Merton Council

South West London Joint Health Overview and Scrutiny Committee Agenda

Membership

Councillors:

Brian Lewis-Lavender
Peter McCabe

Co-opted members:

Substitute Members:

Suzanne Grocott
Gregory Patrick Udeh

Date: **Tuesday 11 October 2016**

Time: **7.00 pm**

Venue: **Queen Anne Suite, Guildhall, Royal Borough of Kingston upon Thames, Surrey, KT1 1EU**

This is a public meeting and attendance by the public is encouraged and welcomed. For more information about the agenda please contact scrutiny@merton.gov.uk or telephone 020 8545 3390.

All Press contacts: press@merton.gov.uk, 020 8545 3181

South West London Joint Health Overview and Scrutiny Committee Agenda

11 October 2016

Note on declarations of interest

Members are advised to declare any Disclosable Pecuniary Interest in any matter to be considered at the meeting. If a pecuniary interest is declared they should withdraw from the meeting room during the whole of the consideration of that mater and must not participate in any vote on that matter. If members consider they should not participate because of a non-pecuniary interest which may give rise to a perception of bias, they should declare this, .withdraw and not participate in consideration of the item. For further advice please speak with the Assistant Director of Corporate Governance.

LONDON BOROUGH OF RICHMOND UPON THAMES

AGENDA

For a meeting of the

SOUTH WEST LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

to be held on

TUESDAY, 11 OCTOBER 2016

At

7:00 pm

in the

Queen Anne Suite, Guildhall, Royal Borough of Kingston upon Thames, Surrey, KT1 1EU

Gillian Norton, Chief Executive

Committee Members:	**Councillor Margaret Mead, Councillor Carole Bonner, Councillor Raju Pandya, Councillor Andrew Day, Councillor Brian Lewis-Lavender, Councillor Peter McCabe, Councillor Margaret Buter, Councillor David Porter, Councillor Sunita Gordon, Councillor Pathumal Ali, Councillor Claire Clay and Councillor Mark Thomas**
Committee Administrator:	**Nicholas Garland ☎ 020 8891 7201;** Nicholas.Garland@richmond.gov.uk

1. DECLARATIONS OF INTEREST

Members are requested to declare any interests orally at the start of the meeting and again immediately before consideration of the matter. Members are reminded to specify the agenda item number to which it refers and the nature of the interest.

2. APOLOGIES FOR ABSENCE

To note any apologies for absence and substitutes for the meeting.

3. ELECTION OF CHAIRMAN

To elect a chairman for the remainder of the 2016/17 municipal year.

Please contact us if you require this agenda in Braille, large print, on audio tape or in a community language.

Democratic Services, York House, Richmond Road, Twickenham, TW1 3AA
Tel: 020 8891 7191 Fax: 020 8891 7701 Minicom: 020 8831 6001
Email: democratic.services@richmond.gov.uk

4. ELECTION OF VICE-CHAIRMAN

To elect a vice-chairman for the remainder of the 2016/17 municipal year.

5. MINUTES

To approve the minutes of the meeting held on 01 December 2015.

6. SWL SUSTAINABILITY AND TRANSFORMATION PLAN

A briefing for the South West London Joint Health Overview and Scrutiny Committee on the south west London Sustainability and Transformation Plan.

7. PROPOSAL FOR THE ADOPTION OF A JOINT PROTOCOL ON CONSULTATION ON HEALTH SERVICE CHANGES IN SOUTH WEST LONDON

Members of the Joint Health Overview and Scrutiny Committee are requested:

(a) to note the work being undertaken on the development of a protocol on consultation on NHS changes; and

(b) to comment on the draft protocol attached as Appendix A.

PLEASE NOTE:

1. The next meeting of the Sub-Committee is to be confirmed.

2. Members are reminded that they are required to securely dispose of agenda packs that contain private information.

York House
Twickenham
TW1 3AA

3 October 2016

This agenda is printed on recycled paper.

Nese keni veshtersi per te kuptuar kete botim, ju lutemi ejani ne recepcionin ne adresen e shenuar me poshte ku ne mund te organizojme perkthime nepermjet telefonit.

Albanian

এই প্রকাশনার অর্থ বুঝতে পারায় যদি আপনার কোন সমস্যা হয়, নিচে দেওয়া ঠিকানায় রিসেপ্শন-এ চলে আসুন যেখানে আমরা আপনাকে টেলিফোনে দোভাষীর সেবা প্রদানের ব্যবস্থা করতে পারবো।

Bengali

જો તમને આ પુસ્તિકાની વિગતો સમજવામાં મુશ્કેલી પડતી હોય તો, કૃપયા નીચે જણાવેલ સ્થળના રિસેપ્શન પર આવો, જ્યાં અમે ટેલિફોન પર ગુજરાતીમાં ઈન્ટરપ્રિટીંગ સેવાની ગોઠવણ કરી આપીશું.

Gujarati

إذا كانت لديك صعوبة في فهم هذا المنشور، فنرجو زيارة الإستقبال في العنوان المعطى أدناه حيث بإمكاننا أن نرتب لخدمة ترجمة شفوية هاتفية.

Arabic

اگر آپ کو اس اشاعت کو سمجھنے میں کوئی مشکل ہے تو، براہِ کرم نیچے دیئے ہوئے ایڈریس کے استقبالیے پر جا کر ملیئے، جہاں ہم آپ کیلئے ٹیلیفون انٹرپریٹنگ سروس (ٹیلیفون پر ترجمانی کی سروس) کا انتظام کر سکتے ہیں۔

Urdu

ਜੇਕਰ ਤੁਹਾਨੂੰ ਇਸ ਪਰਚੇ ਨੂੰ ਸਮਝਣ ਵਿਚ ਮੁਸ਼ਕਲ ਪੇਸ਼ ਆਉਂਦੀ ਹੈ ਤਾਂ ਹੇਠਾਂ ਦਿੱਤੇ ਗਏ ਪਤੇ ਉੱਪਰ ਰਿਸੈਪਸ਼ਨ 'ਤੇ ਆਓ ਜਿੱਥੇ ਅਸੀਂ ਟੈਲੀਫ਼ੋਨ ਤੇ ਗੱਲਬਾਤ ਕਰਨ ਲਈ ਇੰਟਰਪ੍ਰਿਟਰ ਦਾ ਪ੍ਰਬੰਧ ਕਰ ਸਕਦੇ ਹਾਂ।

Punjabi

اگر در فهمیدن این نشریه مشکل دارید، لطفا به میز پذیرش در آدرس قید شده در زیر رجوع فرمایید تا سرویس ترجمه تلفنی برایتان فراهم آورده شود.

Farsi

Jeżeli masz trudności ze zrozumieniem tej publikacji, proszę pójdź do recepcji (adres jest podany poniżej), gdzie możemy zorganizować tłumaczenie przez telefon.

Polish

Civic Centre, 44 York Street, Twickenham, TW1 3BZ; 42 York Street, Twickenham, TW1 3BW; Centre House, 68 Sheen Lane, London SW14 8LP; Old Town Hall, Whittaker Avenue, Richmond, TW9 1TP; Or any library.

This page is intentionally left blank

SOUTH WEST LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Minutes of the meeting held on Tuesday, 1 December 2015.

PRESENT:
Councillor Carole Bonner (Croydon)
Councillor Linsey Cottington and Councillor Andrew Day (Kingston)
Councillor Brian Lewis-Lavender (Merton)
Councillor David Porter (Richmond)
Councillor Sunita Gordon and Councillor Alan Salter (Sutton)
Councillor Dr Allin-Khan and Councillor Claire Clay (Wandsworth)

91. DECLARATIONS OF INTEREST

There were no declarations of interest.

92. APOLOGIES FOR ABSENCE

Kingston – Councillor Raju Pandya gave apologies and was substituted by Councillor Linsey Cottington.

Richmond – Councillor Margaret Buter gave apologies.

Wandsworth – Councillor Jeremy Ambache gave apologies and was substituted by Councillor Dr Allin-Khan.

93. ELECTION OF CHAIRMAN

RESOLVED that Councillor Day (Royal Borough of Kingston upon Thames) be elected as Chairman for the remainder of the 2015/16 municipal year.

94. ELECTION OF VICE-CHAIRMAN

RESOLVED that Councillor Salter (London Borough of Sutton) be elected as Vice-Chairman for the remainder of the 2015/16 municipal year.

