Mid and South Essex Sustainability and Transformation Partnership
CCG Joint Committee

Sustainability and Transformation Partnership Joint Committee (STPJC)
Public Meeting
Wednesday 29th November 2017 3:45pm
The Marconi Room, Chelmsford City Council, Civic Centre, Duke Street, Chelmsford CM1 1JE

Present:	Dr Mike Bewick (MB)	Independent Chair
	Ms Caroline Rassell (CR)	Lead Accountable Officer, Joint Committee and SRO Local Health & Care Accountable Officer, NHS Mid Essex CCG
	Dr Caroline Dollery (CD)	Chair, NHS Mid Essex CCG
	Ms Mandy Ansell (MA)	Accountable Officer, NHS Thurrock CCG
	Mr Ian Stidston (IS)	Accountable Officer, NHS Southend and NHS Castle Point & Rochford CCGs
	Ms Lisa Allen (LA)	Acting Accountable Officer, NHS Basildon & Brentwood CCG
	Dr Anand Deshpande (AD)	Chair, NHS Thurrock CCG
	Dr Jose Garcia (JG)	Chair, NHS Southend CCG
	Dr Kashif Siddiqui (KS)	Chair, NHS Castle Point & Rochford CCG
	Dr Arv Guniyangodage (AG)	Chair, NHS Basildon & Brentwood CCG
In Attendance:	Mr Andrew Pike (AP)	Director of Commissioning Operations (East), NHS England
	Ms Viv Barnes (VB)	Director of Corporate Services, Interim STPJC Secretary, NHS Mid Essex CCG
	Ms Celia Skinner (CS)	Chief Medical Officer, Basildon & Thurrock University Hospitals NHS Foundation Trust
	Ms Nicola Adams (NA)	Head of Corporate Governance, NHS Thurrock CCG (minute taker)
	Ms Jo Cripps	Chief Officer – STP Local Health and Care
Apologies:	None	

1.	**Welcome and Apologies**
	MB welcomed all to the meeting. There were no apologies from the Membership. MB welcomed members of the public.

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2.	**Register of Interests**
	MB asked members to declare any interest not already recorded in the Register of Interests. Members confirmed there were none, with the exception of KS who confirmed that he was not currently working for Spire Wellesley or conducting medical appraisals. His declared interests were therefore as a GP trainer and a GP partner at the Rushbottom Lane Surgery (which was also a member of the GP Healthcare alliance and Essex Clinical Research Network). MB made a statement regarding recent media reports about 'CareRooms', to which he had been affiliated. MB advised that he had provided mentoring advice to Dr Harry Thirkettle (CareRooms Medical Director) through an NHS England scheme which supported the development of clinical entrepreneurs. There was no commercial or business arrangement in place for this, it was a voluntary role. MB had not declared this on the Register of Interests as it was not a pecuniary interest, although it had now been recorded. To ensure there was no further perception of a conflict, MB confirmed that he would be standing down from mentoring Dr Thirkettle. CS was invited to comment on 'CareRooms' and stated that this was a model that might be considered for the future but was not being actively pursued at this time. Declarations declared by members of the STP CCG Joint Committee are listed in Mid Essex CCG's Register of Interests. The current and historic registers are available upon request via the Secretary to the Joint Committee. **Declarations of interest from sub committees** N/A. **Declarations of interest from today's meeting** None declared.
2.	**Questions from the Public**
	MB introduced this item confirming that the STP CCG Joint Committee was a meeting held in public, but was not a public meeting. Members of the public were able to observe the proceedings and were given the opportunity to ask questions under this agenda item. Normally questions would also be taken at the end of the meeting under agenda item 8. MB confirmed that with only one specific topic on the agenda - the decision whether to progress to public consultation on the proposed changes to hospital services in mid and south Essex - questions from members of the public would only be taken under agenda item 2, because if the recommendation was agreed there would be a formal consultation process to obtain public feedback and if it was not approved, there would be no further questions to answer at this point in time. MB stated that a number of written questions had been received in advance. Members would endeavour to answer questions today, but some might need further enquiry and consequently might not be answered immediately. A written response would be provided for all written questions submitted in advance and any verbal questions to which a full response could not be given. MB invited questions from the floor. Alan Hudson (AH) (Thurrock patient representative). AH explained it was clear that change was required to A&E services because they were not sustainable. However he queried why the original proposal in relation to the configuration of A&E services had been amended if it had clinical support and asked what else had changed in the proposals now being presented to the STPJC.

