Suffolk & North East Essex Sustainability & Transformation Partnership Board

Meeting held on Friday 9 February 2018 from 2.30 – 5.30
at Kesgrave Community Centre, Ipswich

Notes and Actions

Attendance:

Nick Hulme (Chair)	NH	STP Lead
Ed Garratt	EG	Ipswich & East Suffolk CCG & West Suffolk CCG
Sam Hepplewhite	SHe	North East Essex CCG
APOLOGIES		Essex County Council
Mike Hennessey	SC	Suffolk County Council
Stephen Dunn	SD	West Suffolk Hospital
Shane Gordon	SG	Colchester Hospital NHS Foundation Trust
Lisa Nobes (representing)	LN	Ipswich Hospital NHS Trust
Julie Cave	JC	Norfolk & Suffolk NHS Foundation Trust
APOLOGIES	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
APOLOGIES		Suffolk GP Federation
Simon Jones (representing)	SJ	Suffolk LMC
APOLOGIES		North Essex LMC
APOLOGIES		Suffolk District & Borough Councils
Pam Donnelly	PD	North East Essex District & Borough Councils
Sharon Alexander	SA	Voluntary Sector Representative – North East Essex
Wendy Herber	WH	Voluntary Sector Representative - Suffolk
Paul Duell	PDu	LPN Chairs Group – Suffolk & NE Essex
Abdul Razaq	AR	Public Health
APOLOGIES		NHS England
Ruth Forbes	RF	NHS Improvement
Lisa Llewelyn	LL	STP Clinical Lead
Sheila Childerhouse	SC	STP Chairs Group
Kirsty Denwood	KD	STP Directors of Finance Group
Susannah Howard	SH	STP Programme Director
Jo Wyatt (Minute taker)	EJW	STP Delivery Support Unit

Also in attendance:

Simon Morgan	SM	STP Communications and Engagement Group
Sharon Rodie	SR	STP Delivery Support Unit
Dr Christopher Scrase	CS	STP Cancer Clinical Lead
Dr P Badrinath	PB	Public Health Suffolk
Jessica Hulbert	JH	Public Health Suffolk

Ref	Item	Action
115	**Welcome, introductions and apologies** The Chair welcomed all to the meeting. Introductions were made and apologies were **noted**. The minutes of the meeting held on 12/01/2018 were **agreed** as a true and accurate record. The Action Log was **reviewed** and updates **noted**. There were no matters arising from the meeting.	

- **Part 1 – Oversight of STP Delivery Programmes**

Ref	Item	Action
116	**Appointment to STP SRO Roles** SH thanked members that had submitted an Expression of Interest for the SRO roles, adding that nominations have been received for every programme. SH advised that three issues had arisen as a result of the submissions: 1. For one of the work programmes more than one EoI has been received. 2. It had been decided that representation on the STP Board from the STP Chairs Group, DoFs Group and the Clinical Community should be decided by the grous themselves. It was noted that Sheila Childerhouse is the representative of the STP Chairs Group and Kirsty Denwood is the representative for the DoFs. A representative of the Clinical Community has yet to be identified. 3. All other applicants for SRO roles need to be full members of the STP Board and could not include temporary members. It was **noted** that the Chair had yet to see the list of nominations. SCh advised that a discussion was held at the STP Chairs Group on 08/02/18 about the need for the process in respect of the SRO recruitment to be robust as these could be powerful positions going forward. The Chairs Group are keen that there is good governance, and have asked that the selection process involve lay input. It was **agreed** that a meeting is to be arranged between NH, SH, SCh and AL to discuss the applications received for the work programmes. It was **noted** that each SRO should be contacted to inform them of the outcome of their application.	**EJW**
117	**Key STP Delivery Programmes Reports** ***1408 – PD joined the meeting*** AR delivered a presentation to members on Public Health's perspective of Cancer in Suffolk and North East Essex STP. Members **noted** the following:	

- In S & NEE the elderly population is expected to grow and therefore cancer cases are likely to increase.
- It is estimated that just over 2,500 cancers can be prevented by positively modifying cancer risk factors.
- The downward trend observed in cancer screening programmes needs to be reversed.
- Colorectal and lung cancer late diagnosis requires attention.
- Cancer diagnosis via emergency admission varies across GP practices and this is positively correlated with deprivation in Suffolk for lung cancer.
- The overall cancer mortality in S & NEE is similar to England.

