Mid and South Essex Sustainability and Transformation Partnership
CCG Joint Committee

Friday 8th September 2pm to 3.30pm

West Barn, High House Production Park, Vellacott Close, Purfleet, RM19 1RJ

PUBLIC MEETING

AGENDA

Item	Time	Title	Lead	Action	Papers	Page No
1.	**14:00**	**Welcome and apologies for absence**	STPJC Chair	To note	Verbal	
2.	**14:05**	**Register of Interests**	STPJC Chair	To note	Attached	
3.	**14:10**	**Questions from members of the public**		To discuss	Verbal	
4.	**14:20**	**Announcements and Items of Interest**	STPJC Chair	To note	Verbal	
5.	**14:30**	**Minutes of the Last Meeting**	STPJC Chair	To agree	Attached	
6.	**14:35**	**Matters Arising and Action Log** - STP JC Terms of Reference and Constitution	STPJC Chair	To agree	Attached	
7.	**14:45**	**Ophthalmology**	Emily Hughes (CP&R CCG)	To agree	Attached	
8.	**15:00**	**Questions from members of the public**		To discuss	Verbal	
9.	**15:15**	**Items for Decision**	STPJC Chair	To agree	Verbal	
10.	**15:20**	**Items for Information** - Board Meeting Etiquette	STPJC Chair	To note	Attached	
11.	**15:25**	**Any Other Business**	STPJC Chair	To discuss	Verbal	
12.		**Date and time of next meeting:** **Extraordinary meeting 15th September 2017 2:30pm - 5pm** Chelmsford City Football Club, Melbourne Stadium, Salerno Way, CM1 2EH **8th October 2:15pm – 5pm** NHS Basildon and Brentwood CCG, Phoenix Place, Christopher Martin Road, Basildon, SS14 3HG				

SUSTAINABILITY & TRANSFORMATION PARTNERSHIP CCG JOINT COMMITTEE

A declared interest will remain on the register for at least six months after the interest has expired.

Historic interests will be retained for a minimum of six years after the date on which it expired.

First Name	Surname	Current Position	Declared Interest (Name of the organisation and nature of business)	Type of Interest Declared			Is the interest direct or indirect?	Nature of Interest	Date of Interest		Actions taken to mitigate risk
				Financial	Non-Financial Professional Interest	Non-Financial Personal Interest			From	To	
Mandy	Ansell	Thurrock CCG Accountable Officer VSM	Nil								N/A
Vivienne	Barnes	Director of Corporate Services	Nil								N/A
Mike	Bewick	Chair of Sustainability & Transformation Partnership CCG Joint Committee	Medica Group.					Non Executive Director	01/05/17	Ongoing	Interest to be declared at appropriate time should a conflict arise.
Mike	Bewick	Chair of Sustainability & Transformation Partnership CCG Joint Committee	FTI Consulting					Senior Clinical Advisor	?	Ongoing	No current assignments in Essex but would preclude me from bidding as part of local Essex based work.
Mike	Bewick	Chair of Sustainability & Transformation Partnership CCG Joint Committee	iQ4u Consultants					Director and Founder	01/04/15	Ongoing	Interest to be declared at appropriate time should a conflict arise.
Mike	Bewick	Chair of Sustainability & Transformation Partnership CCG Joint Committee	Verumed Consultancy Services Ltd. Employment placement agency.					Director. Currently second wave pilot of GP recruitment and recruiting to local Essex GPs and Southend Hospital.	01/10/16	Ongoing	Interest to be declared at appropriate time should a conflict arise.
Anand	Deshpande	Thurrock CCG Chair	Multiconsortium, Thurrock/Basildon Ltd. General Medical practice Activities.	x			Direct	Director	?	Ongoing	

First Name	Surname	Current Position	Declared Interest (Name of the organisation and nature of business)	Type of Interest Declared			Is the interest direct or indirect?	Nature of Interest	Date of Interest		Actions taken to mitigate risk
			Commissioning Group T/B Ltd	x			Direct	Director	?	Ongoing	
			Medical Defence Shield Ltd. Professional Membership organisation.	x			Direct	Director	?	Ongoing	
			South Essex Local Medical Committee (LMC)		x		Direct	Member of LMC	?	Ongoing	
			British Medical Association (BMA) Referral Council, Cambridge	?			Direct	Executive Member	?	Ongoing	
			MCG lead practice for hubs in the Thurrock CCG Area		?		Direct	?	?	Ongoing	
Caroline	Dollery	Chair of MECCG & Elected GP	Danbury Medical Centre		x		Direct	Salaried GP	01/09/15	Ongoing	I will declare my interest if at any time issues relevant to the organisation are discussed so that appropriate arrangements can be implemented
Caroline	Dollery	Chair of MECCG & Elected GP	East of England Strategic Clinical Network for Mental Health, Learning Disability and Neurology		x		Direct	Clinical Director	01/04/12	Ongoing	I will declare my interest if at any time issues relevant to the organisation are discussed so that appropriate arrangements can be implemented
			Eastern Region Collaborations for Leadership in Applied Health Research & Care		x		Direct	Non-Executive Director	01/07/15	Ongoing	I will declare my interest if at any time issues relevant to the organisation are discussed so that appropriate arrangements can be implemented
			Health Education England		x		Direct	Leadership Courses	07/12/16	Ongoing	I will declare my interest if at any time issues relevant to the organisation are discussed so that appropriate arrangements can be implemented
			Local Workforce Action Board (LWAB)		x		Direct	Chair of Local Workforce Action Board (LWAB)	14/12/17	Ongoing	I will declare my interest if at any time issues relevant to the organisation are discussed so that appropriate arrangements can be implemented

