Mid & South Essex Success Regime Programme Board

Monday 24 October 2017 13.00 – 16.30, Committee Room 6, Civic Centre, Thurrock Council offices

Present: Anita Donley (AD), Independent Chair
Andy Vowles (AV), Programme Director
Jo Cripps (JC), Chief Officer Local Health & Care Portfolio
Clare Panniker (CP), SRO In Hospital
Sally Morris (SM), Chief Executive, EPUT
Leanne Crabb (LC), HealthWatch Southend
Roger Harris (RH), Thurrock Council
Sharon Houlden (SH), Southend Council
Eric Watts (EW), Service User Group Chair
Peter Fairley (PF), Essex County Council

Apologies: Caroline Rassell, Donald McGeachy, Simon Leftley, Iain Martin, Ronan Fenton
Minutes: Jacky Dixon, Senior Programme Manager

Item	Discussion	Action Lead
1. Welcome and introductions	AD welcomed attendees and introductions were made.	
2. Minutes and actions	Minutes from the meeting held on 24th July 2017: Matters of fact: **All agreed** **Matters arising:** • Item 6 – The Clinical Cabinet met for the first time on 19th September –members reviewed the draft TORs, clarified membership and representation (Voluntary Sector not yet represented) and had an opportunity to run through and comment on the proposed acute clinical model. Next meeting scheduled for 21st November 2017 **Decision: all agreed the minutes as a correct record of the meeting.**	

Item	Discussion	Action Lead
	AD reviewed the agenda, referring to the SUAG draft paper that she and AV had received from EW on behalf of SUAG, and a subsequent meeting with EW, AV and AD. AD acknowledged several concerns expressed by EW at that meeting on behalf of SUAG. AD thanked EW for the draft paper, and for agreement that the STP team would be preparing with urgency some answers to the questions of fact raised, and that a series of further meetings between AV, EW, WS and SUAG members would address concerns raised.	
3. Programme Director Summary Report	AV provided an update on the overall programme. Over the past few months the key priorities were to finalise the PCBC and progress through the national NHSE assurance process. The PMO are beginning to scope options to develop the wider STP performance reporting arrangements and information as NHS England start to move away from holding individual organisations to account. The STP as a system will need to demonstrate progress against the deliverables within the 5YFV. AV highlighted the following main risks: • Capital funding for the hospital reconfiguration – bid submitted in September as part of the national NHS England process. We expect the outcome to be announced in November as part of the Autumn Budget. • A degree of political controversy about some proposals and we are managing our way through this; improving engagement and broad stakeholder ownership of the options will remain a risk • Capacity – system-wide and varied resource constraints exist across the programme and within organisations **In hospital:** CP provided an update • Review of clinical model undertaken during the summer; there will be a treat and transfer arrangement at all three A&Es and all three hospitals will accept blue light ambulances. It is considered that this model provides the right balance between access and local delivery and enables us to deliver concentrated specialist services to patients across at 24/7 period • Some clinical services proposals have been more challenging than others e.g. where the proposed local model has not necessarily been fully aligned with national guidance as with stroke services. However, we now have a strong model of proposed revision to current arrangements, broad clinical support and agreement that our model can be implemented. Under these proposals local A&E centres would deliver diagnostics and thrombolysis and, if required, the patient would be transferred to a Hyper	