95. MINUTES

RESOLVED that the minutes of the joint meeting held on 17 July 2014 be approved and signed by the Chairman.

96. SOUTH WEST LONDON COLLABORATIVE COMMISSIONING UPDATE

Present, on behalf of South West London Collaborative Commissioning (SWLCC), were Kay McCulloch (Programme Director), Dr Andrew Murray (Chair of the Merton Clinical Commissioning Group) Tim Thomas (Finance Work Stream Adviser).

The joint committee was guided through the presentation that has been provided as part of the agenda pack for the meeting. Members' attention was drawn to SWLCC's 8-year strategy and the four key aims contained within it.

A significant challenge facing acute trusts in the south west London region was improving standards, whilst also needing to reduce a projected cumulative deficit of around £600m by 2018/19. The projected budget deficit at St George's University Hospitals NHS Foundation Trust was observed to be significantly larger than any other hospital in the region. The main reason for this was because it was the major regional hospital with a bigger monetary turnover. It was reported that the projected deficit, as a percentage of St George's overall budget, was broadly comparable to other hospitals in the region.

The similarities and differences between SWLCC's aims and those of the now defunct

'Better Services Better Value' programme were highlighted. It was confirmed that there was a desire to include Surrey Downs CCG within the SWLCC body of work.

A series of harmonised clinical pathways were described, with the aim of making treatment planning easier to understand for patients.

There was discussion about the south west London crisis response pilot. It was reported that those areas in which it had so far been introduced had experienced a 96% success rate in terms of preventing trips to hospitals. It was noted that the pilot's rollout was not yet complete, as it was still being phased in across some of the CCGs in the south west London region. The availability times of the service had been set, based on information held about peak periods of demand.

The provision of online GP services was discussed. Members established that there had been a wide variance in uptake between CCG areas. The possible reasons for this were discussed and it was noted that uptake was heavily dependent on individual GP surgeries promoting the facility's use. It was reported that only around 1% of patients across the south west London region booked GP appointments online, although more residents made use of the prescription renewal facility.

The deliberative events that had been held were discussed. It was reported that the events were aimed at individuals who would not ordinarily engage in consultative events about healthcare. Members questioned whether these and other similar, non-targeted, events represented value for money.

Joint committee members were assured that there had been no decision on what future healthcare services in the region would look like at the end of the process.

In closing the item, it was reported that SWLCC's work needed to happen quickly because of the stark financial position being faced in the region. It was noted that clinical need for any changes was also going to be a driver for future work.

RESOLVED that the joint committee be provided with an update on progress in June 2016.

CHAIRMAN

The meeting, which started at 7.00pm, ended at 7.58pm.

SWL Sustainability and Transformation Plan

Briefing for South West London Joint Health Overview and Scrutiny Committee
October 2016

Background

Following publication of the NHS Five Year Forward View (5YFV) in 2015, all regions (or 'footprints') of the NHS in England are required to publish Sustainability and Transformation Plans (STPs) setting out how they will meet the challenges set out in the 5YFV and deliver high quality, sustainable services for their populations in the years ahead.

STPs are intended to be developed through a partnership of NHS commissioners and providers, working with their local authorities. This is a significant change to previous NHS change programmes, which have been commissioner-led. The partnership approach is expected to continue in development of the STP: while in the past, different areas of the NHS have in effect had competing interests, the STP process requires 'whole system' accountability. NHS England and NHS Improvement, as regulators of commissioners and providers, are taking an active role in ensuring system-wide accountability for STPs.

South West London STP

The South West London STP is currently going through the final stage of drafting. An initial submission was made to NHS England in June 2016, in line with national requirements. As June submissions were very early drafts, NHS England requested that they were not made public at that stage, but a summary of our early thinking has been shared online and forms our presentation pack for this meeting. The final draft – which will remain an iterative document for discussion with local stakeholders and the public – will be submitted in October 2016. The final document will be similar in essence to the June submission, but is likely to be more specific about financial modelling, whole system working and our approach to the configuration of acute hospital sites.

Leadership and governance

STPs are a partnership between commissioners and providers, working with their local authorities. Our governance reflects this. **Decisions are made by CCG governing bodies and provider trust boards, based on recommendations from our programme board, clinical board and collaborative leadership group.**

Day to day management of the STP process rests with a small leadership team:

- Kathryn Magson – SRO for STP and Chief Accountable Officer for Richmond CCG
- John Goulston – Provider Lead – Chief Executive of Croydon NHS Hospitals Trust
- Kath Cawley – STP Programme Director
- Ged Curran – Local Authority Lead and Chief Executive of the London Borough of Merton.

Local authority leaders and CCG Chairs meet on a quarterly basis in the Collaborative Leadership Group, which is the key partnership forum between local authorities and the programme.

The programme has eight clinical working groups, covering different clinical areas, all of which include more than one patient and public representative. These representatives meet on a quarterly basis and the programme also has a dedicated Patient and Public Engagement Steering Group, which advises us on all aspects of our public engagement.

Content of draft STP

The attached slides summarise content of the June submission. It is important to note that the October submission is still being drafted and is likely to update the initial STP significantly.

The key planks of our STP are likely to remain in place:

- A whole system approach based on collaboration between and across commissioners, providers and local authorities
- More care delivered outside hospital in community settings
- An expansion/transformation of primary care
- Proactive, preventative care based on keeping people well and early intervention
- Parity of esteem for mental and physical healthcare
- The need to consider the best configuration of our acute hospitals and of specialised services in south London.

However, we have carried out further work to improve the estimated savings and further close the financial gap and this will be reflected in the submission. We have also looked in more detail at the question of acute hospital configuration through the lenses of clinical pathways, finance, workforce, and deliverability.

Public engagement

The NHS has been talking to the public and stakeholders about the challenges facing local services for several years. In 2015, we published an Issues Paper setting out the challenges and asking local people and organisations for their views. Large-scale deliberative events were held in each of our six boroughs to discuss these issues and all feedback has been recorded and published. We will shortly publish our response to this feedback, which has informed our thinking on the STP . We also commissioned an Equalities Analysis, to look at how changes to services might impact on groups listed as having protected characteristics under the Equality Act 2010.

During 2016, we have continued to engage with local people on these issues.

- In May, we wrote to **over 1,000 local organisations, sharing emerging thinking on the STP** and asking for their feedback, also offering to attend local meetings to talk through the issues.
- We launched an extensive **grassroots engagement programme** in partnership with local Healthwatch organisations. This programme sponsors enjoyable activities for local grassroots organisations, during which the NHS has a slot to talk to local people about health services and the issues raised in the STP. To date, around 27 events

have been held across all boroughs and extensive feedback has been gathered, with a similar number being planned over the remainder of this financial year.

- We published a **summary of the draft STP online** and again shared this with all of the organisations on our database for comment. We again offered to speak to local groups who wish to discuss the STP further.
- Our Patient and Public Engagement Steering Group has continued to meet and to advise us on all elements of public engagement, while all of our clinical groups, our programme board and our clinical board have patient and public representatives.
- We are now working with local authority communications teams to develop bi-annual **Health and Care Forums in each borough** – this will be a means of continuous engagement with local people on the issues raised by the STP and our developing strategy.

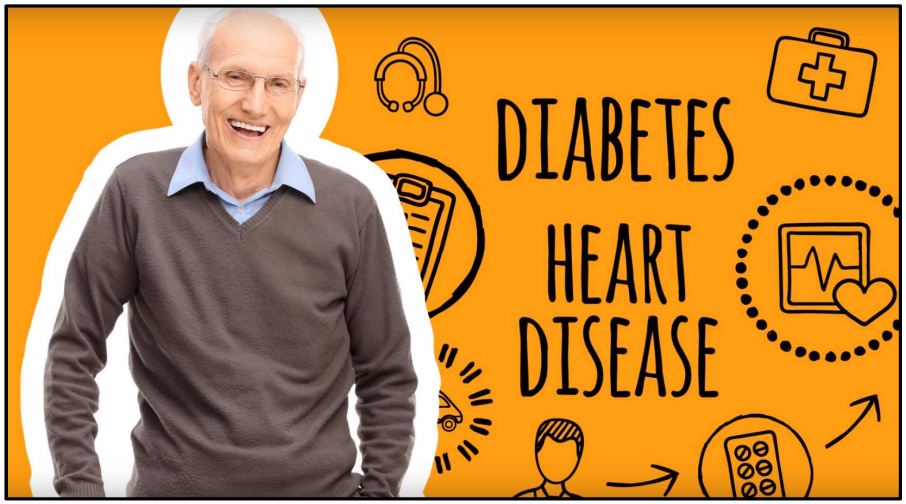
The next steps

When the final draft STP has been submitted, we will undertake further public and stakeholder engagement, as we seek to develop our plans on an iterative basis, in partnership with local authorities and local people. The proposed Health and Care Forums will be one step in this, as will a programme of social media engagement and further attendances at local meetings. We will produce regular 'You Said We Did' updates, summarising all feedback received and our response to it.

