Our Healthier South East London
Improving health and care together

NHS

Committee in Common: Minutes

Thursday 23 June, 10.00 – 12:00
15 Hatfields, London, SE1 8DJ
Chair: Paul Minton

Members in Attendance

Paul Minton (PM)	Independent Chair
Andrew Bland (ABl)	Southwark CCG CO
Richard Gibbs (RG)	Southwark Governing Body Member
Noel Baxter (NB)	Southwark CCG (for Jonty Heaversedge)
Andrew Eyres (AE)	Lambeth CCG CO
Adrian McLachlan (AM)	Lambeth CCG Chair
David Abraham (DA)	Lewisham CCG (for Marc Rowland)
Rosemary Ramsey (RR)	Lewisham CCG
Angela Bhan (Abh)	Bromley CCG
Dr Ruchira Paranjape (RP)	Bromley CCG (for Andrew Parson)
Harvey Guntrip (HG)	Bromley CCG
Annabel Burn (ABu)	Greenwich CCG CO
James Wintour (JW)	Greenwich Governing Body Member
Sarah Blow (SB)	Bexley CCG CO
Mary Currie (MC)	Bexley Governing Body Member
John King (JK)	Patient and Public Voice
Jane Fryer (JF)	NHS England
Matthew Trainer (MT)	NHS England
Mark Easton (ME)	OHSEL Programme Director
Terry Bamford (TB)	Healthwatch

Other Attendees:

Paul White	OHSEL
Paul Bell	OHSEL
Rachael Crampton	OHSEL
Rory Hegarty	OHSEL
Tom Henderson	OHSEL
Deepa Master	OHSEL
Chris Williams	PwC

Apologies:

Andrew Parson	Bexley CCG Chair
Ellen Wright	Greenwich CCG Chair
Jonty Heaversedge	Southwark CCG Chair
Nikita Kanani	Bexley CCG

Actions From Previous Meeting

ID	Type	Risk / Issue / Action / Decision Description	Owner	Meeting	Due Date	Status	Comments
1	Action	review and publish a revised declaration of interest on the OHSEL website	ME	16 March	30 June	In progress	Feedback from 23 June to be fed in
2	Action	Strengthen case for change to pick up comparator issues at next stage	Programme Team	16 March	To be developed for business case/ consultation document	In progress	
3	Action	further work is required in relation to this model to explain rationale for discounting the three site model	Programme Team	16 March	23 June	Closed	Addressed at meeting on 23 June
4	Action	Update evaluation criteria to reflect comments on finance and equalities	Programme Team	16 March	23 June	Closed	Addressed at meeting on 23 June
5	Action	Briefing note be created by the programme team following today's meeting to be circulated to all CGGs	Programme Team	16 March	21 March	Closed	Completed and circulated

Actions From This Meeting

ID	Type	Risk / Issue / Action / Decision Description	Owner	Meeting	Due Date	Status	Comments
6	Action	Sarah Blow to circulate updated timeline for stage 2 submission and evaluation process.	Sarah Blow	23 June	23 June	In Progress	

7	Action	Programme team to update the following sentence on page 11: *"It was agreed that there will [not] be enough demand for consolidating services across more than 2 sites".*	Programme team	23 June		In Progress	
8	Action	ME to make sure the section on transforming care is included in the STP.	Mark Easton	23 June	23 June	Closed	
9	Action	John King requested a jargon buster is created to address the acronyms.	Programme Team	23 June		In Progress	

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1. Welcome and apologies:

1.1 Paul Minton (PM) welcomed the committee and asked attendees to introduce themselves.

1.2 Mark Easton (ME) highlighted apologies and noted that the quorum was not currently met as an additional member was required from Lewisham, Lambeth and Greenwich. It was highlighted that Andrew Eyres (Lambeth), David Abrahams (Lewisham) and Jim Wyntour (Greenwich) would be joining and therefore the quorum would be met.

1.3 ME distributed the declarations of interest form noting that updates to Adrian McLachlan and Mary Currie needed to be added in. Committee members reviewed the declarations of interest and the following corrections were highlighted:

- Andrew Bland (ABl) noted he is no longer a member of SLAM.
- Angela Bhan (ABh) highlighted that Public Health Education England needs to be taken off.
- Noel Baxter and Ruchira Paranjape, who were deputising, noted they were not included and that they would therefore provide their declarations of interest following the meeting.
- Jane Fryer highlighted that the Director of Chapel Street Community Health should be removed.

1.4 **Action: Once these changes are made it was agreed a revised declaration of interest would be published on the OHSEL website**.

