



# Suffolk & North East Essex Sustainability & Transformation Partnership Board

Meeting held on Friday 12 January 2018 from 9.30 – 12.30  
at West Suffolk Hospital

## Notes and Actions

### Attendance:

<i>APOLOGIES</i>		STP Lead
Ed Garratt	EG	Ipswich & East Suffolk CCG & West Suffolk CCG
Sam Hepplewhite	SHe	North East Essex CCG
Peter Fairley	PF	Essex County Council
Mike Hennessey	SC	Suffolk County Council
Stephen Dunn (Chair)	SD	West Suffolk Hospital
Shane Gordon	SG	Colchester Hospital NHS Foundation Trust
Neill Maloney	NM	Ipswich Hospital NHS Trust
Julie Cave	JC	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
David Sollis	DS	Healthwatch Essex
<i>APOLOGIES</i>		Healthwatch Suffolk
<i>APOLOGIES</i>		St Elizabeth Hospice on behalf of the three Hospices
Mark Galloway	MG	GP Primary Choice
<i>APOLOGIES</i>		Suffolk GP Federation
Simon Jones (representing)	SJ	Suffolk LMC
<i>APOLOGIES</i>		North Essex LMC
<i>APOLOGIES</i>		Suffolk District & Borough Councils
Ian Davidson	ID	North East Essex District & Borough Councils
Sharon Alexander	SA	Voluntary Sector Representative – North East Essex
<i>APOLOGIES</i>		Voluntary Sector Representative - Suffolk
Paul Duell	PDu	LPN Chairs Group – Suffolk & NE Essex
Abdul Razaq	AR	Public Health
<i>APOLOGIES</i>		NHS England
<i>APOLOGIES</i>		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
Amanda Lyes	AL	STP Delivery Support Unit
Kate Vaughton	KV	STP Delivery Support Unit
Rebecca Jarvis	RJ	STP Delivery Support Unit
Tess Zermanos	TZ	STP Delivery Support Unit

Ref	Item	Action
105	<p><b>Welcome, introductions and apologies</b></p> <p>The Board <b>noted</b> the apologies from the Chair. In his absence, SD <b>agreed</b> to the Chair the meeting. SD advised that many members are aware of the reason for the Chairs' absence and expressed the thoughts of members of the group to the Chair at this difficult time.</p> <p>Introductions were made and other apologies were <b>noted</b>.</p> <p>SD commented that the past few days and weeks have been challenging for the health and care systems across the country, adding that STP colleagues across the Suffolk and North East Essex footprint have pulled together during very pressured times. The Chair expressed that he was deeply proud of the health and care system across the footprint but added that there is more to do. This is part of the national debate, which is changing and evolving. The support of the County Councils, Mental Health, Primary Care and Community Services, together with that of the CCG in West Suffolk were <b>noted</b>; the Chair commented that other parts of the STP had acknowledged the support received amongst their respective systems. The Chair stressed that these are challenging times and that all parts of the system must come together.</p> <p>The minutes of the meeting held on 20/12/17 were <b>agreed</b> as a true and accurate record. SH commented that the minutes were brief as the meeting had to be shortened and EJW was unwell and therefore unable to attend to take minutes. She advised that the notes from the table discussions were included in the minutes.</p> <p>SH presented the final version of the ACS timetable as agreed at the meeting of 20/12/17. Members <b>accepted</b> the version as the final version.</p>	

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

Ref	Item	Action
106	<p><b>The role of the board in providing system oversight</b></p> <p>SH referred members to the presentation that she delivered at the STP Board on 20/12/17 advising that the slides from the presentation were included in the papers for reference. Members <b>noted</b> that in regards to the RAG rated chart, this remains work in progress.</p> <p>With regard to the roles within the STP and the STP Delivery Support Unit, SH provided an overview of the roles that are developing.</p> <p>Members <b>noted</b> that the role of STP Mental Health Clinical Lead is currently out to advert.</p> <p>SH advised that with a range of new leadership roles emerging for STP Delivery Programmes it was important to achieve clarity with regard to each of the different</p>	

