Our Healthier South East London
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NHS

Committee in Common: Draft Minutes

Tuesday 29 November, 09.00 – 11:00
Venue: Imagine 2 Room, London Bridge-Prospero House, 241 Borough High Street London, SE1 1GA
Chair: Paul Minton

Members in attendance

Paul Minton (PM)	Independent Chair
Andrew Bland (ABl)	Southwark CCG CO
Richard Gibbs (RGi)	Southwark Governing Body Member
Jonty Heaversedge (JH)	Southwark CCG Chair
Andrew Eyres (AE)	Lambeth CCG CO
Adrian McLachlan (AM)	Lambeth CCG Chair
Graham Laylee (GL)	Lambeth CCG (for Sue Gallagher)
Martin Wilkinson (MW)	Lewisham CCG CO
Marc Rowland (MR)	Lewisham CCG Chair
Ray Warburton (RW)	Lewisham CCG Deputy Chair
Angela Bhan (ABh)	Bromley CCG CO
Harvey Guntrip (HG)	Bromley Governing Body Member
Jo Murfitt (JM)	Greenwich CCG CO
Ellen Wright (EW)	Greenwich CCG Chair
James Wintour (JW)	Greenwich Governing Body Member
Sarah Blow (SB)	Bexley CCG CO
Nikita Kanani (NK)	Bexley CCG Chair
Mary Currie (MC)	Bexley Governing Body Member
John King (JK)	Patient and Public Voice
Jane Fryer (JF)	NHS England (acting DCO for Matthew Trainer)
Rikki Garcia (RGa)	Healthwatch
Mark Easton (ME)	OHSEL Programme Director

Other attendees:

Rory Hegarty (RH)	OHSEL Communications Lead
Sam Ridge (SR)	OHSEL Communications Team
Jill Mulelly (JMul)	OHSEL Communications Team
Lucy Ing (LI)	OHSEL Communications Team
Tom Henderson (TH)	OHSEL
Deepa Master (DM)	OHSEL
Nick Jones (NJ)	PwC
Chris Williams (CW)	PwC
Paul Brown (PB)	Member of Public
Ian Fair (IF)	Member of Public
Tony O'Sullivan (TOS)	Member of Public
Moh Okrekson (MO)	Member of Public
Eileen Smith (ES)	Member of Public
Sarah Willoughby (SWi)	Member of Public
Olivia O'Sullivan (OOS)	Member of Public
Elizabeth Rylance-Watson (ERW)	Member of Public

Michael Corden (MC)	Member of Public
Philip Lingard (PL)	Member of Public
Bob Skelly (BS)	Member of Public
Russell Cartwright (RC)	Member of Public
Frances Hook (FH)	Member of Public
John Fraser (JFr)	Member of Public
Stephen Warren (SWa)	Member of Public

Apologies:

Andrew Parson (AP)	Bexley CCG Chair
Rosemarie Ramsey (RR)	Lewisham Governing Body Member
Sue Gallaher (SG)	Lambeth Governing Body Member
Matthew Trainer (MT)	NHS England

Actions from previous meeting (23rd June 2016)

ID	Type	Risk / Issue / Action / Decision Description	Owner	Meeting	Due Date	Status	Comments
6	Action	Sarah Blow to circulate updated timeline for stage 2 submission and evaluation process.	Sarah Blow	23 June	23 June	Closed	
7	Action	Programme team to update the following sentence on page 11: *"It was agreed that there will [not] be enough demand for consolidating services across more than 2 sites".*	Programme team	23 June	30 June	Closed	
8	Action	ME to make sure the section on transforming care is included in the STP.	Mark Easton	23 June	23 June	Closed	
9	Action	John King requested a jargon buster is created to address the acronyms.	Programme Team	23 June	29 November	Closed	Available on OHSEL website

Actions from this meeting (29th November 2016)

ID	Type	Risk / Issue / Action / Decision Description	Owner	Meeting	Due Date	Status	Comments
10	Action	Publish updated declaration of interest on the OHSEL website.	Programme Team	29 Nov		Open	
11	Action	Discuss with Providers to discuss the extent to which they can work together as part of the enhanced status-quo (3 site model).	Programme Team	29 Nov		Open	
12	Action	CiC to receive recommendations for the final decision making process taking into account financial criteria.	Programme Team	29 Nov		Open	
13	Action	Share updated Consultation document with PPAG.	Programme Team	29 Nov		Open	
14	Action	RH to add a note to question 5a in the consultation document which outlines the travel support which will be available.	Rory Hegarty	29 Nov		Open	