1411 – GY joined the meeting

SA queried why Prostrate cancer was not included in the data; PB advised that this sits within urology. It was **noted** that a substantial amount of money has been made available and that choices need to be made on how this is spent.

One area that Public Health colleagues felt that significant resource should be focussed on is smoking cessation. AR added that focussing on early diagnosis for colorectal and lung cancer would benefit from resource also.

The Chair commented that we need to focus our efforts over the next 3 – 4 years on one or two areas where we will gain the greatest return, e.g increasing mortality.

SG commented on the deprivation figures for Ipswich and East Suffolk and queried what approaches can be taken and do we have a sophisticated approach. AR advised that dealing with deprivation is partly within the gift of the STP. He added that the One Life Suffolk service offers a core integrated lifestyle service, and that the most deprived populations are being reached by way of the NHS Healthchecks.

With regards integration of Suffolk and Essex Public Health teams, it was **noted** that Essex Public Health is working with three STPs. However, DS advised that the teams regularly liaise in regards to prevention and there are co-ordinated campaigns. AR advised that the Directors of Public Health meet regularly also. DS commented that there are great opportunities to learn, share and collaborate going forward.

AR commented that there is fragmentation in the commissioning of public health.

The Chair commented that the STP has an opportunity to better align funding from NHSE and Local Government in a way that is better for our population. He added that we need to focus on specific issues and decisions need to be made going forward that are to be driven by the agenda for our population.

LL advised that a key issue to approach is the younger population to so that they will make a difference in the future. AR agreed that this is an important focus and that Public Health work with local schools on the prevention agenda. However, this is all within the remit of the Health & Wellbeing Boards and Local Authorities, so the level of influence diminishes.

PD commented that in regards to deprivation there is a real opportunity to influence in respect of housing. She added that the Suffolk district and borough councils should be encouraged to attend these meetings as issues are emerging.

	It was **agreed** that housing should be a focus for a future STP Board. PD offered to help in the preparation for this agenda item. CS delivered a presentation to members in regards to cancer performance across the STP footprint. Members **noted** the following: • Current (inherited) cancer pathways for the three hospitals in our STP • All three hospitals in our STP provide good patient experience • All three hospitals in our STP are striving to deliver standards for cancer waiting times. CS advised that the dip in figures for 01/18 is due to winter pressures (data yet to be validated). The Chair commented that he was not aware of any cancer cancellations due to winter pressure • CHUFT will deliver the 62 day target for the first time in 4 ½ year this month. The key is to sustain this achievement. • Our 104 GP practices vary in their 'cancer performance' Members **agreed** that a lot of data available and that it needs to be interrogated to ascertain how the cancer agenda is being delivered. With regards to workforce, it was noted that there are shortages across all areas and that this needs a focus within our STP. Members noted the following: • Chemotherapy episodes up 49% over four years; Radiotherapy up >6% • Nearly 1:5 of the workforce could retire in the next five years • 67 additional fulltime consultants required to cover the excess workload undertaken by the current workforce • 28% of vacancies have been unfilled for >12 months CS shared with members the world-class cancer outcomes, advising that the Cancer Alliance is cascading funding to STPs in relation the three key interventions (early diagnosis, recovery packages and stratified follow up). With regards to the Cancer Strategy, CS advised of the following: • Government to prioritise workforce planning (HEE report) and longer term planning • Cancer Alliances to receive necessary funding and support focussing beyond current standards to more transformational elements • Improve accountability and communication • Take a more holistic view of outcomes and performance • Access to timely and detailed data Members were advised that the Cancer Stakeholder group are working on the Cancer Strategy, which will be presented to the STP Board accordingly. With regards to next steps, CS advised that at a recent STP clinical leads meeting there was an appetite for direct access ('open access'), straight to test ('STT') pathways but also a comprehensive diagnostic hub. The Chair **agreed**, commenting that we have a once in a lifetime opportunity. He advised that he has set challenges to colleagues within the STP DSU, but added that	**SH/PD**

