DRAFT MINUTES

Mid and South Essex Community Collaborative (MSECC) Joint Committee

4th June 2024 – 2pm-4pm

Via Microsoft Teams

In attendance:	
Eileen Taylor (ET) - Meeting Chair	Chair - NELFT
Luis Canto E Castro (LCEC)	Lived Experience Leader
Dr Anna Davey (AD)	Deputy Medical Director for Engagement - MSEICB
Caroline Dollery (CD)	Non-Executive Director - NELFT
Simon Evans-Evans (SEE)	Governance Director - NELFT
Gerdalize du Toit (GDT) (on behalf of Dan Doherty)	Community Director – MSE ICS
Simon Griffiths (SG) (on behalf of Nick Presmeg)	Director of Adult Social Care – Essex County Council
Mark Harvey (MH)	Executive Director of Adult Social Services – Southend City Council
Brid Johnson (BJ)	Chief Operating Officer - NELFT
Wellington Makala (WM)	Executive Chief Nursing Officer - NELFT
Siobhan Morrison (SM)	Group Chief People Officer – Provide CIC
Robert Parkinson (RP)	Group Chair - Provide CIC
Philip Richards (PR)	Chief Finance Officer – Provide CIC
Sultan Taylor (ST) (on behalf of Tania Sitch)	Non-Executive Director – Provide CIC
Michelle Stapleton (MS)	System Integrated Care Pathway Director - MSEFT
Lucy Wightman (LW)	CEO, Provide Health
James Wilson (JW)	Transformation Director – MSECC
Invited Guests:	
Alison French (AF) – agenda item 8	Head of Community and Crisis Care, Thurrock
Chris Jennings (CJ) – Observing	Assistant Trust Secretary – EPUT
Meg Kitley (MK) – agenda item 8	Deputy Operational Lead for Thurrock Integrated Community Team
Mark Mager (MM) – agenda item 8	Operational Lead, Thurrock Integrated Community Team
Candice Robinson (CR) – agenda item 9	MSECC Communications Manager
Susan Lees (SL) - Observing	Vice Chair, NELFT
Apologies:	
Dan Doherty (DD)	Mid Essex Alliance Director - MSE ICS
Alex Green (AG)	Executive Chief Operating Director - EPUT
Milind Karele (MK)	Executive Medical Director - EPUT
John Lutchmiah (JL)	Lived Experience User

Nick Presmeg (NP)	Executive Director of Adult Social Services – Essex County Council
Sheila Salmon (SS)	Chair – EPUT
Tania Sitch (TS)	Non-Executive Director - Provide
Ian Wake (IW)	Director of Adult Social Services – Thurrock Council
Minutes:	
Claire McPherson (CM)	MSECC Joint Committee administration support

NO.	ITEM	ACTIONS
Formalities and Administration		
1.	**Welcome, Introduction and Apologies** ET opened the meeting, with this being the first in the format of a Joint Committee under the new governance, with a more inclusive and broader membership than previously. ET noted that we now have lived experience representation and Luis Canto E Castro was warmly welcomed. Previously the Mid and South Essex Community Collaborative (MSECC) Board has met in person but due to the widened membership of the meeting it has been agreed to largely move to on-line with occasional in person meetings, with the next meeting in July 2024 meeting in person at The Lodge, Wickford. Introductions were made.	
2.	**Declarations of Interest** Members were asked to refresh their declarations of interest and new members were asked to submit theirs to CM. No conflicts raised in relation to today's agenda.	
3.	**Minutes of meeting 20th March 2024** The minutes of the previous meeting, held on 20th March 2024 were accepted and agreed as an accurate recording of the meeting.	
4.	**Action Log following 20th March 2024** Updates were given on open actions: Action 94 – Electronic Patient Record (EPR) meeting – Updated that this will be bought back to the MSECC Joint Committee at an appropriate juncture. Action 95 – Risk Review - Update that this will be bought back to July 2024's meeting.	
5.	**Matters arising from previous minutes** See updated actions above.	
Essential Business		
6.	**Draft Terms of Reference (TORs)** PR presented on behalf of SEE and informed the MSECC Joint Committee that the Terms of Reference (TORs) have been developed by the MSECC Governance Workstream. They have been socialised with the 3 partner sovereign boards and formed part of the governance pack that went to the Integrated Care (ICB) Board as part of the approval of the MSECC. The TORs set out the status of this MSECC Joint Committee based on rules of NHS Foundation Trusts. Sovereign boards have delegated to this MSECC Joint Committee as a sub-committee of their boards, applicable to Provide Community Interest Company (Provide CIC) as well.	