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1. Welcome and introductions:

1.1 Paul Minton (PM) welcomed the Committee and asked attendees to introduce themselves.

1.2 Mark Easton (ME) highlighted apologies and noted that the quorum was not currently met as an additional member was required from Bromley. It was highlighted that Angela Bhan (ABh) and Harvey Guntrip (HG) would be joining shortly and therefore the quorum would be met. (Bromley representatives joined the meeting when previous minutes were being reviewed and thus the meeting became quorate).

1.3 ME distributed the declarations of interest form. Committee members reviewed the declarations of interest and the following corrections were highlighted:

- Adrian McLachlan (AM) noted that there were some updates for him but that none were material for this group.
- Andrew Bland (ABl), John King (JK), PM, Ellen Wright (EW) and Mary Currie (MC) noted that this version needed to be updated for them.
- Ray Warburton (RW), who was deputising for Rosemary Ramsey, noted he was not included but had nothing which he would need to declare.

1.4 **Action: update and agree a revised declaration of interest, with those who noted changes were needed, and publish on the OHSEL website**.

2. Minutes of previous meeting

2.1 PM ran through the previous meeting minutes. No corrections or changes were raised.

2.2 Mark Easton (ME) went through the previous meeting actions. ME noted that actions 6,7 and 8 had been addressed through updating the STP and Orthopaedic documentation. ME noted in reference to action 9 that there was now a detailed 'jargon buster' available on the OHSEL website.

3. Brief public questions

3.1 PM introduced the section of the meeting dedicated to public questions. PM emphasised the importance of holding these meetings in public and noted that this meeting was specifically focused around Elective Orthopaedic Centres. PM noted that they have received a number of questions in advance and that they will now look to address these. PM noted that any additional questions should be passed to one of the members of the OHSEL communications team, who are sitting in the audience, and can ensure these are answered following the meeting.

3.2 Moh Okrenson (MO) asked the first question relating to an article in the London Metro, on the 21st November 2016, in which the head of the British Medical Association was credited with a statement suggesting that concentrating services at fewer sites was a cover for delivering cuts. The Committee was asked to respond to these claims and reassure the general public that concentrating services, such as elective orthopaedic planned care centres, was not a smokescreen for delivering cuts.

3.3 ME said that there are essentially two directions outlined in the STP, in which services can be taken. The first direction is to pursue, for the more specialised services, whether there are opportunities for centralisation to see if cost reduction and quality improvements can be realised. The second direction is looking at decentralising services through Community Based Care (CBC) and

making more services available locally. ME said that in terms of Orthopaedics the proposal is to increase capacity, increase quality and lower cost and that where these three elements are met there is an argument for centralisation. ME emphasised that it is not about making cuts but ensuring the system is getting the best value out of every pound and taking opportunities to improve quality.

3.4 Eileen Smith (ES) asked the CiC to confirm that there had been no bias towards the two site model and asked where the evidence base is for better outcomes, lower infection rates and cancellations over the last 5 years. ES said that this information was required to enable the public to make an informed choice.

3.5 Jonty Heaversedge (JH) responded that it is really important at this stage that we re-iterate the case for change and the rationale for proposing this change. JH said that within the Pre-Consultation Business Case there is considerable material which outlines information on areas such as cancellation and infection rates. JH said that some of the outcomes data used in the case for change is national (e.g. Getting it Right The First Time - GiRFT) and looks at South East London compared with South West London, where a collective orthopaedic centre is in place. JH said that the Royal Colleges point towards the value of separating out elective and non-elective orthopaedic work and how this has benefits such as reducing cancellations.

3.6 Sarah Blow (SB) added that following the Joint Health Overview and Scrutiny Committee (JHOSC) on the 28th November an action was taken to include more information surrounding this data as part of the consultation documentation.

3.7 Ian Fair (IF) asked whether we can have a full assessment in any consultative document of the option of consolidating inpatient orthopaedic work on 3 sites with ring-fenced beds backed by an effective SE London orthopaedic network. IF said this should set out the advantages, of which there are a number, as well as the perceived disadvantages. IF said that he understood this had been an agreed action from the JHSOSC and that in effect this would become a fourth option taken forward.

