Mid & South Essex Success Regime Programme Board

Wednesday 24th May 11.00-1.30pm, Room C418 County Hall, Chelmsford

Present: Anita Donley, (Independent Chair)
Andy Vowles, Programme Director
Caroline Rassell, SRO Local Health & Care Portfolio
Roger Harris, Corporate Director of Adults, Housing and Health, Thurrock Council
Simon Leftley, Southend-on-Sea Borough Council
Donald McGeachy, LHC Medical Director
Eric Watts, Service User Group Chair
Peter Fairley, Essex County Council
Iain Martin, Vice Chair, ARU
Tom Abell, (BTUH, MEHT, SUHFT)
Sally Morris, Chief Executive, EPUT

Apologies: Andrew Pike, Thomas Nutt, Ronan Fenton, Clare Panniker

Minutes: Alison Alexander, Programme Support Officer (NHSE)

Item	Discussion	Action Lead
1. Welcome and introductions	AD welcomed attendees and introductions were made.	
2. Minutes and actions	Matters of fact: **All agreed** Minutes of previous meeting: Page 2 - CR had actioned and circulated a summary of the bids **Decision: all agreed as a correct record of the meeting.** Matters arising: • Sally Morris was welcomed to the group as representative of EPUT (Essex Partnership University Trust). Stephanie Dawe would be taking on Sally's role on the A&E specialist delivery group in order to negate any conflict of interest.	

Item	Discussion	Action Lead
	• **Clinical Cabinet Terms of Reference** DMc gave the Board background to the Terms of Reference. SM noted that the Chairmanship was proposed to be a joint position between the acute and community Medical Directors. It was agreed this needed to be clarified to confirm that it would be Donald McGeachy and Ronan Fenton in their roles for the Success Regime/STP. SM confirmed she would also take back to the Community Clinicians and ensure representation would be made. CR asked how the administrative arrangements would be resolved. It was discussed and concluded that it would need to be resolved outside of this meeting. DMc noted that the membership needed to include the LMC. Therefore revised Terms of References to be amended and circulated. • **Primary Care Leadership Group Terms of Reference** As part of the Health and Care element of the Success Regime/STP it had been established there needed to be a Primary Care Leadership Group with a focus on primary care and the localities. EW noted that volunteers could include someone from the local CVS. It was noted there was not clear reporting or accountability within the Terms of Reference. SM noted at a LWAB meeting the Primary Care Leadership Group did not include enough providers and professionals. It was agreed these would be revised and revisited at the next meeting in June. TA noted Celia Skinner was working on the clinical reference group and would share the Terms of Reference with DMc. The Primary Care Leadership group and Clinical Cabinet group would both feed into this Board. **Decision: It was agreed that the Primary Care Leadership group and Clinical Cabinet group would both report to this Board.**	SM DMc
3. Programme Director Summary Report	AV gave an overview of reporting across the Programme. Previously there had been three separate teams reporting and the reports presented today were to try and bring these reporting streams together. Work was credited to TA for his work on this. AV noted there had been a lot of ongoing work around the joint committee which would be discussed later on the agenda, the STP delivery plan would also be discussed further on the agenda, capital had moved on since the last meeting. It had been announced nationally that there was £325m capital to support STPs available via a bidding process. The bids had been submitted and currently there was a positive outlook on this however no final outcome had been received. The third area of ongoing work was a refresh on the PCBC before it is presented to a number of Boards, including this one, before being presented at	