First Name	Surname	Current Position	Declared Interest (Name of the organisation and nature of business)	Type of Interest Declared			Is the interest direct or indirect?	Nature of Interest	Date of Interest		Actions taken to mitigate risk
Jose	Garcia Lobera	Southend CCG Chair and Clinical Lead for Mental Health	GP Partner at Pall Mall Surgery	x			Direct		?	Ongoing	Not part of the commissioning process/decision where conflict may occur
			Trustee of Southend United Community and Education Trust		x		Indirect		?	Ongoing	Not part of the commissioning process/decision where conflict may occur
Arv	Guniyangodage	Basildon and Brentwood	GP Partner, New Surgery,				Direct		?	Ongoing	?
John	Leslie	Basildon and Brentwood CCG Accountable Officer	Nil								N/A
Nicola	Adams	Head of Corporate Governance - Thurrock CCG and Deputy Interim STP JC Secretary	Aston Russell Limited, Business Consultancy	x			Direct	Managing Director			?
Nicola	Adams	Head of Corporate Governance - Thurrock CCG and Deputy Interim STP JC Secretary	TIAA Limited, Business Assurance Specialists. (working with various NHS bodies most notably: Dartford and Gravesham NHS Trust, Swale CCG, Medway CCG, Dartford, Gravesham and Swanley CCG.	x			Direct	?			?
Nicola	Adams	Head of Corporate Governance - Thurrock CCG and Deputy Interim STP JC Secretary	Thurrock Adult Safeguarding Partnership Board.	x			Direct	Interim Business Manager			?
Caroline	Rassell	Accountable Officer and SRO for Local Health and Care Success Regime	Mid and South Essex Success Regime	x			Direct	Secondment to the Mid and South Essex Success Regime	25/03/16	Ongoing	Interest recorded on Board Register and declared at meetings so that appropriate action can be implemented if decisions regarding the success regime are required
Kashif	Siddiqui	Castle Point and Rochford CCG Chair	Spire Wellesley	x			Direct	I undertake medical appraisals.			?
Ian	Stidston	Southend CCG Interim Accountable Officer, and Castle Point and Rochford	Nil								N/A

First Name	Surname	Current Position	Declared Interest (Name of the organisation and nature of business)	Type of Interest Declared			Is the interest direct or indirect?	Nature of Interest	Date of Interest		Actions taken to mitigate risk
Rachel	Webb	Locality Director for Mid & South Essex	Nil								N/A

STP Joint Committee – Part I
7th July 2017 4:30pm
Boardroom, Phoenix Place, Christopher Martin Road, Basildon SS14 3HG

Present:	Dr Mike Bewick (MB)	Independent Chair
	Ms Caroline Rassell (CR)	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
	Dr Sunil Gupta (SG)	GP Governing Body member NHS Castle Point & Rochford CCG (deputising for Dr Kashif Siddiqui)
In Attendance:	John Leslie (JL)	Accountable Officer, NHS Basildon & Brentwood CCG
	Tony Cox (TC)	Deputy Chair, NHS Basildon & Brentwood CCG
	Rachel Webb (RW)	Locality Director. NHS England
	Ronan Fenton (RF)	Mid Essex Hospital Services NHS Trust
	Nicola Adams (NA)	Head of Corporate Governance, NHS Thurrock CCG (minute taker)
	Emily Hughes (EH)	AD and Project Director IUC, NHS CastlePoint & Rochford and NHS Southend CCGs
	Owen Richards (OR)	POD Director, North East London Commissioning Support Unit
	Alan Hudson (AH)	PPG Member, NHS Thurrock CCG
	Maureen Henes (MH)	Member of the Public, NHS Mid Essex CCG
Apologies:	Dr Jose Lobera	Chair, NHS Southend CCG
	Dr Anand Deshpande	Chair, NHS Thurrock CCG
	Dr Kashif Siddiqui	Chair, NHS Castle Point & Rochford CCG
	Dr Arv Guniyangodage	Chair, NHS Basildon & Brentwood CCG
	Viv Barnes	Director of Corporate Services, Interim STPJC Secretary, NHS Mid Essex CCG

1.	**Welcome, Apologies and Declarations of Interest**
	MB welcomed all to the meeting. The apologies were noted as above. All members introduced themselves and provided some background as to their role within the Sustainability and Transformation Plan Joint Committee (STPJC). MB welcomed members of the public and highlighted the importance of consulting with members of the public, particularly in the design of services to ensure that the NHS can deliver quality services that are the safest and delivered in the most efficient manner. No declarations of interest were reported.
2.	**Questions from the Public**
	MH asked if questions from the public could be taken at the end of the meeting after agenda items had been discussed. MB advised he was happy to receive questions at the beginning and end of the meetings. Members agreed to have questions both at the beginning and end of the meetings going forward **(ACTION VB)**.
3.	**Terms of Reference of Joint Committee**
	MB provided some background to the STPJC in the context of the demographic and financial changes in the last 5 years which had led to CCGs needing to co-ordinate across a wider geographical footprint. It was also noted that three areas in the country, including Mid and South Essex, had been designated as success regimes to help address the challenges being faced by these particularly 'stressed economies'. Their purpose was to provide support and help systems to work together. The STP is a natural progression of the success regime where providers and commissioners work together to improve care and deliver services within defined financial parameters. MB noted the need for local experts at the STPJC to provide the support and expertise necessary to facilitate delivery across acute and out of hospital care. The STPJC can push forward the agenda required to deliver. MB stressed the importance of the STPJC being transparent. The ToR have therefore been established to support the committee. No concerns or comments were raised by Committee members or the public about the contents of the ToR. It was noted that the ToR had been reviewed by Accountable Officers and shared with CCG Chairs and that final changes have been made by NHS England where a consensus could not be reached on the 'modus operandi' of the Committee. The Committee **RECEIVED** the Terms of Reference (ToR) of the Joint Committee and agreed that they would be formally adopted at the next meeting of the STPJC when fully constituted **(ACTION VB)**.
4.	**Integrated Urgent Care Service Update**
	IS presented a briefing on Integrated Urgent Care (IUC), noting that information was necessarily limited as a competitive procurement process was already underway. EH (AD and project director) joined the meeting. IS stated that Essex CCGs have already been working jointly on the IUC project, but it is now part of the portfolio of the STPJC. It was noted that the JC were not required to make any decision on the process. EH highlighted that there has been much engagement around this project, which will form a core component of the out of hospital (OOH) and Acute pathways with the technical and operational flexibilities to dovetail with urgent care services. It was noted that the procurement had been halted for around six months, but this had now re-commenced after approval from NHS England. The outcome of the pre-qualification questionnaire (PQQ) has been issued and invitations to tender (ITT) are due to be issued at the end of this month. The timetable for delivery is June/July 2018 for the mobilisation of the service. Contracts will therefore be awarded in December 2017. All CCGs were represented within the project, which included key stakeholders such as lay