3.8 SB replied that the enhanced status-quo option is the three site option as currently 75% of the activity is carried out across three sites and that the activity which sits outside this is generally not inside SEL. SB said that it was agreed at JHOSC that the three site model would be put forward as a fourth option. SB noted that whilst they are proposing including this as an option the Evaluation Group are still recommending the 2 site model as the preferred option.

3.9 IF added that it is important when considering the three site model that we include the positives (e.g. travel and less upheaval) of this approach as well as the perceived negatives.

3.10 Paul Brown (PB) introduced the comment by Lewisham and Greenwich Trust in their submission that the loss of orthopaedic in-patient work at Lewisham would "deplete the number and skill of the remaining workforce and jeopardise trauma and theatre services" because orthopaedics constitutes such a large proportion of the hospital's activity. PB asked if the Committee is satisfied that evaluation criterion 12 on ensuring the "on-going financial and organisational viability of individual providers" has been met for all the options under consideration.

3.11 ME responded that there has been independent assurance proposed to ensure that both the on-going financial and organisational viability tests are met. ME said that there has been a jointly commissioned study in to the financial implications of the centralisation and what mitigating actions may need to be taken to have a commercial model that works for everyone. ME noted that they are continuing to work with the trauma network and clinical senate in assessing the clinical impact. ME highlighted that the full quotation from Lewisham and Greenwich's submission goes on to say that this situation would occur if there is a TUPE transfer of staff which is not what is being proposed. ME said that it is being proposed that staff would still be employed by their original hospital and that activity would still be owned by the original Trusts. ME said that this issue will need to be monitored and if it becomes apparent that this change will destabilise any of the organisations the proposal will not be taken forward. ME highlighted that NHSE will also be carrying out ongoing assurance to ensure that none of the organisations are made unsustainable.

3.12 Tony O'Sullivan (TOS) said that it was unclear what the enhanced status-quo option meant. TOS said that the enhanced status-quo option needed to explore what a network for elective orthopaedic care would look like if each of the three trusts retained their elective inpatient surgery but enhanced this to avoid disruption to the pathway from emergency work and improved pre- and post-operative work and rehabilitation through investment. TOS said without having this option available, as part of the options appraisal, it was incomplete.

3.13 SB responded that the enhanced status-quo option, which is used as the baseline option, is exactly this. SB said that the enhanced status-quo includes having in place the network and the additional work the Trust's need to do surrounding GiRFT.

3.14 JH reiterated that the enhanced status-quo option was not a do nothing option and that it was made very clear by the Evaluation Panel that this was an enhanced option.

3.15 TOS said that this needed to be made public as it was currently not clear that the enhanced status-quo was a collaborative venture.

3.16 SB said that they have asked the Trust's for a collaborative model but they said they were unable to put forward a collaborative option that would work. SB said that, as an action from the JHOSC, they will review the information which has been circulated publically and ensure that this provides a complete picture.

3.17 ME noted that there should be an action taken to go back to Providers to talk to them about the extent to which they envisage they can work together as part of the enhanced status-quo option.

3.18 **Action: discuss with providers the extent to which they can work together as part of the enhanced status-quo (3 site model).**

3.19 ES reiterated that the consultation document needed to spell out exactly what the enhanced status-quo was.

3.20 SB said that this would be addressed as one of the actions from the JHOSC meeting.

3.21 ME said, based on a question he had received earlier, that there was no formal future submission dates for the STP but that operating plans for the next two years needed to be submitted by the 23rd December.

4. Elective Orthopaedic Centres (EOC) – Introduction and Overview

4.1 SB provided an update and over view of the activity which has taken place since the Committee in Common (CiC) last met. SB said that since the Committee last met the following items have been reviewed by the Orthopaedic Evaluation Group:

- Completed financial analysis;
- More detailed travel analysis;
- Updated quality analysis information;

4.2 SB noted that the programme team has engaged with the JHOSC and consulted with individual borough councillors regarding the Consultation documentation.

4.3 SB said that following the JHOSC meeting, on the 28th November, changes were needed to the Consultation document but that the recommendation to the CiC would not change as a result of these. SB noted that the design of the Consultation document was taken to JHOSC and was positively received.

