Minutes of the Healthy Staffordshire Select Committee Meeting held on 31 January 2017

Present: Kath Perry (Chairman)

Attendance

Michael Greatorex (Vice-Chairman)	Stephen Sweeney
George Adamson	Conor Wileman
Charlotte Atkins	Ann Edgeller
Ian Lawson	Janet Johnson
Shelagh McKiernan	David Leytham
Trish Rowlands	Stephen Smith
David Smith	

Also in attendance: Alan White

Apologies: Chris Cooke, Philip Jones, Diane Todd, Maureen Freeman, Barbara Hughes, Andrew James, David Jones and David Loades

PART ONE

102. Declarations of Interest

There were none received.

103. Transforming Cancer and End of Life Care Programme

The following representatives were in attendance for this item;

Andy Donald – Stafford and Surrounds CCG and Cannock Chase CCG, Accountable Officer
Sharon King – Head of Programme
Paul Giles – Patient Champion

The CCG Accountable Officer introduced the report and made the following points;

- It had taken four years to get the Programme off the ground.
- The objective was for professionals to focus on the individual, to improve patient experience and survival rates.
- In terms of end of life care, it was important to provide choice and enable people to have a good death.
- There had been a focus on the methodology rather than the objectives of the Programme. Some were ideologically opposed to the Programme and had concerns regarding privatisation.
- In January 2015 the Programme had been paused following the collapse of the Uniting Care contract in Cambridge and Peterborough.

- There had been a number of reviews which had confirmed that the objectives of the Programme were correct and that the methodology was not unreasonable Procurement and legal advisors had considered NHS England's reviews, and the programme had taken on board the recommendations.
- A number of internal reviews had identified that the Programme was on track and NHS England had given the go ahead to move forward with it.
- A lot had been learnt from the Uniting Care contract and this would inform the next steps.
- There was no guarantee that the procurement would progress to award of contract therefore alternative options were being considered.
- It was important not to lose site of the need to make improvements for the population.
- It was hoped that the cancer care procurement and approval process would conclude by summer 2017.
- A cancer consortium bid would be subject to robust review and be subject to national sign off. There were two major NHS providers involved in the consortium.
- The focus was on ensuring better outcomes for patients.

The Patient Champion stated that initially he was part of the Cancer Not For Profit group and had been opposed to any privatisation of the NHS. He had recognised however that work was required to change the way in which care was provided. He referred to the appointment system and the wasteful use of resources. Patients had been involved in the Programme and had challenged the process the whole way through to ensure that the focus remained on patients and carers. It was important to ensure that the NHS saw the person and not the disease or statistic. Patients had a pivotal role in the Programme. It was important for people to live and die well.

The Chair thanked the Patient Champion for his contribution and noted his commendable role in the process.

A Member referred to the Staffordshire and Stoke-on-Trent Sustainability and Transformation Plan (STP) and that one of the reasons discussed for poor outcomes was late diagnosis. It was queried how the procurement process would have an impact on this?

The Accountable Officer confirmed that earlier diagnosis was one of the objectives of the programme. Improving screening and identifying people earlier were key priorities for the programme. People would be managed through the system more effectively.

It was queried how many people would be screened in the future and why all CCGs were not involved in the programme?

The Head of Programme referred to the variable take up of cancer screening. Breast cancer screening take up for example was better than the take up of bowel cancer screening. In different areas of the county there were different challenges, for example in Cannock and in Stoke-on-Trent, the one year survival rates for the CCGs were not improving quickly enough.

A Member asked where screening took place?

The Head of Programme explained that screening is commissioned by Public Health and takes place in a variety of settings. Screening uptake varied, for example patients were not using kits sent through to them in the post as part of the national bowel screening programme. There had to be novel ways of working with patients. Local GPs wanted to use different approaches but there was not always the support from the national screening programmes to do this.

The Accountable Officer explained that;

- It was hoped that that a Service Integrator would bring in new ideas and invest in the system to do things differently. There would be discussion about different local approaches with the consortium for the first two years, considering what would need investing in to increase screening rates. The provider would be expected to invest time and resources into this.
- In 2012 the health service was fragmented. South East Staffordshire and Seisdon Peninsula CCG had not seen the programme as a priority as patients in the area went out of the area, to Trusts in Birmingham, Derby and Wolverhampton, for care. The programme was now part of the STP but other CCGs could not be brought into the procurement process at this stage as the process would have to begin again, however improvements in the system would benefit patients and other CCGs may wish to adopt changes to pathways.