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CS recognised that the local health economy was struggling and that the focus of the consultation was upon changes to acute services. However, the STP plan included primary and community care working alongside the Acute Hospitals so that patients did not present unnecessarily at A&E. This would provide a more efficient service and was vital to the success of the In Hospital strategy. CS also stated that in describing the network of hospitals, there were a number of designs in principle, some of which were separating emergency and elective care and to bring together specialised services under one umbrella to deliver improved patient outcomes.

CS also clarified that feedback from the public, stakeholders and staff was one of the reasons for the change in direction in relation to A&E services. It had become apparent that the three hospitals in the group were not ready for the proposed changes to the A&E 'front door', particularly Southend Hospital. Recruitment difficulties had also eased, so the hospitals were more confident they could continue to provide safe levels of emergency care. The interaction with Primary and Community care was important to ensure all groups were working together to help patients make the right choices before presenting at the front door of A&E.

Simon Cross (SC) (Save Southend). SC expressed his concerns over the pre-consultation business case, in particular the assumptions that were made about moving more services into a primary care setting. With high vacancies in primary care and many GPs planning to retire, SC said that he had significant concerns about the burden upon primary care and the impact on GP workload.

CS confirmed that primary care capacity issues and the potential impact on workload were recognised and that the Primary Care model might need to change in the future. Any changes to care pathways would focus upon ensuring patients received the right service at the right time.

CD commented that efforts were being made to work with local practices and the LMC, investing money, resource and skills in primary care. Practices were working together to develop wider teams that reflected local needs to serve their patient population.

SC accepted the wider model was reasonable, but expressed concern about the recruitment crisis. He was also concerned about the changes within the hospital model in terms of transporting patients between hospitals and the impact on hospital staff working across three sites.

CS advised that the hospital group saw approximately 900 patients a day, with 300 admitted. The PCBC was essentially a series of design conversations and high level planning assumptions. Within that high level plan of 900 patients, 15 might be required to travel to another hospital. For example under the stroke pathway, patients would attend their local hospital where they would be assessed and receive advanced imaging and/or be prescribed any necessary medication. They would then be moved to Basildon (where specialised stroke services were provided) for a 72 hour period of medical intervention. The joining of the specialised teams across the three hospitals meant that staff at the three locations could work as one team with shared protocols / ethos / rotas. This did not necessarily mean staff would be working at different sites all the time, in fact they were likely to stay where they currently worked, but they would have the opportunity to develop skills in other areas with a consequent upskilling of the overall team which would be advantageous to staff, patients and the hospital. Only a minority of staff would need to move across different sites and all staff would be consulted on any potential impact.

Pauline Amos (PA) (Support the NHS Halstead)
PA said that she believed the messages in the consultation (PCBC) documents from NHS England/CCGs did not 'pan out'. She provided examples of previous public engagement such as in Northumbria in 2013/14 where promises had not been kept about transport to other

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hospital sites or that hospitals were not going to be downgraded. PA suggested that the STP's plans were a precursor to the establishment of an Accountable Care Organisation and the privatisation of NHS services.

PA had provided written questions before the meeting as follows:

Q1 – Where in the PCBC does it say this is all leading towards the creation of an Accountable Care Organisation (ACO)?

CR stated that there had been discussions at the STP Programme Board, with a paper in October that looked at options available to the STP in terms of future organisational models. However, no decisions had been made because this would need a change in primary legislation. At the present time the STP was concentrating on building a strong primary care service, utilising CCGs as the route to deliver this, and working with the hospitals on the reconfiguration of acute services.

AP confirmed that the PCBC was not creating an ACO. AP reminded members and the public that the NHS operated in accordance with parliamentary and government policy, with clear mandates from NHS England. NHS services were and would remain free at the point of care.

Q2 – The consultation has not started … In the minutes from the last meeting, it states that funding [for the PCBC] is dependent on the consultation being launched by 22nd October, the date of the Autumn budget. What funding is this? And having missed the deadline will that now not be available?

CR confirmed that it was a requirement by 22nd November (the date of the national budget) that the PCBC had to be signed off by the national Investment Committee and there needed to be a plan in place to go out to consultation. On 3rd November the PCBC was approved in principle by the Investment Committee and this decision was confirmed in the budget. To get the capital funding, there was still a need to go out to consultation and to bid for available resources (a potential £118m).

Chris Gasper (CG) (patient representative, Southend)
CG enquired how the consultation would take place, particularly in relation to the transport element. He also commented that there was too much detail in the PCBC and therefore care was needed how its messages were conveyed and communicated.

MB agreed that this was an important point and that the consultation must be robust and easy to understand. MB stated that a communications plan had been developed to support the consultation with a timetable of public events, user friendly documents and questionnaires, etc.

