Southend-on-Sea Borough Council

Department of the Chief Executive
John Williams - Director of Democratic & Legal Services

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PEOPLE SCRUTINY COMMITTEE – SPECIAL MEETING
MONDAY, 18TH SEPTEMBER, 2017

Please find enclosed, for consideration at the next meeting of the People Scrutiny Committee taking place on Monday, 18th September, 2017, the following report(s) that were unavailable when the agenda was printed.

Agenda No Item

5. **Mid and South Essex Sustainability and Transformation Plan (Pages 1 - 24)**

   Report of Chief Executive

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Southend-on-Sea Borough Council

Report of Chief Executive
to
People Scrutiny Committee – special meeting

On 18th September 2017

Report prepared by:
Fiona Abbott

Agenda
Item No.

5

Mid and South Essex Sustainability and Transformation Plan
A Part 1 Agenda Item

1. Purpose of Report

To update the Committee on Mid and South Essex Sustainability and Transformation Plan and scrutiny.

2. Recommendation

2.1 The Committee is asked to note the current position with regard to the Joint Committee and officers continue discussions with Thurrock Council.

2.2 That authority be given to the principle of establishing a Joint Committee with Essex and that Thurrock Council be invited to join and that subject to any further comments from the Committee, the proposed terms of reference for the Joint Committee attached at **Appendix 2**, be agreed.

2.3 That the revised terms of reference and nominations to sit on the Joint Committee be considered at the October meeting of the Scrutiny Committee.

2.4 To also note the formation of the STP Joint Committee, as detailed in section 5 of the report.

3. Background

3.1 Over the last year, the Scrutiny Committee has received several presentations and updates with regard to the emerging mid and south Essex Sustainability and Transformation Plan (STP).

3.2 At the special meeting of the Scrutiny Committee meeting on 6th April 2017 NHS England provided an update on the STP (Minute 929 refers). On 20th July 2017 I circulated an update report on the STP, which advised about the new development in the plans for emergency care and options for future hospital services in mid and south Essex. A copy of this is attached at **Appendix 1**.

3.3 Over recent months there have been discussions with colleagues at Essex and Thurrock Councils with regard to the possibility of forming a Joint Committee to scrutinise the implementation of the Mid and South Essex Sustainability & Transformation Plan (STP) Success Regime and how it would meet the needs of the local populations in Essex, Southend & Thurrock.

3.4 The Joint Committee would act as the mandatory Joint Committee in the event that an NHS body is required to consult on a substantial variation or development in service that could affect the patients in the 3 local authority areas.

3.5 The Joint Committee would consist of Members from all three authorities and consideration would need to be given to the political proportionality of those Members.

3.6 Southend is supportive of the need for joint working and clearly within the regulations there is a requirement to establish a Joint Committee for service reconfigurations that cut across more than one area – e.g. review of cancer services, and this has happened in the past. Possible terms of reference have been drafted and are attached at **Appendix 2**.

4. Current position

4.1 Thurrock Health & Wellbeing Overview and Scrutiny Committee held a meeting on 7th September 2017 and considered the issue of joint working[1]. Thurrock has concerns over the creation of this Joint Committee and resolved that officers would explore the most appropriate way for the 3 authorities to co-ordinate their approach to the STP.

4.2 It is understood that the Essex Health Overview and Scrutiny Committee meeting scheduled for 11th October will focus on STP matters.

4.3 NHS England have been asked to provide an update on the STP (currently outstanding). When this is received a copy will be circulated to the Southend Scrutiny Committee Members.

5. Clinical Commissioning Groups in Mid and South Essex

5.1 Along side the developments detailed above, the Committee is asked to note that the five CCG's within Essex who form the mid and south Essex STP area have formed a STP Joint Committee. This is being formed under which will sit a management team (details being formalised). The STP Joint Committee (terms of reference attached at **Appendix 3** for information) will be a committee of each CCG with the purpose of overseeing and providing the appropriate governance for commissioning arrangements across the STP footprint. This will enable the CCG to commission services across the STP footprint 'once' to reduce red tape and the complexities of commissioning with five separate organisations and ensure the best quality and value for our patients. The following services are included within the STP:

- Acute services (NHS and independent sector) commissioning and contracting
- Integrated Urgent Care services (including NHS 111) commissioning and contracting
- Ambulance services commissioning and contracting
- Patient Transport Services commissioning and contracting
- Learning Disability decision making (within the existing pan-Essex arrangements);

[1] The papers for the meeting can be found on this link – see agenda item 11

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

5.2 Overview of CCG functions - The CCG will maintain overall accountability and responsibility for the STP Joint Committee, although services will be commissioned once across the STP footprint.