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	Acute Stroke Unit (HASU) located at Basildon Hospital. Clinical Leads and Nursing leads from all three Trusts are in agreement that this is the best way forward for improving patient outcomes in our area. AD gave an update on two review meetings with the Clinical Senate with particular focus on the proposed model for acute stroke services. The NHS England National Clinical Director for stroke, Professor Tony Rudd, had provided independent advice and spoke in support of the proposed model. New data from the United States where a similar model has been implemented highlights the benefits of thrombolysis taking place prior to transfer. In the US this is termed "drip and ship" to reflect the fact that thrombolysis treatment, where indicated, is given on site and the patient then transferred to a HASU. The Clinical Senate noted the current services in our STP are rated well above average in the national audit process for stroke. CP continued with her update: • Working with the wider team on finalising the PCBC • In the final stages of reviewing local governance and moving forward with local engagement across the hospital and with staff • Now starting to focus on the detail of how and what is required to deliver this model with the commissioners next year. Need to progress the capital scheme and make sure all our detailed plans are worked up. EW stated that the concerns of the Service User Group members remain. The SUAG members had attended a very useful meeting with Essex ambulance staff at Chelmsford. EW asked for confirmation if someone is taken unwell where the benefit of taking someone to a major unit outweighs the benefit of going to a local hospital? CP responded to say that the proposed model will take patients to the nearest A&E in the majority of cases; however as happens currently patients may be taken to the relevant specialist unit; a relatively small number of clinical specialty pathways would be changed and this detail would be worked through in the coming months. In all cases the judgement of the clinical team and the patient on the best way and the best location for treatment would be paramount; this may be within the first 12/24 hours of a patient arriving at hospital. CP acknowledged that engagement with the wider clinical team, members of the community and service user needs to be better.	

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	AD clarified that were there to be a set of clinical protocols emerging it might be helpful to have a discussion with members of the SUAG on how this has been arrived at. Concerns from SUAG should be fed into the clinical pathway development as clinicians develop the criteria. RH asked for more detail on the capital bid submitted and how this would support moving patients out into a community setting. CP confirmed that a capital bid had been submitted for £118M. This is for funding for the whole acute clinical reconfiguration, theatre reconfigurations, and 58 additional beds across the system, support the on-going costs to Tele Tracking information systems etc. This is not for the out of hospital work. SM commented that since the capital bids from STPs across the UK are greater than the amount of money available nationally; there will be a challenge around finding alternative funding for the reconfiguration options. **Out of Hospital:** Jo Cripps provided an update on behalf of Caroline Rassell SRO: • Teams concentrating on finalising the PCBC and supporting papers • Lots of engagement between hospital clinicians and GPs to help set the context and changes being proposed • Formally appointed the CCG Joint Committee Lead ACO and SRO for Local Health & Care, Caroline Rassell • CCG Joint Committee lead director roles appointed to: Chief Finance Office Louise Kampher, Director of Commissioning, Karen Wessen and Chief Nurse, Carol Anderson • The CCG Joint Committee continues to meet and recent meetings have made positive progress • The Joint Committee has signed off a consistent set of commissioning intentions which set the strategic context for working together more closely • A CCG Communications Hub is being established to support the consultation process; this is hosted by Mid Essex CCG, and a Communications Hub Programme Manager has been appointed • The Public Consultation is a CCG-led process and the CCGs are very keen to ensure this is a partnership approach with other organisations • Currently working with the acute executive on a joint programme of work for the next 6 months	

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	• An accountable care partnership has been established in Thurrock as part of the NHS England transformational change programme focussing on children's services and the acute stroke pathway. • Interviews for the CCG Joint Committee roles of Medical Advisor, and of Primary Care Lead will be taking place over the coming week. EW asked why is there no Service User representative on the CCG Joint Committee? JC confirmed that the establishment of the Joint Committee under direction from NHS England had set clear parameters that the membership of this committee was CCG Chairs and AOs from each CCG. The intention being not to form a sixth CCG. PF confirmed that Essex Health & Wellbeing Board had offered a seat to the CCG Joint Committee Chair. The Council welcomed the formation of the joint committee and the clarity this now gave on who was best placed to have conversations with. JC confirmed the capital bid submitted is for the acute reconfiguration only. She confirmed that the LHC had bid for some money in the 1st and 2nd waves but that these were not successful; CCGs are working closely with the Local Authorities on developing integrated hubs. PF asked how conditional the acute reconfiguration is on the success of the capital bid? AV stated that we would only go to consultation if we had a reasonable expectation of being granted the capital funding; the treasury will not allocate capital unless a scheme that is ready for consultation. In view of this we may need to start the consultation after the Autumn budget in November 2017. **Decision: The Board noted the updated reports and progress made**	
4. Local health & care framework	The purpose of the paper is to provide an overview of what is being taken forward in common by the CCGs recognising that statutorily the CCGs are separate organisations. Main workforce issues are in Primary Care - fewer GPs than there should be; recruitment taking place from the EU; problems with retention, and now reviewing the work load of GPs; reviewing new roles and how these can support signposting patients to other clinical services; considering the national requirements and extended GP access across the 5 CCGs areas; looking at different way of offering a consultation with a GP – better use of technology.	

