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Agenda

Dorset County Council

Meeting: Dorset Health Scrutiny Committee

Time: 10.00 am

Date: 8 March 2016

Venue: Committee Room 1, County Hall, Colliton Park, Dorchester, Dorset, DT1 1XJ

Ronald Coatsworth (Chairman)	Dorset County Council
Bill Batty-Smith (Vice-Chairman)	North Dorset District Council
Mike Byatt	Dorset County Council
Michael Bevan	Dorset County Council
Ros Kayes	Dorset County Council
Mike Lovell	Dorset County Council
William Trite	Dorset County Council
David Jones	Christchurch Borough Council
Sarah Burns	East Dorset District Council
Tim Morris	Purbeck District Council
Peter Shorland	West Dorset District Council
Alison Reed	Weymouth & Portland Borough Council

Notes:

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- **Public Participation**

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  (a) Public Speaking

  Members of the public can ask questions and make statements at the meeting. The closing date for us to receive questions is 10.00am on 3 March 2016, and statements by midday the day before the meeting.

  (b) Petitions

  The Committee will consider petitions submitted in accordance with the County Council's Petition Scheme.

Debbie Ward
Chief Executive

Contact: Jason Read, Democratic Services Officer
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Date of Publication:
Monday, 29 February 2016

1. **Apologies for Absence**

To receive any apologies for absence.

2. **Code of Conduct**

Councillors are required to comply with the requirements of the Localism Act 2011 regarding disclosable pecuniary interests.

- Check if there is an item of business on this agenda in which the member or other relevant person has a disclosable pecuniary interest.
- Check that the interest has been notified to the Monitoring Officer (in writing) and entered in the Register (if not this must be done on the form available from the clerk within 28 days).
- Disclose the interest at the meeting (in accordance with the County Council's Code of Conduct) and in the absence of a dispensation to speak and/or vote, withdraw from any consideration of the item.

The Register of Interests is available on Dorsetforyou.com and the list of disclosable pecuniary interests is set out on the reverse of the form.

3. **Minutes** 1 - 6

To confirm and sign the minutes of the meeting held on 16 November 2015.

4. **Public Participation**

(a) Public Speaking

(b) Petitions

5. **Dorset Healthcare University NHS Foundation Trust - CQC Report** 7 - 18

To consider a report by the Director for Adult and Community Services (attached).

6. **Quality of General Practitioner Services in Dorset** 19 - 26

To consider a report by the NHS Dorset CCG (attached).

7. **Dorset Health Scrutiny Committee Protocol Revision** 27 - 42

To consider a report by the Director for Adult and Community Services (attached).

8. **Draft Dorset Joint Health and Wellbeing Strategy, 2016 to 2019** 43 - 60

To consider a report by the Director for Adult and Community Services (attached).

9. **South Western Ambulance Service NHS Foundation Trust – NHS 111 Service** 61 - 66

To consider a report by SWASFT (attached).

10. **Weymouth Community Urgent Care Centre Project and Weymouth Walk-in Centre and the Practice GP Service** 67 - 76

To consider a report by the Director for Adult and Community Services (attached).

11. **Briefings for Information/Noting** 77 - 88

To consider a report by the Director for Adult and Community Services (attached). This report includes the following items:-

- NHS Dorset CCG Clinical Services Review – Minutes of Joint Committee held on 02.12.15
- Non-emergency Patient Transport Services – Performance Update
- Delivery Plan 2016/17 and new Sustainability and Transformation Plans [NHS Dorset CCG]

12. **Dorset Health Scrutiny Committee - Forward Plan** 89 - 92

To receive the Dorset Health Scrutiny Committee's Forward Plan (attached).

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Dorset Health Scrutiny Committee

Minutes of a meeting held at County Hall,
Colliton Park, Dorchester on 16 November 2015.

Present:
Bill Batty-Smith (Vice-Chairman in the Chair – North Dorset District Council)

Dorset County Council
Michael Bevan, Mike Byatt, Ron Coatsworth, Ros Kayes and William Trite

West Dorset District Council
Peter Shorland

External Representatives:
Dorset Healthcare University NHS Foundation Trust: Ron Shields (Chief Executive)
NHS Dorset Clinical Commissioning Group: Elaine Hurll (Senior Commissioning Manager) and Emma Seria-Walker (Deputy Director Review, Design and Delivery)
Healthwatch: Martyn Webster (Regional Manager) and Annie Dimmick (Research Officer)
Weldmar Hospicecare Trust: Alison Ryan (Chief Executive)
Dorset County Hospital NHS Foundation Trust: Anita Thomas, (Associate Director for Cancer and Access Services)
Poole Hospital NHS Foundation Trust: Paul Miller, (Director of Strategy) and Dr Maxine Flubacher, (Consultant Clinical Oncologist);
Dorset County Council Officers: Ann Harris (Health Partnerships Officer), Denise Hunt (Senior Democratic Services Officer) and Joseph Rose (Total Transport Manager)

(Note: These minutes have been prepared by officers as a record of the meeting and of any decisions reached. They are to be considered and confirmed at the next meeting of the Committee to be held on **8 March 2016**.)

Apology for Absence

76. Apologies for absence were received from Tim Morris and David Jones.

Code of Conduct

77. There were no declarations by members of disclosable pecuniary interests under the Code of Conduct.

Minutes

78. The minutes of the meeting held on 8 September 2015 were confirmed and signed.

Matters Arising

Minute No. 66.2 – Memorandum of Understanding Between Dorset Health and Wellbeing Board and Dorset Health Scrutiny Committee

79.1 The Health Partnerships Officer advised that the terms of reference of the Dorset Health Scrutiny Committee had not been referred to the Standards and Governance Committee as the suggested amendment had contradicted recommendations arising from the Scrutiny Review 2015 report.

Public Participation

Public Speaking

80.1 There were no public questions received at the meeting in accordance with Standing Order 21(1).

80.2 There were no public statements received at the meeting in accordance with Standing Order 21(2).

Petitions

81. There were no petitions received in accordance with the County Council's petition scheme at this meeting.

Dorset HealthCare University NHS Foundation Trust – Care Quality Commission (CQC) Inspection Outcome Report 2015

82.1 The Committee considered a report by the Director for Adult and Community Services concerning the outcome of an announced inspection of the Dorset HealthCare University NHS Foundation Trust by the CQC in June 2015. The Trust's Chief Executive presented the summary of findings contained in the report and advised that the full CQC report had been published on both the CQC and the Trust's websites.

82.2 The Chairman highlighted that the "well led" domain had been identified as requiring improvement as a result of the inspection and asked whether this was reflective of the leadership of the Trust.

82.3 The Chief Executive responded that overall the Trust had been rated as requiring improvement over a range of assessments against the five quality domains (safe, effective, caring, responsive and well-led). No service had been rated as inadequate and the mental health inpatient service had been the first in the Country to be rated as outstanding. A key issue was a lack of consistency in service provision across the Trust and he gave examples where this had been evidenced during the inspection. The CQC had expressed confidence in the new leadership team, however, more needed to be done in particular teams where there was a lack of clinical leadership.

82.4 The areas identified as inadequate in the "safe" domain were being addressed by the Trust's management team. These included the specialist community mental health services for children and young people and the Minor Injuries Units (MIUs) in Weymouth and Portland. Steps had already been taken to ensure that appropriate risk assessments were undertaken for young people accessing community mental health services so that those in serious need were given priority. A senior clinical nurse had also been employed across all MIU units to ensure that there was adherence to uniform standards of care.

82.6 A member asked whether adult mental health community services in West Dorset had been subject to low quality ratings by the CQC. It was confirmed that although there were issues in several of the community mental health teams, there were no serious concerns with regard to the services provided in West Dorset.

82.7 Further clarification was sought on areas of concern in relation to safety and unsafe or unsuitable premises. The Committee was informed that issues of patient safety arose through inconsistency of risk assessments and care plans. The Trust had a range of premises and some of these had recently benefitted from a £14m upgrade package.

82.8 The Committee was informed that the CQC would assess progress in 6 months' time and that an action plan would be available for consideration by the Committee at its meeting on 8 March 2016.

Noted

Seven Day Services Update, Dorset County Hospital NHS Foundation Trust

83.1 The Committee considered a report by the Director for Adult and Community Services regarding the requirement of health providers to work towards 7 day services and the 10 clinical standards introduced by NHS England used to measure progress.

83.2 The report was introduced by the Head of Service Improvement & Business Development who highlighted progress against 5 of the 10 clinical standards. One of the main challenges related to staff shortages and the financial impact of employing locums. Sharing staff resources and diagnostic services with partners would help alleviate some of those impacts. A further compliance audit would be undertaken in March 2016 with the results available in a report to the Committee in May 2016. The remaining 5 standards would be delivered during 2016-17.

83.3 The Chairman queried the compliance in relation to "time to consultant review" and was advised that the percentage had previously been higher due to the use of registrars to fulfil this standard.

83.4 A member asked whether the pilot to support people returning home from hospital would be continued and members were informed that although the pilot had been successful in testing what could work in practice, alternative commissioning models would be required in future to allow the Trust to work with partners to the benefit of everyone involved.

Noted

Dorset Street Triage Service

84.1 The Committee considered a report by the Director for Adult and Community Services which provided details of the Street Triage Service established in June 2014. The main objective of the service was to reduce the number of people detained under section 136 of the Mental Health Act.

84.2 The report was presented by the Senior Commissioning Manager, Dorset Clinical Commissioning Group (DCCG) who explained that the street triage service had been provided 7 days per week from 7pm to 3am since June 2015. The hours could be increased in future in order to work more closely with the crisis teams and provide a greater opportunity to identify people whose mental health was deteriorating. It was likely that this service would form part of the crisis response rather than the criminal justice system in future and would be jointly commissioned.

84.3 Members were pleased with the progress that had been made and asked what proportion of the service had been used in West Dorset. It was explained that coverage was fairly equitable across the County and mental health workers were working alongside the police in the call centre based at Winfrith which was a useful way of getting huge coverage with a small team.

Noted

Healthwatch Dorset Report on their Investigations into Dental Services in Dorset

85.1 The Committee considered a report by the Director for Adult and Community Services which outlined an investigation by Healthwatch into dental practices in Dorset which had focussed on access and charges.

85.2 The Healthwatch Regional Manager outlined some of the concerns and the 9 recommendations resulting from the investigation. These actions had been referred to NHS England (Wessex) who had drawn up an 8 point action plan to deal with some of the issues

raised. He reported that NHS England had been receptive and open in its approach to the findings of the investigation and that this had been a good example of how the process should work.

85.3 Since writing the report, Healthwatch had been made aware of the difficulties faced by homeless people in accessing dental services. The community groups working with the homeless had subsequently met with commissioners from NHS England and a new pilot for mobile dental services had been commissioned in Poole that had commenced the previous week.

85.4 The Committee expressed concern regarding inconsistency in display of charges and access to treatment by people on limited incomes. Members were informed that there was inconsistency with regard to the clear display of charges in dental surgeries and that the dental provider had a responsibility to let the patient know of schemes that would reduce the cost of treatment. Healthwatch worked closely with the Citizen's Advice Bureau to provide consistent and accurate information.

85.5 Members also highlighted the need to publicise how to access urgent dental treatment at the weekend and were informed that emergency weekend appointments had been commissioned by NHS England that had not been fully utilised. It was subsequently found that patients had not been correctly signposted to these appointments and further training was provided to the 111 service call handlers so that an appropriate referral for emergency dental treatment was made rather than to a GP.

85.6 The Committee asked whether there had been any improvement in informing patients on how to make a complaint. The Committee was advised that some dental service providers used the NHS Choices website rather than their own website. The NHS 8 point action plan included an action about keeping practice information on the NHS Choices website updated and providing guidance on how to do this.

Noted

Weldmar Hospicecare Trust Quality Account 2014/15

86.1 The Committee considered a report by the Director for Adult and Community Services regarding the Weldmar Hospicecare Trust Quality Account 2014/15.

86.2 The Chief Executive gave a presentation to the Committee on the service provided by Weldmar to 1300 patients and their families in North, South and West Dorset by 212 staff and 300 volunteers. There had been growth in providing the service at home safely for as long as possible which was the only viable strategy in rural West Dorset. Inpatient services were available for people with intensive care need, some of whom were in acute crisis and returned as an inpatient many times. GPs and hospitals were not always referring people that Weldmar could help.

86.3 The presentation highlighted the key issues and challenges facing the charity, including a lack of commissioning focus on end of life and difficulties in recruiting nurses which had been experienced across all healthcare providers.

86.4 The Chairman asked about incidences of pressure sores and was advised that it was recognised that pressure sores were part of basic nursing care, but that there were differences in pressure sores at the end of life than in a normal acute case. There had been instances where nurses had not documented pressure sores on entry to the service as well as occasions where these had developed during care.

86.5 Members asked about the type of bereavement support available to relatives and were informed that support provided by Weldmar included a clinical psychologist, funded by Macmillan, to help people experiencing distress pre and post bereavement and a specialist child support worker. In addition there was a bereavement counsellor and arts psychologist (leading the Chrysallis programme), who were both supported by a number of trained volunteers, a carers group and coffee mornings to allow people to share experiences.

86.6 Further to a question it was explained that Weldmar was responsible for education and training on the Gold Standards Framework and that good practice was the responsibility of commissioners. There was inconsistency in application of the framework across GP practices and a need for GPs to think about end of life medical conditions other than cancer.

86.7 Members asked about intervention and support for dementia which was a growing problem and it was explained that staff were being trained with regard to dementia at end of life. Patients were not always referred to Weldmar and carers were suffering as a result.

Noted

Briefings for Information/noting

Mental Health Member Champion Report

87.1 The Committee considered a report by Councillor Bevan, the Member Champion for Mental Health. Since writing the report he advised the Committee that member champions had been appointed in Trafford Council, Sevenoaks District Council and Bournemouth Borough Council and that there were now over 50 mental health champions in England. He also outlined some events that he would be attending in January 2016 in connection with mental health.

Transfer of 0-5 Children's Public Health Commissioning to Local Authorities

87.2 It was noted that scrutiny of public health was within the remit of the overview committee and the Health and Wellbeing Board rather than the Dorset Health Scrutiny Committee.

Poole Hospital NHS Foundation Trust – Investment in Cancer Treatment Services in Collaboration with Dorset County Hospital

87.3 A short presentation was provided which outlined the introduction of cancer treatment services at Dorset County Hospital and the benefits to patients of the introduction of radiotherapy treatment in Dorchester. It was suggested that a copy of the powerpoint presentation was circulated following the meeting.

NHS Dorset Clinical Commissioning Group – Clinical Services Review Update

87.4 The Committee was informed that a report on the mental health acute care pathway review would be considered by the Joint Health Scrutiny Committee meeting on 2 December 2015. An update on the clinical services review would also be provided at this meeting.

87.5 A request was made for the Committee to receive details of the expenditure on mental health since the formation of the Dorset Clinical Commissioning Group in order to assess whether funding had been increasing in this area and it was confirmed that this information could be provided.

Non-emergency Patient Transport Services Update

87.5 A response to the briefing by the Dorset Clinical Commissioning Group was circulated at the meeting.

87.6 The Holistic Transport Review now came under the Total Transport Programme and this had been extended for a third year. The review would incorporate an investigation of integrating commissioning of services with the DCCG and non-emergency patient transport in order to tackle some of the issues. There was an additional advantage that the E-ZEC and Dorset County Council contracts were due for renewal at around the same time in 2018 which would set a timeframe for this review. He acknowledged that the immediate need would be to increase the number of car schemes as well as advertise existing schemes to people with social need.

87.7 Members expressed the view that this review should be treated as a priority and it was suggested that a strategy was designed in order to signpost people to the various car schemes in each locality.

Noted

Updates from Liaison Members

88. A brief update was provided by the liaison member for the South West Ambulance Service NHS Trust who reported that the out of hours service provided by the Trust was working very well.

Item for Future Discussion

89. It was suggested that a report on commissioning of GPs be requested by NHS England for future consideration by the Committee.

Questions from Members of the Council

90. No questions were asked by members under Standing Order 20(2).

Meeting Duration: 10.00am to 12:40pm

Dorset Health Scrutiny Committee

Dorset County Council

Date of Meeting	8 March 2016
Officer	Director for Adult and Community Services
Subject of Report	**Dorset HealthCare University NHS Foundation Trust CQC Quality Improvement Action Plan**
Executive Summary	The purpose of this paper is to present the CQC Quality Improvement Action Plan following the publication of the CQC Inspection report in October 2015. The action plans have been developed by the designated core service lead manager and lead clinicians, supported by the relevant locality Director.
Impact Assessment:	Equalities Impact Assessment: Not applicable.
	Use of Evidence: Report provided by Dorset HealthCare University NHS Foundation Trust.
	Budget: Not applicable.
	Risk Assessment: Having considered the risks associated with this decision using the County Council's approved risk management methodology, the level of risk has been identified as:

	Current Risk: MEDIUM Residual Risk MEDIUM
	Other Implications: None.
Recommendation	To note the content of the CQC Quality Improvement Action Plan and note the progress made to date. To note good progress has been made in formulating detailed action plans for each core service area supported by corporate plans for cross cutting actions. To note that at the end of January 2016: - 8 ‘must do’ actions completed - 20 ‘should do’ actions completed - No outstanding actions to report - Ongoing monitoring to ensure actions are embedded in practice.
Reason for Recommendation	The Officers Reference group requested a report to provide an update to the Committee following the 2015 CQC Inspection.
Appendices	Appendix 1 provides the progress by core service where ‘must do’ and ‘should do’ actions have been completed. Nine out of 16 services have completed some actions.
Background Papers	N/A
Report Originator and Contact	Name: Sally O’Donnell, Dorset HealthCare University NHS Foundation Trust. Tel: 01202 277127 Email: sally.o’donnell@dhuft.nhs.uk

1. BACKGROUND

1.1 In June 2015 the CQC undertook a five-day announced comprehensive inspection of Dorset HealthCare University NHS Foundation Trust (DHC) to review whether our services are safe, effective, caring, responsive to people's needs and well-led.