The TORs cover off delegation; the role of the MSECC Joint Committee; sets out membership (noting that the 3 provider Chief Executive Officers (CEOs) are no longer members of this sub-committee) and includes the 3 Chairs of each organisation and one Non-Executive Director (NED) from each provider organisation.

PR explained that the remainder of the MSECC Joint Committee membership, specifically for the 3 partner organisations, relates and aligns to management of the workstreams with them representing the workstream rather than their employing organisation.

The TORs also refer to Quoracy and the Accountability Framework (AF).

Questions:
LW made reference that these meetings will be open to the public (and encourages this) and asked if this will be from the next meeting onwards and how will this be advertised and facilitated?

Additionally, considering the level of maturity that the MSECC needs to reach in the contract term (3 years), do we feel that bi-monthly meetings are frequent enough? Are we confident that there is an appropriate sub-committee, where all come together to ensure progress against the plan. Operationally, do we have the right sub-committee structure?

ET noted that this is not an operational committee, rather a strategic meeting and therefore need to ensure the operational structure is in place.

JW responded to LW, that the evolution to today (that the 3 community providers felt they could deliver better as one), over last couple of years, has been as an internal collaboration but at this cross roads of the new contract, it was felt important to have a wider membership to work as one across a wider setting. We are now moving to the next phase of maturity.

JW explained that previously, under the MSECC Board meeting we had the MSECC Community Collaborative Leadership Team (CCLT), the executive leadership function, which brings together a number of executives on this call from the 3 provider organisations from Finance; Quality, Workforce & OD; Communications; Operational; Governance; Performance and that group held responsibility for the day to day oversight and tracking of delivery. Within that we have an operational focus and separately a transformation focus group. We are introducing an AF meeting bringing Quality, Finance and Performance into one place to give assurance to this MSECC Joint Committee.

With regards to MSECC Joint Committee meetings being open to the public, as today we are in the forming stage it made sense to get our bearings, however the intention is, for both virtual meetings and face to face, is to advertise as individual organisation via internet sites. For Provide CIC this is a real shift as they wouldn't normally have their board meetings in public. The next meeting taking place on 25th July 2024 will be opened to the public (face to face).

BJ requested a re-word of point 20:

	`At the invitation of the Community Collaborative Board, the following individuals will be in attendance as and when required'. If we are to move forward and align priorities we need to be a team, not drifting in and out. Keeping fit and out of hospital would need all working together so asked to remove/re-word the reference to *`as and when required'.*  ACTION: TORs – Point 20 – remove/re word *`as and when required'* *`At the invitation of the Community Collaborative Board, the following individuals will be in attendance **as and when required**'.* SG raised around membership, that strategic partners are always good and to consider inviting our largest provider, Essex Cares Limited (ECL) to join as they are closely linked to the MSECC. MH highlighted that when reading the TORs, the Local Authorities (LAs) are not addressed as partners, but as other organisations. LAs could be invited and could be engaged but no other link. Need to be clear about the governance. It is good to see lived experience representation said MH but the TORs talk about user experience and would prefer people/s. ET, we need one set of wording to be used for the 3 parties, those being EPUT, with sub-contracts to NELFT and Provide CIC and also how to refer to the other parties, Local Authorities, Voluntary Sector (VS) etc.. ACTION: TORs – clarify wording to differentiate between the 'contracted parties' and the partners invited to attend the MSECC Joint Committee. MH said that the TORs specifically names the Director of Adult Services (DASS) from the 3 LAs, but as MH has already said, he is unable to commit to meetings going forward so should say '*or its deputy*'. ACTION: TORs – Point 20 – Membership of the DASS (x3) to include *`or its deputy'*. JW responded that these are all good points and that we do have a Memorandum of Understanding (MOU) between ECL and the MSECC to work in partnership. PR agreed and will go away and re-draft to reflect comments received. This MSECC Joint Committee does have a statutory responsibility to the 3 partner organisations, they need to discharge their governance functions as it is not intended to be two-tiered. ACTION: TORs - PR/SEE will re-draft to reflect comments received and retest with partners and will also pick up on comments around the most appropriate term for patient leadership with LCEC's input. CD questioned where public health fit? We have social services but public health and prevention is important. LCEC made comment around the use of *`service user'* throughout the TORs, he doesn't know an appropriate term but the consensus is that service user is not the	