A Member queried how the introduction of a Service Integrator would save money?

The CCG Accountable Officer clarified that the first two years of the contract would not be funded by the NHS, it would then be self financing. The intention was to do more with the resources that were available and create savings. Over the lifetime of the contract, the increase in cancer incidence suggests that ten percent more people will be on a cancer pathway. By doing things differently and investing in new developments there would be some return, but the NHS did not have the resources available to develop services. In terms of end of life care, £10-20 million is spent on emergency admissions which could be avoided if the system worked better. There needed to be investments in for example hospice care, and savings could then be made by the Service Integrator.

A Member asked who would be responsible for the delivery of the Programme?

The Accountable Officer confirmed that cancer and end of life performance was not good. The contract however, once in place, would set robust outcomes. Outcomes would be measured to ensure that the individual could receive care which was better co-ordinated. Patient experience would be an important measure. Four years had been spent refining the anticipated outcomes.

A Member expressed concern that NHS services were not effective at reaching hard to reach groups. The effectiveness of screening programmes and if targets were being met was queried?

The Accountable Officer referred to Cannock, where spend on cancer care was higher than many CCGs but outcomes were worse. Services were not reaching those that they needed to do so.

A Member sought clarification on who would drive through the Programme?

The Accountable Officer confirmed that this would be the CCGs and the Service Integrator's responsibility. Outcomes would also be monitored through the STP. There would be a new Senior Responsible Officer in place from April 2017 when he stepped down from his Accountable Officer role. There would be joint accountability.

A Member commented that the process had taken a long time to develop and asked what impact this had had on the current offer? It was suggested that the implementation would be subject to change over time.

The Accountable Officer gave assurances that things had started to improve as technology and drugs improved. There was still a wide gap however in the outcomes of the population of Staffordshire and the rest of the UK and this was not good enough.

The Head of Programme referred to one of the benefits of the work as being the development of a cancer commissioner across Staffordshire. Good practice in the north had been extended into the south and vice versa. In addition there had been improved engagement with patients and better follow up support for cancer patients. The philosophy of co-design had been built into current pathway re-design. The National Strategy for cancer, published in the previous year, had compared well against the outcome framework of the Programme. The Staffordshire Programme had been stronger in terms of patient voice than the national expectations.

The Accountable Officer confirmed that the contract would include criteria to ensure that national changes could be incorporated so that the contract would move with the times. It there were national changes which meant that the contract was no longer feasible then following the two year period there could be a break in the contract. The contract was however future proofed as national changes could be taken account of. It was a complicated arrangement which had not been done before and therefore had a level of risk but the process would be subject to a three stage national review before it could be signed off which would give confidence that it could be successful.

A Member asked if there would be an initial cash injection into the service integrator or services? The Accountable Officer explained that there was growth each year in the NHS and this would go into the value of the contract.

It was queried why there were worse outcomes for residents in Cannock? The Accountable Officer referred to the demographics of the area, the industrial past and late presentation by patients. Over the last two months there had been a significant increase in patients being referred on a two week cancer pathway. Many people in the areas were diagnosed with cancer as a result of visiting an Accident and Emergency Department.

A Member;

- Explained that GPs often took a watch and wait stance rather than referring people. It was queried if GPs would receive training to recognise the early signs of cancer?
- Commented that the thirty one and sixty two day cancer targets were not being met. It was queried if there were enough staff in hospitals? It was suggested that if there were more clerical staff it would improve the patient journey.

- Referring to end of life care, suggested that some GPs were reluctant to let go of patients and enable them to die at home.

The Head of Programme referred to national awareness raising campaigns. There was work with GPs through the local Cancer Implementation Team. GPs and Consultants had developed a local plan for how to improve care. There was a dedicated nurse in the north who would audit GP practices and identify why there was variation. The same role was being recruited to in the south. There were dedicated end of life GPs who were considering how to ensure advanced care planning and the interface between primary care, consultants and nursing homes.

The Patient Champion referred to the Champion's role in asking the same questions as Members and setting challenging outcomes. It was important to get care right from the outset. The first responsibility was often seen as to save lives but this was not always appropriate for a dying person. It was important to educate, inform and let go of the patient.