1.2 The draft reports (17 in total, 16 core service reports and an overall quality report) were shared with the Trust on 16 September 2015 and rated the Trust overall as 'Requires Improvement'. The final reports were published in October 2015. The CQC reported that:

"It is our view that the provider had made significant progress in developing services and bringing about improvements. We saw that it was well led by its new leadership team and was in the process of deploying effective systems that we were confident would result in the delivery of improved, high quality services for the patients it serves in the near future."

1.3 The Trust considers this to be a fair reflection, recognising the journey of quality improvement the Trust is on. We were delighted to have achieved two outstanding ratings for the acute wards for adults of working age and psychiatric intensive care units, and the community forensic service. The outstanding rating for the former was the first awarded in England.

1.4 Following publication of the CQC report DHC is required to develop a Quality Improvement Action Plan (QIP) to address the themes and issues identified.

1.5 The Trust has been informed that it will be re inspected before end of April. The inspection will focus on areas that require improvement to see what progress has been made.

1.6 Key themes and issues arising from the inspection include:

- Significant variance in the quality of care delivered between some teams across the Trust
- Inconsistencies in the planning and delivery of a number of services
- Areas of non-compliance with CQC regulations.

1.7 The concerns did not result in enforcement action being taken against the Trust. During the Quality Summit meeting there was a clear recognition by partners and commissioners that joint action was required to address some of the key challenges raised by the CQC report. A commitment was made by Dorset CCG, the three local authorities, NHS Dorset and other partners and stakeholders to support the Trust in making these improvements.

1.8 The six main areas of challenge posed by the CQC's report are:

- Mental Health Services for Children and Young People (CAMHS)
    - Inconsistencies in quality of care and service provision between teams
    - Long waiting list and systems required to ensure the safety of the children waiting to be seen
    - Excess demand is a growing problem that is system-wide and requires multi-agency solutions

- Minor Injury Units (MIU)
    - The sustainability, function and purpose of the MIUs
    - The need to deliver consistency in the operating arrangements for all MIUs
    - The need for a county-wide strategy for urgent and emergency care

- Mental Health Crisis & Home Treatment Services and Health Based Place of Safety
    - Inconsistencies between teams
    - Demand and capacity and the commissioned service model requires support and potential investment from the commissioners (Dorset Clinical Commissioning Group)

- Mental Health Services for Older People
    - The need for a clear Trust strategy for Older People's Mental Health Services
    - Inequality in the commissioned services and the need to provide access to services across all of Dorset. This requires consideration within the Clinical Services Review and Better Together Programme

- End of Life Care
    - The need for a clear plan for End of Life Services provided by the Trust to ensure equity of access for patients
    - The need for a commissioned pan Dorset integrated model of End of Life Care as there are multiple providers

- Long Stay Rehabilitation Mental Health wards
    - High levels of detention under the MHA in rehabilitation services
    - Access to comprehensive rehabilitation programmes in the community
    - Review of the long stay rehabilitation service model

1.9 The CQC also identified 41 areas of good practice. These are areas where the Inspectors noted practice that was 'above and beyond' good care.

Core service non-compliance with the fundamental standards regulations

1.10 Within each core service report there are actions required to improve compliance with CQC fundamental standards. There are two types of action:

- Actions the Trust MUST take against the requirement notice(s) – these actions, if not achieved, have a potential to have a negative effect on the Trust provider licence and the Trust reports progress against these to Monitor as well as the CQC
- Actions the Trust SHOULD take to improve as this will have a positive impact on patient care and the support to staff, visitors or carers.

1.11 Across the 16 core service lines the Trust was found to be in breach of 8 (of the 13) Regulations as indicated below:

Regulation Number	Subject	Must Do actions
10	Dignity and respect	5
11	Need for consent	1
12	Safe care and treatment	19
13	Safeguarding service users from abuse and improper treatment	1
15	Premises and equipment	3
17	Good governance	19
18	Staffing	11
20	Duty of Candour	1
	Total	**60**

Must Do Actions

1.12 A total of 60 'must do' actions have been identified through the inspection process. 27 of the must do actions are within the mental health core service areas (45%) with 33 (55%) attributed to the community core service areas.

1.13 The most frequent breaches involve Regulation 12: Safe Care and Treatment (19); Regulation 17: Good Governance (19) and Regulation 18: Staffing (11).

Regulation 12

1.14 This regulation is to prevent people from receiving unsafe care and treatment and prevent avoidable harm or risk of harm. Actions within this domain include:

- Clinical risk assessment and risk management processes
- Staff demonstrating the right skills and competences through the appropriate training and education (mandatory training compliance)
- Premises and any equipment used is safe and regularly tested and/or monitored
- Medicines must be managed safely and administered appropriately
- Prevent and control the spread of infection

Regulation 17

1.15 To meet this regulation we must have effective governance, including assurance and auditing systems or processes. Actions include:

- Contemporaneous record keeping
- Up-to-date risk assessments
- Personalised care plans

Regulation 18

1.16 The Trust must provide sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet the needs of the people using the service at all times. Staff must receive the support, training, professional development, supervision and appraisals that are necessary for them to carry out their role and responsibilities. Actions include:

- Availability of sufficient numbers of skilled and competent staff – e.g. school nursing service and Night Nursing team, CAMHS, CMHT's, MIU's

- Access to clinical supervision and appraisal

Should Do Actions

1.17 Across the core service reports there are a total of 89 'should do' actions. 62 of these actions are within the mental health core services (70%) and 27 (30%) within the community core services. This division is to be expected given that the mental health services have 11 (69%) of the core services.

1.18 Collectively there are 149 must / should do actions which translate across the 16 service lines into detailed action plans with a total of 325 actions. How the actions are distributed across the 16 core service areas are shown in the table below.

KEY	
	Inadequate
	Requires Improvement
	Good
*	Outstanding
	Not rated

KEY	
S	Safe
E	Effective
C	Caring
R	Responsive
W-L	Well-Led

CORE SERVICE	S	E	C	R	W-L	Regulation breached & number of actions	'Must Do' Action	'Should Do' Actions	Service Line total actions
MENTAL HEALTH SERVICES									
MH Adult/PICU			*	*				6	6
MH Rehabilitation						10(1): 12(2)	3	15	18
Forensic Inpatient						12(3)	3	6	9
MH Older People In patient						10(3): 12(1): 15(3): 17(1)	8	2	10
CAMHS Inpatient								6	6
MH Crisis/Home Treatment						12(2): 18(2)	4	5	9
MH Adult Community						10(1): 11(1): 12(1): 17(1): 18(1)	5	5	10
MH Older People Community						17(1)	1	5	6
CAMHS Community						12(1): 18(2)	3	6	9
LD /Autism Community								4	4
Forensic Community		*	*					2	2
Total							**27**	**62**	**89**
COMMUNITY SERVICES									
Children, Families and YP						12(3): 17(3)	6	3	9
Community Health Adults						17(1): 18(1): 20(1)	3	2	5
Community Health Inpatient						12(4): 15(3): 17(3): 18(2)	9	6	15
Minor Injury Units (MIU)						12(5): 13(1): 17(3): 18(2)	12	11	23
End of Life						17(3)	3	5	8
Total							**33**	**27**	**60**
OVERALL TOTAL							**60**	**89**	**149**

2. DEVELOPMENT, IMPLEMENTATION AND MONITORING OF THE CQC QUALITY IMPROVEMENT ACTION PLAN AND LEVELS OF ASSURANCE

2.1 The Trust has developed a comprehensive action plan aligned to each core service area. Each plan has a lead clinician, lead manager and lead Director who is responsible for ensuring the actions are kept on track and supporting evidence to provide assurance is available. These actions constitute the first line of defence in assuring that the plans are owned and actions are being implemented within the service areas.

2.2 Alongside this the corporate services such as Learning and Development, Estates and Human Resources are supporting the core service actions plans where there are cross cutting improvements required. Examples include:

- Compliance with mandatory training and ensuring sufficient, accessible training programmes to meet the needs of staff groups
- Estate improvements
- Recruitment and retention plans to support safe staffing across the services.

2.3 Monitoring and tracking of the plans are managed by the Trust Programme Management Office (PMO) and overseen by the Nursing and Quality Directorate. Quality assurance visits are undertaken by the Trust's Quality Assurance Team to ensure that the evidence is in place once an action has been completed. The internal quality assurance visits constitute the second line of defence.

2.4 The CQC Mental Health Act (MHA) Inspections have continued and the most recent visit took place on St Brelades ward in January; feedback from these inspections will provide the Trust with assurance as to compliance with the Mental Health Act and Code of Practice and any further actions required. External visits and inspections constitute the third line of defence.

Other Sources of Assurance

2.4 Dorset Clinical Commissioning Group continues to visit service areas and provide feedback to the Director of Nursing on their findings. Since the CQC Inspection in June visits have taken place to the following areas:

- Swanage Hospital – 13 July 2015
- Chalbury Ward, Weymouth Community Hospital – 19 August 2015
- Yeatman Hospital, Sherborne – 28 September 2015
- Waterston Unit, Forston Clinic – 12 October 2015
- Portland Hospital – 24 November 2015
- Victoria Hospital, Wimborne – 12 January 2016
- St Ann's Hospital – 27 January 2016
- Shaftesbury Hospital 4 February 2016

2.5 These reports have been mostly positive and where actions are required they are put into immediate effect by the Ward Manager/Clinical Lead.

2.6 The CQC have undertaken two thematic inspections of the Trust during Quarter 3:

- End of Life Care - 19 October 2015
- Safeguarding Children and Looked After Children (Dorset) - 16 November 2015

2.7 The draft Safeguarding Children and Looked After Children inspection report has been shared for factual accuracy; the final report is expected to be published on 1 February 2016 (at the time of reporting 4 February it has not been published). The Trust met with

Dorset CCG in January to review the draft report and to consider the actions required to meet the emerging recommendations.

2.8 The Trust has not yet received the draft End of Life report and has asked CQC when the report is likely to be available.

3. PROGRESS TO DATE

3.1 For the 149 actions identified in the CQC reports, there are 325 component actions being implemented across the services. There has been progress with many of the actions but because some have multiple components, until every component has been achieved the action will remain open.

3.2 At the time of reporting 8 of the 60 must do actions have been completed and 20 of the 89 should do actions. In total 28 actions have been completed (19%) of the 149 actions. However, no actions are past the target dates identified by the core service leads

4. CONCLUSION AND RECOMMENDATION

4.1 Good progress has been made in formulating detailed action plans for each core service area supported by corporate plans for cross cutting actions.

4.2 The Committee is asked to note:

- The content of the CQC Quality Improvement Action Plan and the progress made to date:
  - 8 ‘must do’ actions completed
  - 20 ‘should do’ actions completed
  - No outstanding actions to report
  - Ongoing monitoring to ensure the actions are embedded in practice.

Sally O’Donnell
Dorset Locality Director, Dorset Healthcare University Foundation Trust
February 2016

Appendix 1

CORE SERVICE	'MUST DO' ACTION	ACTIONS COMPLETE AS AT 31.12.15	'SHOULD DO' ACTIONS	ACTIONS COMPLETE AS AT 31.12.15
MENTAL HEALTH SERVICES				
Acute Wards for Adults and Psychiatric Intensive Care Unit	0		6	1) Review description of word seclusion while describing de-escalation on RiO in order that the intervention is accurately recorded.
Long Stay Rehabilitation Wards	3	1) Protect patients against the risks associated with the unsafe use and management of medicines on Glendinning ward by ensuring that the record of the administration of medication is accurate. 2) Nightingale House 51 ligature risks identified – plans in place to mitigate risk however, 3 patients at increased risk of self-harm and upstairs male bathroom was isolated, unobserved, unlockable and had no alarm system.	15	1) Ensure that the frequency of audits of controlled drugs is in line with the trust's policy. 2) Review the current system of smoking breaks in the very small yard in Nightingale House. 3) Cigarette remains should be cleared promptly to ensure patient safety.
Forensic Inpatients	3	1) Provide clear written policies on procedural security on the ward, which should include management of barred items, use of emergency alarms and security of keys. 2) Ensure that sharps bins are used appropriately and that lids are secured when in use.	6	1) Review its blanket policy of locking all patients' bedrooms during the day, and perceived lack of choice by patients when attending groups. 2) Ensure that resuscitation equipment is routinely checked. 3) Review the seclusion room in accordance with the Mental Health Act Code of Practice. 4) Consider the specific training needs of staff working in a low secure service. 5) Review access to secure services for women and consider, with commissioners whether this service should be offered.

Wards for Older People with Mental Health Difficulties	8	1) Provide appropriate wheelchair access to disabled people's bedrooms in Melstock House. 2) *Provide patients with enough access to outside areas and ensure that staff are competent in fire evacuation procedures. (partial completion of full action) 3) Ensure that privacy and dignity are protected on Alumhurst ward and at Melstock House, with robust systems to check and monitor compliance and to ensure that staff understands their responsibilities.	2	
MH Crisis/Home Treatment and Health Based Place of Safety	4		4	1) *Staff working in the Crisis team have up to date mandatory training – additional floating staff added to e-roster to ensure additional staffing is available to support S136 assessments when required (sub action completed).
MH Older People Community	1	1) Ensure that care records are accurate, complete and contemporaneous.	5	
CAMHS Community	3		6	1) Ensure that the action plans it produced following the CQC visit to the community child and adolescent mental health service teams are implemented without delay. 2) *Keep staff up to date with their mandatory training – initial summary position (sub action completed) 3) *Provide systems to ensure greater consistency in the standards and working practices across the different community

				child and adolescent mental health service teams (Partial completion of full action).
Learning Disability/Autism Community	n/a		4	1) Ensure that mental capacity assessments are conducted and documented and ensure that consent to treatment is always sought. 2) Ensure that staff pass on information about how to access advocates in an accessible way. 3) Ensure timely uploading of care information to the electronic record system.
Forensic Community	n/a		2	1) Review access to secure services for women.
Total		**7 Fully Completed**		**14 Fully completed**
COMMUNITY SERVICES				
Community Health Inpatient	9	1) *Ensure that emergency equipment and suction machines are fit for purpose (partially completed). 2) *Implement infection prevention and control policies and procedures (partially completed). 3) *Store medicines in accordance with its policies and standard operating procedures (partially completed).	6	1) Service strategies should be clear and that they are communicated effectively. 2) Encourage and support staff at all levels to raise concerns, promote improvement and contribute to innovation. 3) *Provide enough adequately experienced and trained staff to meet the assessed needs of patients (partially completed).

Minor Injury Units (MIU)	12	1) *Implement a formal system that ensures all patients attending MIUs receive a timely clinical assessment (partially complete).	11	1) Ensure that minor injury units and adjacent departments such as x-ray departments are easily accessible. 2) Support and encourage all staff to report and learn from incidents and complaints consistently to support continuous improvement in service quality. 3) *Ensure that the patient group directions used in MIUs to enable staff to administer prescription only medication are signed by staff (partially complete). 4) *Ensure staff are up to date with safeguarding training (partially complete).
End of Life Care)	3	1) Strengthen strategic leadership and governance arrangements and ensure that there is regular reporting to the trust board on the quality of end of life services.	5	
Total		**1 Fully Completed**		**6 Fully Completed**
OVERALL TOTAL		**8 Fully Completed**		**20 Fully Completed**

*The update includes significant elements of 5 must do and 5 should do have been achieved to date but not included in the number of fully completed actions.

Dorset Health Scrutiny Committee

Dorset County Council

Date of Meeting	8 March 2016
Officer	Matt Wain, Head of Patient Safety and Risk, NHS Dorset CCG
Subject of Report	**Quality in General Practice Services in Dorset**
Executive Summary	The purpose of this paper is to provide the Dorset Health Scrutiny Committee with information relating to the quality of General Practitioner services in Dorset and the work that NHS Dorset Clinical Commissioning Group (CCG) is undertaking to monitor and support practice in making improvements.
Impact Assessment:	Equalities Impact Assessment: N/A
	Use of Evidence: Care Quality Commission. Ipsos MORI.
	Budget: N/A
	Risk Assessment: Having considered the risks associated with this decision using the County Council's approved risk management methodology, the level of risk has been identified as: Current Risk: LOW Residual Risk: LOW

	Other Implications: N/A
Recommendation	That the Committee consider and comment on the findings within the report.
Reason for Recommendation	The work of the Health Scrutiny Committee contributes to the County Council's aim to protect and improve the health, wellbeing and safeguarding of all Dorset's citizens.
Appendices	None
Background Papers	None
Report Originator and Contact	Name: Matthew Wain Tel: 01305 368946 Email: matt.wain2@dorsetccg.nhs.uk

1 Introduction

1.1 The purpose of this paper is to provide the Dorset Health Scrutiny Committee with information relating to the quality of General Practitioner services in Dorset and the work that NHS Dorset Clinical Commissioning Group (CCG) is undertaking to monitor and support practice in making improvements.