<p><b>106.1</b></p>	<p>leadership roles and how they work together with the DSU team and the overall STP programme.</p> <p>Members <b>noted</b> that the existing SROs for delivery programmes had been appointed on an informal basis, with only a small number of STP Board members stepping in or taking on the roles to date. SH expressed her gratitude to EG and SHe in particular for stepping forward to take on these roles to date. She advised that there should be an explicit appointment process for all STP Leadership roles including roles for members of the STP Board to lead as SROs for key delivery programmes.</p> <p><b>Appointment to STP Leadership Roles</b></p> <p>AL presented a paper to members regarding the recruitment of SROs. It was <b>noted</b> that in developing our STP delivery programmes, the intention is to:</p> <ul style="list-style-type: none"> <li>• Refresh the various programmes to ensure that all reflect key features</li> <li>• Review STP SRO roles and open up nominations from STP Board members. The intention is to review the roles and formally appoint or where the current SRO remains interested in continuing the role, reconfirm the appointment. This ensures a process is in place to confirm current arrangements or otherwise.</li> <li>• Refresh the STP Board by further developing the roles and responsibilities of members.</li> </ul> <p>It was <b>noted</b> that there are ten programmes of work with the STP that require an SRO. These are:</p> <ol style="list-style-type: none"> <li>1. Mental Health</li> <li>2. Cancer</li> <li>3. Primary Care</li> <li>4. Urgent and Emergency Care</li> <li>5. Planned Care</li> <li>6. Estates</li> <li>7. Digital</li> <li>8. Communications</li> <li>9. Finance</li> <li>10. Workforce</li> </ol> <p>AL described to members the suggested process for STP Board members be invited to apply/reconfirm their interest. She added that amendments to this process are welcomed. It was <b>noted</b> that the process is to commence w/c 14/01/18.</p> <p>AB commented that if the roles are to be appointed on merit, there could be a risk that all Leadership roles within each of the programme areas could be filled by the same organisation, e.g. the CCG or a Trust.</p> <p>AL advised that once expressions of interest have been received there will be a stock take in regards to how the landscape looks.</p> <p>AR thanked AL for the paper but queried if Prevention was no longer workstream with the STP as he is the existing SRO for this area. AL apologised for the omission on this workstream and it was <b>agreed</b> that this error be corrected.</p>	<p><b>AL</b></p>
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SCh welcomed the robust process, commenting that as the STP develops it will become more powerful. She noted that there is no non-executive involvement, adding that this will be important going forward as it will give credibility to the STP and will show good governance.

She commented that there may not be enough SROs and given the timescale in the paper and considering the winter pressures currently being experienced, she suggested that a 'Plan B' be developed. She also suggested that conversations need to take place with the current SROs to that there is a transition.

EG commented that the NHSE dynamic want the SRO role to be a Chief Executive/Officer and that as this new process develops we will have to be prepared to push back on why we this is the not the case. NHSE may feel that SRO appointments are not senior enough.

SH reminded members that the SRO roles are offered to all members of the STP Board, all of which are senior representatives of their respective organisations.

She commented that in regards to the Workforce SRO HEE have mandated that this has to be a Chief Executive/Officer level.

SH commented that some of the STP programmes are at an early stage and that the right conversations need to take place.

The Chair commented that this process will allow members to have the opportunity to lead, to have more visibility or to contribute to the programmes.

The Chair commented that the level of representation and leadership at the STP Board is right, so it is important that the SRO representation is correct too. It was **noted** that feedback was welcomed.

The Chair **noted** the points made by AB and EG and suggested that a list be drawn up of members of the STP Board who would be best placed to take on the SRO roles, ask them to submit an Expression of Interest. He commented that he, NM and SC should 'step up', adding that he was grateful to CCG colleagues that have taken on the roles hitherto. The Chair stressed that there has to be balance across the programmes.

It was **noted** that the final decision on the appointment will be made by NH (STP Lead). The Chair suggested that a sub-set of the STP Board or perhaps the STP Chairs Group could advise NH as STP Lead to ensure the process is transparent and fair.

It was **agreed** that all programmes have to be representative and have all views from across the system.

With regards to non-executive involvement, the Chair commented that this needs to be reflected on.

ID commented that some programmes are multi-dimensional and suggested that Joint Leads may be appropriate, as they will bring different skill sets to the role.

