Mid and South Essex
Sustainability and
Transformation Partnership
CCG Joint Committee

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Sent via email

Councillor Cheryl Nevin
Chair
People Scrutiny Committee
Southend on Sea Borough Council

21 November 2018

Dear Cllr Nevin

Thank you for your letter of 14 November outlining your intention to refer to the Secretary of State for Health and Social Care the decisions made by the Mid and South Essex STP CCG Joint Committee, following the public consultation *Your Care in the Best Place.* In your letter you ask the CCG Joint Committee to respond to Southend-on-Sea Borough Council by 21st November, and outline that you will send the referral to the Secretary of State on the 23rd November.

The CCG Joint Committee fully respect the right of the Council to refer our decisions for independent examination. On behalf of the CCG Joint Committee however, I must express my disappointment with this outcome. As you recognise within your letter, the current provision of health services within the STP footprint is unsustainable and this referral delays the ability of clinicians, who have led and supported the proposals for service change, to address these issues and to provide better care to the 1.2 million people we serve across mid and south Essex.

While it would be unhelpful at this stage for me to respond in detail to specific items in the referral, I would like to make a number of points.

Overview of Referral

I note that you plan to refer all 19 decisions made by the CCG Joint Committee, although the only clinical service decision you address in detail is that relating to stroke. I have also seen the original paper from your officers, which was published with the People Scrutiny Committee papers (9 October) and provided a recommended course of action based on the need for a specific and sound basis for referral. I would therefore invite you to consider exactly which decisions you seek to refer.

Under the process which is set out in the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations, I would have anticipated that you would make some recommendations on how, in your opinion, changes could be made which would remove your concerns. Notwithstanding this, I am sure you would agree that detailed reasons for objections to any decision should be set out. In only outlining your concerns on decisions made on stroke care, it is not possible for the CCG Joint Committee to substantively respond due to a lack of specificity.

I would like to point out that the impact of making such a wide-ranging referral is that:

- The CCG Joint Committee, a publicly funded body, must expend time and money on seeking to ascertain the basis of the referral.

- It prevents the development of detailed implementation plans, which the Joint Health Overview and Scrutiny Committee (JHOSC) has requested, because there is no clarity on the rationale for referring all decisions.

- It delays the ability to advance the process for accessing capital funding and so risks mid and south Essex losing out on the currently available funds.

I fully understand that public authorities rarely make decisions which receive universal support, although the CCG Joint Committee has sought to do what we believe is in the best interests of the whole community which we serve.

Evidence
In taking decisions on all 19 recommendations presented in the publically available decision-making business case (DMBC), CCG Joint Committee members took an evidence-based approach and made decisions based on improving the provision of acute hospital care for the population of 1.2m people that the STP serves.

This evidence included the outcome of the reviews undertaken by the East of England Clinical Senate and the quality impact assessments undertaken by commissioners that indicated that outcomes would be improved through implementation of the proposed recommendations. The equality impact assessments conducted by individual CCGs agreed that outcomes would be improved, and put in place actions to mitigate any negative impacts that could be experienced by a small minority of patients, all of these actions were translated into recommendations which the CCG Joint Committee approved.

The DMBC was shared with the chair and vice chairs of the JHOSC and chairs of the three Health and Wellbeing Boards prior to the decision-making meeting.

Clinical Transport (Treat and Transfer)
The STP published a variety of information on the plans for the treat and transfer service during the consultation, including detail on how existing transfers between the three hospitals already operate for our existing specialist centres.

Specifically, I am aware that a detailed presentation on progress was made to the JHOSC at its private meeting on 19th June but it is not clear from your referral whether the People Scrutiny Committee subsequently received a report on this discussion from your representatives on the JHOSC.

I would also note, as raised with the JHOSC on a number of occasions, that it was impossible to provide absolute detail on the proposed service model until the CCG Joint Committee had made the decision on service changes. For this reason, it had been agreed that treat and transfer would be a subject for further focus at a future JHOSC meeting.