1.2 Across the Dorset CCG area there are 98 GP practices covering rural and urban communities and a registered population of 788,645.

1.3 Since April 2013 the responsibility for the commissioning and monitoring of Primary Care services (including GPs) has been the responsibility of NHS England. Over the past 12 months the CCG has been co-commissioning General Practice services with NHS England, but as of 1 April 2016 this responsibility will be transferred solely to the CCG under a scheme of delegation. NHS England will only retain the responsibility for individual GP Performance issues and act as the legal contract owner (as set out in the Care Act 2012). NHS England will also retain the responsibility for GP complaints.

1.4 There are a wide range of sources of information relating to the quality of Primary Care services and the experience of patients when using their services. An independent review of indicators of quality of care in General Practices in England concluded that better use of data in the NHS could support significant improvements in care (The Health Foundation, October 2015).

1.5 As part of the preparation for the delegated commissioning of GP services, the CCG is working closely with NHS England on the handover of responsibilities. It is identifying the key data sources to create a 'profile' of practices across Dorset. This will enable the CCG to target support where it is most needed to improve quality and ensure a good patient experience. It is important to note that the practice profile will give one aspect of the quality of services based on data, but should not be viewed in isolation as the reliability of data sources can vary.

1.6 The practice profiling will be a constantly evolving document and will be updated to reflect not only nationally available data sources, but also local intelligence identified through contract monitoring and other primary care work streams.

1.7 In order to have a more robust triangulation of information, the profiling data set will be used to identify:

- Best practice;
- Trends;
- Variation in performance;
- Areas of service improvement need;
- Practices that may require additional support.

and ultimately will be developed to:

- Support improvements in care;
- Enable patients, carers and service users to make informed choices;
- Better account for the quality and outcomes of general practice;

- Provide data for research and practice development.

1.8 The initial indicators that the CCG is looking to bring into the practice profiling include:

- Quality and Outcome Framework achievement
- Referral performance
- Prescribing performance
- Workforce
- Patient Experience
- Primary Care web-tool achievement
- Local intelligence.

1.9 NHS England has also developed a pilot scheme aimed at supporting 'vulnerable practices'. This scheme will provide matched funding to practices identified, either by commissioners or themselves, as requiring additional support. The CCG is currently working with NHS England to identify 'vulnerable practices' and arrange for appropriate support.

1.10 The CCG has established a Primary Care Commissioning Committee, a sub committee of the Governing Body, which will oversee the quality of Primary Care.

1.11 For the purpose of this paper the key elements of CQC compliance and patient experience have been explored, in addition to the support structure the CCG has established.

2 CQC Visits

2.1 Since 2013 GP practices have had to be registered with the Care Quality Commission (CQC) in order to provide services. The CQC is the regulator for Health and Social Care Services in England and monitors compliance against a set of 'fundamental standards of care' that all providers must achieve. These fundamental standards are split into five domains each of which contain a number of core standards, these are:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well led?

2.2 The CQC assess compliance with the fundamental standards by visiting GP Practices with an inspection team of between three and five inspectors. The inspection team is generally comprised of a lead inspector, a GP, a practice management expert and can contain specialist inspectors such as Practice Nursing experts. Based on the visit findings the CQC will issue a rating to the Practice, of which there are four levels of rating:

- outstanding – the service is performing exceptionally well

- good – the service is performing well and meets CQC's expectations
- requires improvement – the service isn't performing as well as it should and CQC has told the service how it should improve
- inadequate – the service is performing badly and CQC has taken action against the person or organisation that runs it.

2.3 During 2014 GP Practices in Dorset were assessed as part of the CQC 'pilot', to test their review methodologies, and 27 practices across Dorset were selected to take part. As this was a pilot, the CQC did not provide ratings for practices. The new model of inspection, which commenced in Dorset in April 2015, provides a rating for each practice and those that were visited as part of pilot will also be revisited by April 2017 and given a rating.

2.4 For all practices that receive a rating of 'inadequate' or 'requires improvement' there is a regulatory requirement to produce a formal action plan to rectify the areas identified.

2.5 To date the CCG has been notified that there have been 24 reports published relating to Dorset Practices, of which 18 were rated as 'good' and six were rated as 'requiring improvement'.

2.6 The CCG is working closely with practices identified as 'requiring improvement' to ensure that robust actions are in place to address the identified issues.

3 Patient Experience

3.1 Annually NHS England commissions Ipsos MORI to undertake an independent national survey of patients to seek their views on the quality, safety and experience of GP services. The latest survey results were published in January 2016.

3.2 The comprehensive survey covers 62 questions and covers the key areas of:

- Accessing GP services
- Ease of making an appointment
- Waiting times
- Practice staffing
- Opening times
- Overall experience.

3.3 The results are published in the public domain and the scores for all questions can be benchmarked against national performance.

3.4 The experience of people accessing GP services in Dorset is good with the majority of practices scoring higher than the national average against individual indicators.

3.5 For the indicator relating to 'overall experience' Dorset GPs scored 90% on average against the national average of 85%. Only 10% of Dorset practices scored below the national average for this indicator with no practice scoring below 75%.

3.6 In relation to getting through to their surgery, Dorset patients reported that 81% found it 'very easy' or 'easy' to get through to their practice against a national average of 70%.

3.7 There were no areas of the survey results where Dorset GPs did not have a combined average that is higher than the national average. As part of the developing practice profiling, individual scores are being looked at for key areas with targeted support being offered to make improvements.

4 CCG Support to General Practice

4.1 Following the CQC pilot visits in 2014 the CCG reviewed the themes and trends from the published reports. Based on these themes the CCG created a menu of options for practices to choose from when accessing support from the CCG which covered:

- Signposting practices to resources
- Subject specific facilitated visits to practices (as resources permit)
- Generic visits to practices (advice on evidence collation and preparing for CQC visits, creating action plans).

4.2 To date approximately a third of practices have requested support of one form or another and those practices that have been identified as 'requiring improvement' have been proactively targeted.

4.3 The CCG will be continuing this work over the coming year and will be providing additional advice and training in the following areas:

- Medicines Management/Prescribing
- Patient Safety and Risk
- Quality Improvement
- Adult Safeguarding
- Mental Capacity Act
- Child Safeguarding
- Professional practice and staffing
- Infection Prevention and Control
- Customer Care/Complaints
- End of Life Care
- Learning Disability
- Dementia.

4.4 Ahead of taking over delegated responsibility in April 2016 the CCG has established six work-streams that Quality will be integral to, these are:

- Business Intelligence
- Estates development
- Commissioning and Contract Management
- Workforce
- Innovation
- Models of Care/Vanguard.

4.5 These work streams will evolve over the coming months and with the aim of ensuring that there is continuous improvement in GP services and that Dorset is well prepared to deal with the future challenges in Primary Care.

4.6. The CCG has developed a number of task and finish groups to support the work described in this paper and one of these is focussing on quality improvement and practice profiling. The CCG has also employed two (GP) Clinical Leads to provide leadership to these work streams and support the development of Primary Care and where necessary provide challenge/support their peers.

5 Conclusions

5.1 This document provides an overview of key elements of quality relating to general practice and the work that the CCG has done to date in relation to the quality and experience of those accessing primary care in Dorset.

5.2 The CCG has a clear plan on how it will develop systems to commission and monitor primary care services following delegation in April and the embedding of quality improvement is integral to this.

5.3 An update on progress against the work programmes highlighted in this report will be available to the Health Overview and Scrutiny Committee in the future.

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Telephone: 01305 368946

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Dorset Health Scrutiny Committee

Dorset County Council

Date of Meeting	8 March 2016
Officer	Director for Adult and Community Services
Subject of Report	**Revised Protocol for Dorset Health Scrutiny Committee**
Executive Summary	The current Protocol under which the Dorset Health Scrutiny Committee operates was adopted in September 2007. Following amendments to the Regulations governing Health Scrutiny in 2013 and the publication of subsequent guidance in 2014, it is necessary to revise the local Protocol. The new Protocol: • Removes references to the scrutiny of the Supporting People Programme; • Sets out the Committee's Terms of Reference reflecting the new regulations and guidance and liaison with the Health and Wellbeing Board; • Clarifies membership; • Clarifies the Liaison Member role, as agreed by the Committee on 10 March 2014; • Notes the Committee's links with Healthwatch Dorset; • Clarifies administrative matters. Appendix 1 sets out the new Protocol with all changes in red and underlined; Appendix 2 sets out the original Protocol. As the proposed changes set out the new Protocol are consequential of changes to regulations and guidance and clarify administrative matters, advice is that these changes can be approved by the Committee itself without the need for any referral to the County Council as host Council. In particular, there are no

	proposals to change the terms of reference of the Committee.
Impact Assessment:	Equalities Impact Assessment: Not applicable.
	Use of Evidence: The revised Protocol is based on The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 and associated Guidance published by the Department of Health in June 2014.
	Budget: Not applicable.
	Risk Assessment: Having considered the risks associated with this decision using the County Council's approved risk management methodology, the level of risk has been identified as: Current Risk: MEDIUM Residual Risk: LOW
	Other Implications: None.
Recommendation	1 That Members consider and comment upon the proposed new Protocol and agree to its adoption. 2 That the new Protocol be posted on Dorset for You, replacing the current version, and circulated to key partners.
Reason for Recommendation	The current Protocol was adopted in September 2007 and no longer reflects current regulation and guidance.
Appendices	1 Protocol for Dorset Health Scrutiny Committee – March 2016 2 Protocol for Dorset Health Scrutiny Committee – September 2007 version
Background Papers	The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013: http://www.legislation.gov.uk/uksi/2013/218/contents/made

	Joint Protocol between Dorset Health Scrutiny Committee and Healthwatch Dorset, November 2014: DHSC Nov 2014 Joint Protocol with Healthwatch Report
Report Originator and Contact	Name: Ann Harris, Health Partnerships Officer Tel: 01305 224388 Email: a.p.harris@dorsetcc.gov.uk

Appendix 1

Dorset County Council

Dorset County Council
Protocol for Dorset Health Scrutiny Committee – March 2016

1.0 Purpose of the Protocol

To set out the roles and responsibilities of County Council, Borough and District Council members of the Dorset Health Scrutiny Committee.

2.0 The role of the Dorset Health Scrutiny Committee

2.1 The Health and Social Care Act 2001 provided explicit powers for Councils with Social Services Responsibilities to scrutinise health services within the authority's area as part of their wider role in health improvement and in reducing health inequalities for their area and its inhabitants.

2.2 The Dorset Health Scrutiny Committee was established jointly with the six borough and district councils (Christchurch Borough Council, East Dorset District Council, North Dorset District Council, Purbeck District Council, West Dorset District Council and Weymouth and Portland Borough Council) to review and scrutinise matters relating to the health service in Dorset and to make reports and recommendations to local NHS bodies on these matters with the aim of helping to improve the health of the people of Dorset and reduce health inequalities.

2.3 The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 and associated Guidance published by the Department of Health in June 2014 set out revised powers and duties, and are reflected in this Protocol.

3.0 What the Committee Does

3.1 The Dorset Health Scrutiny Committee reviews and scrutinises matters pertaining to the planning (including commissioning), provision and operation of health services in the area of the County Council.

3.2 The Committee has the power to require information to be provided by certain NHS bodies about the planning, provision and operation of health services that is reasonably needed to carry out health scrutiny, and it can require employees of certain NHS bodies to attend meetings to answer questions.

3.3 The Committee has the power to delegate authority to borough and district councils to undertake reviews of health services.

3.4 The following principles will guide the work of the Health Scrutiny Committee:

I. work will focus on health improvement and reducing health inequalities within the local authorities' population;

II. health improvement is a shared responsibility. The health of any area is affected by more than the NHS and many agencies, including the Council, are involved in it;

III. the committee will work in liaison with patient and public engagement forums, particularly Healthwatch Dorset, as part of a Patient-Led NHS and will listen to and reflect the views of residents, patients, service users and carers;

IV. health scrutiny should be a constructive activity - our partners in health should view any interchange as positive, if at times challenging and aimed at improving the health of local people. It is intended that health scrutiny should bring something new to reviews of the NHS and will not duplicate the many other forms of performance management and inspection that exist in the NHS and elsewhere and;

V. health service issues should be considered objectively and without regard to political affiliation.

4.0 Terms of Reference

In relation to the Committee's work on Local Authority Overview and Scrutiny of Health:

(a) To review and scrutinise matters pertaining to the planning (including commissioning), provision and operation of health services in the area of the County Council;

(b) To make reports and recommendations to relevant NHS Bodies and/or relevant health service providers and also to the Cabinet and other relevant committees of the County Council on any matter which is reviewed or scrutinised;

(c) To give notice to require the Cabinet or the County Council to consider and respond to any reports or recommendations arising from the committee's work within two months of receipt;

(d) Where relevant NHS Bodies and/or relevant health service providers have under consideration any proposal for a substantial development of the health service in the area of the County Council or for a substantial variation in the provision of such service:

(i) To receive reports from the relevant NHS Bodies and/or relevant health service providers;

(ii) To comment on the proposal(s); and

(iii) To report in writing to the Secretary of State where any of the circumstances set out in paragraph 23(9) of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 apply;

(e) To arrange for its functions under the 2013 Regulations to be discharged by an Overview and Scrutiny Committee of another local authority where that Overview and Scrutiny Committee would be better placed to undertake the functions and the other authority agrees;

(f) In accordance with regulation 30 of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013, to appoint joint committees with other local authorities to exercise relevant functions under the said Regulations;

(g) From time to time, as appropriate, to appoint a task and finish group consisting of members of the Committee to consider specific local issues relating to the overview and scrutiny of health;

(h) To liaise and cooperate with the Dorset Health and Wellbeing Board as set out under the Memorandum of Understanding agreed by both parties in September 2015.

4.1 Membership – Total 12:

6 members of the County Council, or such higher minimum number which is necessary to achieve representation from the three main political groups based on the political balance rules. Every effort being made so that each represents an area of the county which coincides with the district/borough council area in which their County Council electoral division is located, ie one County Council member to represent each of the following areas: Christchurch, East Dorset, North Dorset, Purbeck, West Dorset and Weymouth and Portland.

1 member representing each of the 6 District/Borough Councils in Dorset.

5.0 Role and Responsibilities of Members of Dorset Health Scrutiny Committee

The roles and responsibilities are set out below:-

5.1 Chairman and Vice Chairman:

- provide leadership and direction;
- endeavour to engage all members of Committee;
- act as 'gatekeeper', prioritising, with the committee, the main work to be undertaken;
- co-ordinate with other scrutiny committees and chairmen, including the Dorset Health and Wellbeing Board, and share learning;
- develop a constructive, 'critical friend' relationship with the chief officers in the Trusts and Departments that the Committee scrutinises.

5.2 Members:

- have a commitment to attend meetings, training and briefing sessions;
- be willing to act as liaison person to a specific NHS body, organisation or specific community and lead on liaison with that body;
- be willing to act as liaison person with local health groups;
- as community leaders, have a keen interest in the improvement of health of the people of Dorset;
- not be a member of the executive body of either the county, district or borough council which they represent on the Committee.

Where a specific local issue relating to the overview and scrutiny of health arises, the opportunity to participate in the work of Dorset Health Scrutiny Committee will be made available to elected members in the relevant district or borough council.

5.3 Members' interests

The work of Committee is varied and may on occasion have a direct impact on members or involve witnesses who are known to them. At the start of the meeting and in the usual way, members are expected to make a declaration of any interest which they have. As such an interest may only become apparent during the meeting as evidence is given. Members are expected to remain alert to either disclosable pecuniary interests under the Localism Act or potential conflicts of interest throughout. If such an interest or conflict becomes apparent members are expected to declare its existence.

5.4 Role of Cabinet members

Under the Localism Act 2011 executive members and officers of a local authority could be requested to appear before a scrutiny committee, but in general they will not be expected to take part in or attend scrutiny meetings.

5.6 Liaison between Health Scrutiny Committee and Health Bodies

Liaison members are to be appointed by the Dorset Health Scrutiny Committee to be the main contact with the NHS bodies currently operating in Dorset (NHS Dorset Clinical Commissioning Group, Dorset HealthCare University NHS Foundation Trust, Dorset County Hospital NHS Foundation Trust, South West Ambulance Service NHS Foundation Trust). The main responsibilities of the appointed Liaison Members are:

I. To become aware of the working of the Trust/Board by meeting with key staff and attending Board and other meetings as appropriate.

II. To participate in the work of any Task and Finish group established to scrutinise the Trust/Board to which they are attached.

III. Receive copies of board papers and annual reports.

IV. Be known to the appropriate Local Healthwatch contact.

V. To give a brief oral/written report to the Committee on important or unusual events regarding the Trust/Board to which they are attached when appropriate.

Nomination and appointment of members to each of the liaison roles will be agreed by the Committee as required, and roles will be undertaken on a voluntary basis.

6.0 Involving stakeholders

6.1 Health scrutiny provides opportunities for community involvement and democratic accountability. Engagement with patients and the public can help to improve the quality, legitimacy and long-term viability of recommendations made by the Health Scrutiny Committee.