The Accountable Officer confirmed that it was important to ask patients what they wanted rather than placing them in a system.

The Patient Champion emphasised that some patients did not want anymore intervention but that the NHS wanted to intervene. There were better ways of doing things.

A Member asked if there would be more investment in cancer diagnosis clinicians? The Accountable Officer confirmed that there had been an increase in resources. The system needed to do better, with resources invested in new technologies.

A Member queried the use of mobile scanners in Staffordshire? The Accountable Officer clarified that the CCGs did not commission these services as this was the responsibility of NHS England. Screening could be offered for everything but there was evidence that there was not always benefit. Some screening should be targeted.

A Member;

- Referred to the STP and proposals to cut £13 million from cancer and end of life care.
- Queried how robust the contract would be, how often it would be reviewed and what would happen if the outcomes anticipated were not achieved?
- Referred to difficulties in getting to see a GP in Cannock. It was queried if GPs were educated in making referrals and received training?
- Noted that in deprived areas there were higher incidences of cancer.
- Commented that many patients in Cannock went to Walsall Manor Hospital for treatment. Concerns were raised that the two local STPs were not in sync with one another.
- Queried if the STP would result in increased investment in cancer care or a cut in provision?

The Accountable Officer clarified that;

- The purpose of the STP was to ensure sustainable services in Staffordshire by 2021 and that resources could go further. The intention was not to reduce cancer services but to use resources better to provide cancer care.
- A key outcome of the contract was improved patient experience and the Service Integrator had two years to deliver this. The outcomes were clearly stated and would be robustly monitored.
- There would be improved survival rates in the long term. Macmillan and Patient Representatives had wanted to ensure the appropriate incentives and penalties were included in the contract.
- Some cancer cases were so rare that GPs might only see one case in a lifetime. There needed to be enough information to undertake investigation. More people should be diagnosed through the two week referral pathway. GP Education is important to ensure that they are acting on the most up to date guidance.
- In Cannock Town, more appointments were being offered as part of the Prime Minister's Challenge Fund and it was hoped that this could be extended.
- It was acknowledged that there was no connection between the Black Country STP and the Staffordshire and Stoke-on-Trent STP. Royal Wolverhampton Hospital Trust is involved in the Consortium so were fully involved in the development of the pathway across the cancer care system and work was aligned.

Clarification was sought on whether finances would be cut?

The Accountable Officer confirmed that the provider was being asked to work within the resources presently available. The provider would be expected to make efficiencies. The Consortium would invest significant money in the first two years to change the system and would want to see up to ten percent return on investment.

In response to a further question, the Accountable Officer clarified that £286 million had to be saved by the STP by 2021 to make the system more sustainable. The amount invested in cancer care would increase but in the longer term services would have to be more efficient. He did not envisage that in four years time more money would not be invested in cancer care.

A Member raised concerns about misdiagnosis and late treatment and the Accountable Officer referred to the need to use resources effectively to identify the reasons for problems.

A Member queried patient access via GP referral to the MRI Scanner at County Hospital and the Accountable Officer explained that it was important for the scanner to be used appropriately.

In response to the Chair's question it was confirmed that whether the procurement process had been concluded or not it could be helpful to report back to the Committee in March 2017.

RESOLVED:- That the Committee be kept informed of progress and developments in relation to the Transforming Cancer and End of Life Care Programmes.

104. Drug and Alcohol Service Proposals

The Cabinet Member for Health, Care and Wellbeing introduced the report, highlighting that;

- The paper summarised the recommended new configuration of drug and alcohol treatment services for 2017/18 and beyond, following the funding reductions associated with the Better Care Fund.
- The plans represented the best way to use the available resources with high risk people not required to wait.
- Consultation had been carried out to look at ways to mitigate the impact.
- Concerns had been expressed by clinicians, the community and providers.
- Department of Health estimates suggested that there were between 150,000 and 200,000 adults in Staffordshire who regularly drank above the recommended levels.
- There was an estimated 35,000-40,000 'clinically' dependent drug users (around 5000) and drinkers (around 30,000) in Staffordshire.
- Around 4000 dependent drinkers/drug users had sought and been engaged in treatment services each year.
- The proposed changes would mean that fewer people would receive treatment but every effort had been made to maximise access to services given the availability of resources.
- There had to be a balance between capacity and activity.
- A prioritisation framework using a RAG system had been developed and it was hoped that 'Red' clients would be treated with minimal waiting times.
- In order to maximise efficiency and activity, the range of community (non residential) interventions would reduce significantly.
- It was a very difficult decision to make and the consequences were very serious. The Cabinet Member understood the possible implications. If more could be done then it would be. He had been confronted with the financial challenge and was doing all possible to support social care activity.