	members, HealthWatch and the public. <u>The following questions were raised at the meeting:</u> CR asked if there was any other support required to deliver the project? Some IMT and telephony difficulties were noted, however these were being managed via a dedicated project manager funded by CCGs. Risks are highlighted on a risk log. There is a potential risk in relation to timing as the project now coincides with the national contract negotiation process. At moment, no other red flag issues have been raised. Risks are being managed through project management and engagement. IS asked if there were plans in the longer term around communications and how this links to the STP. EH confirmed that there is a communications and engagement workstream in place. CD asked if clear targets for the forward view on Mental Health (MH) are being built into the procurement. EH confirmed that there is close working with MH colleagues as well as a section on MH within the specification. In response to IS, EH also confirmed similar linkages with dental and out of hours services. JL questioned whether the project had been updated to take account of the 6 month delay. EH confirmed that the project has been sufficiently flexible to account for recent and any future timescale changes. MB suggested that having access to clinical opinions in the most effective and easy to use way possible was the 'holy grail' of commissioning. He emphasised the importance of such a procurement whilst acknowledging the difficulties in procuring during a changing NHS landscape. IS acknowledged the volume of complex work completed by the team. Members thanked the team for their hard work to date.
5.	**Dates and Venues of Future Meetings**
	Members reviewed the dates and venues of future meetings of the STP JC.
6.	**Questions from the public**
	MH stated that having experienced the 111 service recently, she was pleased with the current standard of service in Mid Essex and congratulated the STPJC on proposals which aimed to deliver an excellent service across the entire locality. AH acknowledged proposed improvement, but raised concerns about differing IT services and how integrated services are kept safe in the potential mismatch of systems. IS recognised the challenge and scale of such technological issues and advised that this has been built into the specification. It was noted that that the majority of GPs are now using the same clinical system, which is a good step forward. MB acknowledged the move to improve technical issues and the work of NHS Digital to safeguard patient data and flows. CD commented on the good work around data sharing and members discussed the other important issue of how to gain the public's confidence for their data to be shared.
7.	**Any Other Business**
	No items of any other business.
8.	**Close of Meeting**
	The meeting closed at 5.05 pm.
9.	**Date of Next Public Meeting**
	1:30 pm on Friday 6th October 2017 in the Boardroom, Phoenix Place, Christopher Martin Road, Basildon SS14 3HG.

Part I Action Log

Meeting Date	Agenda Item	Action	Lead	Deadline for Completion	Outcome/Update
07/07/17	2	Agenda to include items for 'Questions from Members of the Public' both at the beginning and the end of the agenda.	Viv Barnes	31/08/17	Complete.
07/07/17	3	The Committee Terms of Reference will be formally approved at the next meeting of the STPJC when it is fully constituted.	Viv Barnes	30/09/17	Complete. On agenda.

Dated: 15 August 2017

(1) NHS Basildon and Brentwood CCG

(2) NHS Castle Point & Rochford CCG

(3) NHS Mid Essex CCG

(4) NHS Southend CCG

(5) NHS Thurrock CCG

MID AND SOUTH ESSEX CCGS

STP JOINT COMMITTEE TERMS OF REFERENCE

V,6

Version	Author	Date
V3	Viv Barnes	18 May 2017
V4	Viv Barnes	8 June 2017
V5	Viv Barnes	12 June 2017
V6	Viv Barnes	15 August 2017

STP Joint Committee

Terms of Reference

1 **Context**

1.1 NHS Basildon and Brentwood CCG, NHS Castle Point and Rochford CCG, NHS Mid Essex CCG, NHS Southend CCG and NHS Thurrock CCG (the CCGs) are working together as part of the Mid and South Essex Sustainability and Transformation Plan (STP) and the Mid and South Essex Success Regime (SR).

1.2 The CCGs are forming a joint committee using their power under Section 14Z3(2A) of the National Health Service Act 2006 to enable them to take certain commissioning decisions jointly.

2 **Establishment**

The CCGs are seeking to form the joint committee with effect from 7 July 2017 to be known as the STP Joint Committee. The joint committee will be established as a committee of each CCG, not of the CCG's governing bodies, and therefore will sit alongside the CCG governing bodies rather than being accountable to them.

3 **Members of the STP Joint Committee**

3.1 The core Membership of the Joint Committee will comprise:

3.1.1 An independent clinical Chair (with casting vote when required)
3.1.2 5 x Clinical Chairs from each CCG (voting)
3.1.3 5 x Accountable Officers from each CCG, including the lead Accountable Officer for the STP (voting).

3.2 The Joint Committee will appoint an independent Chair. NHS England will be consulted on this appointment and, whilst directions are in force relating to the establishment of a Joint Committee, this appointment will be subject to the final approval of NHS England.

3.3 The Joint Committee will appoint a Deputy Chair, drawn from the membership of the committee.

3.4 The Joint Committee will appoint a Lead Accountable Officer who will be accountable for the delivery of its functions. The lead accountable officer will also hold the Accountable Officer portfolio for one of the constituent CCGs. NHS England will be consulted on this appointment and, whilst directions are in force relating to the establishment of a Joint Committee, this appointment will be subject to the final approval of NHS England.

3.5 The Joint Committee will appoint a suitably qualified Board Secretary.

3.6 The Joint Committee will ensure that there is a suitably qualified executive team to support the discharge of its functions.

4 Principles

4.1 In performing their respective obligations under this Agreement and the Commissioning Contracts, the CCGs must:

4.1.1 at all times act in good faith towards each other;

4.1.2 act in a timely manner;

4.1.3 share information and best practice, and work collaboratively to identify solutions, eliminate duplication of effort, mitigate risk and reduce cost;

4.1.4 at all times, observe relevant statutory powers, requirements and best practice to ensure compliance with applicable laws and standards including those governing procurement, data protection and freedom of information, and Nolan principles and Professional Standards Organisation's Standards for CCG Governing Bodies; and

4.1.5 have regard to the needs and views of all of the Commissioners, irrespective of the size of any of the respective Holdings of the Commissioners and as far as is reasonably practicable take such needs and views into account.

4.1.6 Make decisions on behalf of the 1.2 million STP population, not upon CCG populations

4.1.7 Exercise functions effectively, efficiently and economically at all times;

4.1.8 Ensure clinical engagement remains at the forefront of decision making throughout the STP area.

5. Grounds for Removal from Office

5.1 Members of the STP Joint Committee shall vacate their office:-

5.1.1. If in the majority opinion of the Joint Committee (having taken appropriate professional advice in cases where it is deemed necessary) he/she becomes or is deemed to be unsuitable or of unsound mind.

5.1.2. If he or she is a Board appointed member and ceases to meet the criteria for CCG Board membership as set out in Schedules 4 and 5 of The NHS Clinical Commissioning Group Regulations 2012.