6.2 Patients and the public bring different perspectives, experiences and solutions to health scrutiny, particularly if a wide range of people is heard (including young people, people with disabilities, people from black and minority ethnic communities and people from lesbian, gay, bisexual and transgender communities).

6.3 This engagement will help the Health Scrutiny Committee to understand the service user's perspective on individual services and on co-ordination between services. It will also help the committee to take a view on how NHS bodies are meeting their statutory duties to consult and involve local people in the development of services as well as on specific issues.

6.4 Patients and the public may be involved in identifying areas of interest for scrutiny, providing views on and relating their experiences of service provision. Views can be heard directly by the Committee through written or oral evidence or heard indirectly through making use of existing sources of information, for example from surveys.

6.5 The Health Scrutiny Committee agreed a formal Protocol in November 2014 setting out the way in which it would work with Healthwatch Dorset, as the consumer

champion for health and social care. The Regulations governing health scrutiny require that the Committee has a mechanism in place to respond to any concerns that Healthwatch may refer to it, including acknowledgement of such referrals within 20 working days. In addition, the Protocol commits both bodies to share work programmes and clarifies the meetings to which a representative of Healthwatch will be invited as an active participant.

7.0 Meetings

7.1 Scrutiny Committee meetings present two main opportunities:

I. for members and the public to get involved in scrutiny;

II. for scrutiny to demonstrate publicly that it is fulfilling its responsibility in holding local health bodies to account.

Scrutiny meetings are planned in such a way to achieve this.

7.2 Agendas

The agenda is overseen by the Chairman/ Vice Chairman of the Committee and they are consulted on any potential scrutiny agenda items before the agenda is published.

7.3 Briefing papers

Preparation is central to the business of scrutiny. Prior to the meeting officers will meet with the Chairman and Vice-Chairman to preview the agenda papers to help to develop a shared understanding of:

- the issue or topic under scrutiny;
- how they may want to approach the exercise in terms of drawing out the issues of concern and how the matter can be brought to resolution.

7.4 Witnesses in Scrutiny

Anyone can be invited to attend a scrutiny meeting to provide information or answer questions. They can be officers of the Council or a representative from an NHS Body or other outside organisation or a member of the public. All witnesses should be given advance formal notice if they are asked to give evidence at a Scrutiny Committee meeting. They will be supported so that they know what to expect, in a manner which is sufficient and appropriate.

7.5 Questioning

Questioning and interviewing are central facets of scrutiny. Whilst probing lines of questions will be taken by members, witnesses will be treated with courtesy and respect. It is important for members to consider the view of the person facing the scrutiny committee, how to get the most from them and how to put them at their ease.

7.6 Conditions for effective scrutiny

For scrutiny to be effective the following conditions are required:

- member leadership and engagement;

- responsive executive;
- genuine non-partisan working;
- effective direct officer support and management of the scrutiny process;
- supportive senior officer culture; and
- high level of awareness and understanding of the work of overview and scrutiny.

8.0 Recommendations

8.1 Recommendations represent an independent view based upon evidence received.

8.2 The committee can make reports and recommendations to the NHS bodies on any issue scrutinised but they have no power to make decisions or to require that others act upon their suggestions, although NHS bodies are required to respond in writing to recommendations made within 28 days.

8.3 In their response the NHS body can set out its view about the recommendations, the proposed action in response to the recommendations and any reason for inaction to the recommendations.

8.4 Where there is a substantial variation or development in service the Committee must be satisfied that the content of the consultation was sufficient, as was the time allowed.

9.0 Referrals to the Secretary of State

9.1 A referral to the Secretary of State can be made by the Committee where:

- The consultation has been inadequate in relation to the content or the amount of time allowed;
- The NHS has given inadequate reasons where it has not consulted for reasons of urgency relating to the safety or welfare of patients or staff;
- A proposal would not be in the interests of the health service in the area (in which case the Committee must set out the grounds on which it has reached this conclusion).

Key references

Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013: http://www.legislation.gov.uk/uksi/2013/218/pdfs/uksi_20130218_en.pdf

Local Authority Health Scrutiny: Guidance to support Local Authorities and their partners to deliver effective health scrutiny (June 2014): https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/324965/Local_authority_health_scrutiny.pdf

March 2016

Appendix 2

Dorset County Council
Protocol for Dorset Health Scrutiny Committee – September 2007 version

1.0 Purpose of the Protocol

To set out the roles and responsibilities of County Council, Borough and District Council members of the Dorset Health Scrutiny Committee.

2.0 The role of the Dorset Health Scrutiny Committee

2.1 The Health and Social Care Act 2001 provided explicit powers for Councils with Social Services Responsibilities to scrutinise health services within the authority's area as part of their wider role in health improvement and in reducing health inequalities for their area and its inhabitants.

2.2 The Dorset Health Scrutiny Committee was established jointly with the six borough and district councils (Christchurch Borough Council, East Dorset District Council, North Dorset District Council, Purbeck District Council, West Dorset District Council and Weymouth and Portland Borough Council) to review and scrutinise matters relating to the health service in Dorset and to make reports and recommendations to local NHS bodies on these matters with the aim of helping to improve the health of the people of Dorset and reduce health inequalities.

3.0 What the Committee Does.

3.1 The Dorset Health Scrutiny Committee:-

- considers proposals by NHS organisations on substantial developments of or variations to services;
- has an annual work programme of areas to review; and
- scrutinises the Supporting People Programme in Dorset.

3.2 The Committee has the power to delegate authority to borough and district councils to undertake reviews of health services.

3.3 The following principles will guide the work of the Health Scrutiny Committee:

i. work will focus on health improvement and reducing health inequalities within the local authorities' population;
ii. health improvement is a shared responsibility. The health of any area is affected by more than the NHS and many agencies, including the Council, are involved in it;
iii. the committee will work in liaison with relevant Public and Patient Involvement Forums as part of a Patient-Led NHS and will listen to and reflect the views of residents, patients, service users and carers;
iv. health scrutiny should be a constructive activity - our partners in health should view any interchange as positive, if at times challenging and aimed at improving the health of local people. It is intended that health scrutiny should bring something new to reviews of the NHS and will not duplicate the many other forms of performance management and inspection that exist in the NHS and elsewhere and

v. health service issues should be considered objectively and without regard to political affiliation.

4.0 Terms of Reference

In relation to the Committee's work on the Supporting People Programme:-	
(a)	To consider and make recommendations to the Cabinet on the Supporting People Strategy, including the submission of commissioning plans, as required;
(b)	To scrutinise the implementation of the programme, including the effect which this has on different groups of vulnerable people;
(c)	To monitor and review the pattern of provision across the area of the County Council and the arrangements for consultation and the involvement of the public, including those from minority ethnic communities.
In relation to the Committee's work on Local Authority Overview and Scrutiny of Health:-	
(a)	To review and scrutinise matters relating to the planning, provision and operation of health services in the area of the County Council;
(b)	To make reports and recommendations to the local NHS bodies and to the Cabinet and other relevant Committees on any matter reviewed or scrutinised;
(c)	To receive reports from local NHS bodies where they have under consideration any proposal for a substantial development of the health service in the area of the County Council or for a substantial variation in the provision of such service;
(d)	In accordance with regulation 7 of the Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002 and directions issued by the Secretary of State under regulation 10, to establish joint committees with other Councils with Social Services Responsibilities to exercise the above functions;
(e)	To arrange for the above functions to be carried out by an overview and scrutiny committee of another local authority where that authority would be better placed to undertake them and the authority in question agrees;
(f)	From time to time, as appropriate, to appoint a panel of members of the Committee to consider specific local issues relating to the overview and scrutiny of health.

5.0 Role and Responsibilities of Members of Dorset Health Scrutiny Committee

The roles and responsibilities are set out below:-

5.2 Chairman and Vice Chairman:

- provide leadership and direction;
- endeavour to engage all members of Committee;
- act as 'gatekeeper', prioritising, with the committee the main work to be undertaken;
- co-ordinate with other scrutiny committees and chairmen and share learning;
- develop a constructive, 'critical friend' relationship with the chief officers in the Trusts and Departments that Committee scrutinises.

5.2 Members:

- have a commitment to attend meetings, training and briefing sessions;
- be willing to act as liaison person to a specific NHS body, organisation or specific community and lead on liaison with that body;
- be willing to act as liaison person with local health groups;
- as community leaders, have a keen interest in the improvement of health of the people of Dorset;
- not be a member of the executive body of either the county, district or borough council which they represent on the Committee.

Where a specific local issue relating to the overview and scrutiny of health arises, the opportunity to participate in the work of Dorset Health Scrutiny Committee will be made available to elected members in the relevant district or borough council.

5.3 Members' interests

The work of Committee is varied and may on occasion have a direct impact on members or involve witnesses who are known to them. At the start of the meeting and in the usual way, members are expected to make a declaration of any interest which they have. As such an interest may only become apparent during the meeting as evidence us given, members are expected to remain alert to potential conflicts of interest throughout. If such a conflict becomes apparent members are expected to declare its existence including whether it is personal or prejudicial.

5.4 Role of Cabinet members

Under the Local Government Act 2000 executive members and officers of a local authority could be requested to appear before a scrutiny committee, but in general they will not be expected to take part in or attend scrutiny meetings.

5.6 Liaison between Health Scrutiny Committee and Health Bodies and Community Organisations with a health theme:

Those members of Health Scrutiny committee who act as the point of liaison between the Committee and a health body or health themed community organisations should:

i. receive copies of board papers and annual reports;
ii. initially attend board meetings;

iii. be informed about any proposals for change or development to services and copied into press releases about the organisation and as a result broadens their knowledge about how the organisation is performing and what the services "at risk" may be;
iv. meet at least annually with the Chairman and the Chief Executive of the organisation that they link to. Other committee members, such as the Committee Chairman may also participate in these meetings;
v. be known to the appropriate PPI Forum or LINk body;
vi. have a key role in commenting on performance of the body they link to as part of the Annual Healthcheck;
vii. be able to lead discussion or debate in Committee or on behalf of the Committee when reports or scrutiny discussions take place;
viii. communicate with the Committee Chairman before each meeting to ensure that he/she is aware of any potential problems issues that the Member has identified, and;
ix. liaise with local voluntary and community partnerships and other strategic groups as a way of ensuring that the Committee has sufficient information when it discusses issues of concern to all parts of the County.

6.0 Involving stakeholders

6.1 Health scrutiny provides opportunities for community involvement and democratic accountability. Engagement with patients and the public can help to improve the quality, legitimacy and long-term viability of recommendations made by the Health Scrutiny Committee.

6.2 Patients and the public bring different perspectives, experiences and solutions to health scrutiny, particularly if a wide range of people is heard (including young people, disabled people, people from black and minority ethnic communities and people from lesbian gay bisexual and transgender communities).

6.3 This engagement will help the Scrutiny Committee to understand the service user's perspective on individual services and on co-ordination between services. It will also help the committee to take a view on how NHS bodies are meeting their statutory duties to consult and involve local people in the development of services as well as on specific issues.

6.4 Patients and the public may be involved in identifying areas of interest for scrutiny, providing views on and relating their experiences of service provision. Views can be heard directly by the Committee through written or oral evidence or heard indirectly through making use of existing sources of information, for example from surveys. From time to time a committee may wish to carry out engagement activities of its own, by holding discussion groups or sending questionnaires on particular issues of interest.

7.0 Meetings

7.1 Scrutiny Committee meetings present two main opportunities:

i. for members and the public to get involved in scrutiny
ii. for scrutiny to demonstrate publicly that it is fulfilling its responsibility in holding local health bodies to account.

Scrutiny meetings are planned in such a way to achieve this.

7.2 Agendas

7.2.1 The agenda is overseen by the Chairman/ Vice Chairman of the Committee and they are consulted on any potential scrutiny agenda items before the agenda is published.

7.3 Briefing papers

7.3.1 Preparation is central to the business of scrutiny. Prior to the meeting officers will prepare briefing papers that help develop a shared understanding of:

- the issue or topic under scrutiny
- how they may want to approach the exercise in terms of drawing out the issues of concern and how the matter can be brought to resolution.

7.4 Witnesses in Scrutiny

7.4.1 Anyone can be invited to attend a scrutiny meeting to provide information or answer questions. They can be officers of the Council or a representative from an NHS Body or other outside organisation or a member of the public.

7.4.2 All witnesses should be given advance formal notice if they are asked to give evidence at a Scrutiny Committee meeting. They will be supported so that they know what to expect and asked to provide feedback to ensure the support they were offered was sufficient and appropriate.

7.6 Questioning

Questioning and interviewing are central facets of scrutiny. Whilst probing lines of questions will be taken by members, witnesses will be treated with courtesy and respect. It is important for members to consider the view of the person facing the scrutiny committee, how to get the most from them and how to put them at their ease.

7.6 Conditions for effective scrutiny

For scrutiny to be effective the following conditions are required:

- member leadership and engagement,
- responsive executive,
- genuine non-partisan working,
- effective direct officer support and management of the scrutiny process,
- supportive senior officer culture, and
- high level of awareness and understanding of the work of overview and scrutiny.

8.0 Recommendations

8.1 Recommendations represent an independent view based upon evidence received.

8.2 The committee can make reports and recommendations to the NHS bodies on any issue scrutinised but they have no power to make decisions or to require that others act upon their suggestions, although NHS bodies are required to respond in writing to recommendations made.

8.3 In their response the NHS body can set out its view about the recommendations, the proposed action in response to the recommendations and any reason for inaction to the recommendations.

8.4 Where there is a substantial variation or development in Service the Committee must be satisfied that the content of the consultation was sufficient, as was the time allowed.

9.0 Referrals to the Secretary of State

9.2 A referral to the Secretary of State can be made by the Committee where:

- consultation has been inadequate with the Committee
- the committee feels the proposal is not in the interests of the health service in its area (in which case the Committee must set out the grounds on which the Committee has reached this conclusion)

September 2007

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Dorset Health Scrutiny Committee

Dorset County Council

Date of Meeting	8 March 2016
Officer	Director for Adult and Community Services
Subject of Report	**Draft Dorset Joint Health and Wellbeing Strategy, 2016 to 2019**
Executive Summary	This report broadly replicates one presented to the Dorset Health and Wellbeing Board on 2 March 2016, and it is presented here to inform Dorset Health Scrutiny Committee members as to the current progress in developing a new Joint Health and Wellbeing Strategy. Local Authorities and Clinical Commissioning Groups have an equal duty to prepare Joint Health and Wellbeing Strategies (JHWSs), based on the findings of joint strategic needs assessment. The first JHWS adopted by Dorset Health and Wellbeing Board in June 2013 largely focused on the description of health and wellbeing priorities, supported by evidence from the JSNA. Following consultation, six key priorities for action were chosen: 1. Reducing the harms caused by smoking 2. Reducing circulatory disease 3. Reducing the harms caused by road traffic collisions 4. Reducing the harms caused by diabetes 5. Reducing anxiety and depression 6. Improving care for people with dementia The Strategy also included some principles and broad themes about encouraging a more preventative approach to health and wellbeing and working together wherever possible to intervene at an earlier stage in all settings. Appendix 1 sets out the high level

	performance against the six priorities and Appendix 2 outlines the outcomes of thematic reviews which looked in depth at specific priorities. In September 2015 HWB members met to consider the format that the next JHWS should take, and followed this with a review of the function and role of the Dorset HWB in October 2015. Members agreed that their future focus should be on matters where they can most 'add value' and where their work will not duplicate what is already being carried out elsewhere. To that end, the two over-arching priorities going forward will be: • Health inequalities and; • Prevention and early intervention. As a positioning paper, a statement introducing the proposed new Joint Health and Wellbeing Strategy forms the substance of this report. The Strategy aims to deliver a framework which members of the Board and other partners across Dorset can work towards, embedding the principles into all the work they do across areas of service delivery. This statement has been jointly developed for both Dorset and Bournemouth and Poole HWBs, reflecting the pan-Dorset landscape of many services and partner organisations. Health and Wellbeing Boards are required to consult on their Joint Health and Wellbeing Strategies and a draft plan for Dorset to achieve this has been drawn up (Appendix 3). A broader communications and engagement plan will also be produced.
Impact Assessment:	Equalities Impact Assessment: The aim of the Strategy will be to have a positive impact on inequalities; an EqIA will be undertaken as appropriate.
	Use of Evidence: The Strategy will be aligned to the Joint Strategic Needs Assessment and to the Director of Public Health's Annual Report: http://www.publichealthdorset.org.uk/understanding/jsna/ http://www.publichealthdorset.org.uk/wp-content/uploads/2015/09/Dorset-director-of-public-health-annual-report-2015-16web.pdf
	Budget: No additional resources; the Strategy should enable partner organisations to prioritise areas of work under a common commitment.