The Director of Health and Care confirmed that the proposals had been developed in close conversation with providers. The proposals were not without risk but were thought to be the best way of doing things next year. A session with clinicians was held providing an opportunity to understand concerns and confirm what would happen so that it could be undertaken smoothly.

The Senior Commissioning Manager referred to the balance between providing a service capacity that meant high risk people were not required to wait and ensuring that the service was able to cope safely and effectively with the number of people in treatment. The proposed solution was to reduce the number of people in treatment at any one time to a maximum of around 1700. It was however difficult to predict demand. There had to be a balance between quality and activity. It had been proposed that capacity was utilised from the Intensive Family Support Service to ensure that no client with child safeguarding concerns was required to wait for access to the general One Recovery Services. The flexible use of staff could be used to mitigate the risk to other high risk clients such as those within the criminal justice system. Previously intervention had focussed on a cross section of the client's needs but going forward there would need to be referrals to other services such as Job Centre Plus to address a clients needs. This approach was not without risk.

A Member referred to the excellent services which had been developed. In 2005 it had been a very disorientating service. It was queried how outcomes would be measured, including the impact of increased waiting times and on safety? It was noted that prevention work would not be undertaken. It was queried if there would be an impact on just the acute or on those starting their drug and alcohol journey?

The Senior Commissioning Manager referred to the range of outcomes that could be measured. The number of people accessing services, the number of lives changed and the quality of experience would be measured. In addition there could be consideration of wider implications such as overall crime figures and increased risks to children etc. If the number of incidents increased then there would have to be a change to the balance of monitoring with a greater focus on risk.

The Cabinet Member referred to the local and national implications. Unlike in Scotland, health and wellbeing was not a licensing consideration in England.

A Member referred to the need for minimum alcohol pricing.

A Member expressed concern that District/Borough Licensing Committees had no choice but to grant a license. He raised concerns that there would be no drug and alcohol prevention services in Staffordshire and queried provision in Cannock.

The Senior Commissioning Manager clarified that the premises was going in Cannock so there would no longer be a dedicated building but services would remain.

A Member queried if the Council was still pursuing the CCGs for the money that should have been transferred to the County Council through the Better Care Fund (BCF)?

The Director of Health and Care confirmed that £16.5 million had come across to the County Council to protect social care and there had been no disagreement about this. The additional £15 million had however not been agreed upon which had left a shortfall in this years Medium Term Financial Strategy. Savings had to be made this year and next year. There were preparations to sign the BCF again. £16.5 million was guaranteed next year and the deficit had been dealt with. Drug and alcohol services were not core statutory services. The Public Health ring fenced grant had to have regard to these matters but these services were not a core legal requirement.

Concerns were expressed that the changes would affect the most vulnerable in society and their families. Although £3 million in savings was anticipated in the long term it would cost a lot more as people ended up in the criminal justice system and qualified people providing the existing services were lost. The potential impact on the suicide rate was referred to. It was queried if there was anyway in which Recovery Services could be maintained?

The Cabinet Member confirmed that the Recovery Service was being maintained but would be reduced. Reference was made to the STP and the ambitions in the system. Issues had to be addressed as a whole system and the impact of the proposed decision on other parts of the system was acknowledged. It was hoped that once changes had been made the system would still be good enough. It would be the hardest decision that

the Cabinet Member had had to make and the system was working hard together to address the impact.

A Member referred to the impact that drugs and alcohol could cause but also that there was a limited amount of resource available and that this should focus on recovery. It was a small cohort of individuals who could negatively impact on the lives of others.

The Cabinet Member referred to demographics and that drinking amongst eighteen to twenty four year olds had reduced.

The Senior Commissioning Manager referred to the heroin epidemic of the nineteen eighties continuing to have an impact. There would be continued investment in safeguarding and the criminal justice system. Resources would be directed at those who were a priority.

A Member suggested that the Committee should make representations to the government regarding alcohol licensing practices.

The Chair suggested that the Committee could write to MPs raising the issue and this was agreed.