Should the STP lead to proposals for significant service change at any of our hospitals, we would hold a full public consultation on these. Current timescales suggest that if public consultation is required, it would take place during 2017.

This page is intentionally left blank

South West London Collaborative Commissioning



Page 11

Our five year forward plan for south west London

Start well, live well, age well

Croydon, Kingston, Merton, Richmond, Sutton and Wandsworth NHS Clinical Commissioning Groups and NHS England

'Working together to improve the quality of care in South West London'

About our five year forward plan

- Following the NHS Five Year Forward View, all regions of the NHS in England are required to produce five year Sustainability and Transformation Plans (STP)
- Our plan is the product of genuine collaboration between all NHS commissioners and providers in SW London, working with our six local authorities and GP federations
- An initial draft was submitted to NHS England on 30 June - now undergoing assurance from NHS England
- Full draft STP will be shared following assurance and further public and stakeholder engagement will take place. Next draft due to be submitted to NHS England in October 2016

Page 12

We are clear about the challenges we face

- We have a life expectancy gap of 9.4 years from most affluent areas to most deprived.
- Our population is growing and ageing, with increasingly complex mental and physical healthcare needs – we need to do more to help people live healthy, independent lives for as long as possible
- Services in SWL are not set up to achieve this. Too often people are admitted to hospital in an emergency or to inpatient mental health beds when they could have been treated earlier or elsewhere and not needed to be in hospital
- Quality of care varies enormously across SWL depending on where and when patients access services
- None of our acute hospitals meet all of the London Quality Standards for acute urgent and emergency care and we over-rely on agency staff to support acute services
- These pressures on the NHS are compounded by cuts to local councils and social care budgets
- As a result of these pressures, the cost of providing care are rising far quicker than inflation and the money we are allocated

Page 13

Our principles

- Doing nothing is not an option – we need to act now to improve standards and outcomes for people in south west London, whilst making sure services are clinically and financially sustainable

- Our draft plan sets out how we can work together across south west London to support people to keep healthy and well – and to intervene early and deliver the right care in the best place to support them if they do become unwell

- To do this we propose to shift more care from hospitals into the community, so we can provide care that is closer to home, tailored to people's individual needs and supports them to stay as well as possible for as long as possible

- We will work with local people and organisations across south west London over the next few months to develop a detailed plan for high quality, sustainable services for our population

Page 14

The SWL Vision

Our Mission

To help South West London's residents to

Start well, live well, age well

Our Vision

People live longer, healthier lives. They are supported to look after themselves and those they care for. They have access to high quality, joined up health and care services when they need them that deliver better health outcomes at a lower cost of provision to the system

Service Design Principles

1. Care is patient centred & holistic

- Inclusive & recognises the role of family, friends, communities & voluntary organisations
- Joined up and crosses organisational boundaries, encompassing people's physical, mental and social care needs
- Easy to navigate

2. Care is proactive & preventative

- Focussed on enabling people to stay well and avoid healthcare instances
- Prioritises early detection – people have access to early support mechanisms
- Promotes self management – people are encouraged to take responsibility for their healthy lives

3. Care supports the quality of life and the outcomes people value

- People are supported to live life as fully as possible for as long as possible
- People are aware of the choices available and have greater control

4. Care is financially sustainable

5. Our staff and care givers feel supported and able to do their roles

Service Development Principles

1. We focus on **better health outcomes at lower cost of provision to the system**

- We work in partnership across all health and social care organisations including the third sector to design and deliver the solutions
- We make better use of resources, irrespective of the organisation
- We plan for a changing environment

2. We will rapidly adopt **evidence based care** (where possible)

3. We maximise the use of **digital technology,** for the benefit of all stakeholders

Page 15

The three big challenges we need to meet

Gap 1: Improving health and wellbeing

- Growing and **ageing population**, but also an unusually **young population**.
- **Inequalities** with pockets of deprivation that are linked to poorer health and wellbeing outcomes
- **Prevention in early years** could be improved (focus on childhood obesity)
- The number of **people living with dementia** is rising and embedding high quality dementia care into services is key.

Developing cross partner prevention plans
The development of this plan has been welcomed as an opportunity to improve collaboration between the NHS and local authorities.

Gap 2. Improving care and quality

Our care and quality base case demonstrates:

- We are failing to meet minimum standards for acute urgent and emergency care
- More could be done in the community to reduce the amount of care delivered in hospitals
- We can do more to improve the quality of general practice
- We are not consistently meeting the needs of people who have mental health needs or dementia

Underlying factors
Two main factors underpin these gaps in the quality of our services:

- The lack of an available workforce to provide safe, effective care in the existing configuration of services
- The provision of preventative and proactive care, including primary care and services supporting earlier discharge from hospital, is inadequate.

Page 16

Gap 3: Improving finance and efficiency

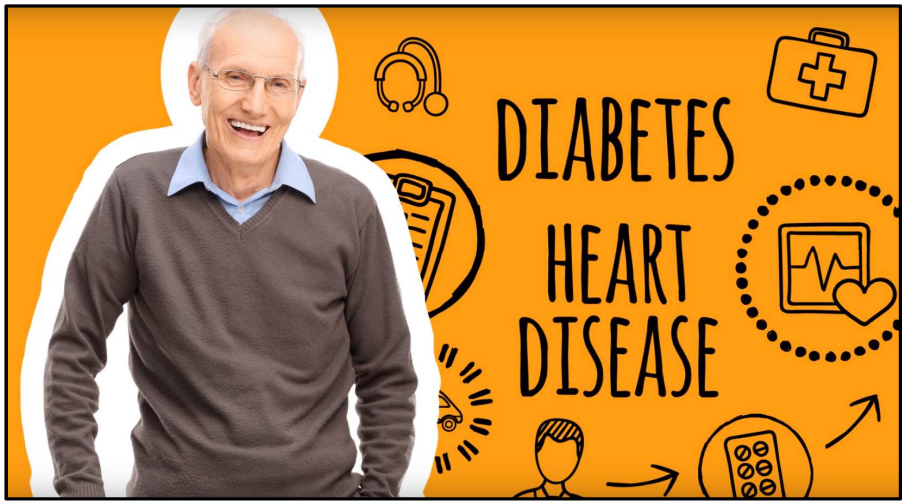
- The cost of delivering services is rising much faster than inflation due to rapidly increasing demand; this is creating a financial gap which will make current services unaffordable by 2020/21 if we do not make changes now.
- Our initial analysis suggested that if we do nothing, the financial gap in five years would be £900m.
- We believe that making changes to the way in which services are delivered can deliver changes that improve the quality of care as well as making services more cost-effective to the taxpayer.

Our draft plan suggests we should:

- Set up locality teams across south west London to provide care to defined populations of approximately 50,000 people. The teams would align with GP practice localities and have the skills, resources and capacity to deliver preventative health and support self-care
- Address both mental and physical needs in an integrated way, because we know this improves the wellbeing and life expectancy of people with severe mental illness and reduces the need for acute and primary care services for people with long term conditions
- Introduce new technologies to deliver better patient care (e.g. virtual clinics and apps)
- Use our workforce differently to give us enough capacity in community, social care and mental health services to bring care closer to home and reduce hospital admissions
- Make best use of acute hospital staff through clinical networking and/or consolidating activity on a smaller number of sites
- Review our acute hospitals to ensure that we meet the changing demands of our populations and to ensure that acute providers deliver high quality, efficient care.