5.3 Implications for scrutiny - There are no direct implications for the Committee and as such it should been seen to be business as usual in terms of how the Committee interacts with the CCG. Representatives from the Committee in line with the public in general can attend the STP Joint Committee public meetings should they so wish[2].

6. Corporate Implications

6.1 Contribution to Council's Vision and Critical Priorities – becoming an excellent organisation.
6.2 Financial Implications – There are no financial implications arising from the contents of this report. The cost of the Joint Committee work can be met from existing resources.
6.3 Legal Implications – the Scrutiny Committee exercises the health scrutiny function as set out in relevant legislation.
6.4 People Implications – none.
6.5 Property Implications – none.
6.6 Consultation – as described in report.
6.7 Equalities Impact Assessment – none.
6.8 Risk Assessment – none.

7. Background Papers

- Email sent to Cttee – 20th July 2017

8. Appendix

Appendix 1 – stakeholder briefing – developing options
Appendix 2 – draft terms of reference for Joint Committee
Appendix 3 – CCG STP Joint Committee

[2] Click on link for further information on the Mid and South Essex STP Joint Committee

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Mid and South Essex
Success Regime

Mid & South Essex STP
PMO Office: 0113 825 4940
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essexsuccessregime@nhs.net
20 July 2017

Dear Colleague

Developing our options for the future pattern of hospital services in mid and south Essex

I am writing to let you know that today we are announcing a new development in our options for emergency care as we continue to think about how future hospital services could be organised and delivered in mid and south Essex.

We are developing our current options with more detail around how the emergency care pathway could work in the future. As part of this we believe the three current A&E departments at Basildon, Broomfield and Southend could continue to receive 'blue light' emergency patients with serious conditions. It would rule out the blanket redirection of all 'blue light' ambulances to Basildon, as outlined in our earlier work on this.

Our local clinicians, including the senior doctors responsible for emergency care in each of the three hospitals, have developed a clinical plan which would see the majority of local people get the specialist emergency care they need via their local A&E. Under this plan, in an emergency, patients would go to their local hospital A&E, be assessed, stabilised and treated there; and then either referred for further care; admitted for ongoing treatment; discharged; or transferred to a specialist team for treatment and care at another hospital, if that's what they need. The 'norm' would be for patients to go to their local hospital in an emergency.

As now, a small number of people who are very seriously ill would be taken by ambulance straight to a specialist centre to get the best treatment, for example, severe heart attack patients already go straight to the Cardiothoracic Centre at Basildon, or people suffering severe burns already go to the Plastic Surgery and Burns Centre at Broomfield in Chelmsford. Clinicians are looking in detail at the clinical evidence to see if there are other emergency conditions that may also require this approach – for example for severe vascular emergencies or upper gastrointestinal bleeds.

Previously, we have discussed with staff, stakeholders and local people the benefits of one hospital, possibly Basildon, providing the most serious emergency treatment directly, for patients in mid and south Essex. But, in the feedback from over 100 local discussion events, we have heard very clearly that some people have significant concerns about all 'blue light' ambulances going straight to Basildon. This new development of our options sees us addressing these concerns.

However, the aim still stands to develop specialist centres and to separate planned operations and treatments from emergency care. We know from national evidence that this can improve the quality of care and patients' chances of survival - particularly with very serious cases. We also want our three hospitals to work increasingly together, offering different specialist services at each of our sites. We know specialising in this way for those with the most serious conditions and illnesses gives better chances of recovery to our patients.

Over the next few months our clinicians will continue to do detailed work to develop our options and understand their impact on clinical outcomes and patient experience; our staffing needs; the numbers and types of patients needing our services; the financial requirements and so on.

We will also continue to gather feedback from our staff, stakeholders and local people, to make sure we develop the right proposals for mid and south Essex. We will then take our proposals to a full public consultation later this year, subject to national assurance, with no decision on the pattern of future services being taken until this has been completed. We will continue to brief you regularly and look forward to working in partnership with you.