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	All CCGs are trying to provide Primary Care at scale and work through the localities. Working at scale across 24 localities and it is recognised that some areas are further advanced than others. The paper submitted to the Board outlines scenarios of current good practice and a framework for the potential improvement and system-wide alignment of Local Health and Care services Work is still taking place on developing the detail of the services to be offered in mid and south Essex STP localities and the supporting workforce plan; e.g. being able to describe to a group of patients of what they might expect to find in a locality hub; what type of clinical conditions would best be managed initially in the LHC locality; and developing communications to share information and engage in discussion on these proposals. CP agreed with the wider principles but said that more detail is needed very soon to describe what a locality hub is; planning what the workforce would be both in terms of core plus additional people, what the case load might be, types of patients who could access that service, social care element in the hub. Service users, clinicians and partners need to understand how this will operate in the future with everything co-ordinated in one place rather than patients having to attend 6 different GP practices. JC confirmed that a suite of documents is being developed to support the consultation and will be covering this. It was agreed that these would be shared at the next Programme Board meeting. RH stated that Ian Wake, Director of Public Health, would be able to assist and given further information and sited Tilbury as an example which has now been formally commissioned and quite well advanced. PF stated that Essex County Council (ECC) welcome these developments and is willing to work with the CCGs on what the core social care offer would be. He stated that there is currently a restructure of the ECC adult social care team which has just been published for staff consultation and would share this with the CCGs to help build into this work. SM echoed CPs views on getting examples of what a locality looks like in practice. It might be difficult to present these at the next Programme Board because of the need to recognise three different local authorities, different input in social care, different community providers and a difference in what has been previously commissioned from each of those providers across the STP footprint. This in turn might have an impact on the	**CR/JC**

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	future design of a hub; the workforce and skills required etc. When redesigning the mental health programme the hardest area has been to meet the different requirements across the footprint and different offer of mental health services. AD stated that, as we are going to public consultation soon we need a more detailed narrative on what "locality" means and what a "hub" is - given that clinical services may operate across more than one hub. The reconfiguration of acute systems depends on a mature population-based system-wide approach to health and social care via the locality hubs. SM stated that for these discussions it would have been helpful to have other community providers at the Programme Board. EW stated the he had recently tested the GP web but that it takes a lot of time to complete if you have a complex issue and more instruction is required on how to use this system. RH asked where NHS England is in this as they still commission Primary Care Services? JC confirmed that the CCGs need to take on primary care commissioning; however there are challenges with engaging GPs as group of providers, engaging with those clinical leaders as professional group has proved difficult. This is now being taken forward by the Primary Care Leadership Group and hopefully in the next few months we will see developments on this. The Primary Care Joint Committee lead role is to help support this work. SH stated that the development of the narrative needs to be in collaboration with Local Authorities; the pace of transformation in social care is fast and to develop a purely clinical model of localities and hubs could be damaging if this needed revision at a later stage to incorporate social care elements. Southend Council would like to contribute to the development of this now rather than being asked to comment on a paper that has already been developed. JC noted. AV summarised by stating that we need to agree what can be brought back as a starting point for further discussions, a pack outlining an optimum model and services, and subsequently a detailed pack on workforce requirement detail at locality level. SM stated that these workforce requirements are currently not reflected in the STP workforce strategy and need clarity on the model for instance impact of a paramedic in primary care and potential problems for staffing in the ambulance services.	