A Member referred to the difficulty in making the decision. The impact on children could not be judged on the financial costs. It was important to highlight the impact of the funding cuts.

The Cabinet Member referred to the work of the Police and Crime Commissioner in addressing domestic violence issues.

A Member sought clarification on the services provided by One Recovery.

The Senior Commissioning Manager explained that prior to July 2014 there were thirty contracts with fifteen different organisations. This lead to a fragmented pathway for clients and key workers to navigate. In July 2014 services were brought under one contract providing separate residential and community services. This created efficiencies and more people were able to receive better treatment as there was a focus on the whole person and not just on addiction issues. Integrated specialist intervention came under one contract which could then subcontract. There would be further integration as pathways became more streamlined.

The Member sought clarification on the role of the Burton Addiction Centre?

The Senior Commissioning Manager confirmed that this helped people to sustain progress where as One Recovery incorporated all services. Burton Addiction Centre was focussed on recovery and was part of the pathway.

The Member commented on the good outcomes achieved by Burton Addiction Centre and raised concerns regarding a lack of beds going forward. It was queried if there was the right balance?

The Senior Commissioning Manager referred to the consensus reached between all parties in acknowledging what could be provided with the resources available.

It was queried by a Member where the One Recovery Service in Cannock would be provided from?

The Senior Commissioning Manager undertook to provide the information following the meeting.

In response to a question from the Chair the Cabinet Member confirmed that the decision would be taken the following day.

The Chair confirmed that the Committee would support the process going forward.

RESOLVED:- That;

- The feedback from the discussion be used to inform the Cabinet Member's decision.
- Information regarding the location of the One Recovery Service in Cannock be provided to the Committee following the meeting.

105. Summary of Joint Health Scrutiny Accountability Sessions 2016-17

The Scrutiny and Support Manager introduced the report summarising the arrangements for and outcomes of the Joint Health Accountability Sessions held in the 2016-17 municipal year and requested Members views on the way forward. It was confirmed that scrutiny of the STP would be undertaken by the Healthy Staffordshire Select Committee as the County Council must take the lead on this. The informal joint scrutiny meeting with the City of Wolverhampton Health Scrutiny Panel on the 13 February 2017 was referred to.

The Chair suggested that any recommendations that the Committee had regarding the Accountability Sessions should be considered in the Work Programming in the new municipal year.

A Member raised concerns that if the meetings were expanded to incorporate more Members from District and Borough Council Health Scrutiny Committees and/or Members from other neighbouring local authorities then the meetings would be too large to Chair effectively and interaction would be limited, reducing the opportunity to scrutinise the Trust effectively. Shorter Self Assessment reports were suggested. It was felt that providing access to a webcast of the meetings negated the need to host them around the county.

A Member suggested that as there were only six NHS Trusts in Staffordshire, each one should continue to be held account at Accountability Sessions and they were keen that the Committee continue to hold the sessions. It was recommended that the Trusts should report on what they planned to do in the future and on any proposed changes or developments rather than just providing past data. A more direct line of questioning was suggested and a more informal arrangement to meet with the Trust Chief Executives,

The Scrutiny and Support Manager explained that relationship management meetings which had been held with Trust representatives in the past had resulted in no formal actions or recorded minutes which could be accessed by the public. Concerns raised by Members had been emailed to the Trusts who were then asked to address these in their presentations to the Committee.

A Member expressed concern that the Committee did not know everything. The Chair confirmed that this was the reason why Trusts had been requested to attend Accountability Sessions.

It was recommended that the Committee should prioritise which Trusts to hold to account. The 2017/18 Committee needed to decide its own Work Programme and not be restrained by the legacy of the previous municipal year's committee. There needed to be a clear focus on where there were issues. There was no support for holding meetings in the District/Borough locations. Comments regarding minimising the size of the Committee for Accountability Sessions were supported. It was noted that the District and Borough Councillor representatives on the Committee were not regularly attending and that there was a need for committed representatives on the Committee as there were a large number of meetings.

The Committee Chair confirmed that Members views on the Work Programme were sought at every meeting.

A Member referred to difficulties in travelling elsewhere to go to meetings and that it was more convenient for them to be held in County Buildings. It was also emphasised that the meeting membership should not become too large.

A Member raised District and Borough Council attendance and the Scrutiny and Support Manager confirmed that only four of the eight representatives were present. In the Joint Code of Working, it was stated that it was the Chairman of the District/Borough Health Scrutiny Committee who was to be the Member of the Healthy Staffordshire Select Committee but this could be revised.

