from Engagement and Communications Teams in sponsor organisations and the wider health and care system (e.g. supporting the development of the plan and collateral, supporting engagement and communication across Shropshire, Telford & Wrekin and mid Wales)
- Clinical and management leaders on sponsor organisations (e.g. providing expert input to the development of consultation materials, speakers and facilitators at consultation events, news and social media interviews)
- Local Healthwatch, CHC and Health Overview and Scrutiny Committees (e.g. engagement, assurance and scrutiny)
- Patient, community and voluntary organisations (e.g. disseminate consultation materials through their networks including websites and newsletters)

A plan will be developed assuming £50,000 resources in addition to the baseline engagement and communications programme.

6 Risks

The primary risks (and *indicative mitigating actions*) associated with the consultation plan include:

- Legal challenge as insufficient engagement at formative stage (Gunning) – *evidence from Call To Action, ongoing engagement and pre-consultation*
- Legal challenge as insufficient information to enable intelligent consideration (Gunning) – *adequacy of consultation materials, identification of consultation questions*
- Legal challenge as insufficient time for adequate consideration and response (Gunning) – *consultation period based on national guidance, adequate time between conclusion of consultation and decision-making to undertake and analysis and due regard, consider independent analysis of consultation responses, all responses provided to decision-makers*
- Legal challenge as consultation responses not conscientiously taken into account (Gunning) – *ensure that post-consultation decision-making process is clarified prior to development of the consultation plan*
- The consultation process itself is deemed insufficient because it does not adequately fulfil statutory and mandatory requirements – *agree consultation framework, develop plan based on this framework through Engagement and Communications Workstream, provide assurance through Assurance Workstream, adequate resources*
- Consultation plans are not delivered due to overly reactive approach and/or the consultation process does not adequately respond to changing circumstances and requirements – *agree and deliver plan, undertaken mid-consultation review*
- The consultation process is deemed insufficient because the plan is over-specified and is not delivered – *agreement of deliverable plan that adequately addresses statutory and mandatory guidance, identification of risks and risk mitigation*
- Significant public anxiety and dissent in relation to proposals and decisions, heightened anxiety in context of winter demands on health and care services – *clarity of case for change, availability of senior clinical and management leaders to engage and explain, adequate winter planning*
- The consultation process is deemed insufficient because of inadequate equalities analysis - *pilot Integrated Impact Analysis (IIA), develop and deliver final IIA, IIA demonstrably considered as part of decision-making*

7 Next Steps

The NHS Future Fit Programme Board is asked to APPROVE the Framework for our Consultation Plan.

Based on this framework:

- Draft risks will be refined and review for incorporation in the Workstream and Programme Risk Register.
- A detailed Consultation Plan will be developed for consideration by the NHS Future Fit Programme Board on 1 October 2015.

Contact Details:

Adrian Osborne, Chair, NHS Future Fit Engagement and Communications Workstream – nhsfuturefit@nhs.net

TELFORD & WREKIN COUNCIL & SHROPSHIRE COUNCIL

JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE – 28TH SEPTEMBER 2015

TERMS OF REFERENCE OF THE SHROPSHIRE AND TELFORD & WREKIN JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

REPORT OF SCRUTINY GROUP SPECIALIST

1.0 PURPOSE

1.1 To update the terms of reference of the Shropshire and Telford and Wrekin Joint Health Overview and Scrutiny Committee.

2.0 RECOMMENDATIONS

2.1 The Committee endorse the draft terms of reference attached as Appendix 1.

3.0 PREVIOUS MINUTES

3.1 CCC – 4 13th July 2013

4.0 BACKGROUND INFORMATION

4.1 The Joint Health Overview and Scrutiny Committee with Shropshire Council has worked effectively for a number of years. However, following the publication of the Health Scrutiny guidance by the Department of Health the existing terms of reference need to be updated.