2. Resolution to meet in private

2.1 PM emphasised that the fact this meeting is being held in private needed to be discussed given that engagement with the public is a key principle underpinning the Programme and that this forum normally meets in public. ME explained that this meeting was being held in private following an NHS England request that the STP is not made public at this stage. ME highlighted that in order to mitigate the effects of not being able to share the whole STP a public facing summary document has been made and that the full document has been shared with members of PPAG. Jane Fryer (JF) acknowledged that this is a difficult issue and that some of the anxiety, from NHS England, is around the timing of releasing the document and also the areas where major reconfigurations are signalled. Terry Bamford (TB) said that at the PPAG meeting strong feelings were expressed regarding it being unsatisfactory that the meeting is taking place in private. TB noted that holding meetings in private increases suspicion and also creates a problem of securing local ownership. PM stated that we need to work hard to avoid these meetings being held in private in the future.

3. Minutes and matters arising

3.1 PM ran through the previous meeting minutes. No corrections or changes were raised.

3.2 ME went through the previous meeting actions.

4. Update on Elective Orthopaedic Project

4.1 Sarah Blow (SB) provided an update on orthopaedics. SB highlighted that all 6 chairs have agreed the evaluation criteria and that these have been signed off. SB told the group that the process now would be for the evaluation group to score and provide a recommendation to the Committee in Common who would then make a decision.

4.2 SB noted that there has been a review by the Clinical Senate who were supportive of the overarching model. The Senate raised a number of areas which need to be addressed and these are being worked through by the processes in place.

4.3 SB informed the group that organisations have now been asked to submit a second stage submission outlining a more detailed version of their proposals. Of note Oxleas/ Dartford and Gravesham Trust have asked that Queen Mary's

hospital be considered as a site option and will therefore be submitting a proposal.

4.4 SB noted that there is also work taking place on the pre-consultation engagement plan in parallel. SB informed the group that the timelines in paper D had changed following a review meeting and that an updated timeline would be circulated.

4.5 **Action: Sarah Blow to circulate updated timeline for stage 2 submission and evaluation process.**

4.6 SB highlighted that one of the actions from the last meeting was to provide the rationale for discounting configuration options with three sites. SB spoke to page 11 (paper D) and emphasised that there was agreement amongst the clinicians that two sites is the optimum. JF endorsed this from a clinical point of view stating how two sites would improve outcomes for patients.

4.7 Harvey Guntrip (HG) asked a question regarding the case load and whether an increase in demand had been factored in. SB responded that they are expecting an increase in caseloads however hoping the size of this increase will be lowered by making sure the pathways are right. SB said that they have asked the trusts, as part of the evaluation process, to give an idea of the flexibility of their capacity.

4.8 Richard Gibbs (RG) asked about the potential perverse outcome of having finance and non-finance criteria separated and asked about the over-ride. ME highlighted that this is a sense check so that the committee can reserve the right to choose an option which is less cost if greater clinical benefits can only be obtained at a disproportionate cost.

4.9 James Wyntour (JW) asked whether the wording on the rationale for discounting consolidation across more than two sites could be made stronger (slide 13). SB noted this comment and it was agreed, with the addition of the remaining data and supporting wording surrounding the complication of workforce, that the case for more than two sites could be dismissed.

4.10 John King (JK) asked whether the report from the Clinical Senate had been received yet and whether this could be shared. ME highlighted that this would be shared at the same time as the response to the Senate.

4.11 JK asked when it comes to agreeing which sites to choose will there be an issue with conflicts of interests for those who have been actively involved. ME responded that when it came to the CiC vote the members of the CiC needed to be having conversations with their respective governing bodies and then voting on their behalf and not as individuals.

4.12 Adrian Mclachlan (AM) said that we need to be conscious of managing individual's accountability to their organisations but also the system as a whole.

4.13 Matthew Trainer (MT) said that if any conflicts of interest do arise that NHSE will look at these and also that as part of the STP people need to be thinking about the decisions they take in the context of the health economy as a whole and the wider system.

4.14 SB highlighted that all the CCGs are represented on the evaluation panel and that when a recommendation is reached they should be able to stand behind this.

4.15 Annabel Burn (ABu) highlighted that the following sentence is incorrect on page 11 and that a 'not' needs to be included: "It was agreed that there will [not] be enough demand for consolidating services across more than 2 sites".

4.16 **Action: Programme team to update page 11.**

5. STP update

5.1 PM introduced the next agenda item of the STP and noted that given the proximity to the submission of the 30th June that the purpose of bringing it to this forum was less about detailed re-drafting and more about thinking about what is now needed to bring the plan to life.