	if 99% of women who find a lump that visit their GP are referred, they should they not just go straight to the hospital? He stressed that we have the capacity to change this. SG commented on the absurdity of withholding money from areas that are under performing. It was **noted** that if patients go straight to diagnostics, then it does not trigger the two-week wait target. This would therefore mean abandoning the two-week wait target. CS **agreed** with the Chair, adding that the current process does not work as we have made it so difficult. It was **noted**, however, that the challenge would be patient ownership. A proposal has been created in regards to "straight to treatment", a process which would have to be owned by the Consultant and their team. SG added that it not just culture, it is about how we are held to account in other areas. The Chair stressed that since NSHE and NHSI keep advising that "it is up to you", and so we should be able to challenge what doesn't work for our population. He added that some access targets have created harm. SD commented that we need to fundamentally change our current cancer pathways and framework. He **agreed** that we should look at direct access to specific diagnostics in specific areas and that we should not be constrained by national access routes. With regard to tracking of outcomes and quality there would have to be clinical consensus on how these were monitored. SD added that these should be clinically led, if possible, and could potentially be a national pilot. He commented that with regard to deprivation, he asked if there is any more we can do going forward. He stressed that pathways need to be clinically owned. The Chair **agreed**. The Chair commented that the major factor in not accessing services is embarrassment, and those with mental health conditions are less likely to access diagnostics. AR suggested that there could be learning gained from the cancer vanguard in Greater Manchester in conjunction with UCL. For example, patients with vague symptoms accessing via primary care may cause an inherent delay in terms of diagnosis. AR also referred to the Danish model, which is "one-stop shop". The Chair stressed that the STP wants to the best that it could be within the next five years in a way that is patient focused and clinically led. SD advised that WSFT has strong links with Addenbrookes and there are joint appointments that would be difficult to unpick, but there could be access across the patch. He **agreed** that we should look at a different offer. The Chair stressed that there needs to be a link with public awareness and that engagement is vital.	**CS**

	SHe advised that similar discussions took place in regards to direct access to diagnostics at the recent Cancer Stakeholder event and that this is now being worked through. SC commented that we should be careful of working in silos and that we should be driven by excellence. She requested that patients who live on the border be considered and that services interlink. CS thanked members for their feedback. ***1518 – CS, DS, PB and JH left the meeting*** SH advised that Dr John Hague has been appointed as STP Clinical Lead for Mental Health. With regards to the Perinatal Mental Health bid for Suffolk and North East Essex it was **noted** that this is due to be submitted by 05/03/18. It was **noted** that the bid would be discussed at the DoFs meeting accordingly. SHe advised that the Essex bid was **noted** as a good model; it was **agreed** that this be shared with EG accordingly.	**SHe/EG**
118	**Cross-cutting STP Delivery Programme Reports** • **Workforce** SHe advised that the first draft of the Workforce Strategy has been produced. It was **agreed** that this should be shared with members. It was **noted** that Rachel Sestak has been appointed as STP Workforce Programme Manager on secondment from CHUFT. • **Digital** It was **noted** that £503k has been awarded across the footprint to estates and transformational funding. This is to be spent by 31/03/18. KW (STP Digital Lead) is working on this accordingly.	**SHe/SH**
119	**Delivery Against STP System Indicators** SH introduced Sharon Rodie (SR), who is working as part of the STP Delivery Support Unit. SR reminded members of the suggested local outcomes for the STP, advising that these are aspirational system indicators that aim to underpin and build on the national outcomes defined by the FYFW. The proposed system indicators are: • **Reducing the health gap** – more comparable health outcomes for those living in our most and least deprived communities • **Reducing loneliness** – 'living alone' no longer being a factor in admission to hospital	