	appropriate term. Need to cast net further to users and their carers to get appropriate wording. Action picked up above. Responding to CD's question about public health, the contract does not include public health services said PR and is why we haven't include public health at this stage. ET summarised that this needs to be living, breathing document and we can recraft as we go to reflect the reality, with broad partnership across many organisations and across our community. JW added that the intention of widening the membership of this Joint Committee was to have wider conversations. Agreed that we need to get the wording right and a period of review. How we interact in this meeting will be the test.	
7.	**Collaborative Update Report** The paper was taken as read. JW talked through the highlights from within the paper and invited any questions: CD asked how we are ensuring that the most vulnerable, those with learning disabilities, dementia for example, are reached out to and included in this piece of work (referring to the MSECC as a whole). JW responded that we have, across all our workstreams, been using our patient engagement teams. There is more we can do for both cohorts in particular and something we have been trying to learn across all 3 providers and hope that through wider membership and additional oversight from LCEC and JL we can test that. BJ, JW, AG and LW have a meeting in the diary with the Alliance Directors as we feel we could be more ambitious but it is about knowing what the right thing to do is. It may influence and make changes for the future.	
Patient Experience		
8.	**Thurrock Case Study** MM, MK and AF were welcomed to the meeting and introduced themselves. MK talked the MSECC Joint Committee through a Resident Case Study slide deck which highlighted the work of district nurses and how the role has changed.  A residents story presentation.pptx Highlights were: • From a district nursing point of view, traditionally we would have gone in, treated and escalated as appropriate but since Covid, we have noticed change in patients that we see consistently via Integrated Community Team (ICT): Presenting with significant wounds but making decisions contrary to what we believe is in their best interests and have had to get legal support. • For this case, we were able to make decisions for her, all very engaged.	

- We have seen a number of cases where we think their (patient) interests would be better served by acute admission but they (patient) are not willing.
- We have altered establishment of our service with increased senior staff/oversight.
- Created specialist roles – End of Life, Continence, to support and manage as best we can.
- For Thurrock specifically, it is different to other areas, it has been a unitary authority for a long time, we have cut out the referral process with introductions rather than referrals and have moved to more meaningful conversations

SEE joined at 14:50.

- Seeing a lot more supportive joint visits with EPUT's Mental Health team with no referral involved.
- Have established a high level risk process and going in right direction. Getting reassurance that we are not holding all responsibility at operational level.
- Reflecting on the presentation to NELFT's board recently that took place at Corringham Integrated Medical Centre (CIMC), we can see advantages of integration and sharing of space, there is a long term desire and want to replicate across Primary Care Network's (PCNs) in Thurrock.

Questions:

CD said this is inspiring and as a general practitioner (GP) in primary care we see this all the time and it is worrying. Engineering social care and housing input, it's how we replicate this. However there is a quick win, which is to encourage referrals between teams. Provide CIC are doing this but EPUT still don't. It's about working together as a multi-disciplinary team (MDT), why have a referral if we can just have a conversation? As a bear minimum we should aim to refer between the 3 organisations.

Integrated Neighbourhood Teams (INT), how does that fit in? MH said that CIMC was the first place we started that, the challenge is very broad, voluntary service, children's service etc.. Trying to say we have the INT to share knowledge, a rolodex of contacts and hope it enables that if in that locality we need to pull together an informal MDT but have contacts from local INT, the INT meetings themselves we have to keep anonymised. Great for networking.

MS said it is great to hear a story that kept a patient out of hospital. However, there is a missed opportunity that they got to that crisis point before intervention. It's how we learn about prevention and early flagging. Great outcome.

MH reflected on how professionals work and have conversations. These are 100s a week referrals, with most resulting in better support in the home. How can we work collaboratively with those that make their own decisions? As systems we can muddle up capacity decisions, everyone has a right to make that decision.

MM, MK and AF were thanked for their time and left the meeting.

