Suffolk & North East Essex Sustainability & Transformation Partnership Board

Meeting held on Wednesday 20 December 2017 from 1400 – 1700
at Brandeston Village Hall

Notes and Actions

Attendance:

Nick Hulme (Chair)	NH	STP Lead
Ed Garratt	EG	Ipswich & East Suffolk CCG/West Suffolk CCG
Sam Hepplewhite	SHe	NE Essex CCG / STP Workforce Group
Patrick Higgs (representing)	PF	Essex County Council
Sue Cook	SC	Suffolk County Council
Stephen Dunn	SD	West Suffolk Hospital
Shane Gordon	SG	Colchester Hospital NHS Foundation Trust
Neill Maloney	NM	Ipswich Hospital NHS Trust
APOLOGIES		*Norfolk & Suffolk NHS Foundation Trust*
Andy Brogan	AB	Essex Partnership University NHS Foundation Trust
Glenn Young	GY	East of England Ambulance Trust
Lynne Woodcock	LW	Anglia Community Enterprise
APOLOGIES		*Healthwatch Essex*
APOLOGIES		*Healthwatch Suffolk*
APOLOGIES		*St Elizabeth Hospice on behalf of the three Hospices*
Mark Galloway	MG	GP Primary Choice
David Pannell	DP	Suffolk GP Federation
APOLOGIES		*Suffolk LMC*
APOLOGIES		*North Essex LMC*
APOLOGIES		Suffolk District & Borough Councils
Pam Donnelly (*Representing*)	PD	North East Essex District & Borough Councils
Sharon Alexander (*Representing*)	SA	Voluntary Sector Representative – North East Essex
Wendy Herber (*Representing*)	WH	Voluntary Sector Representative - Suffolk
Tania Farrow *(Representing)*	TF	LPN Chairs Group – Suffolk & NE Essex
APOLOGIES		*Public Health*
APOLOGIES		*NHS England*
APOLOGIES		*NHS Improvement*
APOLOGIES		*STP Clinical Lead*
Sheila Childerhouse	SCh	STP Chairs Group
Kate Walker	KW	STP Digital Strategy & Innovation Group
APOLOGIES		*STP Estates Group / STP Delivery Support Unit*
Isabel Cockayne	IC	STP Comms & Engagement Group
Jane Payling (Representing)	JP	STP Directors of Finance Group
Susannah Howard	SH	STP Programme Director
Kate Vaughton	KV	STP Delivery Support Unit
Rebecca Jarvis	KV	STP Delivery Support Unit

- **Part 1 – Suffolk & North East Essex STP Board Meeting**

Ref	Item	Action
096	The **chair** welcomed members of the Board to the meeting and thanked them for travelling out to Brandeston. He explained that the meeting had been shortened to reduce the pressure on meeting attendance for those currently support work around winter pressures. Apologies were received as in the attendance log above.	
096.1	**Minutes from previous meeting held on 23/11/17** The minutes of 23/11/17 were **approved**.	
096.2	**Matters arising** There were no matters arising.	
096.3	**Final Synopsis of Facing the Future Event – 25/09/17** Members **received** a copy of the final synopsis of the STP Leaders event held on 25/09/17. Members **noted** the paper.	
097	**Update on appointments to the STP Delivery Support Unit** In the absence of AL, SH provided an update on the appointments within the STP Delivery Support Unit. She updated the board that vacancies for STP Workforce Programme Manager, STP Workforce Project Support Officer, STP Head of Communications and Engagement, STP Mental Health Programme Manager and STP Mental Health Clinical Lead were currently in the process of recruitment with interviews taking place in January 2018.	
098	**Roles in leading STP Delivery Programmes** SH shared a presentation regarding the roles in leading STP delivery programmes. Key points from the presentation were that the STP Board has a key role in overseeing delivery of STP Delivery Programmes. There are a range of key roles emerging in the leadership of these programmes – these include CEO level SRO roles, Chairs of STP Groups, STP Programme Manager, Clinical Lead and CCG Lead roles. Draft role descriptions have been developed for each. Going forward these roles require a comprehensive footprint wide approach and clear reporting arrangements into the STP Board. There is also a need to ensure consistency across delivery programmes to ensure a robust ongoing approach to delivery programme governance, planning, performance measurement, assurance and support for transformation. The STP Delivery Support Unit is currently reviewing each programme against each these criteria. Not all programmes currently have all of the required features. The membership of the STP Board has been reviewed following the meeting in November which was attended by 43 people. It was proposed that going forward the board membership be trimmed to include just stakeholder representatives	