	Risk Assessment: Having considered the risks associated with this decision using the County Council's approved risk management methodology, the level of risk has been identified as: Current Risk: MEDIUM Residual Risk MEDIUM The JHWS is a public-facing document and should demonstrate over-arching links to other organisational strategies. A failure to publish a coherent strategy could reflect poorly on the HWB and the Local Authority.
	Other Implications: Responsible local authorities are required under Section116 of the Local Government and Public Involvement in Health Act 2007 (amended by the Health and Social Care Act 2012) to prepare a Joint Health and Wellbeing Strategy with partner CCGs.
Recommendation	1 That Members consider and comment on the proposed focus of the new Joint Health and Wellbeing Strategy. 2 That Members note the date of the consultation workshop (5 April 2016), to which they will be invited.
Reason for Recommendation	To deliver a Joint Health and Wellbeing Strategy that has full commitment and engagement from all Members and that delivers better outcomes for health and wellbeing.
Appendices	1 Dorset JHWS 2013 to 2016, Priorities and trend data 2 Dorset JHWS 2013 to 2016, Work by the HWB to address the priorities 3 Draft consultation plan, JHWS 2016 to 2019
Background Papers	Dorset Health and Wellbeing Strategy 2013 to 2016 (Dorset HWB, 12 June 2013): Dorset HWB Report - JHWS June 2013
Report Originator and Contact	Name: Ann Harris, Health Partnerships Officer Tel: 01305 224388 Email: a.p.harris@dorsetcc.gov.uk

Introducing the Dorset Health and Wellbeing Strategy: A focus on Prevention and Inequalities.

1 The importance of early intervention and prevention

1.1 Our health and social care system is rapidly becoming unstable and unsustainable largely because of the high and rising costs of ill-health, and rising demand.

1.2 Effective preventive measures to reduce the burden of disease and ill-health, both physical and mental, are the mainstay of any long-term solution to these challenges. The more so when it is estimated that about 40 per cent of the NHS current workload is potentially preventable and relates to behavioural factors that can change.

1.3 Nationally, the challenge of meeting rising demand with decreasing resources available to health and social care systems was described in the *Five Year Forward View*[1]. In this NHS England outlined the need for a "radical upgrade in prevention and public health" in order to secure the "future health of millions of children, the sustainability of the NHS, and the economic prosperity of Britain".

1.4 The prevention theme set out in the Five Year Forward View has been incorporated into national planning guidance that requires all areas in England to produce a 'sustainability and transformation' plan for health and social care. This means the NHS and Local Authorities working together to produce and implement the plan. This plan must set out how local areas will close:

- **The health and wellbeing gap** – inequalities in health and health outcome for different groups of people which are often driven by wider socio-economic factors;
- **The finance and efficiency gap** – understanding how to reduce the longer term costs of health and social care arising from increasing demands on services;
- **The care and quality gap** – including reducing local variations in the quality of services.

1.5 The Health and Wellbeing Board is charged with improving the health and wellbeing of residents and reducing inequalities in health within local areas. As such, it provides a natural focus for identifying and coordinating the implementation of an effective, long term, and systematic approach to prevention in all that health and social care organisations (and the wider public service and voluntary sector) do.

1.6 Through this refreshed Joint Health and Wellbeing Strategy, the Health and Wellbeing Board will, within the frame of reference of the five year forward view and the sustainability and transformation plan, set out the key issues and outcomes for Dorset, Bournemouth and Poole, where a more systematic adoption of efforts to prevent ill-health could make a real difference. And, in the process, support how the NHS and social care can jointly re-design the system to ensure sustainability and effectiveness for the future.

[1] The Five Year Forward View, NHS England, October 2014: https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

2 Prevention

2.1 Despite many references to “prevention” in plans and strategies, there is little shared understanding of what are the most effective and efficient approaches for given conditions and settings, and differing people describe prevention activities in very differing language. This strategy will attempt to provide a common framework and language for understanding all our prevention work across organisations.

1.2 All the partners which are represented on the Health and Wellbeing Board have an important role to play in this. Effective actions range from successful early identification and treatment of risk factors for disease, right through to place-based approaches to improve wider determinants of health including economic development, education, meaningful employment, and transport options that promote walking and cycling.

- **Primary prevention** aims to prevent disease and harm before it occurs. i.e. People live in environments that support their health and wellbeing and people, families and communities are able to live healthy and fulfilling lives.

  Examples include: immunisation, eating well, exercising and not smoking.

- **Secondary prevention** aims to detect disease and identify risk factors before they become harmful to health. i.e. People with increased risk of poor health are identified early on and are supported to prevent premature problems developing.

  Examples include: exercise/drug treatment to lower cholesterol and early detection of disease e.g. cancer screening programmes.

- **Tertiary prevention** aims to slow or reverse disease progression. i.e. People living with long-term health problems avoid complications and maintain a good quality of life.

  Examples include: drug therapy/rehabilitation after heart attack/stroke, support programmes to keep people with conditions such as diabetes well.

2.3 The challenge around implementing a prevention strategy to close the health and wellbeing gap is that it will require a sustained focus over many years, at sufficient scale and reach, to really make a difference. The Health and Wellbeing Board has a key role in ensuring that there is a sustained focus on embedding prevention taking a ‘place-based’ approach that goes beyond just thinking about what public sector services provide.

3 Inequalities

3.1 Embedding a comprehensive approach to prevention is the most effective way of reducing health inequalities – a legal requirement of both Local Authorities and Clinical Commissioning Groups. The national review of evidence on heath inequalities[2] set out six policy objectives that require action:

[2] Fair Society Healthy Lives, The Marmot Review, 2010: http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review

- Give every child the best start in life;
- Enable all children, young people and adults to maximise their capabilities and have control over their lives;
- Create fair employment and good work for all;
- Ensure healthy standard of living for all;
- Create and develop healthy and sustainable places and communities;
- Strengthen the role and impact of ill-health prevention.

3.2 These policy objectives are very broad and we need to translate them into and align them with existing work locally. For example, there is growing evidence that it is vital to work to address the key drivers of the causes of inequalities and this should be used to inform local action to reduce the inequalities experienced in health outcomes between communities across Dorset.

3.3 Reducing inequalities includes action across all areas of work ranging from preventing the development of the risk of poor outcomes (e.g. health, wellbeing, development, attainment), for example by reducing the amount of sugar in the diet, through to diagnosing and treating poor health from these risks becoming disease, for example by managing diabetes to stop complications developing.

3.4 To reduce inequalities, we need both an approach that identifies individual risk factors in people living in small geographical areas that are associated with poorer health outcomes, plus efforts at the whole population level and across organisations. In this respect, the Health and Wellbeing Boards are ideally placed to make a real difference over the medium to long term.

3.5 In order to make a difference we are going to need work differently, not just in our own organisations but also across organisations. The Health and Wellbeing Board can provide the leadership for change, but collective action needs owned by all partners.

3.6 There are now a whole range of opportunities to put prevention and reducing inequalities at the heart of efforts to transform health and social care, including the development of integrated care systems, new models of care, and transformed local authority services.

3.7 Health and Wellbeing Boards are well placed to provide leadership for a real focus on prevention and inequalities in this journey, and above all, push for the development of population health systems as the next step in care integration.

4 Dorset Joint Strategic Needs Assessment – Summary of evidence

4.1 Bournemouth, Poole and Dorset cover an area in the South West of England governed by Dorset County Council and the unitary authorities of Bournemouth Borough Council and the Borough of Poole. Around half the population lives in the urban south east of the pan-Dorset locality, with the rest of the area being largely rural with a low population density.

4.2 Overall, our resident population enjoys relatively good health with a higher life expectancy than the England average. However there is some evidence that trends in early deaths from heart disease (particularly in Bournemouth) and cancer (particularly in Poole) are beginning to level off and the England average is catching up. Key challenges are:

4.2.1 Population change

- The population of Bournemouth, Poole and Dorset continues to grow. By 2025 our population will be almost 814,000;
- The population structure will change:
    - Over 70s increase rapidly (from 18% to 21% of the population by 2025);
    - Core working age population (20 to 59) declines (from 49% to 45%);
    - Children and young people under 20 rise in line with overall growth (stays at 21% of the overall population).

4.2.2 Lifestyle factors

- Bournemouth, Poole and Dorset compare well overall to England for most lifestyle factors;
- Smoking prevalence is low (16%) and falling;
- Overweight and obesity is mostly better than England, but still too high, and is increasing;
- Any improvements in health from fewer people smoking will be offset by more people who are obese;
- Patterns of alcohol use have changed, with levels falling for many groups, however health impacts continue to rise and this is a particular issue for Bournemouth.

4.2.3 Quality and experience of care

- Care within the local health and care system is delivered within a complex network of commissioners and providers with many different services and organisations involved;
- Variations in services are seen at all levels of the system; within primary care, secondary care, community care and social care. For example:
    - Local GP practices vary, with rates of between 66% and 98% for blood pressure control for people with heart disease;
    - Local hospitals vary, with between 1% and 6% of patients waiting longer than 31 days from the time of referral to their first treatment for cancer;
    - Reablement services within social care have different criteria for referral and different offers to the service user;
- Simplifying the system will help people to find their way to the services they need;
- Understanding and addressing inappropriate variation in care within our services will stop some people needing more complex care at a later date.

4.2.4 Inequalities

- Life expectancy within areas of Bournemouth, Poole and Dorset varies. Since the figures reported in 2007 the gap has:
    - Stayed the same for men in Dorset (6 years) and Poole (7-8 years), and for women in Bournemouth (6 years) and Poole (6-7 years);
    - Got bigger for men in Bournemouth (from 8 to 11 years) and women in Dorset (from 4 to 6 years);
    - Overall, average life expectancy at birth between 2010 and 2012 in Dorset was 81.2 years for males and 85.3 years for females;
    - In Bournemouth average life expectancy at birth between 2010 and 2012 was 78.6 years for males and 83.1 years for females;
    - In Poole average life expectancy at birth between 2010 and 2012 was 80.2 years for males and 84.1 years for females (Source ONS).

- Locally we recognise priority neighbourhoods where a range of socio-economic factors, different in different communities, come together to provide particular needs for that community:
    - Bournemouth – Boscombe, West Howe;
    - Poole – Bourne Valley;
    - Dorset – Weymouth and Portland/Melcombe Regis;
- Early childhood experiences impact on future outcomes; delivering a universal service will help us to reach the 5,307 children in need who require more support even where they are not in our priority neighbourhoods.

4.3 In summary the JSNA tells us that:

- More people overall will mean more demand on most health and care services, and older people in particular are more likely to have one or more long term conditions that impact on their health, again with increased demand for health and social care.

- We need to work on improving lifestyle factors and quality and experience of care to slow the increase in demand; this will not be enough on its own, but if we do not then demand will increase even further and faster.

- Equally we need to recognise the inequalities that currently exist in our local system and ensure that any changes we make do not make these worse, but aim to improve. We need to think differently about how we all work together to improve our population outcomes in the light of this increasing demand.

5 Communicating the key messages and the next steps

5.1 The Health and Wellbeing Board members have highlighted the need to promote the work that is needed to achieve the desired outcomes of the JHWS and to maximise the activity undertaken and generated by the Board. The benefits to Dorset's residents associated with the JHWS and the reasons why behaviour change can have a significant and lasting impact on individuals and the community need to be widely communicated.

5.2 The overall message emerging from thematic reviews and associated workshops linked to the original JHWS was that there is a need for a greater focus on early intervention, education and prevention across all areas of work. Development work with Board members in October 2015 highlighted this role and the opportunity that a new Strategy would offer to take this forward.

5.3 In January 2016 audit work began to establish the extent to which organisations, including the Health and Wellbeing Board itself, had followed up recommendations and actions arising from previous thematic reviews (see Appendix 2). The results of this audit will be reported to the Board and will help to identify areas of progress and areas for further development.

5.4 In addition, it was recognised that a great deal of work around the policy objectives to tackle inequalities was already taking place, but partner organisations were not always aware. To capture the level of activity and identify gaps, a second audit will be undertaken, as part of the development work for the JHWS.

5.5 The proposed new JHWS will have a high level communications and engagement programme, seeking support from all the delivery bodies including the local authorities, public services, third/voluntary sector and the private sector (see draft

Plan, Appendix 3). Key to this is understanding what the Strategy can achieve and how best to do this.

Catherine Driscoll
Director for Adult and Community Services
March 2016

Appendix 1

Dorset Joint Health and Wellbeing Strategy 2013 to 2016 – Priorities and trend data

1 Introduction

1.1 The first Dorset JHWS was published in June 2013 following two periods of consultation with a wide range of stakeholders. The final Strategy:

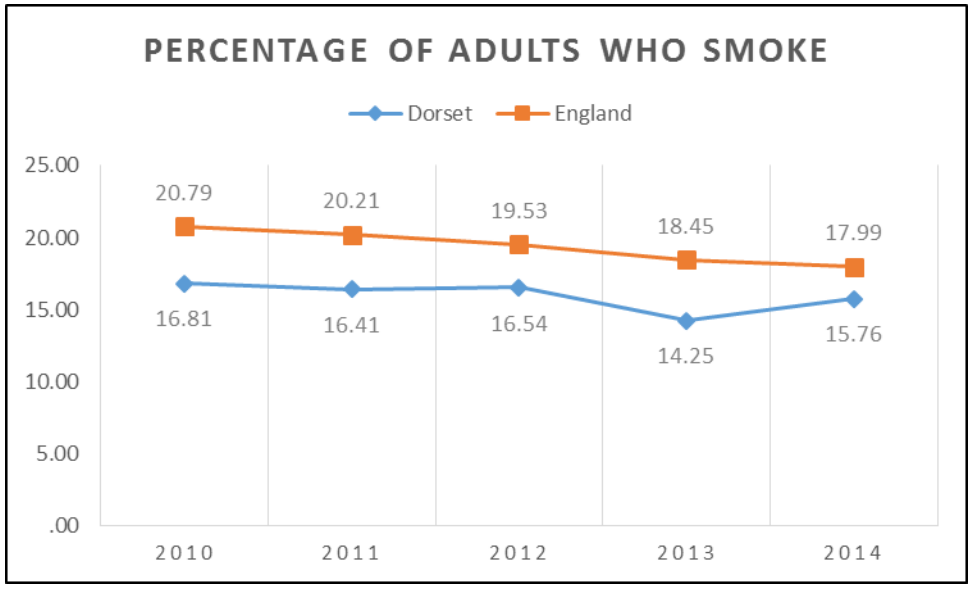
- Adopted nine principles setting out the way in which the Board and its partner organisations would work to achieve the best outcomes for the population.
- Identified four key aims:
    1. People live in environments that support their health and wellbeing.
    2. People, families and communities are enabled to live healthy and fulfilling lives.
    3. People with increased risk of poor health are identified early on and are supported to prevent premature problems developing.
    4. People living with long-term health problems avoid complications and maintain a good quality of life.
- Identified six priorities for action (for 2013-14):
    1. Reducing the harms caused by smoking
    2. Reducing circulatory disease
    3. Reducing the harms caused by road traffic collisions
    4. Reducing the harms caused by diabetes
    5. Reducing anxiety and depression
    6. Improving care for people with dementia

1.2 The above priorities were chosen following detailed consideration of a range of variables such as the scale of the issue, the possibilities for making changes, the financial impact, wider implications and external imperatives for action.

1.3 Lead responsibility for each of Dorset's six priorities was assigned to partners already involved in the respective areas of work. Public Health Dorset therefore assumed responsibility for reducing the harms caused by smoking, under the Tobacco Alliance programme, the Dorset Strategic Road Safety Partnership assumed responsibility for reducing the harms cause by road traffic accidents and the Clinical Commissioning Group assumed overall responsibility for the remainder of the priorities, in conjunction with their existing Clinical Commissioning Programmes.

1.4 Monitoring of progress was to be undertaken via single over-arching outcome indicators, and trend data for the outcome indicators is as follows:

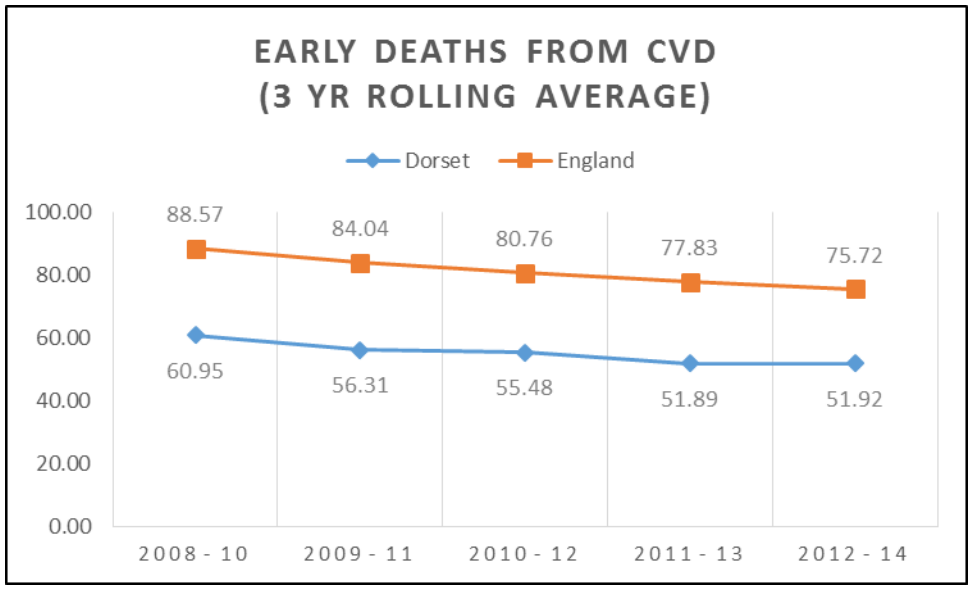
1. Reducing the harms caused by smoking



Percentage of adults (aged 18 and over) who smoke (Public Health Outcomes Framework – PHOF)

Dorset has a consistently lower percentage of adults who smoke compared to the England average, at a statistically significant level. The percentage did rise slightly between 2013 and 2014 however (from 14.25% to 15.76%).