Patient, Family and Carer Transport
As you are aware, the STP established a service user-led Transport Working Group during the consultation to help us better understand issues relating to patient, family and carer transport. This group has continued to meet bi-monthly. As outlined in the DMBC, and on a number of occasions to the JHOSC, we are working on a number of improvements to support patients and their families to access hospital care, led by the priorities identified by the Transport Working Group.

You will be aware that the NHS had agreed with the JHOSC a series of future scrutiny sessions which would have provided further information on areas such as transport, workforce, and implementation planning as work progressed in these areas following decision-making in July. It is unfortunate that the JHOSC meeting scheduled for 30 October was postponed by the JHOSC due to the referral since it was at that very meeting that the chair of the Transport Working Group would have provided information on the steps being taken to improve transport between our hospitals.

Workforce
Like you, we recognise that the workforce is a key challenge for the system. The service changes proposed and approved by the CCG Joint Committee were aimed at making best use of scarce expertise and resource to provide comprehensive cover of key clinical services, to the whole population, all day, every day, rather than rotas which are not only onerous for staff but also unsustainable for the future.

The CCG Joint Committee were able to see detailed workforce plans, specialty-by-specialty, which were included within the DMBC through the acute trusts' deliverability statement. These documents are available on the STP website. Improved workforce sustainability was also a question raised and resolved through the East of England Clinical Senate reviews on the proposals that were also included within the DMBC.

The Joint Committee was therefore content that robust workforce plans were in place to enable decisions to be taken on service change. The STP provided an update on progress with workforce planning to the JHOSC meeting on 30 August and it was agreed that, as an implementation matter, this would be an area for discussion at a future JHOSC meeting.

Capital Investment
The breakdown of the £41m capital investment which was intended for Southend Hospital was described in the pre-consultation business case and includes new theatre and inpatient capacity, radiotherapy bunkers to expand cancer treatment, as well as other site infrastructure programmes. It would be helpful to understand what further information you require.

I would like to underline that your decision to refer to the Secretary of State delays the approval of the business cases to access this capital funding which is much needed to address critical infrastructure issues at Southend Hospital.

Implementation Plans
You are correct that detailed implementation plans have not been shared with the JHOSC – as I outlined in my 10 September letter to the chair and vice chairs of the JHOSC, the STP needed to firstly understand whether the JHOSC would be making

further recommendations for consideration of the STP, and secondly to understand whether a referral would be forthcoming from any individual HOSC as this would impact significantly on any implementation plan, particularly given the dependency between many of the service changes and the approval of the capital funding; this has proved to be the case.

The CCG Joint Committee recognised that implementation would be an iterative and phased process over a number of years. For this reason, the recommendation to establish an independently chaired Implementation Oversight Group was fully supported by the Committee. As described in the DMBC, this group would be tasked with ensuring, before each pathway goes live, that all relevant infrastructure, including workforce, clinical and patient, family and carer transport is in place, and that issues such as discharge and repatriation arrangements had been resolved.

Discharge and repatriation
As described at previous meetings of the JHOSC, approximately 15 patients a day are already transferred across our three hospitals to receive specialist care, and are successfully repatriated or discharged as required.

The JHOSC has also had detailed briefing on the design of the approved clinical pathways, such that any patients requiring ongoing rehabilitation would be transferred back to their local hospital for this care.

Options
The referral has suggested that there were no options provided for consultation. You are aware, and have referenced in the referral, that a detailed options appraisal process took place, engaging with stakeholders and the public, which helped shape our proposals for consultation. This started with over 100 possible service delivery models and developed into the proposals that were eventually consulted upon. Southend Borough Council were represented at the options appraisal workshop.