Another Member gave support for hosting meetings in County Buildings. Reference was made to the Self-Assessment reports provided by the Trusts and that some discussed a Trust as a whole rather than distinguishing the performance of the individual hospitals within that Trust which was frustrating. Issues such as Accident and Emergency waiting times, winter pressures and hospital discharge were very important and would be important to consider individually.

The Scrutiny and Support Manager explained that the Committee could include these items on the Work Programme as a focussed area of concern rather than holding uniform sessions. The Self-Assessment report acted as a mini quality account. It was queried if Healthwatch Staffordshire might be able to assist with highlighting issues of concern to the Committee?

The Chief Executive, Healthwatch Staffordshire confirmed that there was more work that Healthwatch could do with the Committee regarding this. Healthwatch Staffordshire attended CCG Quality Committees, NHS England Quality Assurance Boards and Quality and Safety Sharing meetings. It would be good to feed through the information

gathered to the Committee as well as the information received from the public. Healthwatch Staffordshire could support the Committee in undertaking thematic reviews.

The Research and Insight Manager, Healthwatch Staffordshire referred to the gathering of intelligence through the Experience Exchange, Social Media, the advocacy service and through different engagement events.

A Member suggested that it might be helpful to call to account providers and commissioners at the same time. Having input from commissioners would be interesting as they were commissioning on behalf of residents. It was suggested that one member of the relevant CCG should be in attendance at the meetings.

The Scrutiny and Support Manager confirmed that the CCGs had been invited through a call for evidence to contribute to the sessions when they were initially timetabled but had not done so.

The Chief Executive, Healthwatch Staffordshire confirmed that the behaviour of providers was impacted by the CCGs. Healthwatch also attended the Health and Wellbeing Board and the Accident and Emergency Delivery Boards.

A Member expressed concern regarding the Committee's workload and scrutiny processes. It was suggested that the workload should be manageable and that areas for scrutiny should be highlighted. It was queried why a presentation was required in addition to the Self-Assessment report if Members had read their papers and suggested that additional information should not be encouraged. Rather than the Work Programme focussing on single items, the greater use of Working Groups was suggested. Time constraints on the agenda and that the Work Programme should be one of the first items on the agenda to be discussed was suggested.

The Chair expressed concerns that there were not the resources to support sub Committees of the Committee. The suggestion of sub Committees was not supported by another Member who referred to information in one area applying to other areas. Presentations were needed as they reinforced the information within the reports.

A Member did not welcome the idea of time constraints as these could constrain debates. District and Borough Councils should deal with local issues. Presentations were needed.

Referring to the STP, a Member suggested that this might be done by the District and Boroughs as different places would be effected differently. The Chair however was clear that scrutiny of the STP should be undertaken by the Healthy Staffordshire Select Committee. This was clear following the Francis Inquiry. Only the County Council could make referrals to the Secretary of State for Health.

The Scrutiny and Support Manager referred to the Joint Code of Working which was very clear on where responsibility for scrutiny lay. Where services were being delivered in more than one District or Borough then the County Council must take the lead in undertaking scrutiny.

The Member acknowledged the importance of understanding the bigger picture and expressed concerns that there would be local criticism about lack of scrutiny.

Another Member stated that they were happy for the Borough Committee to consider specific local issues whilst the County Council consider the wider issues. It was suggested that Accountability Session presentations, focussed on work going forward and that Trust, CCG and Healthwatch representatives had an opportunity to contribute and ask questions.

A Member referred to work undertaken in South Staffordshire regarding breast feeding screening over borders and highlighted the importance of the CCGs being held to account.

The Chair confirmed that the views of the Committee would be complied and that the Committee could add to this by sending comments and suggestions regarding the way forward to the Scrutiny and Support Manager.

RESOLVED:- That;

- Any additional views regarding the future of Joint Health Scrutiny Accountability Sessions be shared with the Scrutiny and Support Manager.
- That at the first meeting of the Healthy Staffordshire Select Committee in the municipal year 2017-18 that the Committee consider the comments of Members on the Joint Health Scrutiny Accountability Session in determining the future of them.

106. District and Borough Committee Updates

The report was received and considered.

107. Work Programme

The Work Programme was accepted.

Chairman