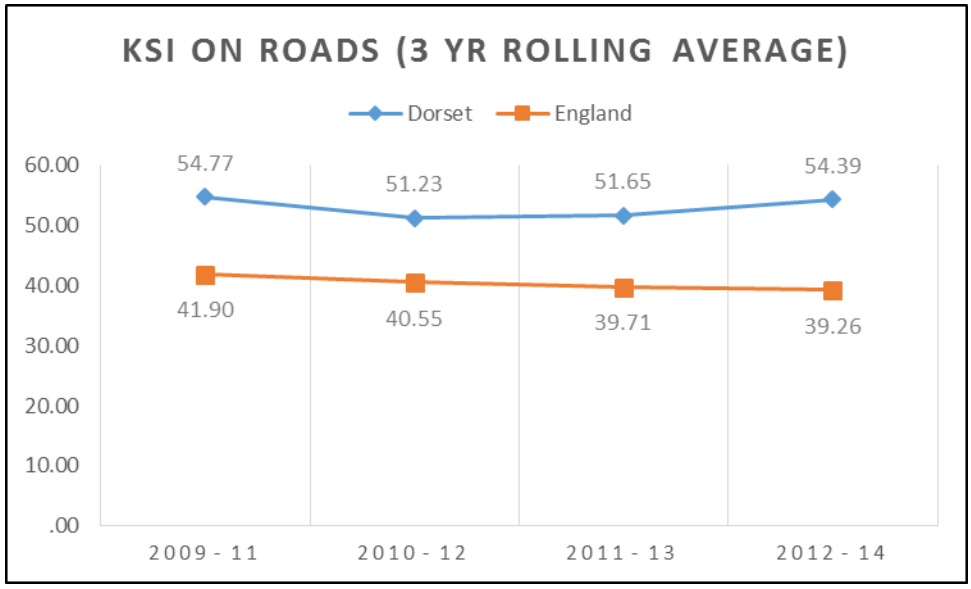
2. Reducing circulatory disease



Early deaths: heart disease and stroke (Directly standardised rate per 100,000 population – 3-year rolling average) (PHOF)

There are fewer early deaths (before the age of 75 years) from cardiovascular diseases amongst Dorset residents than in England as a whole, and both Dorset and England have seen improved rates of death over recent years. Year on year locally there has been no significant change in rates of early deaths from CVD.

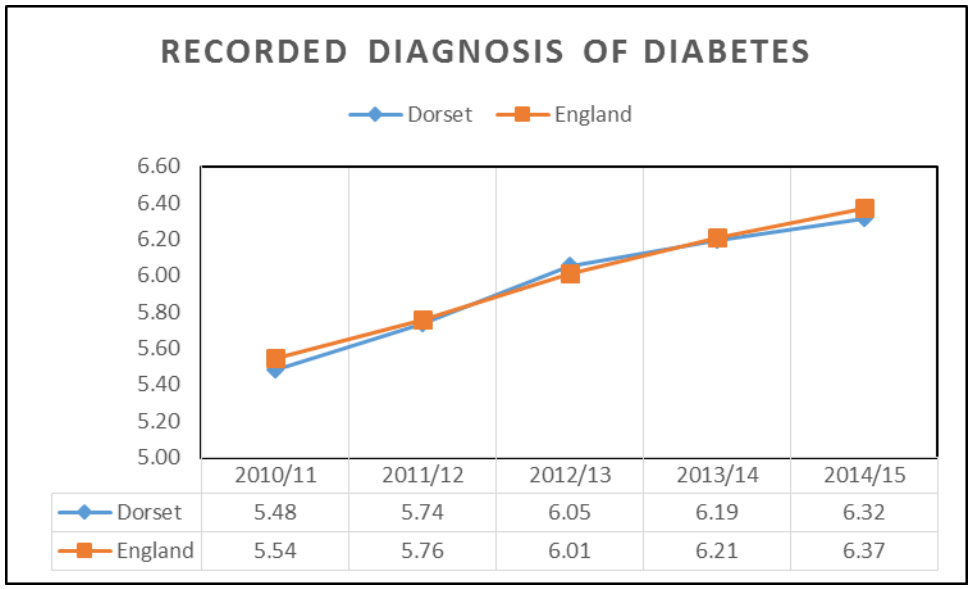
3. Reducing the harms caused by road traffic collisions



Road injury and deaths (rate per 100,000 population – 3-year rolling average) (PHOF)

The number of individuals killed or seriously injured (KSI) on Dorset's roads has been higher than the average for England for some years, and continues to be so.

4. Reducing the harms caused by diabetes

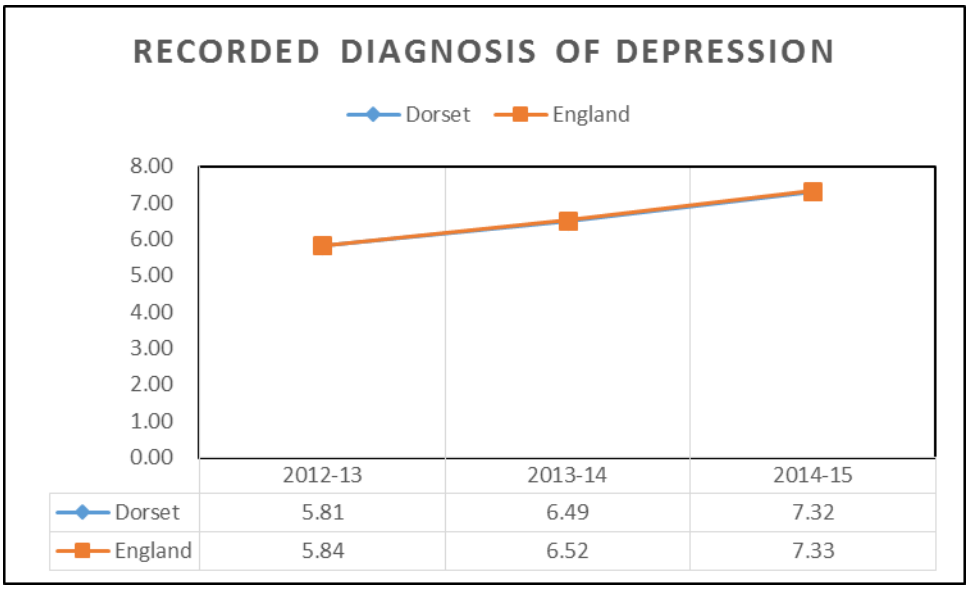


	2010/11	2011/12	2012/13	2013/14	2014/15
Dorset	5.48	5.74	6.05	6.19	6.32
England	5.54	5.76	6.01	6.21	6.37

Percentage of people on GP registers with a recorded diagnosis of diabetes (PHOF)

The rate of recorded diagnosis of diabetes continues to be similar to that seen across England, and has risen in recent years but not at a statistically significant level.

5. Reducing anxiety and depression



Percentage of adults (aged 18 and over) with a recorded diagnosis of depression (QOF data)

The rate of recorded diagnosis of depression in Dorset also continues to be very similar to that seen across England, and has risen in recent years at a statistically significant level.

6. Improving care for people with dementia

A measure of the effectiveness of post-diagnosis care in sustaining independence and improving quality of life for people with dementia is not currently available.

1.5 Overall, in terms of priority areas within the 2013 to 2016 JHWS, the data indicates that:

- Dorset has improved, but is still worse than England with regard to deaths and serious injuries as a result of road traffic collisions;
- For circulatory disease and smoking the County performs relatively well;
- For diabetes the picture is similar to that in England as a whole;
- For depression the picture is also similar to that in England as a whole;
- A suitable measure for an improvement in care for people with dementia is not available, but with an estimated 8,630 people suffering the condition currently this presents an on-going challenge for individuals, carers and services.

1.6 Data from the Dorset Joint Strategic Needs Assessment (JSNA) further suggests that health needs in Dorset have remained fairly stable since 2007, and in general individuals enjoy a long life and good health. Changes over time mostly mirror the national picture, with mortality and rates of smoking falling, but obesity rates and problems with alcohol increasing. There is however variation within Dorset, with a 6 year gap in life expectancy between the best and worst performing areas.

Appendix 2

Dorset Joint Health and Wellbeing Strategy 2013 to 2016 – Work by the Dorset Health and Wellbeing Board to address the priorities

1 Thematic reviews

1.1 In September 2014 the HWB agreed to devote the second part of each Board meeting to thematic reports on topics linked to the priorities identified within the Joint Health and Wellbeing Strategy.

1.2 By the end of 2015 five of the priorities had been reviewed within four thematic reports: Reducing circulatory disease, reducing the harms caused by road traffic collisions, reducing the harms caused by diabetes, reducing anxiety and depression and improving care for people with dementia. The sixth priority, reducing the harms caused by smoking has not been reviewed directly by the HWB, although it was referenced within the report on cardiovascular disease.

1.3 The reports were considered in the context of the following key principles:

- The identified need and equity of need;
- The effectiveness of what is being done about that need;
- The impact and outcomes resulting from what is being done; and
- The efficiency surrounding the use of resources.

1.4 In addition to presenting information and data to set the context in Dorset regarding the identified needs and responses to those needs, stakeholder feedback was gathered via three workshops. All reviews and workshops were conducted by multi-agency groups, including members of the Health and Wellbeing Board, as appropriate.

2 Outcomes from thematic reviews

2.1 **Reducing circulatory disease – 12 November 2014:** Dorset HWB Report - Cardiovascular Disease, November 2014

The first thematic review, focussing on the priority to reduce circulatory disease, highlighted the scale of the issue for Dorset, the (often) preventable nature of the disease, the variation in rates across localities and the importance of risk management. Members resolved to share the findings widely, particularly with the Children's Trust Board, and to ensure that the data informed work of the Clinical Commissioning Group's Clinical Services Review.

2.2 **Reducing anxiety and depression and improving care for people with dementia – 4 March 2015:**
Dorset HWB Report - Mental Health throughout life, March 2015

The second thematic review concerned the two priorities linked with mental health: reducing anxiety and depression and improving care for people with dementia. To inform the report a workshop was held, attracting more than 60 individuals who were able to contribute their views of current services and gaps in provision. A wide range of actions and recommendations were proposed as a result of the review, and the value of early intervention and work with schools was emphasised.

2.3 **Reducing the harms caused by diabetes – 10 June 2015:**
Dorset HWB Report - Healthy eating, Obesity and Diabetes, June 2015

The third thematic review was linked to the priority to reduce the harms caused by diabetes, but was widened to encompass healthy eating (including sustainable food) and obesity. Again a workshop was held, enabling engagement with individuals, statutory and community based organisations with diverse perspectives. Prevention and early intervention, including links with physical activity, schools and general practitioners, were felt to be key to tackling the issues presented.

2.4 **Reducing the harms caused by road traffic collisions – 9 September 2015:**
Dorset HWB Report - Reducing the harms from RTCs, September 2015

The fourth thematic review looked at reducing the harms caused by road traffic collisions and was undertaken in partnership with Bournemouth Borough Council and the Borough of Poole. In addition, the review and associated workshop was coordinated by a multi-agency group which included Dorset Police, Dorset Fire and Rescue Service and the Environment and Economy Directorate within Dorset County Council. The review highlighted the most frequent causes of road traffic collisions and subsequent discussion identified a number of actions for members and partner organisations. Education of children, young people and adults to raise awareness of the risks was widely recognised and the need to invest in more detailed data analysis was proposed, to better understand the circumstances and outcomes of collisions.

3 Actions following thematic reviews

3.1 The overall message emerging from the thematic reviews and associated workshops was that there is a need for a greater focus on early intervention, education and prevention across all areas of work.

3.2 In January 2016 audit work began to establish the extent to which organisations, including the Health and Wellbeing Board itself, had followed up recommendations and actions arising from thematic reviews. The results of this audit will be reported to the Board and will help to identify areas of progress and areas for further development.

Appendix 3

Dorset Joint Health and Wellbeing Strategy Draft Consultation Approach, 9 March 2016 to 20 April 2016

Stakeholders	Method of consultation	Date	Lead
Statutory and internal partners: **Health** **Adult and Community Services** **Children's Services** **Environment and Economy** **Public Health** **Fire and Rescue Services** **Police/PCC** **District and Borough Councils** **Town and Parish Councils** **Housing Associations**	Information regarding the start of the 6 week consultation to be developed and sent via key contacts	By 9 March 2016	Ann Harris
	Key representatives to be invited to workshop on 5 April	5 April 2016	Ann Harris
Other key partners: **Dorset Local Nature Partnership** **Dorset Safeguarding Adults Board** **Dorset Safeguarding Children Board** **Community Safety Partnership** **Children's Trust Board** **Care Quality Commission** **Dorset MPs**	Information regarding the start of the 6 week consultation to be developed and sent via key contacts	By 9 March 2016	Ann Harris
	Key representatives to be invited to workshop on 5 April	5 April 2016	Ann Harris
Elected members	Information regarding the start of the 6 week consultation to be developed and sent via Democratic Services	By 9 March 2016	Ann Harris / Lee Gallagher
	Members briefing	Before 20 April 2016	TBC

Dorset Health Scrutiny Committee	Information regarding the start of the 6 week consultation to be developed and sent via Democratic Services	By 9 March 2016	Ann Harris / Denise Hunt
	Information re Draft Strategy to be presented as Briefing at Committee on 8 March 2016	8 March 2016	Ann Harris
	Members to be invited to workshop on 5 April	5 April 2016	Ann Harris
Voluntary and Community sector including: **POPP / Dorset Age Partnership** **Dorset Community Action** **Healthwatch** **Dorset MH Forum** **People First Dorset** **Dementia Care Partnership** **Carers Partnership** **Dorset Race Equality Council** **Clinical Commissioning Group Patient (Carer) and Public Engagement Group**	Information regarding the start of the 6 week consultation to be developed and sent via key networks, including POPP, DCA and Healthwatch	By 9 March 2016	Ann Harris
	Key representatives to be invited to workshop on 5 April	5 April 2016	Ann Harris
General public	Information regarding the start of the 6 week consultation to be developed and distributed via networks	By 9 March 2016	Ann Harris
	Information to be uploaded to Consultation Tracker	9 March to 20 April 2016	Ann Harris
	Press release and other comms to be developed	By 9 March 2016	Paul Compton

Ann Harris, Health Partnerships Officer, March 2016

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Dorset Health Scrutiny Committee

Dorset County Council

Date of Meeting	8 March 2016
Officer	Director for Adult and Community Services
Subject of Report	**South Western Ambulance Service NHS Foundation Trust – NHS 111 Service**
Executive Summary	This report focuses on the allegations made in the Daily Mail on 15 and 16 February 2016 about the NHS 111 service provided by the South Western Ambulance Service NHS Foundation Trust (SWASFT). SWASFT strongly refutes a number of allegations made in the newspaper articles. There are also actions that Sarah Hayes says she took, reported in the Daily Mail, for which SWASFT can find no paper trail or audit and an investigation in to the allegations made in the newspaper has been commissioned. This is due to start before the next Committee meeting. In addition the Care Quality Commission (CQC) is making an early inspection of SWASFT's NHS 111 services on Tuesday 8 and Wednesday 9 March. This standard inspection has been brought forward as a result of the claims made in the Daily Mail.
Impact Assessment:	Equalities Impact Assessment: Not applicable.
	Use of Evidence: Report provided by South Western Ambulance Service NHS

	Foundation Trust.
	Budget: Not applicable.
	Risk Assessment: Having considered the risks associated with this decision using the County Council's approved risk management methodology, the level of risk has been identified as: Current Risk: LOW Residual Risk LOW
	Other Implications: None.
Recommendation	1 That members consider and comment on the report. 2 That members nominate three individuals who would be willing to join an ad-hoc Joint Health Scrutiny Committee to consider the issues raised in this report, should the members of Dorset, Bournemouth and Poole's Committees which are responsible for health scrutiny wish to take the matter further. 3 That members nominate a substitute for the possible Joint Committee, should one of the three agreed nominees subsequently not be available on the required date(s).
Reason for Recommendation	The work of the Committee contributes to the County Council's aim to protect and enrich the health and wellbeing of Dorset's most vulnerable adults.
Appendices	None.
Background Papers	None.
Officer contact DCC Officer contact external organisation	Name: Ann Harris, Health Partnerships Officer Tel: 01305 224388 Email: a.p.harris@dorsetcc.gov.uk Name: Louise Bowden, Head of Marketing, PR and Communications, SWASFT Tel: 01392 261520 Email: louise.bowden@swast.nhs.uk

South Western Ambulance Service NHS Foundation Trust

1 Introduction

1.1 This report focuses on the allegations made in the Daily Mail on 15 and 16 February 2016 about the NHS 111 service provided by the South Western Ambulance Service NHS Foundation Trust (SWASFT).

1.2 SWASFT strongly refutes a number of allegations made in the newspaper articles. There are also actions that Sarah Hayes says she took, reported in the Daily Mail, for which SWASFT can find no paper trail or audit and an investigation in to the allegations made in the newspaper has been commissioned. This is due to start before the next Committee meeting.