5.1.3 If he or she has been absent for a period of [3] consecutive meetings of the Joint Committee then he or she shall, at the discretion of the Joint Committee, be vacated from his/her office.

6. Commissioning Functions

6.1 The principal function of the Joint Committee is to enable the CCGs to - where appropriate - act collectively in the planning, securing and monitoring of services to meet the needs of the population of Mid and South Essex, as well as represent the STP footprint for services commissioned over a larger area.

6.2 The functions of the Joint Committee will include:

6.2.1. Decisions on relevant STP wide service configurations;

6.2.2 Leadership of relevant public consultations on significant service changes that affect the whole STP area

6.2.3 Agreement of STP wide service restriction policies

6.2.4 Agreement of relevant STP wide outcomes, frameworks and pathways

6.2.5 Agreement of the STP local health and care strategy

6.2.6 Receiving and providing reports on the delivery of the STP local health and care strategy

6.3 The Joint Committee will also have delegated responsibility for commissioning of a range of services on behalf of the CCGs, including:

6.3.1. Acute services (NHS and independent sector) commissioning and contracting

6.3.2 Integrated Urgent Care services (including NHS 111) commissioning and contracting

6.3.3 Ambulance services commissioning and contracting

6.3.4 Patient Transport Services commissioning and contracting

6.3.5 Learning Disability decision making (within the existing pan-Essex arrangements);

6.3.6 Mental Health services contracting and commissioning of Acute Mental Health services.

6.4 Although the Joint Committee will be responsible for all of the commissioning contracts referred to in 6.3.1, 6.3.2, 6.3.3, 6.3.4, 6.3.5 and 6.3.6, these contracts will take account of the priorities identified by individual CCGs. It is anticipated that in many areas the Joint Committee will agree the strategic framework for the STP footprint, with operational delivery of key areas – such as demand management - being shaped locally.

6.5 For contracts held under 6.3.6, it is envisaged that elements of mental health services will need to be shaped and specified by individual CCGs, but there will be strategic alignment across the STP, facilitating a suite of contracts for which the Joint Committee is responsible.

6.6 For all contracts outlined in 6.3, the Joint Committee will ensure there are appropriate arrangements in place to:

6.6.1 Develop the commissioning strategy for the areas delegated, including where relevant setting commissioning intentions and the desired outcomes for the STP population

6.6.2 Establish and manage contracts for the areas/services delegated

6.6.3 Manage the delegated Commissioning Contracts, including in respect of quality standards, observance of service specifications, and monitoring of activity and finance, so as to obtain best performance, quality and value from the Services by assessing quality and outcomes (including clinical effectiveness, patient experience and patient safety);

6.6.4 Manage variations to the Commissioning Contracts or Services in accordance with national policy, service user needs and clinical developments

6.6.5 Manage procurement of services in line with commissioning decisions and manage risk associated with such procurements

6.6.6 Ensure delivery of relevant savings programmes as agreed in the STP Joint Committee annual plan

6.7 The CCGs' Governing Bodies may decide, from time to time, to delegate additional functions to the STP Joint Committee, in which case the list of commissioning functions set out above shall be updated accordingly.

7. Decision-making

7.1 The Joint Committee will have delegated responsibility to make decisions that bind the CCGs in relation to those commissioning functions delegated to the Committee.

7.1 Each member of the STP Joint Committee shall have one vote, with the exception of the independent Chair who will have a casting vote in the event that there is a tied vote. The Deputy Chair will not have a casting vote when deputising for the independent Chair, in which case the same options for achieving a quorum (paragraphs 10.3 and 10.4) should be followed in the event of a tied vote.

7.2 Each CCG is responsible for ensuring that its nominated members to the STP Joint Committee have sufficient delegated authority, in accordance with that CCG's constitution, to act on behalf of that CCG within the remit of the Committee;

7.3 It is the intention that the Joint Committee will arrive at a consensus regarding the decisions to be reported to the CCGs concerning the Services or the Commissioning Contracts.

7.4 Where a consensus is not reached, a decision may be reached by simple majority vote of the Joint Committee. Any recommendation of the Joint Committee arrived at by majority vote will also contain reference to any minority views.

7.5 If members choose to abstain from voting, their abstentions will be noted but will not contribute to the yes or no counts and will not affect the majority vote.

8 Financial delegation

8.1 The Joint Committee has a responsibility to ensure that the services and contracts for which they are responsible stay within the resources allocated to it by the CCGs.

8.2 The Joint Committee and the CCGs will agree, within its implementation plan, detailed arrangements for delegating relevant budgets.

8.3 The Joint Committee implementation plan will outline the decision-making process relating to any future risk/gain share arrangements.

9 Other Attendees

9.1 The Chair may at his or her discretion permit other persons to attend meetings of the STP Joint Committee but, for the avoidance of doubt, any persons in attendance at any such meetings shall not count towards the quorum or have the right to vote.

10 Meetings

10.1 The STP Joint Committee shall meet at such times and places as the Chair may direct on giving reasonable written notice to the members of the STP Joint

Committee, but will meet at least once every eight weeks. Meetings will be scheduled to ensure they do not conflict with the CCGs' respective Governing Body meetings.

10.2 Special meetings of the Joint Committee may be called by any member of the Joint Committee, with the agreement of the Chair, by giving at least 48 hours' notice by e-mail to each member.

10.3 Meetings of the STP Joint Committee shall be open to the public unless the STP Joint Committee considers that it would not be in the public interest to permit members of the public to attend all or part of a meeting.

11 Quorum

11.1 The quorum for conducting a meeting of the Joint Committee shall be a minimum of 50% of total voting members, including the Chair or Deputy Chair, and at least one CCG Chair and one CCG Accountable Officer.

11.2 Any quorum of the Joint Committee shall exclude any member affected by a Conflict of Interest. If this has the effect of rendering the meeting inquorate, then the Chair shall decide on one of the following options:-

11.3 Inviting on a temporary basis one or more additional members to make up the quorum (where these are permitted members of the Joint Committee) so that the Committee can progress the item of business.

11.4 Adjournment of the item, reconvening the meeting when appropriate membership can be ensured.

12. Participation in Meetings

12.1 The Chair may agree that the members of the STP Joint Committee may participate in meetings by means of telephone, video or computer link or other live and uninterrupted conferencing facilities. Participation in a meeting in this manner shall be deemed to constitute presence in person at such meeting.