Dr Shan Newhouse (SN) (GP in Halstead)
SN asked whether the renal dialysis service in Chelmsford was going to be closed down.

CS stated that the references to 'renal' within the PCBC related to inpatient beds and there were no plans to change dialysis provision which needed to be near patients' homes. Out Patient services would continue as usual. Dialysis provision would not change, but the hospitals did want to develop a single specialist team.

SN went on to ask how seriously ill patients would be transported safely, noting that this required specialist staff and resources to keep patients stable.

CS stated that the STP investment plan included the provision of additional patient transport services. Discussions were being held with the East of England Ambulance Service NHS Trust about a partnership/in-house operation looking at patient numbers and their needs to ensure maximum clinical benefit and minimal waits.

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	Eric Watts (EW) EW had submitted a written question before the meeting as follows: *How will the JCC ensure sufficient patient input into the planning of emergency care to ensure that patients receive appropriate treatment at their local hospital? (This applies to patients taken ill at home and not to accidents that may occur elsewhere.)* EW confirmed that the question had already been answered to some extent, but noted that there was still much more work to be done. Cathy Trevaldwyn (CT) (Public Governor, EPUT) CT had provided a written question before the meeting as follows: *Reference is made to the 'STP Joint Committee will also play a role in decision making about Learning Disability Services within the existing pan-Essex arrangements'. In some of the Essex provision (South Essex) Autism services run alongside Learning Disability services, will the STP Joint Committee also play a role in the decision making within the existing pan-Essex arrangements for Autism in the same way?* CR confirmed that autism services would fall within the delegated decision making remit of the STP JCC. Kate Sheean (KS) (Save Southend NHS) (not present at meeting) KS had provided written questions before the meeting. MB stated that KS's first question in relation to CareRooms had been answered at the outset of the meeting. The other questions were technical in nature and so a comprehensive written answer would be provided in due course. MB highlighted the importance of making change safe. MB asked for any final questions. PA commented that the 491 page PCBC was very long for people to read and digest and enquired whether the STP had looked at other evidence apart from UCL (a metropolitan service) regarding stroke. CS stated that a comprehensive evidence search, including evidence from services relevant to the Mid and South Essex STP, had been undertaken and this was detailed in one of the STP documents. **ACTION:** CS to send the evidence reference document to PA.
3.	**Minutes of Previous Meeting**
	The minutes of the public meeting held on 19th October 2017 were **AGREED** as an accurate record.
4.	**Action Log from Previous Meeting**
	Members noted the update provided within the papers against each action. Verbal updates were provided as follows: Action 08/09/2017-7i – The Ophthalmology timeline would be presented at the next STPJC meeting.

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	Action 19/10/2017-2 – Updates to the register of interests had been provided and this action was now complete. Remaining actions were in progress, but not yet due.
5.	**Matters Arising from last meeting (not on agenda)**
	There were no matters arising from the previous meeting.
6.	**Public Consultation and Pre-Consultation Business Case (PCBC)**
	CR introduced the PCBC noting that the briefing paper summarised the current status. CR referred to the consultation document, confirming it was still in draft and several changes had been made to the version previously circulated to members. Further clarity has been provided on a small number of sections to ensure consistency between the PCBC and the consultation document. In particular, there had been clarification in relation to general surgical and gastroenterology services, which were proposed to be located at Broomfield Hospital. CR also noted that the plain text version of the consultation had now been enhanced by graphics and there had been contribution from all system partners to make the document more readable and explicit. The consultation document had been shared regularly during its development and there had been a high level of discussion. Following feedback and approval from the STPJC and provided that any further required changes were minor, a final version would be provided to NHSE to enable the consultation launch tomorrow. CR noted that the case for change had been approved by the CCGs, highlighting the need to work in partnership with the three hospitals for sustainable acute services. In addition, the PCBC was required to enable access to funds for capital for investment to facilitate the changes within the hospitals. The 'Consultation Institute' had been commissioned to review the document and dialogue was ongoing to reflect any proposals or suggested enhancements during the consultation period. Public events had been organised and were detailed on page 13, which summarised the types of meetings and key dates for consultation across the STP and within each CCG area. The purpose of the events was to present the proposals and to note any key issues that needed to be taken into account. CR confirmed that there were no major events/meetings planned in December to ensure that the engagement was effective, particularly as the PCBC was yet to be approved. Engagement activities included a Facebook page, hosting some live webchats in December, with larger engagement events thereafter. This would provide a more personal element to the consultation. Engagement was also planned with Patient Participation Groups (PPGs) within each of the CCG areas. CR asked the STPJC to approve the PCBC for progression to consultation around the proposed changes to hospital services. MB explained that part of the role of the STP was to gain assurance around equality and asked if this process would meet the Public Sector Equality Duty (PSED). CR confirmed that the PSED was considered in the PCBC and was one of the areas scrutinised by the Regional Assurance process. Discussions during the assurance process highlighted that, although it was clear that only small numbers of patients were potentially affected by the proposals, there was further work to be done to gather information on how the proposed service changes could affect members of the protected groups as identified by the Equality Act. It had been agreed with the regional assurers that this work would be undertaken as part of the consultation process with a report on

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progress at the next STPJC meeting.