We remain determined to find the very best solution for delivering excellent, safe, high quality hospital care, within our available funding, into the long-term for people in mid and south Essex.

Kind regards,

Clare Panniker
Chief Executive
Basildon and Thurrock University Hospitals
NHS Foundation Trust
Mid Essex Hospital Services
NHS Trust
Southend University Hospital
NHS Foundation Trust

Dr Anita Donley OBE
Independent Chair
Mid and South Essex Success Regime

Mid and South Essex
Success Regime

Thursday, 20 July 2017

PRESS RELEASE

Embargoed until 13.00, 20 July 2017

Doctors and health care leaders today announced a new development in the options for future hospital services in mid and south Essex.

In recent months, two main options for change have been discussed with patients, staff and stakeholders. Both options would have seen significant changes to the way the three A&E departments at Broomfield, Basildon and Southend hospitals operate.

Having studied the available evidence and listened carefully to the views of local people, patients and stakeholders, clinicians and health leaders have now decided to develop a revised model that would enable all three current A&E departments to continue to treat people who need emergency hospital care, including continuing to receive 'blue light' emergency patients with serious conditions. It would rule out the blanket redirection of all 'blue light' ambulances to Basildon, as in previous options.

Under this plan, patients would be assessed, stabilised and treated in their local hospital, with the most unwell patients transferred to a specialist team, if that's what they need. The 'norm' would be for people to go to their local hospital in an emergency. As before, all three A&E departments would continue to be open 24 hours a day, seven days a week and run by consultants.

As now, a small number of people who are very seriously ill would go straight to a specialist centre to get the best treatment (for example, people suffering severe burns already go to Broomfield in Chelmsford).

Senior doctors are currently looking in detail at the clinical evidence to see if there are other severe conditions that may require this approach – for example for people suffering from burst blood vessels in the brain or heart, or people with very severe abdominal bleeding requiring urgent emergency surgery. This work is not yet complete but doctors are focusing on it over the next few months.

Clare Panniker, Chief Executive of Basildon, Broomfield and Southend Hospitals, explained:

"We have been looking at how we could organise services across our three main hospital sites, working together and using our people and resources as effectively as possible for the

greatest benefit for patients. One of the improvements we want to make is to separate out emergency care from planned operations and treatments needing an overnight stay, to reduce the number of times we have to cancel planned operations. We know when this happens it is frustrating and difficult for those patients and their families. We also want our three hospitals to work together, offering different specialist services at each of our sites. We know specialising in this way for those with the most serious conditions and illnesses gives better chances of recovery to our patients.

"In considering our options, we have discussed with staff and local people the benefits of one hospital, possibly Basildon, providing the most serious emergency treatment. But, in the feedback from over 100 local discussion events, we have heard very clearly that some people have significant concerns about all 'blue light' ambulances going straight to Basildon. We have been thinking how we could address these concerns, and still improve patient care with different specialist teams across our three hospital sites and the separation of planned and emergency care."

Dr Anita Donley OBE, Independent Chair of the Mid and South Essex Success Regime, said:

"The aim still stands to develop specialist centres across our three hospital sites and to separate planned operations and treatments from emergency care. We know from national evidence that this can improve the quality of care and patients' chances of survival - particularly with very serious cases. But we are working with our clinicians and local people to make sure we develop the right proposals for mid and south Essex. We are developing an option where the majority of patients could get the specialist emergency care they need via their local A&E.

"No decision on the future pattern of services has yet been taken. We will only decide what changes to make after a full public consultation.

"We are determined to find the very best solution for delivering excellent, safe, high quality hospital care, within our available funding, into the long-term for people in mid and south Essex."

ENDS

Notes to editors:

For further information, please e-mail claire.hankey@southend.nhs.uk.