5.0 TERMS OF REFERENCE FOR THE SHROPSHIRE AND TELFORD & WREKIN JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE.

5.1 The Health and Social Care Act 2012 made a number of changes to health scrutiny arrangements. The Health Scrutiny Guidance published in 2014 provided greater detail on the specific powers of delegation and it is therefore necessary to update the terms of reference for the Joint Health Overview and Scrutiny Committee. The draft terms of reference attached have been updated to clarify that both local authorities will

agree to delegate scrutiny of pan-shropshire health issues to the Joint HOSC, but that the power of referral to the Secretary of State has not been delegated to the Joint HOSC. While the Joint HOSC will consider the proposed changes and respond to the consultation, the power to refer any contested proposals remains with the individual authorities.

5.2 The proposed changes to the Joint HOSC Terms of Reference which require changes to the Councils' Constitution will be considered through the appropriate process within each local authority.

6.0 EQUAL OPPORTUNITIES

6.1 The recommendations set out in the report aim to ensure all service users and their family are fully engaged in assessing and planning their care.

7.0 ENVIRONMENTAL IMPACT

7.1 There is no direct environmental impact resulting from this report.

8.0. LEGAL COMMENT

8.1 Rules and procedures covering the Council's public health scrutiny responsibilities are set out in the Local Government Act 1972 as amended (section 101), the National Health Act 2006 (as amended by the Health and Social Care Act 2012) and most recently The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013.

The legislative provisions allow for a local authority to choose how the public health scrutiny function is undertaken; a local authority can choose to discharge its functions through its own overview and scrutiny committee, that of another authority or through a joint overview and scrutiny committee with one or more other authorities.

The proposal in this report is complaint with the regulatory requirements.

9.1 LINKS WITH CORPORATE PRIORITIES

9.1 The role of the Joint HOSC contributes to the Council's priority to improve the health and wellbeing of our communities and address health inequalities

10.0 OPPORTUNITIES AND RISKS

10.1 The changes to the terms of reference for the Joint HOSC will need to be agreed through the correct processes by both local authorities

11.0 FINANCIAL IMPLICATIONS

11.1 The adoption of the revised terms of reference in and of itself does not give rise to any financial implications. Reference in the report to the power to refer matters to the secretary of state, which if agreed would remain with the Council is an action which has the potential to give rise to future costs should these powers be used.

RP 23/6/15.

12. 0 WARD IMPLICATIONS

12.1 There are no specific ward issues resulting from this report.

13.0 BACKGROUND PAPERS

13.1 None

Report prepared by Fiona Bottrill, Scrutiny Group Specialist 01952 383113

Background Report: Department of Health Guidance June 2014: Local Authority Health Scrutiny. Guidance to support local authorities and their partners to deliver effective health scrutiny.

APPENDIX 1

DRAFT SHROPSHIRE AND TELFORD & WREKIN JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

TERMS OF REFERENCE

Purpose

To act as a discretionary Joint Health Overview and Scrutiny Committee (Joint HOSC) to ~~jointly~~ consider and scrutinise where necessary, all Health and Healthcare related topics which affect the areas of Telford and Wrekin Council and Shropshire Council including matters referred by Telford and Wrekin and Shropshire Healthwatch.~~.~~

To meet when proposed changes to services are identified to confirm if the Committee will undertake the role of the Committee as a mandatory Joint HOSC and statutory consultee in relation to NHS proposals for a substantial variation or development in service.~~whether formal statutory consultation would be necessary.~~

To actively research any statutory consultation and respond in line with Health Scrutiny Regulations and the Department of Health Guidance on Health Scrutiny (2014) ~~actively research and respond to any formal consultation within the agreed consultation period, usually the statutory 12 weeks period.~~

.

Powers of the Joint Health Overview and Scrutiny Committee

The Joint Health Overview and Scrutiny Committee exercises the powers of both a discretionary and a mandatory Joint HOSC, as set out in the Health and Social Care Act (2001) consolidated in the NHS Act (2006) and amended by the Localism Act 2011 and the Health and Social Care Act 2012, to review any matter relating to the planning, provision and operation of health services across the local authority areas. Both Telford and Wrekin Local Authority and Shropshire Council Local Authority have delegated the health scrutiny power to the Joint HOSC for pan Shropshire health matters. When the NHS make a proposals for a substantial variation or development of service the Joint HOSC will be the only Scrutiny Committee which will:

- Respond to the consultation
- Exercise the power to require the provision of information by relevant NHS body or health service provider
- Require members or employees of relevant NHS bodies ot health service provider to attend before it to answer questions in connection with the consultation.