	with attendance by cross-cutting group chairs and delivery support unit staff when necessary to support specific agenda items. Roles for STP Stakeholder Representatives were suggested to be: ✓ Represent your stakeholder organisation or group ✓ Provide oversight and contribute to system thinking around delivery programmes ✓ SRO role for key delivery programmes ✓ Ensure that your stakeholder organisation or group is appropriately engaged in wider STP governance mechanism ✓ Feedback, disseminate and co-ordinate within own organisations or other stakeholder groups STP Board meetings going forward would be held on the second Friday of each month in the morning with a standardised meeting agenda. This would include a regular, planned cycle of dashboard reporting across all programmes and regular in depth reviews with programme leads in attendance. In summary the proposals were to: • Refresh of STP Delivery Programmes to ensure that all reflect key features • Review STP SRO Roles – circulate role descriptions and open up to nominations • Refresh STP Board – Membership – Standardised meeting agendas – Dashboards reporting for all delivery programmes – Annual cycle for deep dives across key delivery areas In discussion: SC asked for clarification of the STP governance structures. SH responded that these were unchanged and were essentially as originally agreed in the STP Board Terms of Reference and STP Delivery Guide. SCh underlined the importance of NED input across governance structures	
099 **099.1**	**Key STP Delivery Programme Reports (Cancer, Planned Care, Primary Care, Mental Health and Urgent Emergency Care)** There was insufficient time on the agenda to review these programmes in detail, but dashboard reports were **noted** in regards to the following programmes: • Cancer • Planned Care • Primary Care • Mental Health • Urgent Emergency Care Finance Dashboard – Month 7 This was circulated in hard copy to the STP Board and the update noted.	
100	**Any Other Business** There were no further items of business discussed. ***Part one of the meeting closed.***	

- **Part 2 – Planning Workshop for Transition to ACS**

Ref	Item	Action
100	The **chair** introduced the workshop session by reminding participants that we have a unique, once in a lifetime opportunity to lead change to genuinely improve our local health and care system. He underlined the importance of taking a 'can do' attitude to this and the danger of coming up with multiple reasons not to change. He summarised progress to date on developing our approach to exploring accountable care in Suffolk and North East Essex. Key deliverables so far included: • Facing the Future Event – 25 Sept – synopsis report now circulated • Carnall Farrar Stocktake review report – discussed at last STP Board • Strengthened central STP team recruited to support the work • Development of a DRAFT High level Timeline • Development of DRAFT ACS Definitions • Submission of EOI for ACS wave 2 to NHS England in December • Proposal for meeting with national team – February 2018 • Proposed system leaders awayday – March 2018 Next steps for the STP Board this afternoon will be to: • Agree the high level timeline • Provide feedback to shape plans to take forward further work around development of ACS in 2018 The output of the workshop would be some documents that can then be taken back for individual members of the STP Board to discuss with their own organisations. SH outlined some further detail which included early thinking about the membership of an ACS Project Board which would be established in the new year. She suggested that the membership of this would include: • STP Lead & STP Programme Director • CCG CEOs and NHS England • Both County Councils • Leaders of all three provider led alliances • Chair of the STP DoFs Group Those leading key ACS workstreams in the STP Delivery Unit to include: • Lead for Alliance Development • Lead for Strategic Commissioning • Lead for Whole Systems Working SH summarised that draft terms of reference for this group would be prepared for discussion at the next STP Board in January 2018. In order to familiarise the group with some of the work around key areas of ACS development the group then received two presentations. PH talked through some slides recently developed by Essex County Council summarising their position in relation to ACS development, their 'red lines' and their 'offer' to the system. JP then talked through some slides on ACS development from a recent workshop with the HFMA.	