ESSEX, SOUTHEND AND THURROCK JOINT HEALTH SCRUTINY COMMITTEE ON THE SUSTAINABILITY & TRANSFORMATION PLAN / SUCCESS REGIME FOR MID AND SOUTH ESSEX

DRAFT TERMS OF REFERENCE

1.	**Legislative basis**
1.1	The National Health Service Act 2006, as amended by the Health and Social Care Act 2012 and the Localism Act 2011 sets out the regulation-making powers of the Secretary of State in relation to health scrutiny. The relevant regulations are the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 which came into force on 1st April 2013.
1.2	Regulation 30 (1) states two or more local authorities may appoint a joint scrutiny committee and arrange for relevant health scrutiny functions in relation to any or all of those authorities to be exercisable by the joint committee, subject to such terms and conditions as the authorities may consider appropriate.
1.3	Where an NHS body consults more than one local authority on a proposal for a substantial development of the health service or a substantial variation in the provision of such a service, those authorities are required to appoint a joint committee for the purposes of the consultation. Only that Joint Committee may: • make comments on the proposal to the NHS body; • require the provision of information about the proposal; • require an officer of the NHS body to attend before it to answer questions in connection with the proposal.
1.4	This Joint Committee has been established on a task and finish basis, by Essex Health Overview and Scrutiny Committee (County Council), Southend-on-Sea People Scrutiny Committee (Unitary Council) and Thurrock health & Wellbeing Overview and Scrutiny Committee (Unitary Council).
2.	**Purpose**
2.1	The purpose of the Joint Committee is to scrutinise the implementation of the Mid and South Essex Sustainability & Transformation Plan (STP) Success Regime and how it is meeting the needs of the local populations in Essex, Southend & Thurrock, focussing on those matters which may impact upon services provided to patients in those areas.
2.2	The Joint Committee will also act as the mandatory Joint Committee in the event that an NHS body is required to consult on a substantial variation or development in service affecting patients in the 3 local authority areas as a result of the implementation of the STP.
2.3	In receiving formal consultation on a substantial variation or development in service, the Joint Committee will consider:- • the extent to which the proposals are in the interests of the health service in Essex, Southend and Thurrock;

	• the impact of the proposals on patient and carer experience and outcomes and on their health and well-being; • the quality of the clinical evidence underlying the proposals; • the extent to which the proposals are financially sustainable. and will make a response to relevant NHS body and other appropriate agencies on the proposals, taking into account the date by which the proposal is to be ratified.
2.4	The Joint Committee will consider and comment on the extent to which patients and the public have been involved in the development of the proposals and the extent to which their views have been taken into account as well as the adequacy of public and stakeholder engagement in any formal consultation process.
3.	**Membership/chairing**
3.1	The Joint Committee will consist of 4 members representing Essex, 4 members representing Southend and 4 members representing Thurrock, as nominated by the respective health scrutiny committees.
3.2	Each authority may nominate up to 2 substitute members.
3.3	The proportionality requirement will not apply to the Joint Committee, provided that each authority participating in the Joint Committee agrees to waive that requirement, in accordance with legal requirements and their own constitutional arrangements.
3.4	Individual authorities will decide whether or not to apply political proportionality to their own members.
3.5	The Joint Committee members will elect a Chairman and 2 Vice-Chairmen at its first meeting, one from each authority, so that each authority is represented.
3.6	The Joint Committee will be asked to agree its Terms of Reference at its first meeting.
3.7	Each member of the Joint Committee will have one vote.
4.	**Co-option**
4.1	By a simple majority vote, the Joint Committee may agree to co-opt representatives of organisations with an interest or expertise in the issue being scrutinised as non-voting members, but with all other member rights. This may be for a specific subject area or specified duration.
4.2	Any organisation with a co-opted member will be entitled to nominate a substitute member.
5.	**Supporting the Joint Committee**
5.1	The lead authority will be decided by negotiation with the participating

	authorities.
5.2	The lead authority will act as secretary to the Joint Committee. This will include: • appointing a lead officer to advise and liaise with the Chairman and Joint Committee members, ensure attendance of witnesses, liaise with the consulting NHS body and other agencies, and produce reports for submission to the health bodies concerned; • providing administrative support; • organising and minuting meetings.
5.3	The lead authority's Constitution will apply in any relevant matter not covered in these terms of reference.
5.4	The lead authority will bear the staffing costs of arranging, supporting and hosting the meetings of the Joint Committee. Other costs will be apportioned between the authorities. If the Joint Committee agrees any action which involves significant additional costs, such as obtaining expert advice or legal action, the expenditure will be apportioned between participating authorities. Such expenditure, and the apportionment thereof, would be agreed with the participating authorities before it was incurred.
5.5	The non-lead authorities will appoint a link officer to liaise with the lead officer and provide support to the members of the Joint Committee.
5.6	Meetings shall be held at venues, dates and times agreed between the participating authorities.
6.	**Powers**
6.1	In carrying out its function the Joint Committee may: • require officers of appropriate local NHS bodies to attend and answer questions; • require appropriate local NHS bodies to provide information about the proposals; • obtain and consider information and evidence from other sources, such as local Healthwatch organisations, patient groups, members of the public, expert advisers, local authorities and other agencies. This could include, for example, inviting witnesses to attend a Joint Committee meeting; inviting written evidence; site visits; delegating committee members to attend meetings, or meet with interested parties and report back. • make a report and recommendations to the appropriate NHS bodies and other bodies that it determines, including the local authorities which have appointed the joint committee. • consider the NHS bodies' response to its recommendations;
6.2	In the event the Joint Committee is formally consulted upon a substantial variation or development in service as a result of the implementation of the STP, and considers:- ➢ it is not satisfied that consultation with the Joint Committee has been