9.	**Annual Report** CR was welcomed to the meeting. The Annual Report was taken as read. CR thanked all that has inputted into the annual report and drew the Joint Committees attention to the diabetes case study in particular. The Annual Report will now be shared via the 3 provider internet sites and internally via CCLT and the Transformation Steering Group (TSG). JW thanked CR for her input and leadership in pulling the report together. CR left the meeting.	
10.	**Delivery Plan 24/25 – for approval** The Delivery Plan 24/25 was taken as read. JW reminded the MSECC Joint Committee that the Delivery Plan sets out our Strategic priorities for the next 3 years and there are 9 priority areas that we will be tracking via TSG. Those are: • Cardiovascular Disease • Community Beds Consultation – outcome and implementation • CYP & Complex Families • Diabetes • Estates • Finance & Efficiencies • Governance • Place Based Integration (including INTs & Transfer of Care Hub (TOCH) • Virtual Hospital (including Virtual Wards (VW) & Urgent Community Response Team (UCRT) JW highlighted that slide 39 summarises the updated governance. <u>Questions</u>: ET mentioned that knowing that the mid and south Essex (MSE) system is constrained from a financial perspective, the plan on estates where we may be expected to achieve efficiencies, where are we going on that? PR responded that we agreed 4/5 weeks ago that estates needed to be added in as its own strand of work. PR is the nominated as Senior Responsible Officer (SRO) and is waiting for his deputy to start in 2 weeks' time and mentioned that she has experience in managing property. However, PR added that this is work in progress and is injecting urgency into it. LW said, whilst remaining ambitious the Delivery Plan needs to be proactive in its level of delivery and the efficiencies required. Make sure in that ambition to be clear where we will have to make the decisions to get the efficiencies. Approval was given by the Joint Committee with tracking via CCLT. DECISION: The Delivery Plan 24/25 was approved by the MSECC Joint Committee to be tracked via CCLT.	

11.	**Collaborative Governance update** The paper taken as read. SEE informed the MSECC Joint Committee that the Governance has been approved via the 3 sovereign boards. The MSECC agreement is currently with lawyers and will come back to the MSECC Joint Committee prior to signing. Now that the MSECC Joint Committee is in existence and operating it will (and is already) making a different to conversations with the Partnership Directors and will therefore make a difference on the ground. We are looking at delegation model and where we can align. There is now an Accountability Framework which will support the assurance function into this MSECC Joint Committee and via CCLT. Currently developing the Quality Memoranda or Standard Operating Procedures (SOPs) to staff. As issues arise, we will develop more as practical tools to staff on the ground. SEE advised that this has been well socialised.	
12.	**MSECC Finance position update** The paper was taken as read. PR highlighted the following: • The backdrop is the Integrated Care Board (ICB) overall financial position, agreed at a national level of a deficit plan of £96M. • The plan that the ICB has in place has £84M of unidentified Cash Releasing Efficiency Savings (CRES). • The paper sets out the work we have undertaken to establish baseline values. • Until the decision in March 2024 from the ICB, there was little engagement. • Not yet got a contract in place and still being paid individually. • There is £8.4M of services that sits outside of the contract (Out of Scope) and are actively pursuing to get these included in the baseline contract. • Contractual payments are still being paid direct • The value of the Better Care Fund (BCF) yet to be agreed, split between LAs and ICB, this is often delayed. • For now the ICB continue to pay full amount of cash. • The table on page 3 shows the total tariff adjustment, net deflator of 0.49%. • The table on page 4 sets out cost pressures, we have pushed forward to the ICB with a clear response they are not interested. • MSECC central costs are no longer being funded, second line in table on page 4 (Collaborative Central Cost 24/25) and becomes a cost pressure. We will continue to push back to the ICB as the functions being undertaken by the central team is replacing what some would have carried out in the ICB.	

- Table at top of page 5, overall, shows there is a 5.22% efficiency ask. This is not the same across all organisations as levels of cost pressures are different.
- Disinvestments, reducing cost of beds, and in final section upstream savings that the MSECC deliver and how that has to be taken into account.
- The final section is about delivering efficiency in the MSECC and we need to triangulate that with the operational plan.

Questions:

JW, there are 4 different things:

- The squeeze to take costs out, estates may be one;
- Slicing where we are being asked to reduce some of our service offer, or level down;
- Commissioning decision being considered, stopping of services and they won't be commissioned; and finally
- Transformation, where we do the bigger change to support more in community and see the biggest system impact.

JW highlighted we need as a collaborative to get the balance right across these.

We need to triangulate work already happening in organisations and articulate that back to this group the scale in each of these categories and deliverability.

WM referred to section 6, additional cost reduction across systems. Balance around operational colleagues and would like to see more clinical colleagues, not just finance and operational. Where is the Quality Impact Assessment (QIA), patient leadership and clinical leadership?

BJ asked and to check with PR and JW, have we considered everything? Page 6, Continuing Healthcare (CHC), acute beds blocked, could all work to reduce that and feels like we have more work to do.