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	Decision: The Board noted the contents of the report. **Actions agreed:** 1. CR to provide a copy of the suite of documents that is being developed to describe the locality model and hubs as part of the consultation. It was agreed that these would be shared at the next Programme Board meeting. 2. Members agreed that an optimum generic model would be developed with community providers and local authorities for the December 2017 Programme Board meeting and a sophisticated model in March 2018 showing the workforce range of roles and skill requirements.	**CR/JC** **CR/JC**
5. PCBC and NHSE Assurance Process	AV introduced the paper which gives an overview of progress and NHS England national assurance process. • The PCBC is a lengthy document so was not distributed with the papers, but is available to Members. Board members are asked to contact Jacky Dixon for a copy. • Two Clinical Senate reviews have been undertaken on the proposed clinical models. • Meeting all Mid & South Essex MPs on 25th October to brief them and give them opportunity to comment on the outline consultation plan • Meeting with the Minister for Health on 7th November. Give the MPs opportunity to comment and builds on a number of previous conversations. • Paper outlines the proposed next steps and timeline with best estimate that we are likely to launch the public consultation at the end of November after the Autumn Budget • Orsett Hospital is part of this overall wider consultation. SM asked for clarification the there is no expectation that other provider organisations have to formally approve this PCBC at their Board? AV confirmed that this is only for the CCG Joint Committee to approve formally, although other Boards may wish to consider it. JC reiterated the point that the CCGs want to go out to consultation with full involvement of all partners, and need to be assured that community providers support the principles of consultation; and are included in plans within the community providers. SM stated that the out of hospital programme and how the CCGs are looking to develop the hubs thinking does	

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	not appear to be so well advanced as the hospital services and the two initiatives are mutually dependent and that failure to progress at pace re local Health and Care plans may impact on the acute reconfiguration. **Decision: The Board noted the contents of the report.**	
6. LWAB Update	The set of detailed documents, Workforce Strategy, Strategy Implementation Plan and Workforce data had been previously circulated in early September and again prior to this meeting. At present no feedback or comments had been received by the LWAB Chair. SM provided a verbal update on current LWAB status, issues and pressures. One of the main challenges for the LWAB is the lack of clarity of the future models of care both in hospital and out of hospital including mental health and the need for detail and engagement with the STP leads to be able to model the future workforce requirements. Because of this the LWAB recognise that in the proposed strategy there are areas that require strengthening this includes social care workforce plans. Capacity constraints within the system remain the biggest issue for the LWAB. The support from Health Education England is now reduced and considerably less than the old workforce partnerships comprising half a senior workforce manager and half time junior admin role. The GP forward view workforce submission was presented recently to the NHSE panel to allow an early critique and will be resubmitted later this week. Ian Barton, Deputy Postgraduate Dean for Health Education England will be joining the LWAB at one PA a week to provide medical input. The LWAB are planning a wider LWAB engagement event in November 2017 (date yet to be finalised) to develop workforce modelling and base line data where Trust leads, Workforce leads from partner organisations will be invited to attend. An LWAB sub group of HR Directors is leading on this. The LWAB is working with HEE to adopt an evidence-based approach to transformation of the workforce. HEE have established a regional transformation hub (18 people) that is able to undertake research on a particular area or topic. AV asked if they could potentially be a resource to assist help model the workforce of the locality hubs? SM replied that we need the clarification of what is in the localities before we can take this forward.	

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	The LWAB are considering opportunities to extend the members with Staff Side Partnership Forum and other people who want to be part of this planning. Further discussion will take place on this at the next meeting on 7th November. HEE have now appointed a new Regional Director, Phil Carver who will be part of the co-chairing arrangement for the Mid & South Essex STP LWAB. AD asked if the colour coding and formatting on the social care workforce slide could be changed to make it easier to read? SM noted. AD asked if the LWAB have Local Authority representatives on the LWAB membership. SM confirmed that this will be part of the discussion at the event in November. RH asked what the power and responsibility of the LWAB is .SM replied that the LWAB was aligned to the STP footprint and reports to the Programme Board – around the health workforce and clearly a number of integrated teams; clearly we are not planning the social care workforce. AD asked what is the proposed approach to identifying the capacity requirements that has been highlighted? SM replied that thinking has been to develop a full time Band 8A role to take some of this forward with help from HEE and consistent with other LWABs in the Region. SM confirmed that the implementation plan is ambitious and constrained by resource of who is doing what as the support to take forward these actions needs to come from within the partnership. AD suggested that a review of the work plan is undertaken by the HEE research hub and that further discussion on the capacity issue is taken forward outside of the meeting. CP commented that there is a need to ensure a joined up approach to workforce planning and requirements across the STP, potential to develop a joint PMO for strategic change and need to resource this – massive amount of workforce planning to be undertaken. AV suggested that given the capacity constraint of the LWAB we need to be clear about what can be taken forward as part of the implementation plan and suggested a refinement of the plan be submitted to the next	**SM**