13. Conflicts of Interest

13.1 If, at any meeting of the STP Joint Committee, a member of the committee has a conflict of interest or a potential conflict of interest in relation to the scheduled or likely business for the meeting, he or she shall declare the conflict of interest or potential conflict of interest to the Chair at the start of the meeting

13.2 If during the course of an STP Joint Committee meeting, a member of the committee becomes aware that he or she has a conflict of interest or potential conflict of interest

in relation to a matter being discussed at the meeting, he or she shall immediately declare such conflict of interest or potential conflict of interest to the Chair.13.3 The Chair shall be responsible for determining the arrangements that will apply in the event that any member of the committee declares an actual or potential conflict of interest at an STP Joint Committee meeting. It will usually be appropriate for the individual to withdraw from the meeting whilst the relevant item of business is discussed.

13.4 If the Chair declares an actual or potential conflict of interest in any matter before the STP Joint Committee then the Deputy Chair will be responsible for determining what arrangements will apply and will chair the meeting for the relevant item of business.

14. Administrative

14.1 Secretariat support for the STP Joint Committee will be provided by the Board Secretary.

14.2 The papers for each meeting will be sent to the members of the STP Joint Committee no later than 5 working days prior to each meeting and earlier if possible. By exception, and only with the agreement of the Chair, amendments to papers may be tabled before the meeting.

14.3 The draft minutes from each STP Joint Committee meeting will be circulated to the members of the STP Joint Committee with the papers for the next meeting.

15. Reporting

15.1 The Chair shall arrange for a copy of the minutes for each STP Joint Committee meeting, once approved (the Approved Minutes), to be sent to the members of the STP Joint Committee.

15.2 The CCG Commissioners shall be responsible for ensuring that their respective Governing Bodies receive a copy of the Approved Minutes.

16 Review of Terms of Reference

16.1 To be reviewed annually and ratified by the Joint Committee.

Appendix 1

Authorisation Form – STP Joint Committee – Appointment of Deputies

1. Where a CCG nominated representative is unable to attend an STP Joint Committee meeting, the terms of reference permit the Governing Body of the relevant CCG to authorise another member of its Governing Body to deputise for its CCG representative.
2. It is the responsibility of each CCG's Governing Body to use reasonable endeavours to ensure that its CCG Representatives, or duly authorised deputies, attend each meeting of the STP Joint Committee.
3. This form should be completed for each individual who is authorised to deputise for a CCG representative at meetings of the STP Joint Committee and a copy should be sent to the Chair of the STP Joint Committee and the Board Secretary.
4. Where the Governing Body is authorising an individual to deputise for a CCG representative at a particular meeting, a copy of the completed form should be returned to the Chair no later than the day before the relevant meeting.

Name of CCG .....

The Governing Body confirms the individual(s) named below are members of its governing body and authorises them to deputise for its CCG representative [as and when required] OR [at the meeting on [date]

(1) Name: .....

Title: .....

(2) Name: .....

Title: .....

Signed on behalf of the Governing Body:

Name & Title: .....

Date: .....

NHS
Mid and South Essex
Sustainability & Transformation Plan
Joint Committee

Report to: Part I / Part II STP Joint Committee **Meeting Date: 8th September 2017**

Agenda No:	**:**	
Report Title	**:**	**OPHTHALMOLOGY: CLINICAL PATHWAY OPTIONS APPRAISAL**
Submitted by	**:**	**IAN STIDSTON, ACCOUNTABLE OFFICER**
Written by	**:**	**JAYNE MASON, SENIOR COMMISSIONING MANAGER**
Purpose	**:**	**The paper presents the STP Ophthalmology network recommended pathway solution and provides an options appraisal with regards to implementing this pathway**
Approval Route	**:**	Date of meeting / Meeting 19th July 2017 / NHS England Quality Surveillance Committee 10th August 2017 / Castle Point & Rochford CCG Clinical Executive Committee 10th August 2017 / Southend Clinical Executive Committee 11th August 2017 / Joint Commissioning Oversight Group 15th August 2017 / Mid & south Essex STP Programme Board 5th September 2017 / Mid Essex CCG Live Well Committee
Recommendation/s	**:**	**Members of the joint committee are requested to consider the options appraisal and support the recommendation to work with the current service providers to implement the pathway solution as developed by the STP Ophthalmology clinical network.**

OPHTHALMOLOGY: CLINICAL PATHWAY OPTIONS APPRAISAL

Submitted by: **Jayne Mason, Senior Commissioning Manager, Castle Point & Rochford CCG & Southend CCG**

Status: **To agree**

Introduction

The Mid & South Essex STP Ophthalmology Clinical Network recommends implementation of an Ophthalmology pathway that will see more integrated working between current hospital and community providers.

Essentially the reform will see a shift of activity into community providers and ultimately fewer patients being referred into the Hospital Eye Services (HES) at Mid Essex Hospitals Trust (MEHT) and Southend Hospital (SUHFT).

While a cost reduction is anticipated from shifting activity into community provision, the two key drivers for introducing this service are patient safety and quality of care and any financial savings are expected to be negligible:

Patient safety is a key concern for hospital eye services in Essex, with a significant backlog for outpatient follow up appointments and concerns re achievement of RTT at both STP HES. By using the capacity in the community the pathway will reduce the number of referrals to the hospital eye service, enabling capacity to be used elsewhere and reduce the waiting time for patients who should more appropriately be seen in the HES.

The service will support the 'Care Closer to Home' strategy by utilising the skills and knowledge of primary care optometrists enabling a convenient and accessible service for patients and ensuring patients are seen by the most appropriate healthcare professional in the most suitable setting.

1. Background

The Royal College of Ophthalmologists published a review of Ophthalmology services across the UK in January 2017 (The Way Forward). That review overwhelmingly found that the increasing demand for hospital eye services (HES) is not being met and continues to grow – with ophthalmic services currently seeing nearly 10% of all outpatient appointments and performing 6% of the surgery in the UK.