Item	Discussion	Action Lead
	the Investment Committee. Finally the PCBC work had been working on Transport for both public and emergency work and this would be brought to this group. **In hospital:** TA informed the group of work currently being undertaken. A single team would be established by June across the three sites. Redesign priorities were proceeding towards implementation in the Autumn. Clinical lead roles had been assigned to this area. Corporate support was to be in two phases – initial consolidation of bringing the three organisations together over the course of this year, the second phase was establishing the operating target level. Final clarity on what this would look like was not expected until after the General Election. Clinical support was progressing – radiology was moving at pace towards efficiencies e.g. single booking arrangement. The patient interface e.g. booking appointments, switchboard, medical secretaries etc project still needed to be bottomed out and was the area causing the most concern. EW asked if a patient representative was involved. TA confirmed the plan would be to include these. EW asked for these to be involved as soon as possible. AV asked if members of SUAG would be best placed to volunteer. It was agreed TA would send an invitation to members for this to SUAG. IM asked if the end plan had been identified as doing this by piecemeal would potentially cause problems in the future. TA agreed that this was what had been recently identified as was therefore the point they were taking this project back to. SL noted there was lots of 'noise' in the Southend area particularly around the reconfiguration proposals and asked what clinical services were planned to be moved. TA confirmed that was not the role of this group. This group would be looking to consolidate pathways and would not involve moving any clinics at this stage. AV noted that full consultation would be undertaken before any changes were made. EW asked about pathology. TA noted that business cases were under development to move to a standardised process in due course. **Out of Hospital:** CR gave an overview of the work that had been ongoing since the last meeting. This included work around the joint committee. Work had been undertaken to align work outside of the hospital with the in-hospital programme. The other area had been a big focus on the PCBC. CR also informed the Board that she had taken liberty to nominate the STP for the fostering commissioner and provider collaboration category in the healthcare transformation awards for the STP frailty blueprint work she had just been notified that it had been shortlisted. The Board thanked CR and the CCG for her/their initiative.	TA

Item	Discussion	Action Lead
	SL asked if the PCBC should include a piece about how the local authorities were working alongside the group on this. CR agreed to share the PCBC but noted that at this stage it did not contain detail of each locality. RH asked about the joint commissioning agreement. He noted he had not seen this and was unsure how Local Authorities would be consulted etc. This would be discussed further on the agenda. PF asked regarding the PCBC if it was possible to still comment on certain areas. AV agreed to send relevant sections to the local authorities for officer level comment. The financial element was currently under review and it was therefore agreed that this would not be shared again at this stage. RH noted Thurrock's concerns were around the local area rather than what would be commissioned at a broader level. SL noted that he raised his concern to ensure that the LA could support this process. **Decision: The Board noted the updated report and progress made.**	CR AV
4. CCG Joint Committee	AV gave the group background to this. 3 of the 5 CCGs had been Directed by NHS England to form a joint committee. This covered 3 main requirements, 1 to establish a Joint Committee, 2 to complete a joint commissioning plan detailing in essence how the committee would work, 3 submit an implementation plan. The first draft of this plan had been submitted to NHS England. Section 2.7 of the paper detailed the functions that would be delegated to this committee. CR noted her concerns around the Joint Committee not having voting CFO, nurse or quality. There was a risk there would not be anyone to lead the public consultation and that as of 6th June this Board would need to consider that a Medical Director would not be part of the group. AV noted this takes us down the path of minimal membership. CR noted that it was not the expectation that the AOs would be taking items back to their respective Boards but actually the work would only be done once on behalf of the joint committee. She noted concern that patient safety would not have a representative on the board making decisions and this could have a fundamental impact. TA noted the key challenge is the function of the executive and who could make the decision.	

Item	Discussion	Action Lead
	SM noted that it was pleasing to see mental health on the STP footprint but that it would also need to work in collaboration with the Essex footprint as a whole. RH asked how the joint committee would work with this Board. AV noted he would like to see it reporting to this group in the same way that the In-Hospital and Local Health and Care work report to the Board. **Decision: The Board noted the updated report and progress made.**	
5. Hospital Update	This was included under agenda item 3 – SRO In-hospital report.	
6. Public Health	Andrea Atherton and Mike Gogarty joined the meeting at 11.49am. AV gave the Board an overview of this work. Public Health had been identified as being an important strand of the work of the STP. The purpose of the paper presented today was to give an understanding of the plans across the three councils. AA updated the group on the background of this work and how a prevention strategy could be implemented for this STP. AD asked if child health was part of the prevention strategy. AA confirmed this was and was looking at integrated children's services. AD asked for the three Public Health local authorities to come together to align the work of public health in line with the work of the STP. MG noted that lots of changes to services would not see benefits for a number of years therefore would this work need to focus on the things that would achieve early results. IM noted smoking was an area that could achieve an earlier result. MG noted that in terms of smoking cessation numbers are decreasing but this is due to e-cigarettes of which concerns around this on it's on was noted. DMc noted there were a lot of background issues that would not be able to be addressed due to a lack of funding. TA noted there was more that could be done around smoking, particularly smoking outside of hospitals etc. Falls, alcohol, smoking and stroke prevention were the 4 main areas of focus at local level. It was asked if Thurrock would be in agreement of these being the focus areas.	