4.4 SB highlighted that there was an assurance meeting with NHSE later that day (29th November) to discuss the Pre-Consultation Business Case (PCBC).

4.5 SB said that initially the timeline to start consultation was the 5th December but that this was likely to be moved back to allow time to embed the requests from JHOSC.

4.6 SB outlined the following actions which arose from the JHOSC meeting, on the 28th November:

- Re-ordering of the Consultation document questions following feedback;
- Including the enhanced status-quo option as a fourth option for Consultation;
- Ensuing that the word hospital is included in all references to Queen Mary's Hospital;
- Re-word the question relating to the impact the Orthopaedic Centres will have on A&E so that it is not misleading;
- Provide greater clarity and detail on the financial analysis which has taken place in the documentation;
- Ensure that the language in the documentation shows that the public are being listened to whilst making it clear it is not a vote;
- Provide JHOSC with the independent review which will be carried out by the University of Kent following consultation;
- Put in place a follow up meeting with JHOSC mid-consultation to give feedback on the process;
- Provide JHOSC with further information surrounding the quality comparisons with SWLEOC on areas such as infection rates.

SB highlighted that the impact of these changes was that they would not be asking the CiC to sign-off the final consultation document today. SB proposed instead that they would be asking the CiC to sign-off whether they agree we should be going to consultation. SB suggested that, following another conversation with JHOSC to confirm the points above have been addressed, that the CiC could then verify via CCG Chairs' action the wording of the consultation documentation.

5. Elective Orthopaedic Centres – Recommendation of the Elective Orthopaedic Group

5.1 JH introduced the recommendation from the Evaluation Group and gave an outline of the process used by the group for the non-financial criteria.

5.2 JH mentioned that the case for change and proposed models had been reviewed and agreed by the CiC previously. JH emphasised the importance of referencing these throughout the consultation documentation so that it is clear the path that was taken to get to where we are now.

5.3 JH referred to the detailed process which was taken by the Evaluation Group to come to the recommendation (agenda item C).

5.4 JH noted that the Evaluation Group was made up of voting members from each of the CCGs, an expert clinician, social care and patient representatives.

5.5 JH explained that the initial stage for the Evaluation Group was to assess the four site options (King's, Lewisham, Guy's, Queen Mary's Hospital) based on a series of hurdle criteria questions. JH said that at this point it became apparent that the Queen Mary's Hospital site did not pass two of the hurdle criteria, specifically surrounding being able to accommodate 50% of SEL activity and being able to deliver on complex procedures due to a lack of a critical care unit. JH therefore said that the recommendation is that the Queen Mary's Hospital option is not taken forward to consultation as a site option.

5.6 JH said that one of the hurdle criteria was surrounding accessibility and having one inner and outer London site. JH said that following much consideration the Evaluation Group thought that the best way to think about the sites accessibility was not based on geographical or administrative boundaries but on the impact on travel times for patients across SEL. As such the Lewisham and Guy's option, which could be considered to have two inner sites, was not excluded at this stage.

5.7 JH said that as part of the hurdle criteria the importance of not destabilising any of the organisations was discussed. JH emphasised that the model being proposed was a network model and as such the activity would still be owned by the organisations who do not host the EOC. JH said that it is crucial that the commercial model, which is still being developed, allows for no single organisation to be destabilised and for the system to be sustainable and stable going forward.

5.8 JH said that the scoring system used was against an enhanced status-quo and that options could score either positively or negatively against this i.e. for accessibility all options scored negatively against the enhanced status-quo as travel times will increase if there are fewer sites.

5.9 JH explained that they heard presentations from King's, Lewisham and Guy's and had the opportunity to ask them questions surrounding areas such as how they were proposing to work as part of a network model.

5.10 JH noted that the scoring process involved reaching a consensus as a panel on the score that should be given for each of the non-financial criteria. JH stated that all three options received an overall positive score against the enhanced status-quo option, on the non-financial criteria, with the Guy's and Orpington option scoring highest.

5.11 Nick Jones (NJ) provided an outline of the approach which was taken to assess the financial criteria.

5.12 NJ explained that they worked closely with the Trust finance teams to develop submissions for the following three scenarios:

- The base case, with elective orthopaedic services continuing to be provided according to the current configuration, whilst meeting expected growth in patient demand and delivering GiRFT recommendations;
- Cost associated with hosting the EOC;
- Cost associated with not hosting the EOC.