5.2 ME provided an introduction to the STP document emphasising the importance the role OHSEL played over the past two years. ME highlighted that we have now transitioned out of OHSEL to incorporate both providers and commissioners and that the STP remit has extended to include Mental Health, specialist services and learning disability. ME informed the group that the document is in the final round of drafting and that the plan is for the Quartet to sign off the final document on Monday 27th June. ME noted that some aspects of the plan are better developed than others and that the newer aspects have had less public engagement as a result e.g. specialised services. ME summarised the scale of the challenge being faced and that in order to be successful there will need to be changes in the way we operate as a system. ME said that he believes that CLGs will be the vehicle used for delivery but that they need to look again at ensuring these groups have the appropriate resources, authority and information that they need.

5.3 PM then asked members to provide any general comments they have on the document and also to confirm that the CCGs have had sufficient input from their perspective.

5.4 RG said that he does support the document and feels that Southwark Governing body have been engaged in discussions, and a workshop, surrounding the document. RG did flag that there are risks and that we need to get a handle on how to best mitigate these e.g. of specialised services which has £190m aligned with it but the service plans still need developing.

5.5 ME noted that we do have a Programme Risk register which is in summary form on the website but acknowledged that this did need refreshing. In terms of specialised commissioning ME said that the £190m came from NHSE and that significantly more work on specialised commissioning is required.

5.6 Matthew Trainer (MT) provided the NHSE perspective which is that they think that the plan is one of the strongest in the country and that they feel it is made up of lots of sensible and credible aspects which are evidence based. MT said that the approach in the plan is an incremental change in the way in which care is delivered and that it is still transformational but subtly so. MT agreed that more work was required on specialised commissioning but noted that they do have the right people round the table now to address the issues and pressures such as managing demand from outside of London.

5.7 SB said that the specialised services aspect of the plan is probably the most contentious aspect as it is the piece which the public have had the least sight of. SB noted that we need to think carefully about how we position this, and the numbers surrounding it, in the plan.

5.8 Ruchira Paranjape (RP) said that hearing the fact the plan is made up of small and sustainable changes is encouraging as this is exactly what they are telling each practice in terms of everyone making small changes translates in to a large system transformation.

5.9 ABl said that Southwark endorsed the plan and thinks that it contains everything they would expect to see in it. He reflected that the aim is not to just meet the annual and five year goals but to move to a scenario where can meet the population based budget going forward.

5.10 TB congratulated the team on the document which he feels reads very well. TB noted that Simon Stevens had said at the Con Fed that any additional resources that were made available should be invested in Social Care but that this is not the feeling given off when you read the plan. Therefore TB thinks that the plan understates the impact social care reductions will have on achieving the targets in the document. Secondly TB highlighted that the document is full of very ambitious assumptions surrounding items such as the productivity gains and that there are real risks associated with the delivery of these. TB gave the Mental Health Improvements as an example of this as they are not costed in the plan currently.

5.11 MT responded noting that plans are a necessary step but it is true that when you get to implementation you really test the validity of what you are setting out to do. MT highlighted that it will be the quality of the relationships in a network of care and the willingness and commitment to engage with the challenge that will give this plan, which contains large elements of risk, the best chance of

success. MT noted that productivity will be key to this and that need to manage the flows in to the system.

5.12 ME highlighted that they have tried to set out the Social Care numbers on page 2 but acknowledged that is difficult to calculate the financial impacts reductions in Social Care will have on the NHS at a SEL level. ME said that Social Care is sometimes seen as a problem in areas like discharge when actually it is a NHS problem and that we need to be careful identifying whose responsibility it is to solve this.

5.13 SB noted that the work of Local Care Networks does help to bring together the Health and Social Care community approaches. SB thinks that the model is there but do not currently have all the supporting data.

5.14 ABh highlighted that there needs to be further engagement to ensure the link and buy-in of local authorities who still see STP's as alien. ABh also noted that integration plans need to be routed back to the STP.

5.15 ABu responded to TB's comment on Mental Health by acknowledging that it is not as sophisticated as other parts of the plan but that they have been vigilant not to put in un-costed goals that they are not committed to doing. ABu highlighted that whilst they need to do full costing and explore further opportunities the commitments outlined they have the intention of doing.

5.16 Harvey Guntrip (HG) asked if the affordability is predicated on having a prevention strategy in place that will have a medium and long term impact.

5.17 ABu responded that the modelling on Community Based Care is based primarily on the reduction of the number of people going into Emergency Departments by providing NHS services more swiftly and reducing crisis and admission not about long term reduction in obesity and smoking.

5.18 MT highlighted that issues such as diabetes are the long term objectives and that they have to start on that journey but that this document is talking about what can be done now by community based care and support services to reduce inappropriate admissions for example.

5.19 ABh said that it feels that we need to address the long term elements that have been called out such as obesity and that this is something we will need to come back to in order to agree how to address.

5.20 ABl highlighted that from a practical point of view the 30 page document cannot contain everything but that he feels the best way to achieve a prevention agenda will be through changing the incentives that are driving behaviours.