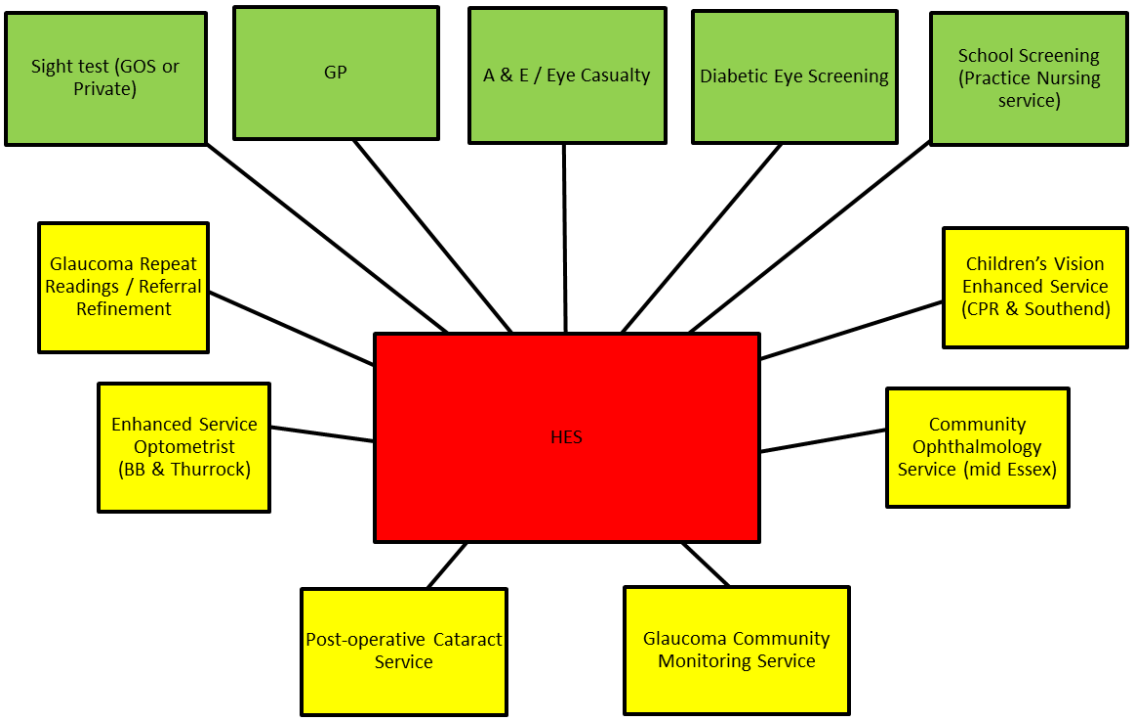
Locally the Ophthalmic system in Essex certainly recognise this picture. Short term responsive actions have been taken to manage patient flows across all services on an ad hoc basis, including Locum Consultants being employed to review backlog activity, use of independent providers to support HES activity, additional evening and weekend clinics, along with commissioning of smaller local pathways however it is recognised that fundamental changes are required to the way ophthalmic care is delivered in Essex.

2. Context

In 2016/17 there were 18000 Ophthalmology first attendances and 46000 follow up appointments at Southend University Hospital NHS Trust (SUHFT) and 11600 first attendances and 24000 follow ups at Mid Essex Hospitals NHS Trust (MEHT).

Both Trusts report pressures in managing demand and there are significant numbers of patients awaiting appointments at both Trusts. This is particularly significant for the monitoring of longer term conditions such as glaucoma and macular conditions and represents an ongoing clinical safety concern.

Currently there are insufficient pathways in place to allow the volume of activity to be diverted to alternative commissioned providers. This means that the majority of activity results in a hospital referral.



At a recent STP wide clinical network it was recognised that at least 50% of all activity that is referred into these Hospital Eye Services could be safely managed outside of hospital if appropriate alternative services were commissioned.

Steps are being taken to address this. This piece of transformational work is known locally as "The Essex Plan".

3. The Essex Plan

The Essex plan for Ophthalmology supports the emerging STP plan and is in keeping with the recommendations within "The Way Forward" from the Royal College of Ophthalmologists.

The Essex Plan for Ophthalmology has been developed to support the continuing shift of activity from hospital settings along with our need to transform service delivery. The intention is to work together as a health system to use the resources available to us to ensure continued sustainability of quality services.

A key element of the Essex plan is the procurement (or transformation) of a Community Service for Essex that will see Enhanced Service Optometrists accepting referrals directly from GPs and Optometrists for more minor conditions. The service will also incorporate Consultant Led Triage to ensure appropriate direction of activity referred into the service. Re-direction to these Optometrists will also be possible following triage.

Two STP wide Ophthalmology Clinical network meetings have now been held and the following principles agreed regarding the pathways and systems that are required to achieve the desired clinically safe and high quality shifts of activity:

- Consultant led triage to lead referral management to ensure compliance with pathways. 10% appropriate for discharge – no further treatment required following triage, advice and guidance offered to referrer

- Enhanced service optometrists required to provide a community based optometry service, enabling a significant proportion of cases to be managed within community setting that would otherwise be referred to secondary care – potentially up to 40% of all current referrals into HES (will also include redirected referrals from HES following triage)

- There is further opportunity for the current HES to be reconfigured to support the proposed model eg consultant led hospital clinics in community settings – “hospital without walls” - with optometrists being employed by the Trusts to support Consultants (the “Moorfield’s model”).

IT / IG issues are paramount to the success of this model – information, including images, will need to be shared between elements of the pathway

The proposed model of care can be seen in Appendix 1.

This pathway has been presented and supported at fore across the STP, a list of those meetings can be found in Appendix 2.

4. Options Appraisal

Given the current capacity issues in the HES, the status quo is not sustainable. However, to date, additional community capacity has been commissioned by Clinical Commissioning Groups (CCGs) piecemeal and in isolation.

At a recent STP wide clinical network it was recognised that at least 50% of all activity that is referred into these Hospital Eye Services could be safely managed outside of hospital if appropriate alternative services were commissioned.

There are essentially three options available to us:

- Do nothing
- Procurement of new service providers
- Transformation of pathways with existing providers

The details of the benefit / risk analysis can be seen in Appendix 3.

5. Finances

Whilst this transformation plan is not dictated by financial savings we can usually assume costs of 80% of the current model for activity shifted from hospital to community services, however, the likelihood is that any financial saving will be re-invested into the system to achieve the quality and safety improvements required to deliver a long term sustainable model of care.

6. Collaborative Commissioning Approach

The commissioning and delivery of eye health and sight loss services can be complex; pathways frequently cut across boundaries and involve many providers in a network of care. A more co-ordinated approach is necessary to support the integration between services and pathways.

With an average population of 1.2million, Sustainability and Transformational Plan (STP) footprints provide the opportunity for groups of CCGs to work with providers to agree consistent pathways, ideally over an area served by the HES, to develop truly transformed and sustainable services – and deliver the ambitions of the 5YFV (Five year forward view).

By working together at a greater scale with clear responsibilities and objectives, there are opportunities for greater efficiency in the commissioning, procurement and delivery of the same service specification by reducing the duplication of effort and the waste of resources.