PR, responded, we did have a discussion at the ICB board a few week ago about CHC, we haven't scoped that properly, have offering from the 3 sovereign organisations but not consistent. The ICB see the MSECC as a part of the solution to this and is keen to think about all those things in section 6 and ensure not to double count.

JW said this needs system thinking. The solution needs to support the individual in the most appropriate care setting. Karen Wesson has been asked to coordinate work around this in the flow programme. We need a joint system solution and the MSECC have a key role to play in this. We are actively engaging in that bit of work.

ET mentioned about ensuring we are clinically led, asking patients and carers what works for them. We can be part of the solution and is a great opportunity.

PR referred to frequency of MSECC Joint Committee meetings and these are the sort of tasks that need to be done in-between and then reported back by the appropriate representative from each organisation.

	Additionally, PR requested a steer on how hard are we going to push back to the ICB, where we are not being fairly treated, they are also part of delivering care. LCEC, highlighting comments around CHC, commented it is important to understand how to mitigate challenges in getting CHC assessments done as quickly as possible and the criteria, technicalities, it would be interesting to see how it is impacting, different experiences on what case manager they (patient) have will have a different outcome. There are a plethora of requests all getting different outcomes. ET responded that we need to prioritise reducing that difference. CD, agreed, as a GP we see that variation in assessment. Work on this would be useful. However would plea with the CHC work to think up stream. We identify those that may have CHC needs, but due to delay they may be admitted. Embed co-production work of this entire process. LW, in response to PR's comment above around how hard do we push back to the ICB, we have to push hard, what we are promising is routed in reality. We need to be honest with the ICB. The ICB is considering development of out of hospital independence work and will pick up a lot of what we have talked about, avoiding crisis, public health interventions, INTs, a longer term understanding that we need to and that the MSECC can be part of the solution. JW commented that this will crystallise quickly and as we now understand the ask we can work out the deliverability of that. What is the collective ask for partners as well, overlay with ask of social care colleague sand others, helpful to understand what it looks like. Avoid cost shunting. If this group has visibility of ask of the total community offer across all partners. ET made comment on what CD and LW have said above, looking at entire pathway, we can't do it without primary care, social services, local authorities and feel that we need to push back and have a position in operating in 3 different systems and this tension exists in all 3 of those systems. We need to ensure requisite investment is there, we need to be part of the solution, redesign pathways, do things differently, working across the 3 organisations to realise the low hanging fruit. ST said, families with the greatest demand, are we prioritising this as could save more costs. JW said there is a specific workstream, high intensity users, it picks up that specific area with the aim of reducing demand on acute trust. MS highlighted the group meeting is on Thursday. CD noted high frequency users is also worth looking at. Also to flag people that don't come to anything and end up in Accident & Emergency (A&E) via Patient Participation Group (PPG), we will look at all over 80year olds, with no medications but haven't attended and could easily tip into crisis. Also young mothers, domestic violence victims, a lot of safeguarding, link into safeguarding, social care, good to look at the data.	

	LW, good challenge from ST, work that looks into high intensity users, we need to be cognisant that it is right to wrap care around them, and the MSECC's more holistic provision of care that reduces level of demands but does involve cost, to say these are the savings due to keeping out of hospital? MH commented that data is key, we go down to street level in social care, less than 30% come from health, we are not capturing or sharing and they will fall in to health if not picked up. Look where you have demand before it gets to health intervention. ET said that is a great point. MH, we do need to make sure that these workstreams, neighbourhood teams/alliances and what is going on here, work together. Nothing in isolation. AD commented that she, as Deputy Medical Director at ICB level, has been tasked with pulling together a GP provider collaborative, to speak with one voice to the system. It is in its infancy but hoping in future to form strong partners with the MSECC to keep patients out of hospital and will keep this MSECC Joint Committee up to date.	
13.	**Any other business** ET thanked members for their support during her time as Chair of the MSECC Joint Committee (formerly MSECC Board). It is an exciting ride, new contract, move to a MSECC Joint Committee and emphasise of hearing the patient voice. ET officially handed over to RP who will take over as Chair from July 2024 meeting and that ET will continue to be a contributing member of the MSECC Joint Committee. **The meeting closed at 4pm.**	
Date of next meeting: Wednesday 25th July 2024, 11am-1pm, The Lodge, Trust Head Office, St Lukes Way, Runwell, Wickford SS11 7XX – Training Room 1		

Signed …….. **Date……**
Eileen Taylor, Chair