Mid & South Essex Success Regime Programme Board

Monday 27 March 2017, Board Room, Swift House, Chelmsford

Present: Anita Donley, (Independent Chair)
Andy Vowles, Programme Director (NHSE)
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
Clare Panniker, Chief Executive (BTUH, MEHT, SUHFT)
Eric Watts, Service User Group Chair
Peter Fairley, Essex County Council
Ronan Fenton, Medical Director

Apologies: Rob Tinlin, Andrew Pike, Frances Shattock, Iain Martin, Thomas Nutt

Minutes: Jacky Dixon, Programme Manager (NHSE)

Presentation: Mandy Ansell, Mark Tibbs and Caroline Dollery – Mental Health update

Item	Discussion	Action Lead
1. Welcome and introductions	AD welcomed attendees and introductions were made.	
2. Minutes and actions	Matters of fact: **All agreed** Matters arising: Integrated pathway – AV/CR - will cover as part of planned frailty discussion **Decision: All agreed as a correct record of the meeting.**	
3. Programme Director Summary Report	AV presented a summary of the overall programme activity during February 2017. **Overview** Slightly shortened revised format as both SRO led workstreams are currently being redesigned following establishment of Joint Executive in the hospital and changes to the Local Health and Care	

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	team. Future reports will be revised in format following discussions with the new Chief Officer, Jo Cripps for out of Hospital and Tom Abell for In Hospital. Progress is being made on other workstreams, Transport, workforce and digital. BCG will end their assignment at the end of the month and handover arrangements being taken forward. EW asked when BCG finish and queried what external support be used. AV stated there were no funds to get consultancy support going forward. **In Hospital portfolio** CP gave an update. Changes are being made to the programme management of this portfolio which will now be led by Tom Abell in his new role incorporating all elements of the acute change programme and transformation team. This new role brings together the change capacity across the three Trusts under one team. The team are currently working through prioritisation of clinical pathways and services. Some have particular sustainability issues which will form early priorities. **Local Health & Care portfolio** CR reported that 40 projects have now been mapped into the new Road Mapping tool. Hard copies of a report were handed out at the meeting. Feedback welcomed from the Board members direct to CR. This will help with the development of the new reporting mechanisms within the CCGs. AOs have met to discuss and agree as a group the level of detail, information and monitoring arrangements which will be required for these projects. Future clarification on the governance arrangements for the 5 CCGs will enable the approach to system wide projects to be resolved. Simon Leftley commented that it will be important to be clear how to balance what needs to be done once and how the needs of the localities will be met with the 5 CCGs working together. It will be important too start having these discussions as soon as possible for integrated health and social care to become a reality **Programme Risks** AV highlighted the headline risks which are similar to previous reports: • Availability of Capital • CCG joint decision making	

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	• Non-recurrent support on pump priming of out of hospital services and wider national funding position (may be covered in the 5YFV publication due later this week) **Decision: The Board noted the updated report and progress made.**	
4. Programme Timetable	AV gave a summary of the proposed revised timelines for the PCBC and acute reconfiguration. AV pointed out that there are separate timescales on some of the Local health & Care work stream which will move forward as part of that overall portfolio. The timetable being considered by the Board applies to those particular areas that require national assurance and major consultation process. Main milestones set out give an overview. RH stated that obviously the timetable had slipped to that originally intended. Need to be clear on the arrangements on how the PCBC goes through local governance. AV stated that the intention is to form an appropriate Joint Committee for the CCGs will sign off the PCBC. D McG queried the length of time the Investment Committee will take to consider and give approval following the 6th September. AV stated that we anticipate this can be turned around quite quickly. CR commented that is was important to narrow down the scope of the options so that the work can be done to the right level for the investment committee. We need to scrutinise the financial assumptions again; need to review the amount of capital being asked for and review the financial bridge. AV confirmed that engagement with the HOSCs is still on-going and continues; we will agree with them the consultation plans and how this will be taken forward at the appropriate time. AV confirmed this will also be taken forward with the H&WB as well. This item is on the agenda for the next joint Chairs meeting. RF commented that we need to ensure there are clear communications around the timeline slipping, including the need for a communications strategy to get the message out and reason for slippage, otherwise we may lose clinical engagement. **Decision: The Board agreed the revised timeline.**	
5. Mental Health Update	Mandy Ansell provided assurance on the direction of travel for the Mental Health plan for the Mid &	