	<p>SH reminded members that in addition to the NHS Five Year Forward View programmes the following cross-cutting programmes were in the process of being established:</p> <ul style="list-style-type: none"> <li>• Deprivation</li> <li>• Loneliness</li> <li>• Obesity</li> <li>• Unplanned admissions</li> <li>• Suicide</li> <li>• EoL care</li> <li>• Older adults</li> </ul> <p>She added that these programmes would require a broader skill set and leadership from the STP Board.</p> <p>It was <b>noted</b> that one of the key aspects is that the SRO role has to be a member of the STP Board. SH added that if the pool is broadened then the membership of the Board will increase.</p> <p>ID referred to Mental Health, advising members that in Tendring 30% of police call outs involve mental health. He added that having two leads would help, and that they could nominate who attended the Board.</p> <p>LL commented that there needs to be public and clinical representation in STP Delivery Programmes going forward.</p> <p>SH commented that the SRO lead did not need to be the same person who Chairs the programme meetings, or who is the programme manager, e.g. digital. She added that the SRO could appoint a separate Chair, who could bring an entirely new perspective e.g. from industry, public, patient or clinician. SH stressed that there is a need for more diversity in programme leadership. ID <b>agreed</b> as this fits in with his commented in regards to skill sets.</p> <p>The Chair reminded members that WSFT is a global digital exemplar so he should therefore step up in regards to the Digital workstream. He informed members that Gary Norgate, a non-executive director for the Trust, is the Head of Professional Services at BT and that his links and expertise could bring outside expertise to the digital programme therefore increasing success and fit in with the wider agenda. The Chair added that there are wider opportunities and dynamics and that this is a big opportunity.</p> <p>ID cautioned about the dangers of creating a new board and suggested that other sectors/areas be looked at to ascertain what work is going on. For example, in relation to digital, work is going on across Essex in regards to integration and people sharing. He added that we should link in with what is already happening.</p> <p>The Chair <b>agreed</b>, adding that a mapping exercise should be built into the work programmes for SROs to ascertain what is already being undertaken so that work can be rationalised to ensure success.</p> <p>Following further discussions it was <b>agreed</b> that the paper be revised and that AL would proceed with the process on the basis of the discussions held at the Board.</p>	<p style="text-align: right;"><b>AL</b></p>
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	The Chair <b>thanked</b> AL for the paper.	
<b>107</b>	<p><b>Key STP Delivery Programme Reports (Cancer, Planned Care, Primary Care, Mental Health and Urgent Emergency Care)</b></p> <p>SH advised that she had met with colleagues from NHSE on 11/01/18 to review the STP approach Dashboards. They have suggested some additional detail to be added to dashboard and so the design of dashboards may need to change.</p> <p>It was <b>noted</b> that Dashboards are to be produced for other programmes going forward – prevention and cross-cutting programmes.</p> <p>SH advised members that in the future there is to be particular focus on escalation.</p> <p>Update were <b>noted</b> in regards to the following programmes:</p> <p><b>107.1</b></p> <ul style="list-style-type: none"> <li>• <b>Primary Care</b></li> </ul> <p>SHe advised that there is nothing to escalate in respect of Primary Care at the current time.</p> <p><b>107.2</b></p> <ul style="list-style-type: none"> <li>• <b>Workforce</b></li> </ul> <p>However, workforce continues to be an issue. She added a good pre-meet has taken place to ascertain how this programme links with other cross-cutting programmes. With regards to the delivery of the Transformation Plan work is being undertaken in regards to milestones. SHe welcomed any feedback on the dashboards.</p> <p><b>107.3</b></p> <ul style="list-style-type: none"> <li>• <b>Cancer</b></li> </ul> <p>SHe advised that the focus at the 09/02/18 STP Board will be on Cancer. She asked members to advise what added value would a discussion at the Board give that they don't have already have. It was <b>noted</b> that whilst there is a focus on the 62 day target, it was felt that there should be a focus on what is happening outside of the STP. It was <b>noted</b> that the Cancer Alliance play a major role in the Cancer programme.</p> <p>NM commented that the regional perspective would be very helpful. It was <b>noted</b> that a decision has been made in regards to the reconfiguration of the radiology service and the transfer of three oncologist posts transferring from Mid Essex to South End.</p> <p>SG commented that all the metrics within the Cancer dashboard relate to the hospitals, adding that he is aware that some Primary Care data has been published. He asked if this could be reflected in the KPIs, especially the two week hit rate in regards to a positive diagnosis and direct access diagnostics. He added that workforce is not a KPI within the dashboard, and that all the focus is on quality and not performance and workforce.</p> <p>SHe advised that data in respect of workforce is now being received and that data has not previously been available.</p>	