MB stated that these plans had been developed over a long time and had been subject to a considerable degree of scrutiny. MB noted that the STPJC and CCGs had a duty to be transparent and open and emphasised the importance of everyone around the table sharing the plans with their local communities and making sure any concerns were voiced. MB also reminded members of the duty of candour and the duty to serve patients.

Questions were invited from Members:

KS referenced the different funding mechanisms and asked CR to elaborate on the detail included on page 185, paragraph 9.3 of the papers.

CR stated that one funding mechanism available to CCGs was the 'LIFT' companies who could develop premises and lease them back to the NHS. There had also been good partnership working between the Local Authorities (LAs) and CCGs in terms of funding smaller infrastructure with a number of developments funded by LAs in Thurrock, Mid Essex and Basildon. Public sector capital funding was not ruled out however it was fairly complicated to access. There would be other opportunities moving forward to enable CCGs to access resources for primary and community services. Some indicative figures of the funding required were provided in the PCBC and funding streams had been identified for these.

KS ask what current funding was set aside for CCGs. CR responded that for Mid Essex and Thurrock resources were available from LAs or third party developers. The resources required by other CCGs were currently under discussion and so there was no total figure yet for the entire STP footprint.

JG commented that the document lacked a clear commitment for investment outside of the hospital setting. An indicative investment of £118m had been identified for Acute services and JG stated that he would like there to be similar clarity regarding the investment required for primary care reconfiguration (GPs, Mental Health and Community Health Services).

CR gave a commitment to provide un update at the next STPJC Part II meeting in January in terms of each CCG's plans for out of hospital (OOH) investment. All CCGs must ensure that robust primary care plans were established during the consultation period so that there was an overarching STP view of the primary care and OOH offer.

KS raised concerns that previous investment proposals for Primary Care had not been delivered. Whilst this was understandable because of pressures elsewhere in the system, the plan for A&E services depended on a robust primary care infrastructure (including Community and Mental Health).

AG noted the challenge for CCG JC members who remained accountable to their Boards and local population. In addition to the queries from Basildon and Brentwood CCG's Board about OOH funding, concerns had also been raised regarding the funding allocated for transport to transfer patients between hospitals.

CS explained that the cost associated with non-resilient small Acute teams was not sustainable. Joining small number of specialists across the hospital group would support savings and achieve better patient outcomes. CS stated that the majority of care for the frail and elderly would be delivered locally and in the future would be delivered from primary care services, according to the needs of the patient. If there was a clinical need for a patient transfer, this would be arranged.

AD noted that the consultation was for the hospital strategy and was concerned that there was

no equivalent strategy for primary care or recognition of the impact upon primary care.

CD emphasised the importance of presenting the Primary Care strategy in January to identify those impacts and consequent requirements.

KS stated that the plans in place for all CCGs were very good in terms of locality planning but were weakened by a lack of supporting resources.

AP reminded members that the recommendation was to consider and approve the PCBC to go out to public consultation; a decision was not being sought on the proposed changes to services as this would be undertaken at the end of the consultation period. The consultation process would consider the proposed changes, taking feedback from stakeholders, the public, CCGs and other partner organisations and using these to refine the overarching strategy. It was important to understand the OOH offer for each CCG, but this could be provided during the consultation period and AP offered NHS England's support in reviewing these plans.

JG noted that the concerns raised were in relation to the primary care strategy, not the Acute elements of the strategy, on the basis that the two were mutually interdependent.

AP acknowledged the concerns raised and noted that the PCBC provided a clear, sensible vision about the overarching OOH strategy, however there was a need to ensure this vision was fully supported within CCG's OOH plans. AP noted that all CCGs were making good progress in developing the OOH offer, but that more detail was required about how this would be delivered. This could be clarified during the consultation phase.

AD echoed the comments made by KS and JG regarding the lack of assurance about Primary Care investment.

MB clarified the recommendation to go out to public consultation for the Acute reconfiguration for a period of 14 weeks with feedback on the outcome planned for May / June. At that point, the STPJC would assess the support for the proposals and whether there were sufficient resources committed to approve it at that point.