	Copies of the draft ACS timeline and draft ACS definitions were circulated to each table. The group was distributed across five tables and facilitators for key workstreams spent 10 minutes on each table discussing feedback as follows: Governance (SH), Strategic Commissioning (SG on behalf of AL), Alliances (KV), Finance (JP), Local Authorities (RJ).	
101	**Roundtable discussion on the development of Alliances** **General comments** • Public Health resources should be aligned to each emerging Alliance – this is in place in Suffolk from 03/18 • Suffolk Alliances were stronger when they were delivering against a defined piece of work i.e. contract bid, but they have lost their way slightly since • More clarity required on who is in charge of each Alliance to allow them to drive it forward and therefore making it more than just a partnership • For 18/19 need to determine what goes into strategic commissioning and therefor what commissioning goes into the Alliances • For 19/20 greater clarity required on what moving into commissioning space would entail • We have to take the public with us and being able to demonstrate plans are centred on local needs and priorities set by local teams • Creating a pipeline for Alliances to help them see how they can develop and give them the freedom to innovate. Set the design principles and agreed outcomes • Wider consultation to be carried out on what the views on the term on ACO • Clarity required on what is included in strategic / tactical commissioning • FT being used as a funding vehicle for the Alliances • Overarching need to progress people's understanding of 'Accountable Care' • Stakeholders need to include more than usual suspects • CCG transformation function needs to shift into the Alliance to support delivery • The Alliances cannot develop in the same form as the CCGs – true transformation will be missed **Principles** • We need to free staff from current governance churn so they have the capacity to start delivering • New Alliance Governance cannot be layered onto existing arrangements – staff with drown and the point will be missed • Interdependencies between the different lines of delivery in ACS roadmap need to be taken in account i.e. defining strategic commissioning will give the Alliances more clarity on their role and remit • Rather than talking about organisational change priority has to be frames	

	around achieving integrated care for public and patients • Properly resourcing strong comms and engagement programme is essential • Leadership behaviours should be agreed across the system, including the following: respect for all organisations, system leadership roles rather than organisation specific, talent mapping on a system footprint **Concerns** • ACO/ACS terminology will cause people to disengage (LMC / Primary Care) • Until we know some of the redlines of other parts of the system we may keep hitting bumps that slow progress • Leadership of Alliances needs to be defined and delivery of this to move from an add on to a role to business as usual • Inability to collapse existing governance to enable capacity to be released to ensure development and delivery of new model	
102	**Roundtable discussion on System Control Total** **General comments** • It is the direction of travel • Where will we have the strategic discussions? • Will there be any seed corn funding available? • Focus needs to be on system change, with money flows happening because they need to, rather than being an end in itself. • May help to increase clarity on the fact that there is only one pot of money • Would be good to work out what can be done if we have a longer planning timetable, which is more likely to bring people onboard. • Benchmarking needed to see how we are spending our STP £ - a system control total might be a way in • Inclusion or exclusion from a control total may or may not mean anything about investment or control. Might be better to focus on overall system resources and their deployment, seeing control total as a way of satisfying NHS regulators and gaining permission to review and invest locally. • Want to focus on the prevention agenda and enhance the overall pot available. • Important message about money staying and being used locally. Need to be clear about who we are working for – organisations or system • Must remember this means next to nothing to our population/patients – is it just a diversionary tactic? **Considerations to make it work** • Need to be aware of perverse incentives • Needs transparency • Needs to be fair • Need to focus on overall resource use • Think about how to measure outcomes and the benefits of any investments – evidence base • Important to hold each other accountable for performance • Need to understand appetites for risk • Could have hard and soft budgets included in the control total (?)	

	• Need to consider how to set budgets/control totals at the start of the year. Need not to result in unreaslistic CIP levels (e.g. WSH 8%). • Money and commissioning may be in the alliances – need to look at things together • Need to think about contingencies **Concerns** • Shouldn't underestimate the difficulties of asking one part of the system to sacrifice something for the good of the whole – will need a huge selling job • Councils may wish to stay out, as this is an NHS issue and inclusion may be too complex due to differing financial regimes. • To include councils, councillors would need to see the overall benefits – both short and long term • Beware of moving too quickly (keep organisational controls) • Digital agenda means we need a different attitude to capex and opex. **Cross STP organisations** • Might wish to include cross boundary organisations (such as ambulance) as a nominal figure • Consider national commissioning for services such as ambulance, but need to think about how a local focus is maintained. Could it be brought into local government alongside fire and police? If not included in the control total would this mean that the service is excluded from discussions • Larger scale projects such as digital may be better commissioned at scale with an 'accord' in place (?). • Might be a hybrid between local responsibility and higher level accountability • Note it is likely to exclude all non-NHS elements anyway. • Can we look at a BCF type approach? A financial framework to underpin the H&SC commissioning needs?	
103	**Roundtable discussion on the role of Essex and Suffolk County Council** **General Comments** • Alliances work differently across three footprints within the STP. The current models in the STP footprint support this but if we move to a different model this may have an impact • In Suffolk, SCC has devolved commissioning budgets to their respective alliances • Governance within Local Authorities is complex and engaging Politicians in helping shape and endorse the transition into Accountable Care Systems is key • Language and definitions is key to getting the right engagement – whilst the transition plan outlines a pathway to the ambition, there needs to be consideration as to how we position and describe Suffolk and North East Essex STP **The role of a local authority in an ACS** • **Scope** The Local Authority offer is broader than Adult Social Care, and understanding how they activity can align and shape the future direction of the Accountable Care System is crucial, for instance around strategic commissioning	