1.3 In addition the Care Quality Commission (CQC) is making an early inspection of SWASFT's NHS 111 services on Tuesday 8 and Wednesday 9 March. This standard inspection has been brought forward as a result of the claims made in the Daily Mail.

2 The allegations

2.1 Patient care and safety remain top priorities for SWASFT. Wherever possible we have worked personally with the families involved in the cases referred to in the Daily Mail to ensure that all of their concerns were addressed. An apology and assurances have been issued to those families, and the Trust has thanked them for their input.

2.2 The Trust is proud of the work that its staff delivers day in, day out, and is fully confident of the robust procedures it has in place around the NHS 111 service. The Trust though does take any allegation seriously which is why it immediately commissioned an investigation.

- As a supervisor within the NHS 111 service, the Trust was surprised and disappointed that Ms Hayes did not follow the Trust's well-established whistle-blowing process – 'Speak up, Speak out' – and that she has taken so long to make these allegations, as SWASFT actively encourages its staff to report any incidents of concern so that they can be fully investigated and lessons learned.

- The Daily Mail made suggestions of a 'cover up'. As is standard practice, investigations into the circumstances of a serious incident may be published, but the Trust has a duty of care to patients and information will not be released to the media without the necessary permission of the family.

  In this instance, in line with established processes and procedures, details of the incident reported in the national newspaper were shared with the local Clinical Commissioning Group (CCG). A summary report was also shared with the CQC in line with national framework around reporting

- The Daily Mail made allegations around staffing and resourcing. The SWASFT service is not unsafe in relation to staffing and resourcing and is under ongoing scrutiny both internally and externally. There is always clinical cover. Additionally, the clinical hub (control room) in Dorset hosts a number of services including out of hours, 111 and 999, ensuring there is plenty of support available.

- The Daily Mail made allegations about non pathways advisers (NPAs). Patients are not put at risk with the use of NPAs. The introduction of NPAs was agreed with NHS England and NHS Pathways.

  NPAs are call takers answering calls to the NHS 111 service for patients who do not require clinical assessment and have chosen from a series of automated options to help better direct their call.

  The people working for SWASFT in this role are of all ages. The Trust focuses on whether an individual has a set of certain competencies and do not discriminate against age.

  This role was not introduced as a performance measure, but to improve the experience of patients because not all callers need to go through the NHS Pathways system of questioning. Many people use the service to be signposted to other healthcare services and do not require formal assessment.

- The Daily Mail made allegations in relation to the death of William Mead and a SWASFT call handler. A full investigation was carried out into William's death by NHS England CQC and the SWASFT call handler's performance was not linked directly to the death of William. The work of several organisations came under scrutiny and the Trust acknowledged there was a missed opportunity to identify how unwell William was and formally apologised to Mr and Mrs Mead over the sad death of their son. We also worked closely with them during the investigation. The member of staff in question did not carry out any intentional or wilful act of neglect when carrying out his duties and therefore no formal disciplinary proceedings were required. The Trust is not aware of any performance related concerns raised about this call handler since the death of William Mead.

- The Daily Mail made suggestions that staff sleep while on duty. The Trust has not received any reports of 111 staff falling asleep prior to publication in the newspaper. SWASFT does not condone it and will be investigating the matter. SWASFT also expects all its staff, especially those in a supervisory role as Sarah Hayes was, to escalate and report any issues of this nature, but no evidence of this being reported can be found.

3 General information.

3.1 Of the total number of calls in 2015, Dorset 111 received 244,784, an increase of 1.5% over the previous year of 241,195 calls handled.

3.2 Dorset received on average 728 calls per day in December 2015. The highest average daily calls offered in 2015 was in May with 749 calls per day offered.

3.3 In December 2015 of the 1.36 million calls handled nationally, Dorset 111 answered 90% of their calls within 60 seconds. Above the England performance figure of 86.1%.

3.4 Last year the SWASFT NHS 111 service across the region answered 805,739 calls, six of which resulted in serious incident investigations which represents approximately 0.0007% of calls handled.

Please also note that the inspection of all Trust services in June is still going ahead as planned.

Louise Bowden,
Head of Marketing, PR and Communications,
South Western Ambulance Service NHS Foundation Trust

March 2016

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Dorset Health Scrutiny Committee

Dorset County Council

Date of Meeting	8 March 2016
Officer	Director for Adult and Community Services
Subject of Report	**Weymouth Community Urgent Care Centre Project and Weymouth Walk-in Centre and the Practice GP Service**
Executive Summary	The purpose of this paper is to provide the Committee with an update on the Weymouth Community Urgent Care Centre Project, the progress to date and next steps. Sections 2-5 are presented on behalf of Dorset CCG detailing the work the CCG has been leading on. Section 6 is presented on behalf of NHS England detailing the work it has been leading on regarding The Practice, Melcombe Avenue (The press release at Appendix 1 sets out the latest position). Both NHS England and the CCG have been working together throughout this project ensuring links and engagement with the locality and feeding into the Project Board.
Impact Assessment:	Equalities Impact Assessment: Report provided by NHS Dorset Clinical Commissioning Group
	Use of Evidence: Report provided by NHS Dorset Clinical Commissioning Group
	Budget: Report provided by NHS Dorset Clinical Commissioning Group

	Risk Assessment: Having considered the risks associated with this decision using the County Council's approved risk management methodology, the level of risk has been identified as: Current Risk: LOW Residual Risk: LOW
	Other Implications: N/A
Recommendation	That the Committee consider and comment on the findings within the report.
Reason for Recommendation	The work of the Health Scrutiny Committee contributes to the County Council's aim to protect and improve the health, wellbeing and safeguarding of all Dorset's citizens.
Appendices	1 Press release from NHS England - South (Wessex), 25 February 2016, regarding the Practice, Melcombe Avenue
Background Papers	Briefing paper to Dorset Health Scrutiny Committee, 22 May 2015: Dorset Health Scrutiny Committee briefing 22 May 2015
Officer Contact - External organisation	Name: Mike Wood, Director, Service Delivery, NHS Dorset Clinical Commissioning Group Tel: 01305 368900 Email: Mike.Wood@Dorsetccg.nhs.uk **NHS England Contact:** Melanie Smoker, Contract Manager (Medical), Wessex NHS England, Oakley Road, Southampton, SO16 4GX Email: Melanie.smoker1@nhs.net

1. UPDATE

1.1. The purpose of this paper is to provide the Committee with an update on the Weymouth Community Urgent Care Centre Project, the progress to date and next steps.

1.2. Sections 2-5 are presented on behalf of Dorset CCG detailing the work the CCG has been leading on.

1.3. Section 6 is presented on behalf of NHS England detailing the work it has been leading on.

1.4. Both NHS England and the CCG have been working together throughout this project ensuring links and engagement with the locality and feeding into the Project Board.

2. OUTLINE OF THE BACKGROUND, CONTEXT AND SCOPE

2.1. There are currently three services, independently contracted, based at Weymouth Community Hospital: The GP-led Walk In Centre (WIC), Minor Injuries Unit (MIU) and Out of Hours (OOH) service. These services see and treat service users who walk in or are triaged from 111 with a varying range of primary care needs, minor illness, minor injuries and urgent care needs.

2.2. It was decided not to include the Out of Hours service within the tender and continue with the existing service as this service is delivered from this site as an element of the pan Dorset OOHS service provision.

2.3. The contract for the GP led Walk in Centre contract expires 30 June 2016 and there is no option to extend the contract further.

2.4. NHS England currently commissions the Walk in Centre contract which includes a primary care patient list. The patients who are currently registered on the list have been given an opportunity to comment on the options for future care. An engagement exercise took place during January 2016 with an open day event at the practice on 19th January. Further details on the process and progress can be found in section 5.

2.5. The Government's vision of future models of care referenced in the NHS Five Year Forward View, 23 October 2014, NHS England indicates a need for an integrated approach with service users seen by the right people, in the right place at the right time.

2.6. The vision is to reduce inappropriate attendances in settings such as Emergency Department and likewise redirect those patients who should be treated in primary care or could be seen by a pharmacist.

2.7. The Keogh report presented NHS England's future vision for urgent and emergency care in 'Transforming Urgent and Emergency Care Services in England: Urgent and Emergency Care Review End of Phase 1 Report'. The report sets out a vision for change summarised as follows:

2.7.1. For those people with urgent but non-life threatening needs, we must provide highly responsive, effective and personalised services outside of hospital.

2.7.2. For those people with more serious life threatening emergency needs, we should ensure they are treated in centres with the very best expertise and facilities in order to maximise their chances of survival and a good recovery.

2.8. Engagement has taken place with locality GP practices, carers and service user representatives, current staff from the WIC, MIU and OOH, Voluntary/third sector, secondary care service such as CADAS, Sexual Health, local councillors, locality health network, NHS England, Public Health, Weymouth Community Hospital League of Friends and Volunteers and the wider public to identify the needs and through an iterative process has refined and understood the service needs. Feedback received contributed to the design of the new specification.

2.9. Once a framework for the service was established, a market engagement event was held on the 22 January 2015 inviting any interested party to fully engage in the process. The underlying theme of the engagement event was to encourage providers to consider a vision of seamless integrated care and partnership working.

2.10. The specification and principles were formally presented to the Health Scrutiny Committee on the 10th March 2015 and presented at the Governing Body meeting and approved on 18 March 2015.

3. PROCUREMENT PROJECT TEAM AND OBJECTIVES

3.1. A formal project team and oversight was established to manage the procurement process. This included independent GP leads, independent patient leads and an independent oversight member on behalf of the Governing Body. This process was led by the Procurement Specialists within the CCG to ensure a correct and transparent process.

3.2. Following extensive liaison with the public of Weymouth and Portland, clinicians and the provider market place it was agreed the service should provide:

3.2.1. A more focussed and appropriate response to the needs of service users currently attending emergency departments with illnesses and injuries which do not require intensive or specialised care.

3.2.2. Greater integration between community urgent care service and services delivered in the community facilitated by the stronger links with primary care practitioners enabling individuals to be referred more rapidly and seamlessly to relevant pathways, and improving access to community-wide responses to people's care needs.

3.2.3. Increasing the interdependency, networking and mutual support of primary and secondary care practitioners, with a gradual transfer of skills, knowledge and shared competencies creating a more integrated and flexible workforce over time.

3.2.4. Shorter waiting times for service users and a reduction in Emergency Department attendances.

The objectives included:

3.2.5. Contract with a compliant provider (or group of providers) of the services meeting the agreed specification;

3.2.6. Full integration with interdependent services;

3.2.7. Ensure the service design is future proofed in line with emerging models of care agreed through the clinical services review;

3.2.8. Engage, communicate and consult effectively with all key stakeholders;

3.2.9. Secure the full range of services at a cost effective price;

3.2.10. Ensure compliance with all relevant legislation, internal corporate governance and procurement best.

4. PROCUREMENT PROCESS

4.1. An advert for the service was placed on 27 July 2015, following a formal briefing session. Tenders were issued on 4th September 2015 to eleven providers who expressed an interest in the service. Four tenders were received on 20th October 2015.

4.2. An evaluation plan detailing how tenders would be evaluated was prepared and distributed to the project team prior to the issue of tenders. Two meetings were held where the team met to have evaluation training and guidance to ensure the consistency of scoring. The evaluators' scores and comments were consolidated onto a summary spreadsheet and where scores for a particular question differed by more than 1 point from the mean these responses were flagged for moderation. A moderation meeting was held on 16 November 2015 to review scores and to shortlist providers to be interviewed by the panel. It was decided to offer interviews to all four providers. Interviews were held on 30th November 2015.

4.3. At a meeting of the Governing Body of NHS Dorset CCG on 20th January 2016 recommendation to award the contract was made. The CCG is not yet in a position to formally announce the new provider as the procurement process has not been finalised.

5. NEXT STEPS

5.1. Once the procurement phase is finalised, a mobilisation period will be set for this contract to consolidate the teams and engage patients regarding the changes.

5.2. A large engagement and communications service programme will run alongside to inform and shape patient behaviour.

5.3. With regard to the registered patient population of the practice surgery, NHS England will determine the most appropriate options available following the patient engagement exercise. It will work with the current provider to ensure that patient care continues until the end of the contract and ensure a seamless transition to the surgeries in the locality. The locality is working on the development of a specific service for the homeless and vulnerable patients which it intends to commission at the same time as the current service ending. This will ensure consistency of service for this patient group.

6. Weymouth walk-in centre and the practice surgery update

6.1 The walk in Centre and Practice surgery is currently commissioned as one contract held by NHS England and is provided by The Practice PLC. NHS England has been reviewing the options for the future provision of medical services at Weymouth Community Health centre known as the Melcome Avenue practice surgery since September 2015. The contract was due to expire at the end of June 2014 but was extended to 30th June 2016, to enable the CCG to work through what its commissioning intentions should be regarding the non- registered Walk in Centre element.

6.2 The options for the future of these local medical services are being carefully considered, particularly given the recognised health issues linked to deprivation, homelessness and substance misuse. This will ensure the best decision can be made about services for patients registered with the practice.

6.3 **Current provision:** The GP Walk-In Centre is based at Weymouth Community Hospital and is open 7 days a week from 8am to 8pm. Patients can walk in to see a GP without the need for an appointment.

6.4 **Future provision:** The options currently being explored by NHS England include:

6.4.1 Finding another service provider in the area. This option would allow another local practice, already offering a service within the area at a different location, to provide services from Weymouth surgery as a 'branch surgery'.

6.4.2 A single new location for the service. This would involve all registered patients being transferred to another local practice within the Weymouth area.

6.4.3 Patient choice. All patients would be provided with the information about the other practices in the area, and would be advised to re-register with the one of their choice. This option is also available to all patients at any time even if options 1 or 2 are preferred.

6.4.4 Commissioning the registered patient list as it currently stands is not an option as it would involve the open market procurement of a new provider for 391 patients. A registered list of this size would, on average, require services of about two sessions per week of GP time. This is not a practical basis for securing full time general practice services and the standard price per patient would yield insufficient income to a provider to offer the standard GP opening hours on five full days per week. Attempting to secure standalone services for a population of this size runs counter to the strategic direction of scaling up services to obtain efficiency and effectiveness.

6.5 No decisions about the future of this service have yet been made. These are the options available and NHS England is currently in the process of engaging with patients and stakeholders to gain feedback so patients' needs are at the forefront of the decision-making process.

6.6 A Communications and Engagement Plan was established in November 2015 with engagement commencing in January 2016 including patient surveys and engagement events and drop in sessions inviting feedback from patients, local residents, the practice, local parish council, local providers, community and voluntary sector groups, health watch, local councillors and the Local Medical Council.

6.7 **Next Steps:** Analysis of the responses from engagement events will be taking place in February followed with feedback to stakeholders of the outcome and recommendations made for the future.

Mike Wood,
Director, Service Delivery
NHS Dorset Clinical Commissioning Group

Appendix 1

Community update: The Practice, Melcombe Avenue

NHS England has been reviewing the options for the future provision of medical services at The Practice, Melcombe Avenue because the current contract will end on Thursday 30 June 2016 and cannot legally be extended.

The options for the future of these local medical services are being carefully considered as we recognise some of the registered patients have health issues linked to deprivation, homelessness and substance misuse.

To inform upcoming decisions about this local health service, we sought patient feedback between Monday 4 January and Friday 22 January 2016.

Patient feedback clearly expressed a wish for the practice and service to remain as it is. Lots of patients are very happy with their GP and do not want things to change. Unfortunately the contract cannot legally be extended, so we need to make the best decision we can for these patients some of whom are very vulnerable.

As a reminder, the options we are exploring include:

- **Finding another service provider in your area**
  This option would allow another local practice, already offering a service within the area at a different location, to provide services from The Practice Melcombe Avenue as a 'branch surgery'.

- **A single new location for the service**
  This would involve all registered patients being transferred to another local practice within the Weymouth area.

- **Patient choice**
  All patients would be provided with the information about the other practices in the area, and would be advised to re-register with the one of their choice.

Patient feedback told us that the best option we can pursue is ***finding another service provider in your area***. This means patients will be able to access GP services from the same location, but it will be provided by another local practice which will run The Practice Melcombe Avenue as a 'branch surgery'.

A challenge is explaining to patients why we cannot yet confirm who their GP will be from 1st July 2016, but we have offered reassurance that they will be registered and able to access one. We understand that patients would like Dr Armitage to remain as their GP, but as you will understand, he is an independent practitioner so we cannot tell him where to work. He is no doubt considering his options and deciding what he would like to do.

If NHS England cannot secure another local practice to run The Practice Melcombe Avenue as a branch surgery group, all registered patients will need to be dispersed. This means

patients will be automatically registered with the most convenient practice for them. For example, this might be the nearest practice to their home address.

Drop in sessions
We will have a clearer idea of what will happen in a few weeks' time. As such, we are inviting patients to come and talk to us again at the practice. We will be there on **Tuesday 15 March 2016 from 1pm – 6pm**. You are more than welcome to drop in and see us too but we will ensure you are kept informed.

If you have any questions, please contact the NHS England Primary Care Team on **england.wessexmedical@nhs.net / 0113 824 8076**.