5.21 ABu noted that the transforming care piece had been missed out of this version of the STP but that it would be put back in.

5.22 **Action: ME to make sure the section on transforming care is included in the STP.**

5.23 Mary Currie (MC) agreed with the points that have been put forward noting that the proactive elements of implementing the plan are important and the challenges around Social Care are real.

5.24 AM noted the challenge of engaging local authorities and general practices and highlighted that there is a risk given the perceived secrecy relating to the STP document.

5.25 PM said that the next steps need to be formulated with NHSE.

5.26 ME recapped that it appears that all governing bodies have been sighted on the document and noted that the document would go to the quartet on Monday 27th June before submission on the 30th June. There will then be a meeting in mid-July with NHSE to discuss the submission. In terms of delivery the roles of the CLG's may need to be looked at and redefined and the importance of developing a STP intelligence system to track progress was raised. ME said that the plan is to carry out a conference in September in which key stakeholders will get together to discuss key areas for delivery.

5.27 ABh provided a summary on the Workforce supporting strategy. ABh highlighted that the approach to workforce has shifted to now include both a provider and commissioner focus. Secondly workforce now includes NHS education and it is using Healthy London Partnerships as a means of driving this.

5.28 ABh noted that there are 3 strategic priorities which have been identified to ensure successful delivery of the workforce objectives. The first is to review and redesign the workforce to help address short-term challenges and deliver the ambitions of new models of care. The proposal to achieve this is to carry out workforce modelling to establish what the current workforce is doing before redesigning existing roles in order to achieve optimisation. The second strategic priority is to facilitate workforce capacity and capabilities to ensure effective commissioning of new models of care. To achieve this there needs to be a focus on effective workload management and facilitating skills development for the commissioning of new models of care. The third strategic principle is to facilitate a whole-system culture and behavioural change. In order to do this a diagnostic on the current culture needs to be carried out and staff need to be engaged at scale on how they interface with their colleagues.

5.29 ABh noted that the workforce steering group has been re-fashioned to engage providers and that they are working closely with Health Education England as a lot of their resource is focused on training health professionals and developing new ways of working.

5.30 PM asked if there were any immediate observations or comments on workforce and none were raised.

5.31 Paul White (PW) provided an update on the Estates supporting strategy noting that it has been developed with providers, commissioners and NHS England. PW drew attention to section 7 of the document (overview of the Estate) highlighting that this document is still a work in progress and that more work is required to obtain a detailed understanding of the whole estate. PW noted that there are a list of potential bids which are being worked through by CCGs to prioritise.

5.32 PW informed the group that there are 3 strategic priorities for Estates. Firstly surrounding ensuring the estate is available where and when it is needed. This needs to be informed by the mapping of the entire estate incorporating population growth assumptions. Secondly supporting the development and enhancement of existing and new buildings where required is essential to ensure physical facilities are fit for delivery. This will be delivered by enhanced community-based care and delivered through Local Care Networks. The third strategic priority is to support whole-system transformation and financial stability through estates utilisation, maximisation and safe disposal. The key to delivering this priority is to ensure that the system is working together and that there is alignment of strategies. PW noted that this work is still at the development stage but that it is in the context of looking to create one estate across the STP. PW highlighted that there is still work on how this is going to be done required but that there is already significant collaboration taking place.

5.33 HG commented that where there are areas where it is likely there will be large growth it would be useful to see a blueprint of what the health system could look like. SB highlighted that working with local authorities on this is key to ensure alignment with developments.

5.34 Rachael Crampton (RC) provided an update on the Local Digital Roadmap. RC informed the group that the Roadmap had been through the digital team at HLP (Healthy London Partnership) and the IMT steering group. RC noted that the document will be submitted as a work in progress on the 30th June with an expectation that a final document will be created for November. RC informed the group that this document is high level and has several annexes which sit behind it. RC flagged that the timeline shown on page 9 is an example but that it is not specific to SEL. RC noted some of the key aspects included in the document such as the digital element of integrated care, the path forward for Local Care Networks and single information sharing. RC highlighted a key achievement of successfully deploying two portal solutions being Connect Care and the Local Care Record. These solutions offer a level of digital interoperability between primary and secondary care and have been very well received by the health care professionals in areas they have been deployed.

RC noted that there is more work to be done surrounding universal capabilities and how well the systems in place are being used.

5.35 ABu raised a question as to whether technology should be a separate workstream or whether it is something that is being embedded across that Programme as a whole. MT agreed that the role of technology will be important and the general consensus was that this is something that needs to be considered across the Programme as opposed to as an individual workstream.

5.36 **Action: John King (JK) requested a jargon buster is created to address the acronyms.**

5.37 PM thanked attendees and noted that the date of the next meeting is still to be considered given the fluctuation of timescales.