Page 17

South West London Collaborative Commissioning



Page 18

Summary of suggested changes

Start well, live well, age well

Croydon, Kingston, Merton, Richmond, Sutton and Wandsworth NHS Clinical Commissioning Groups and NHS England
'Working together to improve the quality of care in South West London'

Prevention and early intervention

- We need to better support people to live healthy, active and independent lives for as long as possible: this includes advice and support to stop people getting ill and to help patients to manage their long term conditions
- Where people do get ill, we need to ensure they are diagnosed and supported at an early stage
- Mental and physical health issues must go hand in hand: support for people with long term conditions like diabetes, medically unexplained symptoms and chronic pain should take into account mental as well as physical health needs
- We need to do more to identify people at risk of developing long term conditions and use modern technology and a modernised workforce to develop proactive care to support them at home and in the community
- Much closer work between the NHS and local authorities, who provide social care, is critical to supporting the prevention agenda
- Modern technology can support the prevention agenda – e.g. online, apps and text-based services, Skype consultations
- We need to improve the uptake of health checks

Page 19

Transforming access to outpatients

- We want to deliver more consistent outpatients services across SWL, stop patients having to attend unnecessary appointments and bring outpatient care closer to home
- We aim to stop unnecessary follow-up appointments by only providing annual reviews when clinically necessary, ideally in a primary care setting, stopping automatic follow-up appointments and making it easier to be re-referred
- We want to reduce variation between GP practices by expanding the use of referral management systems, setting up one-stop clinics and standardising protocols in our diagnostic services
- Better use of technology – eg Skype or telephone appointments, remote monitoring via smartphone apps, online services (eg for sexual health), better sharing of information between GPs and hospitals, text reminders for appointments
- More community-based clinics (e.g. musculoskeletal and dermatology), upskilling primary care work force to support community-based care, more ambulatory care in the community.

Page 20

New models of care

- **Maternity**: Support women's choice in place of birth, increasing availability of home births and midwife-led care. Safe an sustainable hospital services for women who need obstetric-led care. More personalised antenatal and postnatal care, including reviewing consistency of carer and provision of perinatal mental health support.

- **Children's services:** Most children who are unwell should be treated in primary care and the community; better access to and availability of community-based care will reduce the need for hospital attendances. Children who need hospital care for a short period to be assessed, observed and treated in paediatric assessment units sitting alongside A&Es. Quick access to specialist inpatient care for the small number of children who need it. Increased networking between hospitals and between GPs/primary care and hospitals.
- **Urgent and emergency care**: An integrated service which achieves the core standards is a high priority. 24/7 integrated urgent care access, treatment and advice via an improved 111 service. Priorities include mental health crisis care, self-care support and 'see and treat' models for London Ambulance Service.

Page 21

New models of care (2)

- **Ambulatory emergency care (AEC)**: Treatments such as deep vain thrombosis or cellulitis are delivered in hospital but need not require hospital admission. AEC provides timely treatment and improved experience for patients, avoiding unnecessary admissions. All 6 CCGs have signed up to further delivery of AEC. We also need to improve support outside hospital for people with mental health conditions, who are three times more likely to attend A&E at present.

- **Care for the frail elderly:** We want to improve care in the community for frail older people, building on existing work, for example in Croydon where acute hospitals work with other NHS and social care providers to support older people. We might consider converting parts of our acute sites to provide specialist elderly care. We know more older patients could be treated in the community, including dementia patients as well as those being treated in acute hospitals.

Page 22

Primary care

- **Locality teams** to be set up across SWL to support defined populations of approx. 50,000: role will be prevention/public health, early intervention, working closely with the voluntary and community sector, aligning with GP localities and supported by GP federations. There will be a single point of access for professionals.
- Commitment to **accessible, coordinated and proactive** primary care
- **Investment** in primary care will be higher than baseline core contract allocations, to cover cost of developing primary care hubs, continued federation development and increased workforce costs
- **Community Education Provider Networks** (CEPNs) to deliver a range of training to practice staff
- More **Care Navigator** roles; explore recruitment of practice-based clinical pharmacists, mental health therapists and others
- **Sutton Care Home Vanguard** rolled out across SWL
- **GP federations**: 6 established and have formed a collaborative. Kingston & Wandsworth already have contracts in place (eg diabetes, ophthalmology, dermatology and musculoskeletal outpatients); Richmond has 8am-8pm GP access 7 days a week

Page 23

Acute hospital services

- We want to improve quality and optimise our workforce, in particular meeting the **London Quality Standards** (LQS). Since LQS were introduced, there has been more emphasis on multi-disciplinary teams and drawing on skills of a wide range of staff, so there may be other ways of delivering the outcomes the LQS aim for.

- We need to make the best use of clinicians, increasing **clinical networks** across the trusts OR **consolidate services** on a smaller number of sites.

- We are considering a shared cancer centre, pooling the resources of St George's, Epsom, St Helier and Royal Marsden. We would only look to move routine cancer surgery , with Kingston and Croydon to a new centre if this would deliver demonstrably better outcomes.

- Every hospital does not have to provide every service. We will explore which services are provided on each site and how we might use clinical networks, get remote support from specialists or a lead site providing shared cover at quiet times.

Page 24

Page 24

Acute hospital services (2): specialised commissioning

- NHS England has announced a review of specialised services in south London
- We will work with south east London, NHS England and all stakeholders across both areas (providers trusts, CCGs, local councils and the public) as this develops
- South London has some similar services being provided in close proximity – need to consider long term sustainability of specialised services at Guy's and St Thomas', King's College Hospital and St George's. Other providers such as Epsom & St Helier will also be involved in the review.
- Four projects are in development: children's oncology, neuro-rehabilitation, HIV services and Tier 4 child and adolescent mental health services. Work also underway to address local challenges in cardiovascular care and haematology. Cancer was agreed to be out of scope as it was important to follow through on existing proposals
- Formal governance structures being developed for all specialised commissioning across London, including creation of a Specialised Commissioning Planning Board
- Collaboration expected between specialist mental health providers in south London (South London and Maudsley, Oxleas and SWL & St George's) to transform adult secure services

Page 25

Acute hospital services (3): hospital configuration

- Demand for services is likely to increase by 2020/21, so we need to plan for this. Moving more care into the community will offset growth in demand to some degree: intermediate beds can be delivered in a range of ways in different places. Changes to specialised commissioning may potentially impact the numbers of beds needed in SWL

- All our hospitals have areas of estate that need improvement and investment. St Helier is not currently compliant with modern standards for safe and high quality care and St George's has significant estate problems requiring investment.

- We are awaiting the modelling of bed numbers, the specialised commissioning review and further info on estates costs at St George's before deciding whether we need to consider potential scenarios for configuration of acute sites.

- Transformation of services outside hospital would be a major consideration if acute hospital reconfiguration was proposed; any major service change would also subject to public consultation.

Page 26

Page 26

Estates

- Fundamental change is needed in the way we manage SWL health and social care estate
- New models of care will increase primary care provision location of acute and mental health services in primary care/community settings
- 20 multi-specialty community hubs providing an integrated range of services – mainly through repurposing existing premises where possible, with small amount of new build
- Future acute estate will depend on bed audit/bed volumes, future configuration and review of specialised services
- We are working with local authorities and across the local NHS to develop an Estates Strategy for south west London

Page 27

Workforce

- We need to develop our health and social care workforce across organisational and clinical boundaries, delivering integrated, patient-centred care that is high quality and value for money
- 25,000 NHS staff and 32,000 in social care. Over 18,000 of NHS staff work min acute sector and only 2,500 in community settings. Without improved recruitment and retention, demand will outstrip supply
- National shortage of qualified staff such as GPs, nurses and paediatricians. Currently over-reliant on agency staff. Some staff roles likely to change as services are delivered differently.

Four core priorities to develop our workforce:

- Securing sustainable workforce and improving recruitment and retention
- Capacity and skill mix
- Working differently
- A healthy workforce

Education and training is a key enabler running across all priorities. We will work with local academic institutions/education providers to ensure sustainable workforce and right competencies.