MB went on to ask each CCG Chair to indicate how they intended to vote, in response to which KS, JG, AD, AG stated that they were considering abstaining from voting. MB then offered to pause proceedings to enable members to consider their positions.

Following a brief adjournment, MB asked each STPJC member to provide their vote and the reasons for their decision.

JG confirmed that he was speaking on behalf of the Southend CCG Board (clinicians and non-clinicians) and advised that he would abstain from voting not because he disagreed with the consultation proposals but because of concerns about the required Primary Care investment.

AD stated that Primary Care sustainability was also the main concern of Thurrock CCG's Board and consequently he would also abstain from voting because of the lack of clarity about the accompanying Primary Care strategy.

AG confirmed that Basildon and Brentwood CCG's Board was supportive of the consultation going forward and therefore he had decided upon reflection to vote in favour of the recommendation, but reiterated the need for clarity on the out of hospital approach.

KS (Castlepoint & Rochford CCG) thanked acute colleagues for their work on the PCBC, but noted that primary, community and social care services were a key component to these proposals and so he would abstain from voting.

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CD stated that there had been much debate at the Mid Essex CCG Board and with member practices about in and out of hospital care, however the CCG Board had concluded that there would be stagnation if the consultation did not proceed as the current system was not sustainable. CD would therefore vote in support of the recommendation.

LA agreed that it was important to open up the discussion and hear the views of the public and other stakeholders and advised that she was consequently voting in support of the recommendation.

IS stated that it was positive to have a debate around the OOH requirement and that investment was needed going forward to ensure delivery. This had been discussed with the Boards of both Southend and Castlepoint & Rochford CCGs, as a result of which IS was voting in support of the recommendation on behalf of both CCGs.

MA commented that this had been a difficult journey so far. There was a need for resources and discussions around pathways across acute and primary care, however it was appropriate to consult upon these proposals. MA would consequently support the recommendation.

CR confirmed her support for the recommendation in her capacity as Accountable Officer for Mid Essex CCG.

MB explained the governance around voting as set out within the STPJC Terms of Reference. MB explained that an abstention was classed as neither a 'yes' or 'no' vote and would therefore not count towards a majority decision. MB did however note that by abstaining from voting, members had sent a clear message regarding the issues that needed to be addressed during the consultation process.

The final vote was recorded as follows:

Member	Organisation	Vote
CD, CCG Chair	NHS Mid Essex CCG	For
KS, CCG Chair	NHS Castle Point & Rochford CCG	Abstain
JG, CCG Chair	NHS Southend CCG	Abstain
AG, CCG Chair	NHS Basildon & Brentwood CCG	For
AD, CCG Chair	NHS Thurrock CCG	Abstain
LA, Acting Accountable Officer	NHS Basildon & Brentwood CCG	For
IS, Accountable Officer	NHS Castle Point & Rochford CCG	For
IS, Accountable Officer	NHS Southend CCG	For
MA, Accountable Officer	NHS Thurrock CCG	For
CR, Accountable Officer	NHS Mid Essex CCG	For

Seven votes were received in support of the PCBC moving into a consultation period. Three members abstained from voting.

The STPJC **APPROVED** the decision for the PCBC to go out to consultation

CR outlined next stage of the process and asked members if there were any changes required to the current draft consultation document. LA confirmed that there were some minor wording changes proposed at the Accountable Officers meeting, otherwise there were no other changes required. The document would therefore be forwarded to NHS England for final assurance in order to commence the consultation tomorrow.

AG asked for clarification how the outcome would be notified to CCG Boards. CR stated that the decision should be noted at the CCG Boards and any feedback provided to the STPJC. IS noted that it should also be recorded at the clinical executive meetings.

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8.	**Any Other Business**
	There were no items of any other business from the membership. Members of the public asked whether any further questions could be raised. MB reiterated his earlier explanation that the PCBC was now approved for public consultation so any further questions could be raised during the consultation process itself. Members of the public requested that action be taken to ensure that the STPJC meetings were more accessible, particularly for hard to reach groups. More visible name plates should be considered as well as arrangements for those with hearing difficulties (noting that one member of the public was lip-reading). ACTION: Further consideration be given to the environment in which the public meetings are held to ensure that all members of the public (specifically hard to reach groups) were accommodated.
9.	**Close of Meeting**
	The meeting closed at 6.22 pm.
10	**Date and time of Next Joint Committee Meeting in Public:**
	3:15pm on Friday 2nd February 2018 at the Priory Suite, Southend CCG, Harcourt House, Harcourt Avenue, Southend on Sea, Essex, SS2 6HT.

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