	• **Obesity: prevention and treatment** – fewer children and adults developing obesity and more people with obesity able to access treatment and support including bariatric surgery • **Care closer to home** – reduction in the number of unplanned admissions to hospital • **Zero suicides** – year on year progress towards achieving a zero suicide rate • **Positively ageing** – the local profile of service delivery is aligned to the profile of an increasingly ageing local population • **Improved end of life care** – less people dying in hospital and more people enabled to die either at home or the place of their choice SR advised that the draft paper provided so far the beginnings of a local and national picture at a high level. It is population wide and tries to address issues that affect everybody in the patch. Members were asked to review the paper and feedback to SR in particular about what is being done currently and how it can be measured. Members were also asked to note that the next stage is how we can take this further by not just meeting targets but by actually taking them forward. SR stressed that the challenge is not being tokenistic about these terms. SR queried if members felt that these were the right outcomes to focus on, and if all partners could see how they could be involved. SH queried what are the ways we can measure these outcomes? She added that further discussion about these outcomes was the intended focus of the STP Leaders Event scheduled for 20/04/18. EG commented that the outcomes align with the Health & Wellbeing Boards, which is key, but they are massive areas to tackle. AR commented that a lot of work has been done in regards to deprivation within Suffolk County Council and that this should be linked in. PD commented that district and borough councils have been involved in this for years, adding that again this should be linked in with as there is a lot happening. She added that she is encouraged that the event on 20/04/18 is focusing on these areas. It was **noted** that SR would like to capture further detail about what is already happening across the footprint. Members were asked to send information to SR. SM commented that this document is useful for supporting community conversations about the STP. WH commented that it links in with the work being done within the voluntary sector.	**ALL**
120	**Finance Dashboard – Month 8** KD presented the Finance dashboard for month 8. Members **noted** that the system submitted to regulators a plan with an annual total deficit of £46.42. At Month 8 the forecast is (£49.44m) deficit. This is £3m worse than plan but an improvement on last month adverse variance of £4m. Positive	

	movement is largely contributed to by positive revision of forecast by CHUFT of £2.54m in respect of STF incentive payment).The largest forecast adverse variance is by Suffolk County Council. This will be fully covered by available reserves in line with the Council's statutory duty. Essex County Council figures were last updated at Month 5. Members **noted** that actual performance YTD at Month 8 shows an overall deficit of £5.84m with Ipswich Hospital showing the highest adverse variance at £5.56m. Adverse variances are partly offset by a positive variance from Colchester Hospital of £3.57m. With regards to savings, members **noted** a total of £104m savings was planned by the system. At Month 8 the forecast is that 92% of these savings will be delivered. West Suffolk Hospital is planning to achieve £1.10m above its savings targets with other organisations either meeting plan or below it. Members **noted** that the savings plan YTD is £6.28m behind plan. This is a 91% achievement YTD. KD advised that planning guidance has been issued from NHSE and NHSI in respect of how we deliver as a system. It was **noted** that we need to understand which organisations would be in the control total and which wouldn't. The Chair suggested that in moving this work we shouldn't feel afraid to challenge the rules. KS advised that the workplan would be discussed at the DoFs meeting on 15/02/18.	
120.1	**Capital – next steps** With regards to Capital bids, KD advised that a letter has been received from NSHE advising why were not successful for all our bids. She advised that this letter has been shared with colleagues but she had requested more specific feedback so that we can understand their rationale. Three schemes have been submitted for phase 2. Feedback has been received and more information has been submitted. KD advised that we are still on track and our bids were still in the running. SD advised that WSFT has received a letter in regards of its' controlled total, adding that there is no way the Trust will meet this target. He added that he presumed that CHUFT and IHT were in a similar position. The Chair commented that there is huge potential for AOs, CEOs and DoFs working with NHSE together. RF advised that this has happened within the Essex system and has been very powerful.	
121	**Feedback from the STP Chairs Group** SC advised that it was **agreed** at the STP Chairs Group on 08/02/18 that meetings should now take place monthly in advance of each STP Board.	