Page 28

Page 28

Delivering an information revolution

- Technology is a critical enabler for many of the recommendations set out in our draft plan. It is critical that clinical information about patients follows them between different health and social care services
- **Self-care** for patients can be supported by digital technology, enabling patients to get information about their condition, or provide information such as their record, to help them make informed decisions about managing their health
- Technology such as **video conferencing** can help break down barriers between patients and clinicians and help clinicians get rapid specialist input when needed
- **Information sharing** which combines clinical, operational and financial data can help us take a 'whole system' approach to improving the way services are delivered
- **Digital technology** should be available to all clinicians and care professionals when they need it
- There are pockets of good practice already in SWL: these will need to be expanded significantly if we are to achieve our ambitions

Page 29

Closing our financial gap

- By organising services better and delivering the initiatives set out in our plan, we can close our financial gap with **no reduction in the quality of care**
- An audit of acute hospital beds suggests that we could substantially reduce the number of days people spend as inpatients by delivering improved models of care
- By changing outpatient services, we could reduce unnecessary appointments by 20%
- By reducing the use of procedures which have limited clinical effectiveness, we could reduce elective surgery by 13%
- Programmes to increase acute provider productivity by sharing non-clinical 'back office' functions are underway: areas being looked at by hospitals include procurement, a shared staff bank, reduction of corporate and administrative costs and more efficient management of our estates
- CCGs have also identified that they can make significant savings by working together more closely, including sharing 'back office' functions internally and with providers or councils.
- Pharmacy teams across SWL are working together to identify opportunities for medicines-related savings: for example by reducing use of medicines that are less clinically effective or significantly more expensive than alternatives

Page 30

Involving local people

- We published an Issues Paper in 2014 which was widely distributed across SWL and discussed at large scale events with the public and stakeholders in each borough – feedback from these informed our five year forward plan
- In May, we wrote to over 1,000 local voluntary, community and campaigning organisations in SWL setting out our emerging thinking and asking for their views – these views were considered as our plan was being developed
- All feedback received to date and our response to it will be published shortly. We will produce regular 'You Said We Did' reports summarising feedback received and our response
- We plan further public events later in 2016, where we will discuss the content of our draft plan and seek people's views
- We are running a large grassroots engagement programme with local Healthwatch organisations, leading to 7-10 events in each borough for groups whose voices are seldom heard. The feedback will continue to inform our thinking
- Patients and the public are directly involved in each of our clinical workstreams and we have a Patient and Public Engagement Steering Group which oversees our public engagement

Page 31

Our plan for the next six months

- Our initial draft plan (STP) was submitted to NHSE at the end of June 2016
- Once national assurance is complete, the final plan will be published and further public engagement will take place
- We anticipate a series of public events in the autumn, which will help inform the next iteration of our plan
- Should any proposals emerge that require public consultation we would envisage this would take place in late 2017
- A number of plans are already underway – for example plans to improve primary care, better preventative care, a more joined up approach between services and development of a SWL Estates Strategy.
- Further modelling work, further information and further public engagement will be needed before we can finalise our strategy.

Page 32

SOUTH WEST LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE - 11 OCTOBER 2016

Proposal for the adoption of a joint protocol on consultation on health service changes in South West London

SUMMARY

Attached to this paper is a draft protocol setting out standards and process for consultation on changes in health services. It is intended for use by NHS bodies, Healthwatches and local authority scrutiny committees across South West London. This protocol is subject to revision in the light of comments from South West London Collaborative Commissioning, and it is therefore presented for information as 'work in progress'. Members are invited to comment on this draft.

RECOMMENDATIONS

1. Members of the Joint Health Overview and Scrutiny Committee are requested:
   (a) to note the work being undertaken on the development of a protocol on consultation on NHS changes; and
   (b) to comment on the draft protocol attached as Appendix A.

INTRODUCTION

2. Earlier this year, the majority of health scrutiny committees in South West London have gave some consideration to proposals from St George's University Hospitals NHS Foundation Trust for change to its urogynaecology service. There is acceptance from all parties that the consultation on these changes was not well handled. The problems with the process included the following:
   (a) Scrutiny committees were not notified at the correct time of the suspension of the service on safety grounds;
   (b) There was no formal discussion as to whether or not the change was 'substantial';
   (c) There was a lack of clarity over commissioner and provider responsibility for the consultation;
   (d) There were unclear expectations about the extent and duration of consultation required, resulting in an initial proposal for an unrealistically short consultation period, with subsequent multiple extensions;
   (e) There was a lack of clarity about which OSCs should be consulted, with just Wandsworth being consulted in the first instance, with other OSCs being consulted only after they had been contacted by campaigners against the proposals.

3. The net result was that reaching a final decision on the proposed change was significantly delayed, yet there remained a feeling amongst those affected by the proposal that consultation had been inadequate. In view of this, Wandsworth Council's Adult Care and Health Overview and Scrutiny Committee agreed:

Consultation protocol

(a) That officers engage in discussion with the Trust and with Wandsworth Healthwatch with a view to develop agreed principles that should govern the Trust's approach to consultation with the public and its partners, for use should the Trust wish to propose other significant service changes in future; and

(b) That officers seek the views of the neighbouring Councils whose residents would also be patients at St George's Hospital, to ensure that the proposed protocol for managing of consultations was acceptable to all the relevant Health Scrutiny committees.

PROPOSED PROTOCOL

4. The attached protocol is a product of this process. It has been developed with input from Scrutiny Officers from across South West London. It sets out a process to be followed in determining the appropriate consultation process to be followed, and is accompanied by a note prepared by Wandsworth Healthwatch covering good practice in consultation and engagement, a 'trigger template' developed by Southwark Council, which collates the information relevant to deciding if formal consultation is required. And a flow chart summarising the key decision points.

5. It has been shared with South West London Collaborative Commissioning, which has strongly endorsed the principle of adopting a protocol but, on behalf of NHS organisations across South West London, has raised a number of questions about the proposed wording. It should therefore be regarded as 'work in progress' rather than the finished article.

CONCLUSION

6. Members are invited to review and comment on the attached draft protocol.

Town Hall
Wandsworth SW18 2PU

3rd October 2016

Richard Wiles
Health Policy Team Leader
Wandsworth Borough Council

Background papers

No background documents were relied upon in the preparation of this report

Consultation on changes in health care: proposed South West London protocol

Introduction

Change in health services is unavoidable and necessary. In broad terms, three levels of change may be identified:

- Minor changes that are undertaken as part of routine management in order to address identified problems or bring about service improvements. For such very minor changes, it is unlikely that any specific consultation or engagement process will be required;
- Changes that go beyond routine management but are still relatively minor in nature. For such changes, engagement with service users and other stakeholders may be necessary, but a formal consultation process is unlikely to be required;
- Changes involving a substantial reconfiguration of services, on which there should be formal consultation in accordance with the relevant health scrutiny regulations.

The purpose of this protocol is to assist local agencies in agreeing into which category a proposal falls, and in setting out the process to be followed in undertaking a formal consultation, including management of joint scrutiny where a proposed change affects residents from more than one borough. It does not, however, provide a detailed set of instructions to be followed in all cases, and its value is dependent on the exercise of common sense and the readiness of all parties to agree a proportionate approach.

Preparing the ground

For this protocol to be effective, it must be underpinned by good ongoing communication between those responsible for commissioning and providing health care and the bodies responsible for scrutinising and commenting on health services on behalf of patients and the public. Providers and commissioners should share plans and proposals with officers of Healthwatches and local authority scrutiny bodies at an early stage in their development, so that informal discussions on likely consultation requirements can take place before a proposal for change is fully formulated. Where such informal information sharing is undertaken in confidence, this must be respected by the Healthwatch or local authority scrutiny body.

Where a proposal for change goes beyond routine management, engagement with service users and other stakeholders will be required. The guidance attached as Appendix One, prepared by Wandsworth Healthwatch, sets out good practice in this. This engagement process should commence at an early stage, potentially before the proposed change has been fully formulated or endorsed, and the results of such early engagement may help to inform the decision on whether there is a need for formal consultation.

Determining the need for formal consultation

The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 set out specific requirements for consultation with local authorities over substantial developments or variations of health services.

The stage at which such consultation should take place is when specific proposals for change have been developed. Broader plans setting out overall ambitions and intended direction of change should be subject to wide engagement and informal consultation, but they will generally lack the detail that local authorities are looking for in this formal consultation process.