	adequate in relation to content, method or time allowed; ➢ it is not satisfied that consultation with public, patients and stakeholders has been adequate in relation to content, method or time allowed; ➢ that the proposal would not be in the interests of the health service in its area the Joint Committee will consider the need for further negotiation and discussions with the NHS bodies and any appropriate arbitration.
6.3	If the Joint Committee then remains dissatisfied on the above 3 points it may make recommendations to Essex, Southend and Thurrock Councils. Each Council will then consider individually whether or not they wish to refer this matter to the Secretary of State or take any further action.
6.4	The power of referral to the Secretary of State is a matter which will not be delegated to the Joint Committee.
6.5	Each participating local authority will advise the other participating authorities if it is their intention to refer and the date by which it is proposed to do so.
7.	**Public involvement**
7.1	The Joint Committee will meet in public, and papers will be available at least 5 working days in advance of meetings
7.2	The participating authorities will arrange for papers relating to the work of the Joint Committee to be published on their websites, or make links to the papers published on the lead authority's website as appropriate.
7.3	A press release may be circulated to local media at the start of the process and at other times during the scrutiny process at the discretion and direction of the Chairman and the 2 Vice Chairmen.
7.4	Patient and voluntary organisations and individuals will be positively encouraged to submit evidence and to attend.
7.5	Members of the public attending meetings may be invited to speak at the discretion of the Chairman.
8.	**Press strategy**
8.1	The lead authority will be responsible for issuing press releases on behalf of the Joint Committee and dealing with press enquiries, unless agree otherwise by the Committee.
8.2	Press releases made on behalf of the Joint Committee will be agreed by the Chairman and Vice-Chairmen of the Joint Committee.
8.3	Press releases will be circulated to the link officers.
8.4	These arrangements do not preclude participating local authorities from issuing individual statements to the media provided that it is made clear that these are not made on behalf of the Joint Committee.

9.	**Report and recommendations**
9.1	The lead authority will prepare a draft report on the deliberations of the Joint Committee, including comments and recommendations agreed by the Committee. Such report(s) will include whether recommendations are based on a majority decision of the Committee or are unanimous. Draft report(s) will be submitted to the representatives of participating authorities for comment.
9.2	Final versions of report(s) will be agreed by the Joint Committee Chairman.
9.3.	In reaching its conclusions and recommendations, the Joint Committee should aim to achieve consensus. If consensus cannot be achieved, minority reports may be attached as an appendix to the main report. The minority report/s shall be drafted by the appropriate member(s) or authority (ies) concerned.
9.4	Report(s) will include an explanation of the matter reviewed or scrutinised, a summary of the evidence considered, a list of the participants involved in the review or scrutiny; and an explanation of any recommendations on the matter reviewed or scrutinised.
9.5	In addition, in the event the Joint Committee is formally consulted on a substantial variation or development in service:, if the Joint Committee makes recommendations to the NHS body and the NHS body disagrees with these recommendations, such steps will be taken as are “reasonably practicable” to try to reach agreement in relation to the subject of the recommendation.
9.6	The Joint Committee itself does not have the power to refer the matter to the Secretary of State.
10.	**Quorum for meetings**
10.1	The quorum will be a minimum of 6 members, with at least 2 from each of the participating authorities. This will include either the Chairman or one of the Vice Chairmen. Best endeavours will be made in arranging meeting dates to maximise the numbers able to attend from the participating authorities.

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APPENDIX 1

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: .....

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