Having a more consistent approach to eye care pathways will lead to earlier detection of eye problems, and quicker access to appropriate services and treatment which are so important to achieve better outcomes for patients. Working at STP level will lead to better management of limited NHS resources.

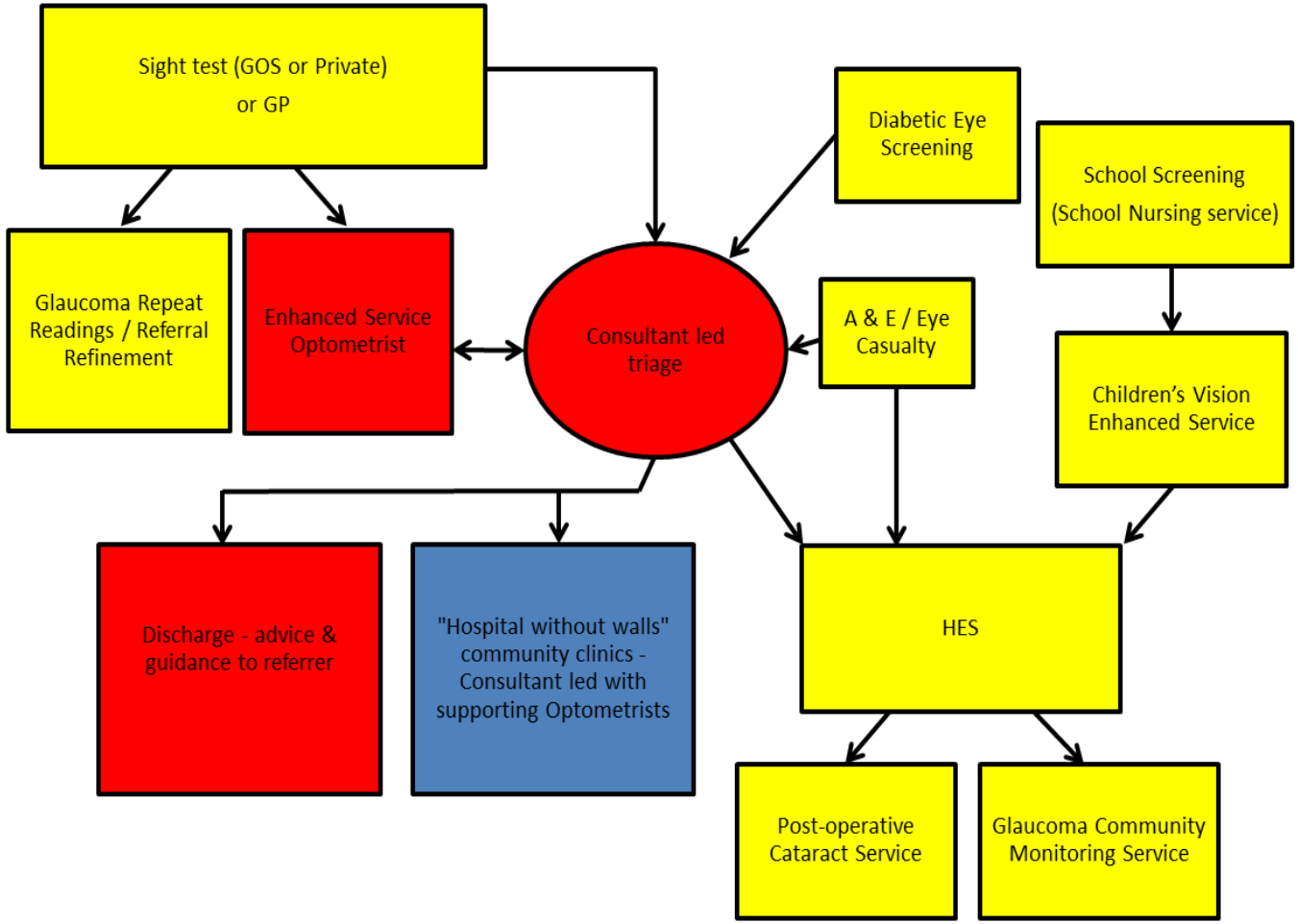
All local eye care providers should be able to collaborate to deliver this pathway and there are benefits in administering these services via our acute hospital contracts while still offering patients a wide choice of practices for eye health services. At the same time, optometrists and opticians will be attracted by the efficiency of the approach, as it eases the administrative burden and allows practices of all sizes to participate in delivery of pathways.

7. Recommendation

Members of the joint committee are requested to consider the options appraisal and support the recommendation to work with the current service providers to implement the pathway solution as developed by the STP Ophthalmology clinical network.

8. Appendices and Supporting Documentation

Appendix 1: Proposed model of care as recommended by the STP Ophthalmology Clinical Network



Appendix 2 – List of committees the proposed pathway has been presented to

Date of meeting	Meeting
19th July 2017	NHS England Quality Surveillance Committee
10th August 2017	Castle Point & Rochford CCG Clinical Executive Committee
10th August 2017	Southend Clinical Executive Committee
11th August 2017	Joint Commissioning Oversight Group
15th August 2017	Mid & south Essex STP Programme Board
5th September 2017	Mid Essex CCG Live Well Committee
7th September 2017	STP HES Clinical Summit
14th September 2017	STP Ophthalmology Clinical network

Appendix 3 – Options Appraisal

	Option	Benefits	Risk / Challenge
1	Do nothing	No additional financial cost to the system No change required	System is unable to respond in current format to the demands of the local population RTT targets will not be met Follow up backlogs will continue to grow Clinical risk concerns will remain
2	Procurement exercise for Consultant led triage, Enhanced service optometrists, IT system	Provides IT solution Full system solution with capacity to incorporate other elements of the community pathways Provider will be completely responsible for all out of hospital eye care	Will require decommissioning of activity from HES Risk of lack of buy in from Hospital services Potential redundancies within the current HES team Implications for system relationships Likelihood of extensive procurement exercise prior to implementation

	Option	Benefits	Risk
3	Work with the current providers to transform existing services to deliver the recommended pathway	Clinically developed pathway solution Uses the skills, equipment and estates of local community Optometrists to support the Hospital Eye Service Hospital team to determine which activity will be seen in the hospital eye service Will enable advice and guidance to be given to referrers to support 10% discharge levels Opportunity for internal transformation by HES to develop “hospital without walls” community clinics Overall clinical decision making, education and training for optometrists and clinical governance lies with the Trusts Enthusiasm within the local system to work together to deliver this model Procurement exercise not required Elements of pathway could be in place within months Opportunity for CCG to drive forward transformation project using project management framework	IT interface – clinical information will need to be transferred between organisations – may not be shared efficiently and opportunities for direction to appropriate element will not be achieved – procurement of new system may be required for this element Relies on internal transformation by HES to develop “hospital without walls” community clinics