There are three specific exclusions from the requirement for consultation on substantial change:

- Where the relevant NHS body or commissioner is satisfied that the change needs to be made urgently in the interests of patient or staff safety or welfare. In these circumstances, the local authority must be notified as soon as possible of the change and why consultation was not undertaken;
- Proposals for dissolution or changes to the constitution of NHS Trusts or CCGs (unless these also involve substantial changes to health services);
- Proposals in a report from a trust special administrator (put in place by the Secretary of State where a trust is in financial difficulties, as these will be dealt with under separate consultation arrangements.

The term 'substantial' is not defined in the regulations or the subsequent (2014) health scrutiny guidance. However, the guidance commends the development of protocols between local authority scrutiny bodies and their NHS counterparts to assist in deciding whether a change should be considered as 'substantial'.

Where such protocols exist, they generally refer to the four factors presented in the 2003 Health Scrutiny Guidance as 'to be taken into account' in determining if a change is substantial:

a) **changes in accessibility of services**, for example both reductions and increases on a particular site or changes in opening times for a particular clinic. Communities attach considerable importance to the local provision of services, and local accessibility can be a key factor in improving population health, especially for disadvantaged and minority groups. At the same time, development in medical practice and in the effective organisation of health care services may call for reorganisation including relocation of services. Thus there should be discussion of any proposal which involves the withdrawal of in-patient, day patient or diagnostic facilities for one or more speciality from the same location;

b) **impact of proposal on the wider community** and other services, including economic impact, transport, regeneration;

c) **patients affected.** Changes may affect the whole population (such as changes to accident and emergency), or a small group (patients accessing a specialised service). If change affects a small group it may still be regarded as substantial, particularly if patients need to continue accessing that service for many years (for example, renal services);

d) **methods of service delivery**. Modernisation of provision usually involves changed methods of service delivery, and such changes can normally be

considered as routine management interventions. However, changed methods might contribute to a service change being viewed as substantial. Relocation of a service from hospital to the community, having roles formerly undertaken by doctors being transferred to nurses, or replacing face to face interactions with on-line services might all be seen as significant by patients. Consideration should be given as to whether they might have an impact on the accessibility or acceptability of the service, either to service users as a whole or to particular population groups.

Whilst the 2003 guidance is no longer current these criteria still appear relevant and the current guidance does not suggest any alternatives.

The variety of circumstances that may apply is such that there is little value in attempting to define thresholds that will determine whether or not a variation is or is not to be regarded as substantial. However, the following observations may be made:

a) case law generally suggests that the threshold for a consultation to be considered as 'substantial' is relatively low, with judges usually upholding the duty to consult formally where there was a legitimate case for this;

b) that if the responsible NHS body declines to undertake consultation on a change that the local authority considers substantial, the local authority is entitled to refer the matter to the Secretary of State on the grounds of inadequate consultation.

Thus, it is suggested that, in determining whether or not a change should be considered substantial, the default position is that the views of the local authority should prevail, provided that they can be justified in reference to the four criteria set out above.

Individual changes in services are often part of a wider process. Where interdependent changes are proposed, it will usually be best for these for these to be addressed in a single consultation, with consideration of whether the change is substantial being applied to the overall package rather than to each individual change. An example might be a group of service moves across a Trust's estate. In this case, the consideration would be as to whether the overall reconfiguration package represented a substantial change, rather than whether this was the case for each individual move.

In reaching a decision, the views of actual service users and the local population will be very significant for the local authority scrutiny body. Prior engagement and informal consultation with those likely to be affected by a change is thus likely to be very helpful in deciding whether or not it should be regarded as substantial. Without such prior engagement, the scrutiny body will necessarily adopt a precautionary approach, regarding the change as substantial unless there is strong evidence to the contrary. This means that the decision on whether a change should be treated as 'substantial' will not necessarily be taken when it is first proposed, but the need for consideration of whether or not a change is substantial and for the formal consultation processes associated with a substantial change should be considered in drawing up a timetable.

Collating the information

When a responsible NHS body (NHS Commissioner or provider with sign-off by NHS Commissioner) has in mind a proposed service change that goes beyond business

as usual and might reasonably be considered a substantial change, they will complete the 'Trigger Template' attached as Appendix Two, which is designed to bring together the information that local authority scrutiny bodies will require in deciding whether or not formal consultation is required.

In preparing this information sheet, it may be helpful for the commissioner and provider to meet and discuss the issue with the health scrutiny officer and Healthwatch co-ordinator for the borough most directly affected, although this is not a mandatory part of the process.

This information sheet will be shared with the lead officers responsible for health scrutiny in each of the boroughs from which patients are drawn.

Reaching a decision

If the NHS body itself believes that the change is substantial and formal consultation is required, then formal consultation procedures will be implemented and no decision is required from the local authorities.

Where the NHS body is uncertain or believes that formal consultation is not necessary, the final decision will depend on response from the local authorities. Within two weeks of receiving the information sheet, and following consultation as necessary with the elected member responsible, each scrutiny officer will give one of the following four responses:

a) The change is definitely substantial and formal consultation is required;

b) The change is not substantial and formal consultation is not required;

c) The issue is marginal and would need to be referred to the full scrutiny committee for a decision;

d) Further information is required before the local authority can reach a decision.

The response will be supported by an assessment of the proposal in relation to the four decision-making criteria set out above.

The majority of hospital-based acute services in South West London, especially those provided by St George's, serve patients from more than one borough. Each borough is entitled to make a decision as to whether a proposal represents a substantial change for its residents, and no borough has the power to impose its view on other boroughs.

Where all boroughs are agreed that the change is substantial (or just one borough is affected and it considers the change substantial), then the NHS body will be expected to accept this and move to formal consultation.

Where all boroughs are agreed that the change is not substantial (or just one borough is affected and it considers the change is not substantial), then formal consultation is not required and the NHS body will be expected to undertake an appropriate level of informal consultation and engagement on the proposal, in accordance with the locally agreed guidelines on good practice in consultation.

Where at least one borough considers that the issue is marginal, or that further information is required before it can make a decision, the NHS body should seek to provide any further information that is required to enable that authority to reach a decision.

As each borough will reach its decision independently, it is possible that different boroughs will reach different decisions as to whether or not a change is substantial. This carries with it the risk of perverse results, where the borough with the highest number of patients decides that a change is not substantial, but one with a smaller number of patients concludes that it is.

Where there is a disagreement between boroughs, it will be the responsibility of the scrutiny officers from the relevant boroughs to arrange for discussion between elected members from their boroughs (which could be face to face, by telephone or by e-mail) with the aim of agreeing a common position. If further information is required to enable the local authorities to reach a consensus, the NHS body should endeavour to provide this. If a consensus is reached on the need for formal consultation, the NHS body will be expected to abide by this.

Where a common position cannot be agreed, the default is that a change will be treated as substantial if any borough considers it to be so and is able to justify its view in relation to the four decision-making criteria. If the NHS body still believes that the change is not substantial, it is entitled to opt not to undertake formal consultation but, in doing so, it will face a risk that any local authority considering the change substantial will refer the matter to the Secretary of State on the grounds of inadequate consultation and it may face a legal challenge.

In the event of a disagreement between boroughs (including instances where at least one borough considers that there is uncertainty over whether or not a change is to be considered as substantial) it remains open to the NHS body to decide to proceed to formal consultation without waiting for a final local authority decision.

Managing the consultation

Where there is consultation on a proposal for substantial change in health services affecting more than one borough, the options for fulfilling the scrutiny role on this consultation may either be undertaken through a joint committee or through one borough taking the lead, with others delegating their scrutiny powers to the lead borough. The local authorities in South West London have established a standing Joint Health Overview and Scrutiny Committee with the power to establish sub-committees constituted so as to respond to consultations affecting more than one borough, meaning that joint scrutiny arrangements on substantial changes can be put in place relatively quickly.

The decision as to whether joint scrutiny arrangements or delegation of responsibilities to a lead authority is more appropriate is one that will need to be agreed between the affected boroughs in each case. In general, where multiple boroughs have reached the conclusion that the change is significant for their residents, then joint scrutiny arrangements are likely to be most relevant. Where only one borough considers the change substantial or the change clearly affects the residents of one borough far more than any other borough, lead scrutiny arrangements are likely to be preferable. However, as no authority can be required to delegate its scrutiny powers to another authority, joint scrutiny arrangements will be required if there is not unanimous agreement on the delegation of powers to a lead authority.