	With regards to a stakeholder event for District and Borough Councils, SC advised that following discussions with PD it has been agreed that communication and engagement with these stakeholders be taken on by the alliances. With regard to the role of the STP Chairs Chair, it was **noted** that is to be reviewed in 06/18. SC advised that one of the key message from the meeting was that Alliances should be allowed to develop in their own way but they should come together to share learning. It was **noted** that the Chairs Group expressed concern in respect of non-executive members and the challenge and wider discussion they can bring. It was **noted** that the STP Chairs group had discussed a helpful paper from NHSE in regards to the NEDs role. Further discussions took place in regard to NED involvement.	

- **Part 2 – ACS Transformation**

Ref	Item	Action
122	**Feedback from meeting with NHSE re: ACS Wave 2 ACS Workstream Planning** SD updated members on the ACS (ICS) meeting that took place on 01/02/18. It was noted that our Wave 2 submission was likely to be successful, but no official announcement would be made until 04/18. It was **noted** that NHSE are keen to have one strategic commissioner for the three alliances. However, there are issues and difficulties in respect of working out the detail of this. Discussions took place at the meeting in respect of finances – in respect of what would happen if one part of the system was in an adverse position. It was **noted** that as per the planning guidance issued on 02/02/18, the term ACS is no longer to be used. It was **noted** that because the terms ACS/ACO were American this had led some to concerns that this meant that the NHS was being privatised. Going forward the more accurate term ICS (Integrated Care System) would be used. SD advised that community services in Suffolk, which were previously run by Serco, are now being run by WSFT which was part of the NHS. SD advised that the national team were happy with STP work programmes around system transformation but had also raised the need for NED and clinical engagement. SD congratulated SH and her team for pulling all the relevant documentation together adding that it was very well presented. He added that we have already made significant progress and are ahead of some of the Wave 1 ICSs and that collective credit should go to all concerned.	

	SD concluded that it was a good meeting, but underlined that there is still a lot of work to be done. The main message is to deliver more for less money. He added that West Suffolk has had a strategy for integration for some time, which will be continued. The STP is a vehicle for the acceleration of this integration. SH advised that the national team have asked how they can give their support and have suggested we connect with other areas to gain learning. It was **noted** that the national team are working with the DoFs group on solutions and issues. SHe commented that this is the first time we have heard that we are a good system. It was **noted** that the plans need to be discussed within organisations. The Chair commented that in future the STP Board meeting should be held in public so that the public can see a group of leaders coming together to fix the problems. With regards to the STP Board scheduled for 09/03/18, SH confirmed that Michael MacDonnell will be attending from 1130 onwards. The STP Chairs Group, the STP DSU Team and the NSHE National team will also be joining members from 1100 onward to participate in a Q&A session. It was **noted** that the meeting would be followed by lunch to support networking opportunities.	
123	**Communications and Engagement Workstream** SM previewed to members the holding page for the STP website and introduced the "can do health & care" branding. Members were positive in their feedback to this branding as it relates to an aspiration for patients, people and staff. SM advised that he would like to engage members to get their ideas for comms going forward, and that he would like to arrange to meet with as many members as he can. SH commented that the "can do health & care" branding allows us to move away from looking like an organisation. She added that it unites us and challenges us. AR commented that we are still an STP, which is emerging into an ICS which is not a great brand especially in the perception of the press and the public. The Chair stressed that it is about how we work together. SD agreed, adding that it says what we want to do for our population. Members **agreed** to use the "can do health & care" branding going forward. Members **noted** that there is a Twitter account for "can do health & care". SM also shared with members the first draft of an e-newsletter.	
124	**Terms of Reference for ACS Project Board** SH advised that the paper was written prior to the planning guidance and the change to ICS.	