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	South Essex STP. This plan is currently rated as moderate, (Amber), however there is lots of work going on across Essex and with all stakeholders (about 20) under Section 136. Constructive conversations taking place with Sam Hepplewhite in NEE. STP dashboard and mental health strategy/ most elements have implementation plans; £3.2M CAMHS service and seeing early benefits of that. South CCGs invested with SEPT to meet targets; opportunity to model new models of care and opportunity to submit a bid for funding. Suicide preventions – matrix for measurement include admissions for self-harm at A&E; 7 day follow up. Differences in spend across the STP from CCG allocations varies 9 – 12.5% and need to understand how everyone is counting. Rating of moderate is probably correct and some areas of work not delivering at the pace we need these to do; equally we are not starting with a blank sheet of paper, starting from a reasonable pace to take forward. D McG commented that at a recent SUAG event there were a large number of users that raised mental health as a problem with interface between hospital services and appropriate destination for patients. Potential to increase street triage which could divert 70% of cases into mental health services rather than A&E. Cambridgeshire and Peterborough 111 model is simple and we should look to adopt. Lots can also be provided with support over the phones, need to review crisis work. When seen by RAID often discharged but follow up is often lacking which see re-presenting at A&E. RH stated that there is some fantastic work going on and work on the crisis pathway which he felt had not had the profile within the STP/SR. RH expressed nervousness around the forthcoming SEPT/NEPT merger from 1 April with the desire to not loose the local focus. MA in response stated we are still looking at Essex footprint for CAMHS and reviewing in that way at the moment; will need to ensure this is included in the STP. SL stated that there needs to be conversation on the transforming care partnership; crisis service and particularly CAMHS, 25% of people going into this are under 26. Need to bring together CAMHS and	

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	transforming care to break down the barriers. CR said the CCG Joint Committee arrangements may assist with this; a view across the footprint on how we commission successfully. Slides to be circulated after the meeting. MT offered to pull together narratives in the context of the STP supported by 5/10 key statistics. It was suggested that a regular update is given to the Programme Board every 3 months on the Essex wide mental health strategy which was welcomed by Board members. **Decision: The update was noted by the Board.**	 JD CR SRO
6. Social Care Strategy Funding update	SL/RH/PF reported that all areas still have gaps in plans for the coming year. Conversation held locally some of the money has to be targeted on improving and keeping DTOCs down. It was pointed out that the additional funds are not recurrent funding and decreases each year for the next 3 year. It was noted that funding will be required to stabilise the system in terms of care provision and a review of what schemes will reduce pressures on hospitals and community services is taking place. A quick piece of work to be signed off in May. A question was raised on how this is being taken consistently across the footprint. RH responded that the provider market is very fragile, three home care providers in Thurrock and concerns about the quality of the service in all three. There is recognition of this at a national level with the promise of a green paper on social care funding; big residential care providers are leaving the market; auto-enrolment and the national living wage have made it difficult to get the staff. People are not entering the social care market to meet the current demand. EW said that for the SUAG members they considered the biggest threat of the STP is that there is not the assured funding for those patients moving care out of hospital into the community and concern there will not be enough resources to deal with this.	

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	PF stated that the position in Essex is similar to Thurrock and Southend. Demand is high. Local Authorities pay 30% less **Decision: The verbal update was noted by the Board and further updates requested.**	RH/PF/SL
7. Options appraisal update	AV introduced the paper. All five options were assessed against the criteria as part of the options appraisal process that has previously been discussed and agreed by the Board. The highest ranking options from the models were 1A and 2A. Discussions had taken place during March on the results of the options appraisal with wide range of stakeholders and feedback collated. Key points in feedback are: • Recognition that an objective and through process has been followed • Concerns in South East on option 2A and the ability to move straight to a yellow hospital model • Concerns around access particularly emergency access • The importance of not viewing the acute configurations in their own right and need to have assurance that LHC is making good progress to enable the hospital changes SL reiterated previous comments that there remain concerns about the proposed changes from Southend Local Authority. Peter Fairly asked if the business case would take forward both options and how this linked to the consultation. AV clarified that the proposal is to develop both options in the PCBC, and then to set out all realistic options in the consultation. Next steps are now to finalise the PCBC on these 2 highest ranking options. It is likely these may be refined further depending on discussions with local clinical groups over the pre-consultation process. CP stated that the advantage of considering both options enables further work to be done to refine and really sharpen up on the pros and cons to help all stakeholders understand what the main differences are and the impact of those differences. It is incumbent upon us to be really clear what the drawbacks are of both options, as well as no change. CP stressed that we also need to be clear that there is likely to be a staged implementation with checks and balances along the way. Taking the changes forward incrementally to ensure quality and safety is paramount.	