5.13 NJ said that follow up sessions took place with each of the Trusts to help ensure that there was consistency in the approach that was being taken across all the sites.

5.14 NJ said that over the five-year-period to FY20/21 that all three options are marginally more expensive in total than the enhanced status-quo option but that they all present a position that is a lower recurrent cost by that end point. Thus they position the system at a lower expenditure for the longer term. NJ added that the amount by which the options are a lower cost to the system varies between the options with option 1 being just under £9m, option 2 just over £2m and option 3 between the two.

5.15 JH provided a summary of the findings and the recommendations to the CiC.

5.16 JH emphasised that they have heard that there is non-financial benefits from all the options as well as long term financial benefits for the system from all the options.

5.17 JH stated that based on both the financial and non-financial criteria the recommendation from the Evaluation Group is that all three options, should be considered as part of the consultation as the preferred options, but that the enhanced status-quo option should also be described.

5.18 ME confirmed that whilst the Evaluation group are recommending to the CiC that they take the enhanced status-quo option through consultation as option 4, that the consolidated two-site model was the preferred option.

5.19 The floor was then opened for comments and questions from the Committee.

5.20 James Wintour (JW) said that Greenwich supports the recommendation that is being put forward and proposed a suggestion that, as part of the next phase, the financial criteria is also weighted in the same way as the non-financials have been. JW said that so far we have had a hurdle criteria for the finances but that when it comes to the final decision for which sites to use the financial savings should act as a criteria, which is weighted with the non-financials, and factored in accordingly.

5.21 JW noted that the other two comments which he was going to raise have been addressed earlier but were surrounding the financial and operational viability of

the individual providers needing to be set out more clearly and the enhanced status-quo being quantified more obviously.

5.22 Marc Rowland (MR) said that he felt further clarity was required on the financial analysis so that it is clear what exactly the objectives and requirements are. MR said that it needed to apparent what the financial imperatives are and how these are being managed in conjunction with the non-financial criteria.

5.23 SB responded on this question emphasising that initially it was viewed, by the CiC, that the non-financial options should be viewed as the most important and that any option that was financially viable should therefore be assessed on the non-financial benefits. SB said that whilst this was the approach taken to understand what options should be taken to consultation the CiC should now consider how they wish to incorporate the financial implications of the options as part of the final decision process. SB noted that it may be that the existing approach is then agreed upon or that the financial impacts need to be weighted and incorporated but that the CiC need to take advice on the best way to do this.

5.24 **Action: CiC to receive recommendations for the final decision making process taking into account financial criteria.**

5.25 Ray Warburton (RW) said that he thought that the Orpington site was temporary, in order to deal with pressures at the Denmark Hill site, and therefore was there a consideration regarding the opportunity cost of using the Orpington site as a permanent option.

5.26 Angela Bhan (ABh) responded to this question emphasising that King's have invested significantly over the last few years in to Orpington and has already consolidated much of the in-patient orthopaedic activity there. ABh said that Orpington now performs very well for patient outcomes, offers a range of specialist services and as such it is a facility which could be used as an option.

5.27 JH said that the opportunity cost of using Orpington as an option has been considered in the same way as it has been for all the options.

5.28 RW asked what the proposal is to measure and assess whether any sites are destabilised as a result of a change in configuration.

5.29 SB responded that she feels there will need to be an on-going process to access the impacts on each of the organisations effected. SB highlighted that there is an external trauma network, amongst others, who will be engaged in the consultation period to look at the likely impacts. SB said that post consultation there will need to be on-going assessments of both the positive and negative clinical and financial impacts of the changes carried out by an external body.

5.30 Martin Wilkinson (MW) said that it is important that whilst we emphasise this is about improving quality we are also clear in the documentation on the financial objectives of the proposals in relation to the STP. MW said that it is important to bring out the context of the financial implications and that questions on these should be included in the consultation documentation.

5.31 SB said it was clear from JHOSC that more needs to be done to get further clarity and visibility of the financial objectives and implications of the options. SB said that one follow up from JHSOSC is to discuss, with NJ, how to do best do this.