Item	Discussion	Action Lead
	AD asked what additional areas would be focussed on if there was more funding. MG noted hypertension was an area. Alcohol noted marginal investments would result in small wins. Falls was delivering but had to change due to a lack of funding. Health check programmes had been including the elderly. The current focus was around maintaining these services. The added value of the Board would be to help maintain these services. AA noted that in Southend they would be encouraging more physical activity. IM noted regarding STP quick wins, there could be an opportunity for changing licensing regulations to reduce the number of A&E alcohol related incidents. It was noted this would be difficult but possible. AD to write a note to AA, MG and IW to thank them for their work in this area. All to be invited to a future meeting. **Decision: The update was noted by the Board**	
7. Workforce (LWAB)	Caroline Dollery and Louise Kitley joined the meeting at 12.05pm CD and LK introduced themselves to the Board. CD gave an overview of the paper presented and asked the Board and the STP how their work could link into this. LK also noted how to link in the STP workforce lead into the LWAB. EW asked with regards to paramedics, what numbers were expected to be recruited and what numbers were in training. CD did not have the figures to hand but she would be able to find out. It was noted that recruitment was a challenging gap. LK did confirm that over the previous year there had been an increase in the numbers taking up training. With regards to social care, PF noted that across Essex there was a vacancy rate of around 25% and asked if there was something that could be done around incentivising people to come and work in this county. CD noted that there were plans for a session to be set up to discuss this in detail and would welcome the opportunity to strengthen the work on social care. RH noted that the majority of the actual care staff were in the private sector. Skills for Care had done a lot of work to try and enhance the vocational care staff but he was struggling to fill the vacancy gap. It was noted this was an area that could possibly be done at scale. LK	

Item	Discussion	Action Lead
	noted that there had been a lot of work in Essex to try establish patterns of people living here. IM noted clinical placement capacity was a big area of concern. Also he thought there were things that could be done to increase incentivisation. One area they are looking at in another area was around writing off student loans etc, or providing local market rent for key professionals. For the STP the golden handcuffs approach would be required. LK agreed but noted the challenge would be doing the same across the whole area. AV noted around Appendix B there was still work to be done around alignment and metrics. The LWAB to report back to the Programme Board in July of how it would be progressing. SM/CD/LK to let AD know once meeting in June has happened. AD noted that she had met with the LPN and optometry leads for Essex. **Decision: The update was noted by the Board and agreed the LWAB would report to this Board.**	
8. Social care strategy and funding proposals	RH noted that BCF guidance was still awaited. It was anticipated this would not be until after the General Election now. RH left the meeting at 1.00pm. PF noted they had had initial meetings with CCGs and care providers. The amount of money available for new initiatives was disappointing but would be reflected more at the next meeting. SL noted they had had constructive meetings and were now moving towards shared accountabilities in principle e.g. care management and what they could use BCF for. **Decision: The update was noted by the Programme Board.**	
9. STP delivery plan	AV gave background to the paper. In March NHS England published: Five Year Forward View: Next Steps. This set out NHS priorities for 2017/18 for urgent and emergency care, general practice, cancer and mental health. There was a national view on priorities for STPs to develop a delivery plan. AV thought this may be something this Board would need to revisit after the election. **Decision: The update was noted by the Programme Board.**	
10. Digital	AV updated the group on the work of the Shadow Greater Digital Essex Board following discussions at the last	

Item	Discussion	Action Lead
	Board meeting. Clare Morris confirmed she was happy to be accountable to this Board. Regarding the Terms of Reference: SM noted they needed to reflect work with the voluntary sector and other commercial organisations providing healthcare. TA was supportive of this Board being accountable for this. IM asked what its role would be moving forward in the long term. AV agreed that over time this would be standalone but in its infancy it would need to be steered by this Board. **Decision: The update was noted by the Programme Board. The Terms of Reference to be amended as above.**	
11. AOB	None	
	Date of next meeting: Monday 26 June 10.00-12.30 Committee Room 6, County Hall **Forward items:** Frailty integrated pathway to use as a framework on how to approach the involvement of workforce with the clinical pathways – May/June PCBC and mental health - June Digital update - June/July Public health update - July STP governance – August STP Metrics published for partnership - August SUAG – August	