Appendix One

healthwatch Wandsworth

Introduction

The NHS England Effective Service Change - A Support Guide toolkit", published in June 2014 states that: "NHS England will expect **ALL** NHS service change to comply with the Department of Health's Four Test for Service Change".

The Four Tests, as set out in the 2014/15 Mandate from the Government to NHS England are that proposed service changes should be able to demonstrate evidence of:

- Strong public and patient engagement;
- Consistency with current and prospective need for patient choice;
- A clear clinical evidence base;
- Support for proposals from clinical commissioners

In this document we will focus on the requirements around *Strong Public and Patient Engagement*. We will assume that the service changes suggested are based on sound clinical evidence and made in the best interests of patients.

Core value: "The best proposals are characterised by early and on-going engagement through all stages of the process, where communities are involved as partners and in actively developing proposals rather than as passive recipients. Effective engagement both helps to build support for proposals but also ensures that proposal are genuinely shaped around patients' needs". *(*Planning and delivering service changes for patients, December 2013, NHS England*)*.

Service change: There is no single, accepted definition of what constitute "substantial" service change and this is a matter for local agreement. Were a service change is deemed substantial, consultation will need to adhere to the procedures set out in The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 and the detailed guidance set out in the Department of Health Guidance on Local Authority Health Scrutiny. However, the NHS guidance is clear about the need to involve patients and the public in **ALL** service changes. The effort has to be proportionate to the scale and the impact of the changes; however the good practice checklist set out below is intended to be applicable to all consultations irrespective of whether the change is "substantial".

Good-practice Checklist

Before the consultation period starts:

- Be clear about who you are going to involve by mapping your stakeholders and draft an involvement plan and a communications strategy that are integral to the service planning process and appropriate to the scale of the proposed change.
- Key stakeholders will always include the existing users of the service which is about to change and their carers; local communities who are more likely to be affected by the changes; the OSC and Healthwatch.
- Approach community leaders to ask their support in the consultation. Identify upcoming community events and ask to be able to attend them to discuss the changes with the patients. Having strong links and a relationship of trust with local community groups and "gatekeepers" is vital to this process.
- Identify a lead person who is responsible for leading on the delivery of the involvement plan and the communication strategy.
- Identify a senior clinical lead who will make sure that other clinicians are involved in developing the proposals and who is prepared to work with the other staff and stakeholders, including users, throughout the process.
- Plan who is going to make the decisions and what the decision-making process will be at each stage and communicate this to all stakeholders.
- Be clear about what information you need to give people at the start of the process to assist them to engage in the discussions.
- Make sure that you are planning to use a range of appropriate, innovative and creative ways to involve users.
- Think about the timing and the length of a consultation. If over Christmas and New Year or during the summer holidays, add on a couple of weeks and try to avoid times when local or national elections are being held.
- Prepare consultation documents for the different groups of users you will be consulting, for example children aged 5–11 and teenagers and people with learning difficulties.
- If possible, organise engagement events to obtain feedback from stakeholders before the consultation process starts.
- Should the care pathways change as a result of the changes suggested, make sure that the patients as well as the other agencies involved are clear about what to do and expect in the future well in advance of the changes being made.
- Recognise that consultation is a key part of the change process and needs to be given sufficient resources.

During the consultation period:

- The ideal length for a consultation process is 12-13 weeks. However, this may be proportionate to the scale and complexity of the proposal and if meaningful external stakeholder engagement activity pre-consultation has taken place, the consultation process can be reduced to 7-8 weeks.
- Use sensitive language when writing to the users to inform them about the suggested changes. Give users a named person to discuss any concerns they may have.
- Ensure contact details for people to respond are clear and accessible
- Be clear about what points you are asking people to give their views on.
- Use plain English in documents and correspondence and take advice from community leaders about translating written material.
- Make sure that you have effective communications processes in place to respond to and where necessary correct any misleading information that enters the public domain, and to publicise the involvement process
- Have systems in place for capturing and analysing feedback.
- If any pre-consultation engagement has taken place: include in the communication document anything you learned during earlier involvement activity and describe how you considered and have responded to the issues raised during this time.
- Acknowledge every response you receive and explain how this will be analysed and considered.
- Communicate a clear timescale for the decision making process.

After the consultation period:

- Make the outcomes of the consultation publicly available and easy to access within 12 weeks of the consultation, according to the Cabinet Office guidance on consultation.
- Any decision should be based on the best balance of clinical evidence and evidence gained through public consultation, as stated in Planning, assuring and delivering service change for patients, NHS England, 2015
- When communicating your decision, explain how users' feedback has been analysed and considered during the process.
- Should major service changes go ahead, tell users how they will be supported throughout the changes and make sure they feel confident that their care is not going to be adversely affected.