<p><b>107.4</b></p>	<p>AR advised that early staging data is available, particularly in regard to health outcomes for the population and differentials in regards to health equity. He added that conversations are taking place in respect of transformation monies in regards to early diagnosis.</p> <p>SHe advised that she is confident the 62-day standard and that we must use clinicians to support the conversations.</p> <p>SG commented that there should be equity to access and outcomes and referred to the work undertaken by Public Health in conjunction with the CCG.</p> <p>SH commented that the key issue is the transformation money and that there we demonstrate there is a considerable issue at a system level.</p> <p>SHe advised members that the Norfolk system is not as advanced in its planning but they have received their transformation monies. The advice of the Cancer Alliance has been to start planning now so that we are ready once the money has been received.</p> <p>It was <b>noted</b> that the dashboard needs to capture a more systematic picture. SHE added that she wants the dashboard to add value rather than members just receiving a report.</p> <p>It was <b>noted</b> that the recovery trajectories are broadly on track and that any help or support the wider system can do to meet the targets would be appreciated. SHE added that anything that would benefit system working in the future.</p> <p>ID referred to mental health, advising member that the area he represents (Tendring) has the highest number of mental health issues. He added that mental health has a direct impact on other services and that often the resolution is not within health. He stressed that early intervention and system working could make a big difference. It was <b>noted</b> that there are individual initiatives but a system approach would make a huge difference. ID queried if any mapping has been undertaken in terms of who to contact in regards to a specific issue.</p> <p>JC advised that there is to be an in-depth conversation/focus on mental health at a future STP Board meeting. ID advised that staff at Great Bentley Primary School are making a huge difference with primary school children.</p> <p>AB supported the comments made by ID adding that mental health is the problem of the mental health providers and not a system issue. He added that the NHSE Five Year Forward View for Mental Health places a big focus on prevention, particularly in regards to suicide. This is a system wide issue. It was <b>noted</b> that more needs to be wider consideration in regard to mental health.</p> <p>EG agreed, adding that the STP mental health strategy is based around the two main providers. He queried whether this was the right way to continue or how much can be done as an STP as a whole to ensure that we have the right operating model for the future.</p> <p>SH advised that she is liaising with Great Bentley and plans are in place to share their work more widely through the STP.</p>	
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JC responded to EGs query and advised that she is a real advocate for bringing the services together as there is a lot of learning that can be shared.

The Chair commented that there is a strategic framework as well as a delivery framework.

- **Urgent Care**

EG referred to the Chair's comments on winter pressure, adding that the three systems are all experiencing high bed occupancy. It was **noted** that IHT/CHUFT have performed well and that congratulations should be sent to all staff. WSFT was recovering from some poorer performance but had hit the 95% target on 11/01/17. EG reiterated that there has been a lot of work undertaken across the system.

It was noted that the footprint has three well-established A&E Delivery Boards and that work is being undertaken in respect of discharge and patient choice. NM advised that work is taking place at CHUFT/IHT in respect of urgent care. It was **agreed** that ideas be brought to future meetings and discussed.

SHe advised that as a category 4 system, NEE CCG had to take huge responsibility for what they had planned for and what was delivered, which was very difficult. SHe offered to share the learning adding that winter was approached with a completely different mind-set this year.

NM commented that this winter there has been more activity, but then activity does increase year on year. He advised that planning for next winter should commence now. He added that he recognises the challenges that the system faces, and that some of the decisions take to invest at short notice are not ideal and that we should have a realistic view of what we need to do next winter and have honest conversations. The question is what, as a system, are we prepared to do?

AR commented that from a Public Health perspective, Flu (both A & B strains) have added pressure to the system, particularly in regards to respiratory conditions. He added that the flu vaccine, care management etc. was well promoted, but the number of cases is the worse seen for the past five or six years. Work is being done to look at whether enough was done to prevent such an outbreak.

The Chair informed members that performance at WSFT was strong last winter. However despite a lot of plans had been put in place last week such as support to go home, additional beds, 80 escalation beds, EIT MDT etc. performance was between 60 & 70%. He added that patients were being placed in maternity beds and hip & knee beds, which is not acceptable. The Chair advised that should there be another surge in admissions and the hospital is full the question will be where do the patients go? The Chair suggested that if an old gymnasium had to be used this would be like a third world country.

The Chair raised the question of how do we create 30 additional beds in the hospital quickly and do we have 400 of the sickest people from our community in our hospital? If not, can people be placed elsewhere, such as a care or nursing home? The Chair advised that the Trust had received a positive response from Suffolk County Council and that the West has the lowest DTOCs in the region. It was **noted** that 20 beds have been identified, but the issue of patient choice is being tackled, as some patients are waiting for their ideal place of residence. The Chair advised