However, both local authorities have retained the power of referral as set out in the Councils' Constitutions. Any referral of proposed substantial change or variation in service to the Secretary of State will be made in line with Health Scrutiny Regulations and the Department of Health Guidance.

The roles and responsibilities of the Joint HOSC, commissioners and providers of NHS and Local Authority public health services is set out in the Department of Health Guidance, Guidance to support Local Authorities and their partners to deliver effective health scrutiny (2014)

Membership of the Joint Health Overview and Scrutiny Committee

There will be three elected members from each local authority.

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APPENDIX 1

There will be three co-opted members from each local authority area who are independent of the relevant Council.
The Co-opted Members of the Committee have voting rights as determined by full council at both authorities. Copies of the voting schedules are attached.
Executive Members for Health and Social Care and Health and Wellbeing Board Chairs issues may attend the meeting at the Chair's discretion in a non voting capacity.

Chairing Arrangements
Meetings alternate between the Council areas. The appropriate Chair will take the lead for meetings in their Local Authority Area.

Chairs' Casting Vote
The Chair will not use their casting vote due to the alternating venue.

Political Balance

Political balance applies to this Committee. The political balance applies to each participating authority.

Administration
In line with the Department of Health Guidance ~~Telford and Wrekin Council and Shropshire County council will share the cost and resource implications of supporting the Joint Health Overview and Scrutiny Committee~~ the support for the Joint HOSC will be made available by the local health and social care system to enable the powers and duties associated with the function to be exercised appropriately.. Meetings will alternate between local authorities. Each council will take the lead in arranging venues and co-ordinating agendas with organisations and individuals invited to present reports or papers or give evidence, for the meetings taking place in their Local Authority Area.

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The agenda will be agreed by both Health Scrutiny Chairs ~~at an agenda setting meeting about 10 working days before the Joint Committee meeting~~. Papers and presentations will be considered during this meeting to establish running order and specific instructions to those attending.
Pre-meetings will be at the Chair's discretion, to be attended either by the Chairs' alone or for members of the whole joint Health Overview and Scrutiny Committee.

Additional Support
Each local authority will identify an agreed resource which it can provide to support the work of the Joint Committee. This may be officer time and/or a financial contribution to cover the costs of any specialist advice.

Frequency of Meetings
To be detailed in the Joint Committee Work Programme.

Quorum
One third of the membership of the committee. At least 2 elected members must be present including 1 from each authority. There must be 2 representatives from each authority including co-optees.

APPENDIX 1

Ways of Working
Under the Department of Health Guidance (2014~~03~~) the Joint Health Scrutiny committee must:

~~Represent the interests of the population that receives services provided by or commissioned by the NHS body~~
Strengthen the voice of local people, ensuring that their needs and experienced are considered as an integral part of the commissioning and delivery of health services and that those services are safe and effective.

Operate in a way that will lead to rigorous and objective scrutiny of the issues under review and carried out in a transparent manner that will boost the confidence of local people in health scrutiny. ~~.~~

In considering substantial reconfiguration proposals health scrutiny needs to recognise the resource envelope within which the NHS operated and should therefore take into account the effect of the proposals on sustainability of services as well as their quality and safety.

The Joint Committee will hold formal meetings, and will undertake visits – which as far as possible will involve representatives from both authorities. Each authority will be able to lead and undertake individual pieces of work. The Joint Committee may also hold meetings with relevant representatives and officers outside of the main scrutiny forum such as focus groups, public meetings and consultation with relevant patient/service user groups.

Reports
Wherever possible all reports will present joint evidence based conclusions and recommendations. However, where differences exist reports will be able to ~~65~~ include sections setting out evidence based conclusions and recommendations reflecting the different views within the joint committee.

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Review of Terms of Reference
Annually or as required when issues arise for joint scrutiny.

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