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	Programme Board. SM stated that "*the ask"* will continue to shift again in the next 3 - 6 months and need to prioritise the work plan. Lots of items on workforce are feeding a national process. **Decision: The Board noted the update** **Actions agreed:** **1.** SM to review the implementation plan to identify the top priorities and update at the next Programme Board meeting **2.** Further discussion on the capacity constraints to take place	 **SM** **SM**
7. Towards an ACS	AD referred to the slide presentation outlining the anticipated future state of an Accountable Care System. This pack had been developed to promote discussion amongst the STP partners of what the future form of the STP might be after public consultation and after decisions have been taken about the service changes across the footprint. This presentation included a proposal to review the existing governance arrangements and respective groups. EW commented that still has concerns on the service user input and need to be involved earlier on in discussions. PF stated that ECC does not disagree with the proposed governance ; more comfortable with ACS than ACO; CEO Gavin Jones would like to use a session in November to think through how Essex CC works with 3 STPs; what we think sitting at what level and what is the added value. RH stated that there is speculation that the BCF may disappear and will be on STP footprint going forward and that he has concerns about that. RH expressed some scepticism on the ACS governance, as architecture is getting very crowded, the role of the Joint Committee and recognise there is a need to commission at scale and some things that need to done on a bigger footprint however does not want to undermine the supremacy of the local H&WB and local arrangements. SM stressed the importance of being clear about the future role of the Programme Board. What is the purpose of bringing in ARU and HEE if we are looking at STP performance? HEE and ARU are better placed within the LWAB otherwise this has the danger of becoming a talking shop.	

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	AD accepted that as a fair point for HEE but ARU are helpful in their independent academic standing and hope that this can be considered. RH asked what is the role of the Joint Committee? Should all 5 CCGs be on here or members of the Joint Committee? CP stated that it was clear there was a need for a group of CEOs to come together in some way and the STP footprint seems to be the obvious way of doing that. There are numerous meetings about integration, H&WB others – need an amnesty on other meetings and what can go as a result of this – need to review other groups. AV summarised by saying that the STP is a collaborative way of working, it is not statutory and therefore complex in set-up and partnership working arrangements and, as a result, will cross over other areas of governance. There is a need to reorganise ourselves from the initial establishment as a Success Regime and changing this forum so that it is inclusive of all the CEOs is the right thing to do. It is important that conversations start to take place on single financial control totals for all NHS Finances and how this can be progressed. As well as governance changes we don't have a role in our system that most other STPs have, namely an Executive Lead, who would take on that Executive Leadership role on behalf of the partnership and that needs exploring. SH stated the ACS is a welcomed concept – and direction of travel thus far is the right one – need for more partnership and collaboration is quite real and in terms of different membership is the right way to go. AD suggested that members have further discussions of what issues this raises; what we do, the proposals presented for the change of STP Programme Board members, structure of governance, establishment of a STP Executive Lead role. Members were asked to send comments to Jacky Dixon for collation and further discussion at the next meeting in November. Members were then asked to debate the proposal issued on 11 October to all STP stakeholders to change the name from Success Regime to Mid & South Essex Health & Social Care Partnership. Feedback had been collated and whilst some partners had not responded the general consensus agreed with the rational to review the name as we move towards a public consultation process. Members agreed that Mid & South Essex STP would be more acceptable	**All**