<p>107.4</p>	<p>that in some cases the Trust has to take the hard line with patients that are medically optimised as they need to leave the hospital. This could raise issues with patient choice and should be tackled accordingly. He added that he felt the health and social care teams feel that this is an argument we will win with patients and the public, as the sickest patients should be in the hospital. It was <b>noted</b> that the Chair and MH are to meet to discuss in more detail. The Chair advised the same argument will be taking place across the STP in order to help with current pressures. It was <b>noted</b> that whilst 40 medically optimised patients is a low number, it is still 40 patients that do not need to be in hospital.</p> <p>LL commented that the three systems are similar and that tough conversations have taken place with the County Councils, patients, relatives and NEE CCG. It is important that this is managed as a pathway of care, rather than a discharge or transfer. It was <b>noted</b> that a lot of lessons can be learnt from the A&amp;E Delivery Boards which should be taken forward. LL added that she totally supported this policy and that it should be embedded properly.</p> <p>MH added that proper referrals are required and that we must ensure that we remain compliant to the Care Act. He added that relationships are improving with councils and that he supports the policy. MH advised members that the council has a ‘thin’ service in regards to out of hospital working, particularly as it is working with a 24-hour system. He added that this can be done for a two – three day period, but cannot be sustained for longer. This therefore needs to be looked at going forward.</p> <p>It was <b>noted</b> that although 40 beds are available in the system there are issues with obtaining staff. Work is being undertaken to upskill existing staff.</p> <p>ID commented that the felt the description ‘pathway of care’ is better than using the terms discharge or transfer. He suggested that conversations with local politicians take place early in regard to what is occurring, so that they get the message and narrative earlier which will allow them to be more engaged. This way they are more likely to become and be advocates rather than critics.</p> <p>The Chair accepted the points raised by MH and LL. He added that the whole pathway of care is not ending the choice policy; it will still allow choice to be exercised but at a different point. The Chair <b>agreed</b> that conversations need to take place with local politicians as soon as possible.</p> <p>MH commented that the message has to be articulated in the right way; LL <b>agreed</b>.</p> <p>GY advised members that there are some STP areas that came to complete halt this winter. He added that ambulance offloading was poor with unacceptabluy large numbers of patients across the region kept waiting. However, the Suffolk &amp; North East Essex STP worked well as a system which was helping get us through the winter, although it was very challenging.</p> <p>It was <b>agreed</b> that planning for next winter commence now. Members <b>noted</b> the co-operative work that has been exhibited across the system, and that staff should be congratulated accordingly. It was <b>agreed</b> that work should be done in particular with respect of elderly patients with multiple LTCs. It was <b>agreed</b> that patient choice should be maintained but that patients should not be kept in hospital if they are medically optimised.</p>	
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<p><b>108</b></p> <p><b>108.1</b></p>	<p><b>Cross-cutting STP Delivery Programme Reports</b></p> <p>SH advised that interviews had taken place for the STP Workforce Programme Manager and the STP Workforce Project Support role. Neither role were recruited to and so the role has been re-advertised . All members were asked to ensure that any STP roles are advertised and circulated within their respective organisations.</p> <p>With regards to the STP Prevention Programme Manager, a 0.5 secondment has been made from Suffolk County Council Public Health team (Caroline Angus).</p> <p><b>Key focus: STP Communications &amp; Engagement</b></p> <p>SM, newly appointed STP Communications and Engagement Lead, shared a video with members entitled “What is the Sustainability and Transformation Partnership?” SM advised that the video had been put together in house and he welcomed feedback from members. It was <b>noted</b> that SH and SM are developing milestones in regards to the Communications and Engagement Plan, and that the intention is that the plan is to be brought to a future meeting. It was <b>noted</b> that contact has been made with communications teams in in Cumbria and in Mid &amp; South Essex.</p> <p>Following viewing the film, members made the following comments:</p> <p>AB commented that there was no mention of mental health in the film. SA commented that there was mention of the Friendship Café but it was <b>agreed</b> this it was not explicit enough that it was about mental health.</p> <p>RJ commented that she thought the film was very good but added that she felt it was more of an ambition. She added that the STP is yet another acronym, and asked what does this mean for patients, as the STP is more about services and infrastructure.</p> <p>LL commented that she felt the video was a very good start but it needs to include the role of the pharmacist, as feedback to NEE CCG is that the public do not identify pharmacists as a key player.</p> <p>The Chair queried the purpose of the video and whether a more detailed plan be compiled. He added in essence there is a need to ensure that services are maintained, but how do we articulate this to and engage with the public?</p> <p>AR commented that the video was good, but he felt it could be better. He added that members of the public with visual impairment or learning difficulties need to be considered, particularly in regard to how the message would land with them.</p> <p>PF commented that the video is a good start, but suggested that it be edited to half the time. He added that it needs to be broader.</p> <p>KV commented that this is a very good start and from the Alliances point of view, comms and engagement is a priority and that we need to build on the patients expectation/experience of what we need. She added that there needs to be co-ordinated links with comms networks.</p>	
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	<p>SG commented that the video is a great ‘starter for ten’ and that it could be part of a suite of communications. He asked what impact is the video hoping to make? What is the call to action for the public to make this real?</p> <p>The Chair congratulated SM for the work done.</p> <p><b>1106 – ID left the meeting.</b></p> <p>The Chair added that we need to articulate what we are trying to achieve, and that a more systematic communications and engagement plan is needed across the STP.</p> <p>EG commented that the term “STP” may change, so suggested that the video be future proofed.</p> <p>SM thanked members for the constructive feedback.</p> <p>SH advised members that in regards to the cross cutting system indicators, NH had requested that members be reminded of the STP Leaders away day, which is scheduled for 26/02/18. Speakers are being contacted, and SH advised that Michael Marmot has been invited to speak at the event. SH also advised that staff from Great Bentley Primary School will also be invited to showcase their scheme.</p> <p>SH advised that invites have been sent to all STP Board members, senior colleagues and non-executive directors.</p> <p>The Chair commented that it would be good to get Michael Marmot to speak at the event.</p>	
<p><b>109</b></p>	<p><b>Finance Dashboard – Month 7</b></p> <p>KD presented the finance dashboard for Month 7, advising that this is a developing dashboard.</p> <p>It was <b>noted</b> that the spend per head of population has been added to the dashboard. This provides detail on where the CCGs spend their money. KD advised that the next stage will be to provide the spend per head of population for the acute hospitals.</p> <p>It was <b>noted</b> that the system submitted to regulators a plan with an annual total deficit of £46.42m. At Month 7, the forecast is (£50.6m) deficit. This is £4.2m worse than plan. However, the largest forecast deficit is by Suffolk County Council. This will be fully covered by available reserves in line with the Council’s statutory duty.</p> <p>It was <b>noted</b> that actual performance YTD at Month 7 shows an adverse variance of £4m with IHT showing the highest adverse variance at £4.4m. Adverse variances are partly offset by a positive variance from CHUFT of £2.72m.</p> <p>With regards to savings, it was <b>noted</b> that a total of £104m of savings was planned by the system. At Month 7 the forecast is that 91% of these savings will be delivered. WSFT is planning to achieve £1.14m above its savings targets with other organisations either meeting its plan or below it.</p>	