Indeed having listened to our communities and stakeholders through our pre-consultation engagement activities you are aware that we made further changes to our proposed model for A&E services which formed the final set of proposals that proceeded to formal public consultation. This process is clearly described within the pre-consultation business case, a document that has been shared with individual HOSCs and Health and Wellbeing Boards, and that is publically available.

I also note that at no time has Southend Council made any substantial proposals on alternative options to the service configurations proposed.

Lack of clarity
I would disagree that there has been a lack of clarity in the decision-making process. Decisions to consult with the public and the DMBC were made by a properly constituted Joint Committee of the five CCGs in mid and south Essex, these proposals having undergone national assurance processes and clinical senate review.

Stroke
In relation to stroke, you have outlined that the Council understands that the model was developed by, and has support from, clinical leads. You also acknowledge that

the evidence for the model was considered and endorsed by the East of England Clinical Senate. The national clinical director for stroke care, Professor Tony Rudd, also supports the model. The rationale for moving the post-stroke period of care to Basildon is to concentrate staff and expertise in one place and to ensure that patients receive the full range of intensive therapy input in the critical 72-hour period post-stroke (as per the Royal College of Physicians National Clinical Guideline on Stroke).

While all three stroke units perform well, we cannot guarantee that the standards for post-stroke care are consistently met; the units operate with locum consultants and agency nurses; this is costly and does not offer the level of care that the hospitals would wish to provide. The rationale for the specialist stroke unit being at Basildon, which has been explained at both JHOSC and Southend Health and Wellbeing Board, is due to clinical interdependencies meaning that specialist stroke care should be co-located with interventional radiology, vascular and renal services – all based on the Basildon site. In turn, each of these specialties have interdependencies with the Essex Cardiothoracic Centre. This evidence was presented to and supported by the Clinical Senate.

You outline within your referral that Southend has the highest number of strokes within the STP footprint. This appears to be conflating incidence with prevalence. Using the numbers outlined within your document, the 14 patients from Southend need to be weighed against the 22 patients from elsewhere in mid and south Essex, which does not appear to have been factored into your judgement on this issue. It is important to note that the CCG Joint Committee is charged with securing the best overall outcomes for the 1.2 million people who live in mid and south Essex and is rightly required to take a population based view.

On the incidence of stroke you rightly outline that Southend has a significant number of stroke admissions and that this figure is rising. I know that the Council will be keen to deliver on its public health duties and enhance prevention work, linking closely with primary care and community services to put in place improved prevention and early identification mechanisms for patients with cardiovascular risk factors, such as atrial fibrillation, thus reducing the number of strokes.

Consultation & Engagement

With regard to your comments on the public consultation, we are clear that the primary purpose of consultation is to understand any issues and concerns that people, and in particular those most likely to be affected, might have had about service change so that we could consider these in our plans and seek to mitigate any risks or negative impact as far as possible.

Whilst it is disappointing that higher numbers did not formally respond to the consultation, we have demonstrated to the JHOSC that the reach of the consultation was significantly beyond the response rate – for example our social media marketing alone reached in excess of 350,000 people.

At the core of many of the areas raised in your referral appears to be a perception that the STP has failed to provide information to the Council. I hope you can see from the above that we do not consider this to be the case.

As you have pointed out, there has been extensive engagement between the STP team and Southend on Sea Borough Council through the Health and Wellbeing Board and, prior to the formation of the JHOSC, with the People Scrutiny Panel. Throughout the process the STP has sought to be open and transparent, sharing with the Council and JHOSC our emerging plans. We have reflected on the process and believe we have undertaken a robust and transparent consultation with elected members both through the JHOSC process and locally.

I sincerely hope that the outcome of any independent review will enable us to move forward and deliver on our obligations to our local communities to secure much needed improvements in the provision and sustainability of health services.

Yours sincerely

Professor Mike Bewick
Independent Chair
CCG Joint Committee

Cc. Caroline Rassell, Lead AO for CCG Joint Committee
Jo Cripps, Interim Programme Director, Mid & South Essex STP