Kind regards,
Emily Grainger
For and on behalf of Melanie Smoker (Contracts Manager)

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Dorset Health Scrutiny Committee

Dorset County Council

Date of Meeting	8 March 2016
Officer	Director for Adult and Community Services
Subject of Report	**Briefings for information / noting**
Executive Summary	As agreed, briefings are now presented collectively under one report on items that are predominantly for information, but nevertheless are important for members to be aware of. For the current meeting the following updates/briefings have been prepared: • NHS Dorset CCG – Non-emergency Patient Transport Services update; • NHS Dorset CCG – Delivering the Forward View: NHS Planning Guidance 2016-17 to 2020-21 • Clinical Services Review Joint Health Scrutiny Committee, minutes of meeting held on 2 December 2015; Should Members have questions about the information contained in these briefings, a contact point for the relevant officer is provided. If a briefing raises a number of issues then it may be appropriate for this item to be considered as a separate report at a future meeting of the Committee.
Impact Assessment:	Equalities Impact Assessment: Not applicable.
	Use of Evidence:

	Information provided by Public Health Dorset, Poole Hospital Trust, NHS Dorset CCG, Dorset County Council and the West Dorset Partnership.
	Budget: Not applicable.
	Risk Assessment: Having considered the risks associated with this decision using the County Council's approved risk management methodology, the level of risk has been identified as: Current Risk: ~~HIGH~~/~~MEDIUM~~/LOW (Delete as appropriate) Residual Risk ~~HIGH~~/~~MEDIUM~~/LOW (Delete as appropriate)
	Other Implications: None.
Recommendation	The Committee notes and comments on the content of the briefing report and considers whether it wishes to scrutinise the issues in more detail at a future date.
Reason for Recommendation	The work of the Committee contributes to the County Council's aim to protect and improve the health, wellbeing and safeguarding of Dorset's citizens.
Appendices	1 NHS Dorset CCG – Non-emergency Patient Transport Services update 2 NHS Dorset CCG – Delivering the Forward View presentation 3 NHS Dorset CCG – Clinical Services Review Joint Health Scrutiny Committee, minutes of meeting, 2 December 2015
Background Papers	None.
Report Originator and Contact	Name: Ann Harris, Health Partnerships Officer Tel: 01305 224388 Email: a.p.harris@dorsetcc.gov.uk

Appendix 1

Dorset County Council

Briefing for Dorset Health Scrutiny Committee
8 March 2016

Title of Update Update on Non-Emergency Patient Transport	Matthew Wain Head of Patient Safety and Risk NHS Dorset CCG Vespasian House Barrack Road Dorchester DT1 1TS 01305 368946 Matt.wain2@dorsetccg.nsh.uk

1. This briefing is to provide an update on the quality and performance of Non-emergency Patient Transport provided by E-zec Medical to the population of Dorset.

2. HOSC members will be aware of the issues that the service experienced at the start of this contract and since then NHS Dorset CCG has been working closely with the provider to ensure that the initial capacity issues which led to a high volume of complaints have been addressed.

3. The latest data (December 2015) demonstrates compliance with all of their call-centre and significant compliance with their transport key performance indicators. During quarter three 94% arrived at their destination by their planned appointment time (against a target of 95%) compared with 84% in quarter four of last financial year. There have also been significant improvements in patients being collected at their agreed discharge time and a reduction in the number of aborted journeys.

4. In relation to the quality of the service, the number of patient complaints have fallen with the latest data demonstrating only 12 complaints for 14360 contacts. The number of incidents and safeguarding alerts have also reduced.

5. HOSC members will be aware that E-zec received a visit from the CQC in 2014 which found that the service was compliant in areas relating to care and welfare of patients, staffing levels, staff training, staff recruitment, complaints and infection prevention and control. The visit highlighted some issues with Medicines Management. A subsequent visit in August 2015 confirmed that the service is now compliant with the medication indicator, but did highlight issues relating to equipment, supervision and appraisals. E-zec have developed an action plan to address these issues that is being monitored through contractual processes.

6. NHS Dorset CCG will continue to work with E-zec and our acute providers to ensure that the residents of Dorset receive a high quality Non-emergency Patient Transport Service.

Appendix 2

Dorset County Council

Briefing for Dorset Health Scrutiny Committee
8 March 2016

NHS
Dorset
Clinical Commissioning Group

Delivering the Forward View: NHS Planning Guidance 2016-17 to 2020-21

Dorset Overview and Scrutiny Committee Update

February 2016

Supporting people in Dorset to lead healthier lives

Overview

NHS Dorset Clinical Commissioning Group

- Delivering the Forward View, the NHS planning guidance for 2016/17 – 2020/21 was published in December 2015;
- Jointly authored by six national NHS bodies with a clear set of national priorities for 2016/17 and longer term system wide priorities;
- Reflective of the Governments Mandate to the NHS and sets out objectives for the NHS as a whole, not just the commissioning system;
- NHS are required to produce two separate but connected plans as follows:
  - A one year **organisation based Operational Plan for 2016/17**, consistent with the emerging STP.
  - A five year **Sustainability and Transformation Plan** (STP), place based and driving the Five Year Forward View; and

One Year Operational Plan

NHS Dorset Clinical Commissioning Group

NHS Dorset CCG is currently developing it's one year operational plan for 2016/17, this plan sets out how we will deliver the 'nine must dos' set out in the planning guidance as follows.

	9 Must do's for 2016/17
1	Develop high quality STP
2	Return system to aggregate financial balance (Lord Carter)
3	Develop and implement local plan to address sustainability and quality of general practice
4	Achieve access standards for A&E and ambulance waits
5	Improve and maintain 18 week RTT target
6	Deliver 62 day cancer waiting standard and two week and 31 day standards
7	Achieve and maintain the two new mental health standards: i) 50% of people experiencing 1st episode psychosis commence treatment in 2 weeks ii) 75% of people with a common mental health condition will be treated in 6 weeks of referral 95% 18 weeks); and iii) Continue to meet dementia diagnosis rate at least 66% of people with dementia
8	Deliver actions set out in local plans to transform care for people with learning disabilities
9	Develop and implement an affordable plan to make improvements in quality

Sustainability and Transformation Plans (1)

NHS Dorset Clinical Commissioning Group

- The purpose of the STP is to bring every health and care system to come together to create its own ambitious blueprint for accelerating the implementation of the FYFV:
  - covering period October 2016- March 2021;
  - submission June 2016;
  - formal assessment July 2016.
- STPs scope includes health, local government and voluntary organisations (where appropriate) within the locality and must cover all areas of CCG and NHSE commissioned services.
- We are required to develop system wide local financial sustainability plan as part of the STP, spanning both providers and commissioners;

Sustainability and Transformation Plans (2)

NHS Dorset Clinical Commissioning Group

It needs to address the national challenges with a clear vision and plan for how the system addressing the three gaps, as follows:

- How will you close the health and wellbeing gap?
- How will you drive transformation?
- How will you close the financial gap?

STP- Progress to date

NHS Dorset Clinical Commissioning Group

Progress to date:

- STP Footprint has been agreed with partners and submitted to NHS England- 29 January 2016;
- CCG leading the process on behalf of the system supported by Public Health Dorset;
- planning leads from each organisation have been identified and meeting arranged for 22 February 2016;
- reviewed requirements and completed a gap analysis against the questions posed in the national planning guidance;
- draft structure and outline STP has been developed;
- shared draft project plans, existing information and gap analysis with project group.

STP- next steps

NHS Dorset Clinical Commissioning Group

Next Steps:

- planning group meeting planned for week commencing 22 February 2016;
- governance arrangements for sign off of STP to be confirmed;
- planning guidance awaited;
- 1st draft STP to be presented at CEO Reference Group Meeting 23 March 2016;
- 2nd draft STP to be presented at CEO Reference Group Meeting 1 April 2016;
- final submission of STP to NHSE end June 2016.

Appendix 3

Dorset County Council

Briefing for Dorset Health Scrutiny Committee
8 March 2016

Joint Health Scrutiny Committee on the Clinical Services Review

Minutes of a meeting held at County Hall,
Colliton Park, Dorchester on 2 December 2015.

Present:
Michael Bevan (Vice–Chairman in the Chair – Dorset County Council)

Bournemouth Borough Council
Eddie Coope and Rae Stollard

Dorset County Council
Bill Batty-Smith, Michael Bevan and Mike Byatt

Hampshire County Council
Roger Huxstep

The Borough of Poole
Vishal Gupta and Marion Pope

Dorset Clinical Commissioning Group (DCCG) Representatives:
Dr Paul French (Locality Chair for East Bournemouth), Tim Goodson (Chief Officer), Dr Forbes Watson (DCCG Chairperson) and Charles Summers (Director)

Officers:
Dorset County Council: Ann Harris (Health Partnerships Officer) and Denise Hunt (Senior Democratic Services Officer)
Borough of Poole: Victoria Mainstone (Team Leader (Overview and Scrutiny))
Hampshire County Council: Katie Benton (Scrutiny Officer)

Appointment of Vice-Chairman

Resolved

10. That Michael Bevan be elected Vice-Chairman of the Joint Health Scrutiny Committee for the year 2015/16.

Apologies

11. Apologies for absence were received from Ron Coatsworth (Dorset County Council), Jennie Hodges (the Borough of Poole), David d'Orton-Gibson (Bournemouth Borough Council); Chris Carter and David Harrison (Hampshire County Council).

Code of Conduct

12. There were no declarations by members of disclosable pecuniary interests under the Code of Conduct of each local authority.

Minutes

13. The minutes of the meeting held on 20 July 2015 were confirmed and signed.

Public Participation

Public Speaking

14.1 There were no public questions received at the meeting in accordance with Standing Order 21(1).

14.2 There were no public statements received at the meeting in accordance with Standing Order 21(2).

Petitions

15. There were no petitions received in accordance with the County Council's petition scheme at this meeting.

Clinical Services Review Programme Update

16.1 The Joint Committee received a presentation by Dr Phil Richardson of the Dorset Clinical Commissioning Group (DCCG). He informed members of the revised timetable for the Clinical Services Review (CSR) which included the development of clinical models to the end of January 2016; approval by the CCG in March 2016 and a number of assurance processes between April – June 2016 (including NHS England and Monitor). No specific date had yet been agreed for the public consultation on the proposals for services and models of care.

16.2 In response to a question in relation to cross border health services, the Joint Committee was informed that the DCCG worked collaboratively with neighbouring CCGs despite the requirement for each CCG to carry out its own public consultation.

16.3 Members asked how patients could be engaged in their healthcare pathway and have ownership of their information and were advised that ways in which this could be achieved included having a key point of access in the community and community teams working together. There was a need to look at all available technologies with regard to patient information and access, however, there were some effective systems that were already in place, such as the Dorset Care Record.

16.4 Members were advised that the Royal College had been engaged in medical training and that the shape of the workforce would change over the next 5-10 years due to multi-disciplinary teams blurring the edges between health and social care. It was requested that information about workforce and training issues be provided at a future meeting of the Joint Committee.

16.5 It was also confirmed that the DCCG was sharing information with similar Acute Vanguards and that there was a Vanguard group in the Wessex area. Some interesting models had been investigated in other areas including the Isle of Wight, Salford and London.

16.6 Members asked about transport in order to access health services and it was acknowledged that although this was a challenging factor, this could potentially be alleviated by bringing services such as chemotherapy into community settings.

Noted

Mental Health Acute Care Pathway: View Seeking Evaluation

17.1 The Joint Committee considered a report by the Director of Adult and Community Services on the review of the mental health acute care pathway which was being run in parallel with the CSR. An update on the mental health acute care pathway review had been provided to the Joint Committee in July 2015.

17.2 The Joint Committee received a presentation on progress of the review including the results of the view seeking phase undertaken from July to September 2015.

17.3 The Chairman asked about the practical implementation of the emerging proposals given the lack of clinical workforce which was understaffed and under resourced. He asked whether sufficient numbers of staff would be in place before the new models were implemented. The Joint Committee was advised that the new models of care would create changes in the workforce. This would therefore require a staged implementation process in order to accommodate those changes

17.4 In response to a question regarding different pathways according to the needs of the individual, members were informed that the GP or nurse would tend to identify the start of the pathway, but it was everyone's responsibility to increase awareness and improve access. Additional training would be necessary to ensure that the pathway functioned correctly. Outreach working would also be brought into GP practices to provide specialist advice.

17.5 The increasing number of ex-servicemen coming forward with mental health issues was highlighted and it was confirmed that the service charities would be asked to comment on the proposals.

17.6 Members were informed that the review would take into account transition services which was the subject of a working group and that this aspect would be brought back to the Joint Committee. It was also stated that early diagnosis in childhood would stop serious problems in adulthood and that there would be investment in early intervention services. In response to a question it was confirmed that the DCCG did not commission dyslexia services as most were seen by an educational psychologist rather than a mental health practitioner.

17.7 In response to a question about issues relating to urban residents, it was acknowledged that ideally efforts were made to support individuals in their own community, but inpatient units were also being reviews.

Noted

Date of Next Meeting

Resolved

18. That officers be asked to arrange the next meeting in March or April 2016.

Meeting duration: 10.00am to 12:30pm

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Dorset Health Scrutiny Committee – Forward Plan, March 2016

Committee: 8 March 2016			
Format	Organisation	Subject	Comments
Report	Dorset HealthCare University NHS Foundation Trust	CQC Inspection (June 2015) – Action Plan update	Follow up report – as requested by DHSC on 16/11/15
Report	NHS Dorset Clinical Commissioning Group	General Practitioner services in Dorset	Report re quality of services
Report	Dorset County Council	Dorset Health Scrutiny Committee Protocol	Revised Protocol for discussion and agreement
Report	South Western Ambulance Services NHS Foundation Trust	NHS 111 Services – Concerns regarding performance	Late item, following concerns raised in the media
Report	Dorset Health and Wellbeing Board	Dorset Joint Health and Wellbeing Strategy 2016/2019	To inform DHSC re the progress of the JHWS
Report	NHS Dorset Clinical Commissioning Group	Weymouth Urgent Care Centre project and changes to GP services at Weymouth Community Hospital	To inform DHSC re progress with the project
Items for information or note			
Briefing	NHS Dorset Clinical Commissioning Group	Clinical Services Review, minutes of Joint Committee	To provide the minutes from 2 December 2015
Briefing	NHS Dorset Clinical Commissioning Group	Non-emergency Patient Transport Services	To update DHSC re performance
Briefing	NHS Dorset Clinical Commissioning Group	Delivery Plan 2016/17 and new Sustainability and Transformation Plans	To inform DHSC re requirements for CCG plans in 2016
Forward Plan	Dorset Health Scrutiny Committee Forward Plan	Dates of future meetings, including planned agenda items	To raise awareness of future agenda items, meetings, workshops and seminars.

Committee: 7 June 2016			
Format	Organisation	Subject	Comments
Report	Dorset County Hospital	CQC Inspection findings	Following inspection in March 2016
Report	Dorset County Hospital	Seven-day services audit	As requested by DHSC on 16/11/15
Report	Various	MH Crisis care / CAMHS	TBC – Suggested by Healthwatch
Report	Dorset Health Scrutiny Committee	Annual Work Programme	To agree the Programme discussed at annual workshop
Report	Dorset Health Scrutiny Committee	Appointments to sub-Committees	Following any changes to membership in May 2016
Items for information or note			
Briefing	NHS Dorset Clinical Commissioning Group	Clinical Services Review, minutes of Joint Committee	To provide the minutes from 18 April 2016
Briefing	Dorset Health and Wellbeing Board	Dorset Joint Health and Wellbeing Strategy 2016/2019	To inform DHSC re the progress of the JHWS
Forward Plan	Dorset Health Scrutiny Committee Forward Plan	Dates of future meetings, including planned agenda items	To raise awareness of future agenda items, meetings, workshops and seminars.

Committee: 6 September 2016			
Format	Organisation	Subject	Comments
Report	Healthwatch Dorset	Annual Report	To update members re the work of Healthwatch and priorities
Items for information or note			
Forward Plan	Dorset Health Scrutiny Committee Forward Plan	Dates of future meetings, including planned agenda items	To raise awareness of future agenda items, meetings, workshops and seminars.

Committee: 14 November 2016			
Format	Organisation	Subject	Comments
Report	Weldmar Hospicecare Trust	Annual Accounts	To update members re the work of Weldmar and annual accounts
Items for information or note			
Forward Plan	Dorset Health Scrutiny Committee Forward Plan	Dates of future meetings, including planned agenda items	To raise awareness of future agenda items, meetings, workshops and seminars.

Agenda planning meetings (Officers' Reference Group only)				
Date	**Venue**	**Papers required by Health Partnerships Officer**	**Papers dispatched by Democratic Services**	**Comments**
7 April 2016 (for 7 June)	County Hall	13 May 2016	27 May 2016	
29 June 2016 (for 6 September)	County Hall	12 August 2016	26 August 2016	
14 September 2016 (for 14 November)	County Hall	21 October 2016	4 November 2016	

Workshops and development sessions (all DHSC Members)			
Date	**Venue**	**Topic**	**Comments**
1 March 2016 (2pm)	Committee Room 1, County Hall	Dorset Health Scrutiny Committee members annual workshop	A workshop for members to hear about some key issues for local health services and to consider the work programme for 2016/17.
5 April 2016 (2pm to 4.30pm)	Committee Room 1, County Hall	The Joint Health and Wellbeing Strategy	A workshop led by the Dorset Health and Wellbeing Board to consult with key stakeholders regarding the draft Joint Health and Wellbeing Strategy.

Ann Harris, Health Partnerships Officer, March 2016.