	<p>It was <b>noted</b> that the savings plan YTD is £5.5m behind plan. This is 90% achievement YTD.</p> <p><b>1112 – ID returned to the meeting.</b></p> <p>KD requested that should members require more detail to contact her directly.</p> <p>With regard to risks, it was <b>noted</b> that IHT has indicated that included in £13.5m risk is the risk of losing the STF of £6m.</p> <p>Members <b>noted</b> that other key messages from the finance dashboard.</p> <p>The Chair commented that this is a great piece of work and that he looks forward to further iterations in the future. He added that the DoF group should be commended, adding that dashboard was well presented and very clear. The Chair commented that the profound question will be the spend per head across the patch, as well as the in year variances etc. He added that we may not end up where predicted.</p> <p>The Chair queried if there was a system control total, what would the variance mean in practice, and what would this mean for other parts of the system? It was noted that this may take the system in to difficult territory for decision making.</p> <p>KD advised that this is one of the key workstreams for 18/19, and that once NHSE confirm the rules, the system will operate on a shadow format in regards to the control total.</p> <p>It was <b>noted</b> that there is a £43.6m deficit across the system.</p> <p>The Chair commented that where parts of the system are more challenged for historic reasons, we need to ensure that local services continue.</p>	
<p><b>110</b></p>	<p><b>Capital – next steps</b></p> <p>KD referred members to a letter from NHSE/NHSI to NH in regard to the next steps on STP capital bids which were supported for further work up.</p> <p>KD advised that she has queried with NHSE/NHSI why they asked for the bids to be prioritised and then not use the same process to evaluate the bids. The regional office has advised that they are unable to advise. Therefore an answer is being awaited from the National office. KD stressed that feedback is needed particularly as the process has not been adhered too.</p> <p>Members were reminded of the priority 1 bids that were submitted (ED at WSFT, Clacton and the merger of IHT and CHUFT).</p> <p>It was noted that the STP has been invited to further develop priority 2 bids, but it is unclear as to how they have prioritised the order.</p> <p>The Chair expressed his anger with the National team for not allocating funds to the WSFT ED bid. He advised that the National A&amp;E Director had visited WSFT and commented that the estate was shocking. The Chair commented that he was very</p>	

	<p>surprised that this bid was not prioritised, and that he is to push and articulate the need.</p> <p><b>Comfort break: 1122 – 1136</b></p>	
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- **Part 2 – ACS Transformation**