5.32 Harvey Guntrip (HG) asked how we are going to ensure post-decision that all the organisations are appropriately feeding in elective care patients and releasing staff as expected.

5.33 SB responded that they are working with the Trusts to develop a collaborative business model which supports this post the decision being made. SB emphasised that the clinicians do support this and that she anticipates once a decision is made that they will be able to progress positively towards this model. SB said that they achieved this model in South West London and it benefits all the Trusts there.

5.34 JH said that he feels that this is a very real challenge for the STP to address as a whole and it is particularly difficult when looking at one area in isolation. JH said that by getting other opportunities, where consolidation and collaboration is required, moving alongside Orthopaedics some of the competitive tensions should be mitigated.

5.35 SB noted that providers are working collaboratively across productivity and that work has begun to look which areas can be taken forward alongside Orthopaedics to ensure all organisations remain stable.

5.36 John King (JK) asked that the changes which are being made to the consultation documentation are shared as soon as possible with PPAG.

5.37 **Action: share updated consultation document with PPAG.**

5.38 JK asked if there was any scope for including providers on the CiC.

5.39 ME responded that the CiC is set up to be a commissioner led forum and that the Strategic Planning Group is where Providers and Commissioners meet. ME said that the Strategic Planning Group is meeting on 2nd December and will discuss orthopaedics there.

5.40 ME said that it is important to remember that it is the commissioning arrangements which will underpin the Planned Care Orthopaedics activity and whilst we need to work with the Trusts to get them aligned with this it is the contracts let that will ultimately drive the change.

5.41 Mary Currie (MC) added that in order for successful implementation robust governance needs to be in place to ensure quality, performance and access is managed for all those who need access.

5.42 MR raised concern about the scale of the capital requirements that were needed for the proposals and the ability to access this.

5.43 ME responded that they have been working very closely with NHSE and NHSI colleagues to make sure they are sighted on the capital requirements. ME said that the capital requirements for all three options are within a range that would be expected to be supported, as long as the business cases are viable, but that this has not been confirmed by NHSE at this time.

5.44 JH raised that his governing body had expressed concern surrounding the general instability which many providers are experiencing currently and how this is being factored in.

5.45 ME said that as part of the consultation process they should return to the question of deliverability to ensure that they are confident that the chosen sites can deliver the proposal. JH said that hopefully at that point, during consultation, there will be a developed commercial model which should support further understanding of how the models will be delivered.

5.46 JH noted that the other two comments which he was going to raise have been addressed earlier but were surrounding the importance of ensuring the sustainability of all the organisations and including the case for change throughout the consultation documentation.

5.47 PM confirmed with the CiC that they:

- **AGREED once the Consultation document is updated to include the actions from JHOSC that they will review the updated wording and agree via a Chair's action.** (ref. minute 4.15);
- **AGREED with the recommendation of the Evaluation Group that the three site option should be in the consultation document as option four but that the three consolidated two-site options should be the preferred options.** (Lewisham and Guy's, Guy's and Orpington, Lewisham and Orpington) (ref. minute 5.17);
- **AGREED that they need to decide as a Committee the criteria, for both the non-financial and financial impacts, for the final decision process** (ref. minute 5.22).

6. Elective Orthopaedic Centres – Pre-Consultation Business Case

6.1 SB introduced the Pre-Consultation Business Case (PCBC) drawing attention to the summary slides which had been provided (agenda item D).

6.2 SB noted that there have already been conversations at the CiC surrounding the case for change and the two-site model and that they are now at the stage where a document (the PCBC) has been created.

6.3 SB noted that they have provided the PCBC to NHSE and will meet on the 29th November to discuss assurance surrounding how they reached the preferred option of a consolidated two site model. SB said that NHSE will be looking for assurance on the four tests of service reconfiguration;

- 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.

6.4 SB said that they feel they have addressed the four tests and that there is a robust evidence base for how they have done this.

6.5 **PM confirmed with the CiC that they AGREED that the programme should to move to launch of a consultation on elective orthopaedic centres, subject to NHSE assurance.**

7. Elective Orthopaedic Centres – Consultation plan and Consultation document

7.1 Rory Hegarty (RH) introduced the Consultation plan (agenda item E).

7.2 RH said that the plan has been tested with a range of stakeholder groups including PPAG, Stakeholder Reference Group, Planned Care Reference Group and JHOSC.