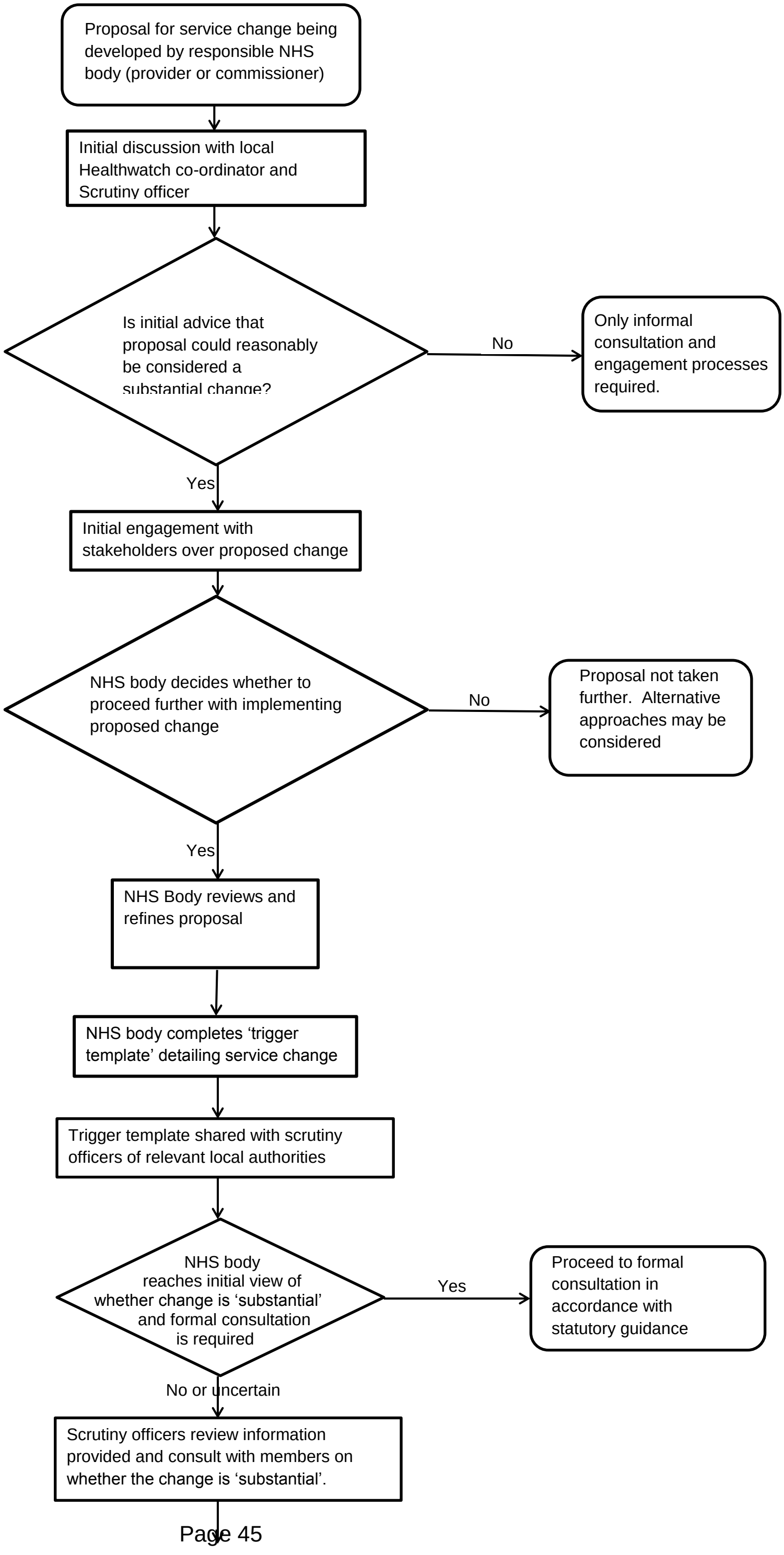
Appendix Two

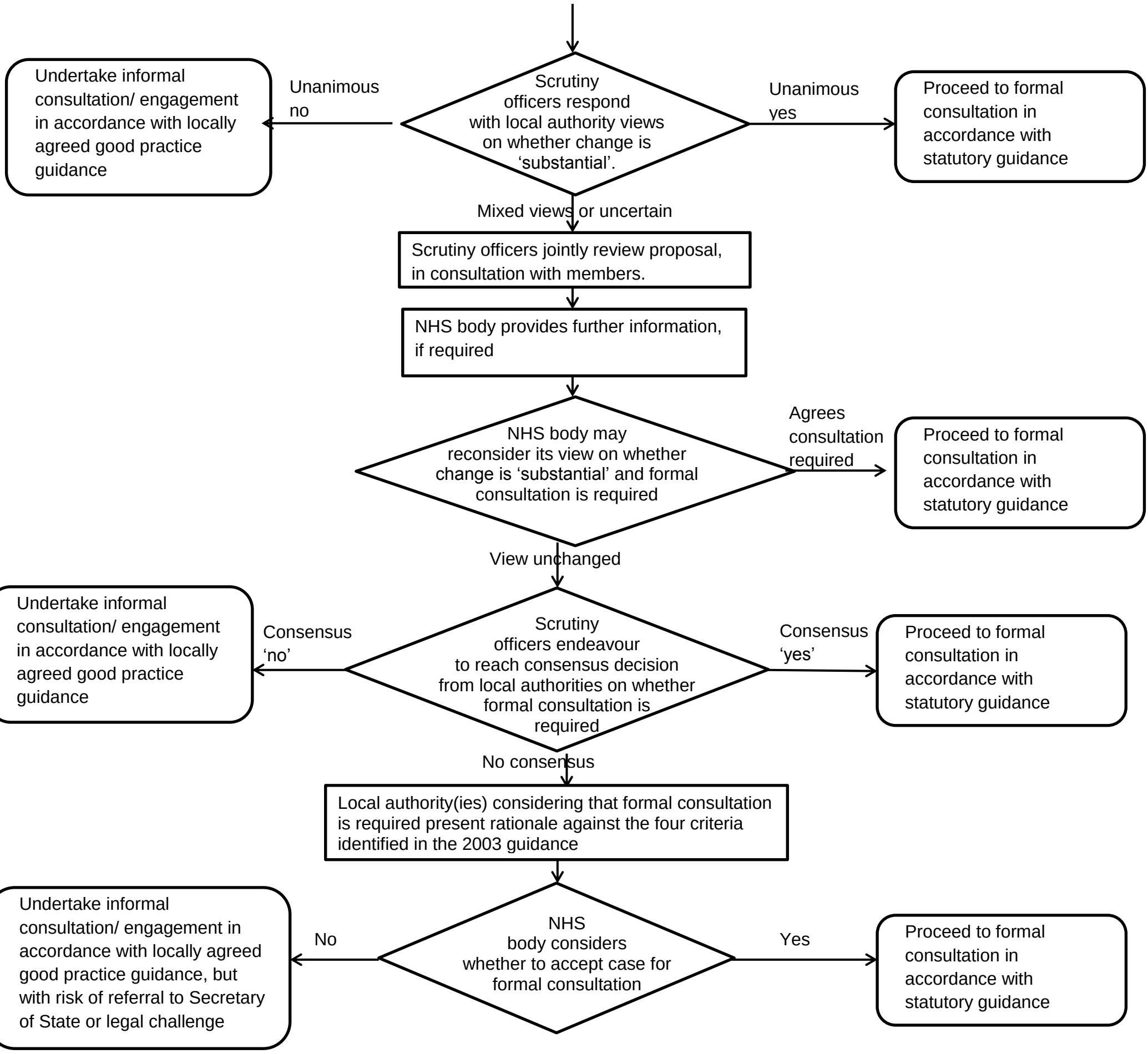
TRIGGER TEMPLATE

NHS Trust or body & lead officer contacts:	Commissioners e.g. CCG, NHS England, or partnership. Please name all that are relevant , explain the respective responsibilities and provide officer contacts:

Trigger	Please comment as applicable
1 Reasons for the change & scale of change	
What change is being proposed?	
Why is this being proposed?	
What is the scale of the change? Please provide a simple budget indicating the size of the current investment in the service, and any anticipated changes to the amount being spent.	
How you planning to consult on this? (please briefly describe what stakeholders you will be engaging with and how). If you have already carried out consultation please specify what you have done.	
2 Are changes proposed to the accessibility to services?	**Briefly describe:**
Changes in opening times for a service	
Withdrawal of in-patient, out-patient, day patient or diagnostic facilities for one or more speciality from the same location	
Relocating an existing service	
Changing methods of accessing a service such as the appointment system etc.	
Impact on health inequalities across all the nine protected characteristics - reduced or improved access to all sections of the community e.g. older people; people with learning difficulties/physical and sensory disabilities/mental health needs; black and ethnic minority communities; lone parents. Has an Equality Impact Statement been done?	

3 What patients will be affected? (please provide numerical data)	**Briefly describe:**
Changes that affect a local or the whole population, or a particular area in the borough.	
Changes that affect a group of patients accessing a specialised service	
Changes that affect particular communities or groups	
4 Are changes proposed to the methods of service delivery?	**Briefly describe:**
Moving a service into a community setting rather than being hospital based or vice versa	
Delivering care using new technology	
Reorganising services at a strategic level	
Is this subject to a procurement exercise that could lead to commissioning outside of the NHS?	
5 What impact is foreseeable on the wider community?	**Briefly describe:**
Impact on other services (e.g. children's / adult social care)	
What is the potential impact on the financial sustainability of other providers and the wider health and social care system?	
6 What are the planed timetables & timescales and how far has the proposal progressed?	**Briefly describe:**
What is the planned timetable for the decision making	
What stage is the proposal at?	
What is the planned timescale for the change(s)	
7 Substantial variation/development	**Briefly explain**
Do you consider the change a substantial variation / development?	
Have you contacted any other local authority OSCs about this proposal?	


Proposal for service change being developed by responsible NHS body (provider or commissioner)
Initial discussion with local Healthwatch co-ordinator and Scrutiny officer
Is initial advice that proposal could reasonably be considered a substantial change?
No
Only informal consultation and engagement processes required.
Yes
Initial engagement with stakeholders over proposed change
NHS body decides whether to proceed further with implementing proposed change
No
Proposal not taken further. Alternative approaches may be considered
Yes
NHS Body reviews and refines proposal
NHS body completes 'trigger template' detailing service change
Trigger template shared with scrutiny officers of relevant local authorities
NHS body reaches initial view of whether change is 'substantial' and formal consultation is required
Yes
Proceed to formal consultation in accordance with statutory guidance
No or uncertain
Scrutiny officers review information provided and consult with members on whether the change is 'substantial'.


Scrutiny officers respond with local authority views on whether change is 'substantial'.
Unanimous no
Undertake informal consultation/ engagement in accordance with locally agreed good practice guidance
Unanimous yes
Proceed to formal consultation in accordance with statutory guidance
Mixed views or uncertain
Scrutiny officers jointly review proposal, in consultation with members.
NHS body provides further information, if required
NHS body may reconsider its view on whether change is 'substantial' and formal consultation is required
Agrees consultation required
Proceed to formal consultation in accordance with statutory guidance
View unchanged
Scrutiny officers endeavour to reach consensus decision from local authorities on whether formal consultation is required
Consensus 'no'
Undertake informal consultation/ engagement in accordance with locally agreed good practice guidance
Consensus 'yes'
Proceed to formal consultation in accordance with statutory guidance
No consensus
Local authority(ies) considering that formal consultation is required present rationale against the four criteria identified in the 2003 guidance
NHS body considers whether to accept case for formal consultation
No
Undertake informal consultation/ engagement in accordance with locally agreed good practice guidance, but with risk of referral to Secretary of State or legal challenge
Yes
Proceed to formal consultation in accordance with statutory guidance