Ref	Item	Action
111	<p><b>Terms of Reference for ACS Project Board</b></p> <p>SH presented the draft Terms of Reference (ToR) for the ACS Project Board and reminded members of the roles that RJ, AL and KV have in progressing the ACS.</p> <p>With reference to the ACS Project Board it was <b>noted</b> that this group is to be a smaller group and will report to the STP Board. SH commented that the board is to be made up of ‘doers’ around the ACS workstreams.</p> <p>SH advised that the draft ToR are based on the same principles as the ToR for the STP Board.</p> <p>It was noted that an email has been circulated to potential members of the ACS Project Board with suggested dates for the meetings. SH advised that the first meeting is scheduled for either 29/01/18 or 02/02/18; this date is to be confirmed.</p> <p>The Chair queried if this is effectively the engine room for the STP; SH confirmed that it is.</p> <p>With regards to section 3 (purpose) it was <b>agreed</b> that the voluntary sector be included. SCh reminded SH that non-executive directors need to be included also.</p> <p>EG queried what the ‘doers’ will be doing; adding is this a Programme Office (in that they will plan the STP Board agenda etc.) or will it be a working group designing what the ACS will be in the future?</p> <p>SH advised that it will be both; the ACS Project Board will be organising the programme of work and the alliance work. It will be a place where these programmes are brought together and explored.</p> <p>KV advised that the Alliance plan to meet to make decisions at a local level. The ACS Project Board will be a forum to meet and share these plans and therefore be a mechanism for getting to the STP Board should a decision be required.</p> <p>SH queried if there should be NHSI representation, as there is NHSE representation? SH <b>agreed</b> that they should be, adding that NH has stressed that both NHSE and NHSI need to be involved and be vocal in discussing and working with us going forward.</p> <p>EG queried if there is to be clinical representation at the ACS Project Board, adding that this may not be needed but it feels like an Officer led group. The Chair <b>agreed</b>, adding that he thought this was a strong point.</p>	SH

	<p>MH commented that the ACS Project Board looks quite hierarchical, adding that the solutions may be inward looking and that the power may be downward rather than up to the Board.</p> <p>PF queried if the Chairs Group will be actively involved, as there is a close relationship between the STP Chairs Group and the STP Board. He queried if there is to be Chair representation at the ACS Project Board?</p> <p>SG commented that the roles are well described but the timelines are not referenced.</p> <p>SH reminded members of the workshop/speed-dating session that took place at the STP Board held on 20/12/17. It was at this session the plan began to take shape of what the ACS Project Board might look like.</p> <p>It was <b>agreed</b> that SH would email STP Board members regarding membership in respect of representation from their respective organisations. It was <b>noted</b> that the Alliances are working through whom their representatives will be.</p> <p><b>1148 – SCh left the meeting.</b></p>	<b>SH</b>
<b>112</b>	<p><b>An STP Approach to Population Health Management</b></p> <p>AR delivered a presentation to members to seek agreement in the approach to be taken in respect of Population Health Management.</p> <p>It was <b>noted</b> that the paper has been co-produced with a range of stakeholders. AR advised that Anna Crispe who had helped to develop the paper was unable to attend the meeting to do a prior commitment.</p> <p>AR stressed that there is a need to define the Alliance population.</p> <p><b>1203 – SG left the meeting.</b></p> <p>The Chair advised that there is a population health based solution module within Cerna, the software used at WSFT. He added that this module is to be rolled out across the community; it is currently being used with the Trust.</p> <p>Following the presentation, AR asked four key questions of members.</p> <p>PF commented that he welcomed the conversation in respect of population health, adding that Essex County Council regard this as a priority, if not the highest priority. He added that if we don't get population health right, then the ACS will not succeed. PF added that if this approach is agreed, then the same approach should be extended across the whole of Essex. This will ensure that the same system is being used across the footprint. PF commented that he is very comfortable with the proposal and asked if there is to be any extra capacity or resource to allow this proposal to move forward.</p> <p>With regards to the Millaman proposal referred to in ARs presentation, it was noted that this is just a proposal and has yet to be agreed. It was <b>noted</b> that there are many companies offering this software solution.</p>	