7.3 RH outlined the following activities that would take place as part of the Consultation Plan:

- Focus Groups for those with protected characteristics, including those classed as deprived or as carers;
- Deliberative events for members of the public;
- Public events on hospital sites;
- Consultation hearing mid-way through the consultation process where attendees can submit evidence for and against the proposals;
- Briefings with key stakeholders such as Healthwatch and interest groups;
- Planned Care Reference Group meetings;
- Service user engagement to reach past, present and future users;

- Existing networks and groups which the programme currently utilises.

7.4 RH said that a range of communication channels have been created including media, social media, websites, the programme newsletter and targeted advertisements.

7.5 RH noted that the timeline for the consultation plan was 14 weeks and was intended to begin in December.

7.6 The floor was then opened for comments and questions from the Committee.

7.7 Richard Gibbs (RGi) said that he supported the plan and stressed the importance of ensuring there is sufficient participation from clinicians. RGi emphasised that in his experience it is the clinicians who the public will truly value being able to question and hear from throughout the consultation plan.

7.8 RH responded that he agreed that this is key and that they have looked to incorporate clinical involvement throughout the plan to provide the public with the opportunity to discuss with clinicians the patient impacts.

7.9 SB highlighted that clinicians have been helpful in the process to date engaging with PPAG and JHOSC showing their support for the model. SB added that Tim Briggs (National Director for Clinical Quality) has also been vocal in his support for the model.

7.10 Nikita Kanani (NK) highlighted her support for the plan and raised the importance of ensuring that it uses the 6 local Healthwatchs, which are in place across SEL, to reach the community.

7.11 RH agreed and emphasised that they are in regular communication with Healthwatch organisations and will be looking for their support throughout the consultation plan.

7.12 Rikki Garcia (RGa) reinforced the importance of engaging with the Healthwatch's but noted that the consultation plan should not rely entirely on them to reach out to everyone in the community. RGa said he was pleased to see that carers are being addressed as part of the plan but that he thought this could be clearer in the documentation. RGa stated the importance of making sure that the focus groups were spread out across the SEL community. RGa added that the consultation document needed to be available in an easy read format and that the dates for the meetings are advertised as soon as possible.

7.13 RW said that he welcomed the approach to the consultation and in particular how it addresses those with protected characteristics. RW stated the importance of engaging as wider population as possible throughout the process and clearly being able to articulate and talk through the issues. RW said that in particular with the financial criteria it may be that further support and explanation is required.

7.14 RH said that he is discussing with NJ the possibility of creating a summary document on the finances which could be shared alongside the other documentation.

7.15 HG suggested developing a video as a practical solution to ensuring that clinician's perspectives can be shared at the meetings even when a clinician is unable to attend in person.

7.16 RH responded that a video, as well as other animations, are being developed and will include clinician input. RH also noted that the consulting hearing will be broadcast.

7.17 JH re-emphasised that the readability of the document is crucial, in particular surrounding the finances. JH said that the case for change needs to be made clear throughout the consultation document as it is vital that people understand why we are doing what is proposed.

7.18 AM said that he feels it is crucial to the success of the plan to ensure that local people are part of the local presentations as it is them who will have the required credibility.

7.19 RH responded that the aim is get local feedback throughout consultation and to supplement the central team, who are closer to the detail, with this throughout the engagement.

7.20 SB re-emphasised the importance of this and said that it is crucial that the CCGs own this and take this forward in to their boroughs.

7.21 RGa said that he felt that question 5a in the consultation document should include additional information so that it is clear what additional travel could be expected.

7.22 SB agreed that a note should be included to outline the travel support that will be offered and who it will be offered to as part of the revised model.

7.23 **Action: RH to add a note to question 5a in the consultation document which outlines the travel support which will be available.**

7.24 RW said that it would be useful to articulate what could arise from the consultation process that would; prevent the proposals going ahead, cause the process to pause or confirm the desire to progress.

7.25 ME said that the justification for stopping the process would be if there was a justifiable threat to organisational viability, evidence the clinical benefits will not be realised or evidence the financial benefits will not be realised.

7.26 **PM confirmed with the CiC that they AGREED the consultation plan.**

7.27 PM thanked attendees and noted the next meeting will be scheduled for after consultation.

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