	It was noted that the ToR for the ICS Project Board had been reviewed by the STP Chairs group, and their feedback had been incorporated. It was noted that a timetable of meetings has been set, and that these would fit alongside the cycle of STP Board meetings. The ICS Project Board will meet two weeks after the STP Board and prior to the STP Board, and that plans/programmes developed by the ICS Project Board will be brought to the STP Board. Complete details of the group membership is yet to be confirmed; it was **noted** that the Alliances are undergoing different processes on how they are represented. The first meeting is scheduled for 26/02/18. AR advised that he will attend for Public Health in the first instance. LN advised that the system indicators will be mapped to the work of the ICS Project Board following the STP Leaders event on 20/04/18. The Chair requested that representatives be put forward as soon as possible. SH requested that representation and involvement be sought from NHSE and NHSI. RF agreed to take this action on and advise accordingly. Members formally **agreed** the Terms of Reference for the ICS Project Board.	
125	**Update from East of England Ambulance Trust** GY provided a verbal update in regards to EEAST. It was **noted** that EG had attended the recent Risk Summit. GY reported that a number of actions arose from the Risk Summit, but the two key actions were: • Increase operational hours from 79,600 hours a week to 83,000 hours a week. It was **noted** that in our region the operational hours are between 81,000 – 82,000 a week. This is a challenge in regards to fleet capacity. Staff are to be incentivised, and some clinically trained staff are to be redeployed into front line roles. • 15 minute handovers. Workshops have been held with the ED departments at WSFT and CHUFT/IHT, but it is challenging as there has to be a cultural change. GY advised that the revised SoP is to be signed off by 19/02/18, but confirmation is being awaited in respect of guidance. LN commented that this is the right thing to do as it manages clinical risk. She added that staff are gearing up on how they can support these handover times. GY advised that it is out of hours when it goes wrong, adding that a workshop with on-call staff is being organised to maintain a clear understanding. SD commented that it is unfair to isolate EEAST as there are challenges across the system.	

	GY advised that a demand management scheme in Hertfordshire which halved the number of 999 calls by encouraging the public to dial 111 is to be looked at in our region. It was **noted** that a clear plan for S & NEE is to be in place by 10/18, if not earlier. SD commented that staff are needed to 'take care' of patients for handover in the short term. Consequently this might attract new staff in. He added that this needs to be worked through, as this just moves the problem from one part of the system to the another. GY agreed, advising that 10 senior paramedics in East Suffolk have resigned to work in GP surgeries. SC commented that this is a key workforce issues and that there needs to be system engagement in workforce change. SG queried what is the status of the training new paramedics; GY advised that they are awaiting an independent service review. The Chair commented that we need to support the use of 111 and not 999 and the ambulance service. EG commented that clinical triage is the key. GY advised that 3 paramedics have been embedded in CHUFT but it is vital that they are used as staff and not as students as they have skills. PD commented on the merger in Essex of the Fire and Police services into a single authority. She queried if any discussions have taken place with the Fire Service, particularly as this is the first time in nine year that full time fire fighters are being recruited. EG advised that this is part of the action plan, and that conversations have taken place with the Fire Service, with retained staff showing keenness to be involved. LL commented that we need to understand why staff are leaving the system. The Chair expressed his support for EEAST, adding that the focus could have been on any one of us as it is a system problem.	
126	**Update on STP Stroke Review** SHe advised that the Norfolk and Suffolk Operational Group met and there is a focus on stroke standards and ESD. Next steps for the group are discussions in regards to thrombolectomies. It was **noted** that the AF work sits within prevention. SH queried if there is an output for the group; SHe advised that that she has asked the question and it was **agreed** that any output should be shared with the group.	**SHe**
127	**Any other business**	

	The Chair thanked all for attending and for all the work they are doing. ***1644 – meeting closed.***	