	<p>It was <b>agreed</b> that capacity be explored across other STPs and Public Health teams.</p> <p>PD commented that the data does not include Pharmacies, adding that the LPNs/LPCs have three years' worth of data that can be included. He suggested that Clinical Cabinets could be involved in this going forward.</p> <p>ID commented that the scoping of data analytics is much wider than health, adding that housing should be included.</p> <p>AR advised that a JSNA has just been completed for housing and is to be presented at the Suffolk Health &amp; Wellbeing Board on 25/01/18. He added that this data will be pivotal.</p> <p>AR stated that the issue in the SPT context is how we see commissioning within healthcare or the broader framework. He added that conversations need to take place. It was <b>noted</b> that there are wider determinants, e.g. care leavers, accommodation for offenders, aging population and new homes.</p> <p>SHe commented that she felt that population health is very important, but the approach should not be by way of a workstream. She added that one agreed, and as the STP work goes forward, there should be a strategic decision in regards to the population approach to the way that health and social care are delivered.</p> <p>EG commented that the ACS Project Board could be the vehicle that oversees this work.</p> <p>NM commented that in regards to scope, several populations extend beyond this, e.g. NSFT. This may mean that two databases will have to be fed into.</p> <p>Questions were raised with regard to IT systems integrating.</p> <p>The Chair commented that we need to sustainability commission for the future, adding that we need to take stock of where we are with approaches both within and outside the system.</p> <p>It was <b>noted</b> that the proposal is embedded and that it links to both the alliance and digital agenda and that we need to get to a situation where we can actively link data across the health and social care system. This may then produce the data that needs to be considered in the future.</p> <p>The Chair advised that at a recent West Suffolk system event, Wirral CCG attended to speak about the stakeholder/public engagement work they had undertaken in regards to sharing data. He suggested that this could be done on a West Suffolk basis and the could be broadened out.</p> <p>It was <b>agreed</b> that agreements should be made in regards to what data is being collected to ensure that all are producing the same analytics. It was <b>agreed</b> that systems need to be able to speak to each other. SHe added that the three Alliances need to work together in some area therefore future proofing the system.</p> <p>SH commented that we need to have access to the Public Health expertise.</p>	
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<p><b>103</b></p>	<p><b>NSFT Special Measures Programme</b></p> <p>JC gave a verbal update on NSFT and its current special measures programme. She reminded members that NSFT were placed into special measures in 10/17, following a CQC inspection. It was <b>noted</b> that similar issues were raised during the CQC inspection in 2014.</p> <p>JC stressed that although the Trust had received an overall rating of ‘inadequate’, several areas within NSFT were given a ‘good’ rating, and that specialist children’s services in Lowestoft were given an ‘outstanding’.</p> <p>JC advised that the issues were due to culture and that a systematic programme of work has been put in place to address this.</p> <p>It was <b>noted</b> that NSFT has been given a deadline by CQC of 11/03/18 to embed the cultural changes required; JC advised that this target would not be met.</p> <p>JC advised that there has been an issue with leadership within NSFT; the Board is currently being rebuilt and the Chief Executive post is currently out to advert.</p> <p>The key theme of the CQC concerns was the safety culture, particularly in regards to ligature points. Although the clinical team are aware of the risks, they feel that it is the estates teams responsibility to alleviate these risks. It was <b>noted</b> that workshops are being organised, with the clinical teams being taught how to manage and own the issue.</p> <p>With regards to the removal of the ligature points, JC advised that removing these from door closures in all areas would cost £1m. Removal of the ligature points in community toilets would cost an additional £1m. To give context to the issues raised by CQC, JC advised that there has been one ligature harm within NSFT since 2012.</p> <p>JC also advised that there are staffing issues in West Suffolk and West Norfolk, adding that there is a national shortage of nurses across the system, which also affects NSFT.</p> <p>Engagement is taken place with both medical staff and consultants in regards to the important part they have to play. To this end, JC sent out an email to all staff asking for positive, focused ideas and outcome focused solutions. She expected little response, but received forty-five. A meeting is being organised to take these suggestions forward.</p> <p>JC stressed that NSFT are determined to deliver, although it may take longer than CQC expect.</p>	

	<p>AB commented that JC has his full support, adding that when things go wrong it is often felt that it is just the organisations issues, but it is a system issue, e.g. workforce. He added that CQCs tolerance in some key areas has changed, e.g. ligature risks which means significant investment. AB questioned if we 'are all in this together' or not? He added this is a challenge to all across the system and what the STP should be doing to support.</p> <p>The Chair fully supported ABs point and expressed his support to JC and NSFT. He added that it is incumbent upon all to help – and should help be required then they should ask. The Chair added that we all know that the physical and social conditions being seen in health and social care are closely linked to mental health which therefore adds further demand to services.</p> <p>It was <b>agreed</b> that there needs to be in-depth discussions in regards to mental health at a future STP Board meeting, particularly in regards how we evolve our system approach to mental health going forward.</p>	
<p><b>104</b></p>	<p><b>Any other business</b></p> <p>The Chair thanked all for attending and for all the work they are doing.</p> <p><b><i>1205 – meeting closed.</i></b></p>	