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	At a future stage of development towards an Accountable Care System it might be more appropriate to move towards the Mid & South Essex Health and Care Partnership. **Decision: The Board noted the information provided in the presentation** **Actions agreed:** 1. Programme Board members agreed that they would cascade the pack on the ACS development within their respective organisations for discussion and feedback to the next Programme Board meeting. Comments to be sent through to JD. 2. The Programme Board members agreed unanimously with the change of name to Mid & South Essex STP. JD to take forward appropriate confirmation to wider stakeholders and PMO arrangements. 3. AV and JD to develop more detailed proposals to come back to a future Programme Board	**All** **JD** **AV/JD**
8. Clinical Networks – resource to STP	JD provided a summary of the report which highlighted the changes proposed by NHS England to strengthen the transformation capability of STPs. NHS England is proposing alignment of the clinical networks for maternity, diabetes and mental health and associated funding in a hub and spoke model. Existing cancer networks are being replaced by Cancer Alliances and a hub and spoke model is in place within each STP already. Funding is being made available to STPs to stretch the resource into 2018/19. The STP will be held accountable for the deliverables against the 5YFV. **Decision: The Board noted the contents of the report and associated accountabilities**	
9. SEPI (Strategic Estates Planning & Implementation) Update	JC provided an update. As part of the work on the SEPI pilot we have secured some estates expertise and support to undertake a review of local plans, how to access capital from Local Authorities and other providers as part of support for the wider plan. AD asked how does this fit with Local Authority plans? JC responded that the strategic advisor is working with the CCGs so that we can be clear of the plans being proposed. AD invited detailed comments from the Local Authority members. SH stated that there had been many missed opportunities in the past now need to ensure we work together at the very beginning and welcome being involved as early on a possible in the process to influence the thinking.	

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	RH said we have a clear vision of where we want to get to with the 4 integrated medical centres in Tilbury and Chadwell. Funding has been committed for the design team to develop the business case and go through the protracted NHS England assurance processes. A joint strategy has been developed however there may be a shortfall in capital for Purfleet and Corrigan and redevelopment of other estates. PF stated that ECC are keen to be involved early on, able to raise capital and members would see benefits of that – as we move to a locality model we need to see what opportunities there are to make better use of estates. AD asked that the SRO for LH&C ensures there is early collaboration with our Local Authority colleagues. AD asked for a formal written report on SEPI covering what has been achieved and what steps have been taken to take forward partnership working for the next Programme Board in November. **Decision: The Board noted the update provided.** **Actions agreed:** **1.** The Board asked for a written report on SEPI at the next meeting in November.	**CR/JC** **CR/JC**
10. Social Care Strategy Update	RH stated that the whole process has been poorly managed nationally; at a local level BCF plans have been agreed by Council Board – no one understands the assurance process, still awaiting letters etc. All out of 65s budget into our BCF and feel comfortable with what is being taken forward locally. Thurrock, Essex and Southend – high impact model all trying to retain capacity on prevention and primary care. All three plans submitted and recommended for approval and still waiting to hear the formal outcome. ECC cabinet has taken the decision to spend the BCF funding. **Decision: The Board noted the update**	
11. HealthWatch Essex Insights	AV introduced the report. The STP had engaged HealthWatch Essex to conduct a study on the views of citizens on A&E services against the initial thinking regarding hospital reconfiguration of specialised emergency care. The report is an interesting read and highlights some areas we already know especially some of the concerns on those proposals and access to A&E. AV noted that since this study had been commissioned the options have been developed further. The report does provide intelligence from service users and useful insights as we carry forward to consultation and the	

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	shift in the model. EW stated that it was similar in content to the SUAG report, focus is still on what happens to someone and how they are assessed. PF stated that the report sets out what we know that people go to A&E first for any treatment, there are no recommendations from a communications perspective on what we should be doing to highlight that is not appropriate – how real can we be about what the alternative is? EW commented that lots of patients present too late for issues to be addressed. CP acknowledged that there are generational differences on how patients access care which needs to be considered as we present the locality model moving forwards. **Decision: The Board noted the report.**	
12. Next Meeting	**No other business** **Date of next meeting: 27th November** Committee Room 6, Essex County Council, County Hall, Market Road, Chelmsford CM1 1QH **Actions agreed for next meeting:** • Locality and hub model pack as part of consultation documents – CR • SEPI written report – CR • LWAB revised implementation plan with key priorities – SM • LWAB capacity discussion update– SM • ACS development – all members to provide feedback **Forward Items** • Mental health • Child Protection Information Sharing	

Item	Discussion	Action Lead
	• Local Maternity Services • SUAG update 20th December meeting: • Optimal model for LHC	