Board etiquette specimen

The purpose of this board etiquette policy is to specify the type of behaviour appropriate for board and committee meetings, and throughout the organisation. Board members should act with independence, rigour, integrity, probity, honesty, mutual trust and display high standards of conduct. [7]

Before the meeting

- be clear as to the purpose of the meeting and the role you play at that meeting
- having received the board papers 5 working days before the meeting, read the agenda, and any supporting papers ahead of the meeting and prepare questions to be raised at the appropriate time, or think of suggestions to resolve problems
- be clear on the decision that is being asked for
- request further information ahead of the meeting or seek clarification from the company secretary[8] or report author (including highlighting typographical and other errors not of material consequence), where appropriate
- submit apologies, and (where appropriate and where the governing documents permits it) arrange for an alternate to attend (ensuring the alternate is well-briefed)
- arrive for the meeting on time, stay for its duration, and ensure regular attendance at all meetings[9]
- if you have to leave before the end of the meeting, you should inform the chairman beforehand. However, you should avoid this whenever possible.

During the meeting

- declare any potential or real conflicts of interest with regard to any matter on the agenda
- if using an electronic device to make notes during the meeting of discussions and decisions made, it is advisable to inform fellow board members of your intention and gain the permission of the chairman. Some organisations may decide that only the company secretary should be given permission to use electronic devices to take minutes of the meeting, other boards may have collectively adopted paperless meetings
- if people are joining the meeting via video conferencing be aware of time delays when listening/responding
- unless there are specific reasons for doing so[10], no part of the meeting should be visually or audio recorded. If such recording is agreed the chairman must inform the meeting beforehand.

[7] A model code of conduct for NHS foundation trust governors can be found on the ICSA website.
[8] Where the guidance refers to 'company secretary' we usually mean the person primarily responsible for the smooth and efficient running of meetings of the board and any committees, providing assistance and support to the chair of the board. Alternative titles could include the 'trust secretary', 'charity secretary', or 'clerk to council' depending on the organisation in question.
[9] In some organisations director attendance at meetings of the board and any of its committees will be recorded and reported in the annual report or website.
[10] For example, a presentation from an external consultant on general issues not sensitive to the business of the board meeting.

Focussing on the agenda

- stay focused on agenda items
- dedicate your attention to the purpose of the meeting and refrain from performing other duties at the same time
- turn off your mobile phone/electronic communications device[11]. When an electronic device must be kept on[12], turn to silent/vibrate and excuse yourself from the meeting. Should you need to answer an urgent call[13]; forewarn attendees that you are expecting an urgent call and seek the permission of the chairman to keep the electronic device on[14]
- refrain from private conversations with others at the meeting (whether spoken or written), and the passing of notes.

Contributing to the discussion

- if appropriate, attract the chairman's attention when wishing to contribute to the discussion, and wait until the chairman indicates that you may speak so as to avoid interrupting a fellow board member. Direct comments and discussion through the chair
- when invited to speak by the chairman, do so clearly, concisely and at a volume that all attendees can hear (especially the minute-taker), without shouting. Avoid the use of jargon and acronyms
- throughout the meeting be respectful of the role of the chair in encouraging debate, summarising discussion and clarifying decisions made
- be constructive and professional in the way you impart an opinion or information
- listen attentively and respectfully to others, making notes of any points you would like to raise when an opportunity to respond arises; do not interrupt when others are speaking
- ensure you maintain body language that demonstrates your participation and engagement in the meeting
- challenge inappropriate behaviour/language from other board members at the time via the chair or after the meeting if more convenient
- treat attendees fairly and consistently, even when you disagree with their point of view
- challenge and provide critique constructively, and ensure that any challenges are proportionate and based on fact. Challenge the issue being discussed, not the personality of other individuals taking part in the discussion
- seek clarification or amplification when necessary
- do not attend the meeting if under the influence of any substances that will impair your performance and contribution to the meeting.

The unitary board

- know and understand the role you play at the meeting and the need for the board to act as a corporate body (i.e. not to pursue self-interest or the interest of another body)
- do not act territorially/personally, remember the need to contribute to the corporate nature of the board. Regard and welcome challenge as a test of the robustness of papers and arguments presented
- do not cause offence or take offence, accept the diversity of opinions and views presented.

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[11] An article in *The Financial Times* ('Why e-mail must disappear from the boardroom', 27 July 2009) postulated the theory that directors using such devices in board meetings were at more risk of breaching their fiduciary duty.

[12] For example, a clinical director may be on-call and therefore it may not be appropriate to leave the electronic device outside of the meeting room.

[13] It might be appropriate for individual organisations to define 'urgent', for example a medical consultant may well have to respond to an urgent medical call, while this is unlikely to be the case for others.

[14] Alternatively, someone not attending the meeting could be nominated to receive any urgent calls (such as the chief executive's PA), and then in accordance with a protocol agreed by the board could discreetly notify the chair and appropriate board member if there is a need to leave the meeting.

Accountability

- seek professional guidance/clarification from the chairman during the meeting (or company secretary outside the meeting) wherever there may be any concern about a particular course of action
- keep confidential matters confidential. Do not participate in gossip arising from board matters.

After the meeting

- participate and contribute to any post-meeting review with a view to making future meetings more effective
- draft minutes should be produced within one working week after the meeting. These should be read with a view to clarifying matters and sending amendments to the company secretary at the earliest opportunity. This should help to reduce the time taken approving the minutes at the next board meeting
- read any post-meeting action plan and ensure you complete the tasks accorded to you and report back appropriately on their completion in a timely manner
- observe the confidentiality and sensitivity of matters discussed at the meeting and ensure that all papers, both electronic and paper copies are stored safely
- remember that decisions were taken collectively by the board and therefore that responsibility remains collective too.

Breaches of the board etiquette

Where there is evidence that the board etiquette policy has been breached, the chair, with guidance from the company secretary, will recommend the necessary action to be taken. Any meeting to discuss breaches of board etiquette will take place with the presence of the member accused of inappropriate behaviour, in accordance with the board's code of conduct, where applicable.

Board behaviour and performance, collectively and individually, should be reviewed as part of an annual board evaluation process.