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	Decision: The Board agreed the recommendations in the paper including for the 2 highest scoring options to be submitted in the PCBC	
8. Communications/Engagement update	This paper presents a report on local views that: • Summarises the engagement work that has helped to frame options and contributed to the appraisal process itself • Highlights the main issues and implications raised by services users and local representatives EW provided an update from the Service User Advisory Group. Benefit of patient activation; others keen to get on with designing new models of care. Insider/outsider paradox to do some good academic work on these models and use the enthusiasm on those patients. Prime fear of the unknown and a genuine sense that this is something being done to us. Hope the relationship with SUAG can develop in a much more constructive manner in a partnership style. Lots of questions on the days; SUAG would like a message board on the external web site PF stated that there are lots of myths out there, need to be more assertive at addressing some of those myths. **Decision: The Programme Board noted the verbal update given by the Chair of the Service Users Advisory Group. The Programme Board approved the paper and agree that it should be published.**	AV
9. EU GP Recruitment	Patricia D'Orsi , Chief Nurse CP&R CCG, leading on Primary Care workforce for STP spoke to the paper which outlines the progress of an initiative to recruit GPs from abroad (mainly from the EU) to work in Essex. Discussion took place on the recruitment process, standards to be set and assurances to be given by a robust induction process. HEE supporting this framework with the development of a prescriptive induction to ensure level of language skills, support to be given over the first six months. RF asked how similar is the environment in which these doctors work at home and are used to	

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	practicing in, and how similar is it to how they will be expected to work here? Will the level of responsibility and level of decision making be similar? PD stated that the models are different in different countries; Portugul and Hungary are the most similar – supported period at the front end and I&R programme; paediatric care is the most different. SL said that there are considerable pressures on the primary care lists in Southend. Was the intention to put these GPs in the more deprived areas? PD stated that they are conscious this could be challenged to be an elite programme – set up with HEE a bespoke course over a weekend for those who were a single handed GP; 2 practices from Southend are currently interviewing from this scheme. Will also include support and development. Workshops held to raise profile of this scheme to the practices. **Decision: Programme Board are pleased to note the progress made.**	
10. Governance Review	AV introduced the review of the governance of the STP/Success Regime. He noted that the STP provides a strategic umbrella for partners, but is not in itself a statutory body. AV also pointed out that the 5YFV Next Steps document is likely to outline further arrangements on governance for STPs and how this is going to be progressed. It should also be noted that local arrangements are also shifting: • Three acute hospitals forming a Joint Executive Group • CCGS joint working arrangements developing The paper raised a series of issues for consideration, including: • Direct membership of the Board by mental health, community and primary care sectors • The need to review whether the Chairs of the Joint Working Board and the CCG Joint Committee should become STP Board Members • System Leadership Group established at the start of the Success Regime – other arrangements for engaging across the footprint – recommend this is stood down • Clinical leadership – lots of groups in place – may now need an overarching strategy group that is clinically led at a practical level rather than some groups that do not connect like they should	

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	and a proposed reporting line for primary care and ALG. • FOG formal reporting line into the Programme Executive and need to flow to the CCGs SL pointed out that CAMHS/Mental health & Transforming Care need some linkage into the Programme Board RH commented on the need to be cautious about the STP being the decision making group given the role of the statutory bodies and the need to balance local decision making with a 'do once' approach where this makes sense **Decision: The Programme Board discussed the proposals and agreed the following:** • **The refresh of STP governance was noted** • **The Programme Board considered the proposal to invite a mental health/community representative representative –AV to review and inform following discussion** • **Primary Care leadership forum – The Programme Board agreed to invite the Primary Care Leadership Forum to nominate one individual to join the Programme Board to represent the sector, and for that person to be a provider of services** • **Discussion took place on the inclusion of the Chair of the Joint Working Board and the Chair of the CCG Joint Committee as members of the Programme Board, and the potential timing of any invitation to join the Board – it was agreed to continue to include these postholders as members** • **The Programme Board agreed to stand down the SLG with immediate effect** • **The Programme Board discussed the merits of seeking to establish a cross-system Clinical Cabinet locally to drive STP clinical strategy and pathway redesign. It was agreed that further scoping of how this has been established in other STP areas would be required and Ronan Fenton and Donald McGeachy were asked to take this forward and provide an update at the next Programme Board.** • **The Programme Board agreed to stand down the CPLG** • **The Programme Board agreed that the ALG and PCLF should refresh their terms of reference to ensure there is a commonality across both the groups which will enable them to integrate**	AV AV AV AV RF/DMcG AV AV

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	their work and share a work agenda for the integration of services across the system. AV to work on a template to take that forward. All agreed to support. • **The proposed reporting arrangements were supported for FOG to take all key decisions for approval to the Programme Executive as well as local Boards, where required**	AV
11. AOB	AV – briefed the Programme Board that at least some of the five CCGs within the footprint were likely to be directed to form a Joint Committee to enable collective decisions to be made. This intervention by NHSE follows a failure of the five CCGs to reach a consensus themselves.	
	Next meeting: 26th April – 10.00 – 12.30 at Committee Room 5, Civic Centre, Victoria Avenue, Southend on Sea SS2 6ER (or 6EQ for satnav) Forward items: • Social Care Strategy/Changes/Finances – future agenda and update at next meeting • Workforce – LWAB – May • Frailty integrated pathway to use as a framework on how to approach the involvement of workforce with the clinical pathways - May • Mental health – August • Public Health – April/May	