	• **Estates** Local Authorities have multiple assets/estates that could be utilised in the development of an Accountable Care System • **Digital** Local Authorities are exploring different ways of using digital to transform outcomes for people. Capitalising on this activity, sharing practice, aligning projects and where possible sharing responsibility for outcomes through jointly commissioning would support the transition • **Infrastructure** Understanding the organisation and the challenges of the Local Authority to help shape the future Accountable Care System **The strength of partnership** • **Deliver** Consider what we can do now to move towards the longer term ambition. Agree how we Local Authorities can align to system activity, work together and integrate through practice before we consider budgetary issues/ control totals and ensure the impact of working together is visible and showcased • **Influence** The STP can help Local Authorities to challenge dynamics and engage Politicians into understanding and agreeing to the longer term ambition. Equally Local Authorities can help the STP understand common myths across Social Care, Communities and populations have gathering insight to develop a shared view of risks, challenges and opportunities can help to develop a more efficient and sustainable system • **Shared vision** Understanding the formal definition and ambition for creating alliances as part of the transition into an ACS, and the role Local Authorities play within, and what stage is crucial. Consider how to strengthen the voice between ECC and SCC • **Transform** Alliances need time to evolve towards the agreed STP footprint and needs to be planned collectively with the right Political oversight at alliance level	
104	**Roundtable discussion on strategic commissioning** **Table 3** • What is tactical versus strategic commissioning? Define. • Needs to align with alliances timeline • Barriers – CCG Boards not understanding <u>why</u> – what problem we are trying to solve. • Member practices and boards = barriers • Who is accountable and responsible? Is it 'out of control'/ local control • Is timeline feasible? On paper – yes, changes in behaviour required, e.g. I work for locality X, needs OD and careful use of language • Need to articulate benefits clearly of different approach **Table 4** • Straightforward • Delegation of budgets in line with responsibilities • Is the strategic commissioner one organisation (and of what type? CCG or local government?)	

- Issues: not losing local focus (or not gaining it?)
  - Primary Care clinical engagement required
  - What would make this work? How local relationships work
  - Risk of ending up with four organisations instead of three
- Ways of working – transitioning CCG human resource into either Alliance or strategic commissioning
- What opportunities are there to align LA's earlier on key themes, e.g. mental health, children, obesity
- What makes it work? Clarity in areas of focus, especially specialist areas, e.g. CAMHS

Table 5

- If we want LA's involved, need to define strategic commissioning carefully and devolve as much as possible
- Is strategic commissioning just about "allocations and priorities"?
- Opportunity: Population health analytics including PH (IG definitions required)
  - Link to environment and wellbeing but is this the same as the Health & Wellbeing Board?
  - Could HWB's be the Strategic Commissioner?

Table 1

- Yes!
- Opportunity: Reducing headcount/resource in commissioning
  - Needs to be a strong case
  - Data driven focus on individual wards, streets, families
- Issues: Must not lose sensitivity to local need and has to maintain a sense of representation

Table 2

- Alliance/Strategic Commissioning need to move forward in step
- Opportunity: Closing the gap between commissioning and provision – get providers involved in solving the problems
  - Collective agreement on allocations – requires mature relationships and trust in Alliance
- Barriers: What capabilities are required in Alliances, e.g. information
  - What is the common definition of commissioning? Contract management, provider market management, allocations, prioritisation and standards/standardisation
- Issues: Mental Health commissioning