Suffolk & North East Essex STP Board
Meeting held on Friday 14 December 2018 from 0930 - 1230
at Kesgrave Conference Centre, Kesgrave

Notes and Actions

Nick Hulme (Chair)	NH	STP Lead
Ed Garratt	EG	Ipswich & East Suffolk CCG & West Suffolk CCG
APOLOGIES	SHe	North East Essex CCG
APOLOGIES	PF	Essex County Council
Sue Cook	SC	Suffolk County Council
Mike Hennessey	MH	Suffolk County Council
Stephen Dunn	SD	West Suffolk Hospital
Shane Gordon	SG	East Suffolk & North Essex NHS Foundation Trust
Antek Lejk	AL	Norfolk & Suffolk NHS Foundation Trust
Andy Graham *(Representing)*	AG	Essex Partnership University NHS Foundation Trust
David Allen	DA	East of England Ambulance Trust
Lynne Woodcock	LW	Anglia Community Enterprise
APOLOGIES	DS	Healthwatch Essex
Andy Yacoub	AY	Healthwatch Suffolk
Mark Millar	MM	St Elizabeth Hospice on behalf of the three Hospices
APOLOGIES	JH	GP Primary Choice
APOLOGIES	DP	Suffolk GP Federation
Simon Jones *(Representing)*	RW	Suffolk LMC
APOLOGIES	BB	North Essex LMC
APOLOGIES	IG	Suffolk District & Borough Councils
APOLOGIES	PD	North East Essex District & Borough Councils
Sharon Alexander	SA	Voluntary Sector Representative – North East Essex
Wendy Herber	WH	Voluntary Sector Representative - Suffolk
Anne Humphrys	AH	Higher Ambition Group/Patient & Carer Representative
Paul Duell	PDu	LPN Chairs Group – Suffolk & NE Essex
Phil Carver	PC	Health Education East of England
Amanda Jones	AJ	Public Health
Joan Skeggs *(Representing)*	CT	NHS England
APOLOGIES	RF	NHS Improvement
Lisa Lewellyn	LL	STP Clinical Lead
Sheila Childerhouse	SC	STP Chairs Group
APOLOGIES	MS	STP Chairs Group
Kirsty Denwood	KD	STP Directors of Finance Group
Susannah Howard	SH	STP Programme Director
Sherri Lawrence *(notes)*	SL	EA to Susannah Howard, STP Programme Director

Also in attendance:

Sir Bernard Jenkin MP	BJ	MP for Harwich and North Essex
Terry Leigh	TL	Medical Mediator
Dame Clare Marx	CM	East Suffolk and North Essex NHS Foundation Trust
Mark Jarman-Howe	MJ-H	St Helenas Hospice and North East Essex Alliance
Karen Chumbley	KC	North East Essex Alliance
Dawn Scrafield	DS	East Suffolk and North Essex NHS Foundation Trust
Richard Watson	RW	Ipswich & East Suffolk CCG & West Suffolk CCG
Eugene Staunton	ES	Ipswich & East Suffolk CCG & West Suffolk CCG
Simon Morgan	SM	STP Communications Lead
Victoria Fennell	VF	STP Delivery Support Unit
Glenn Young	GY	STP Delivery Support Unit

Ref	Item	Action
207	**Welcome, introductions and apologies** The Chair, Nick Hulme, welcomed all to the meeting, introductions were made and apologies recorded. The minutes of the meeting held on the 14 November 2018 were reviewed and accepted as a true and accurate record of the meeting. Matters arising: Brexit paper EG updated on the work being done in Essex and Suffolk, working with network of resilience forums to engage. GY is bringing together a group of leads from each organisation for a coordinated approach and SM has developed good communications for staff, including filmed interviews with NH and SD. It has moved forward quite a long way. GY said the paper outlines opportunities as well as risk, especially in areas of deprivation where we might seek to expand the workforce. Many people in low paid jobs are confined to their community so we are looking to see how we can target that local workforce as part of the workforce issues across the patch in that many EU workers are in caring work. Chair said that EU workers who wished to continue to work in the UK after Brexit were expected to pay £65. For ESNEFT that would total £39k so to show support to those workers the Trust has agreed to pay this on their behalf. A paper would be going to the next ESNEFT Board. The cost across the STP amounted to around £300k which, if agreed as a system, would avoid creating an internal market across the system and send a strong message of support to our EU workers. SC said she was unsure where the Council were with the £65 per head, but training and support had been put in place for EU workers. She will come back at the next Board with an update. MH said many of their workers came through private providers so they would ensure they were included in this. Chair summarised that we should be sending out a positive message without creating competition between organisations. **ACTION:** Paper to be brought to the next Board to confirm agreement for individual payments of £65 for EU workers wishing to continue working in the UK across the UK. **ACTION:** STP Workforce Programme to look at targeting local workforce for caring role opportunities. **ACTION:** Update on Suffolk Council's position regarding the £65 per head.	**GY** **PC** **SC**

- **Part 1 Specific Issues for Discussion**

Ref	Item	Action
208	**Medical Mediation** BJ gave an introduction, outlining his work overseeing the Parliamentary and Health Service Ombudsman which is an apex to the complaints system. About 80% of all their cases look at clinical incidents. Difficulties are:- • that cases don't reach the Ombudsman until 1-2 years after the incident. • the quality of investigations undertaken are generally poor. A new body, the Healthcare Safety Investigation Branch of the Department of Health, domiciled within NHS Improvement, was set up to find the causes of clinical incidents without blame. However, this is not complaints driven and there are still a huge number of complaints in the Health Service with about £30bn litigation outstanding. Key issues are that:- • Most patients are scared to complain, particularly if they have a patient still in treatment. • Most complaints are made to ensure the same incident doesn't happen again and lessons are learnt. • The same type of incident often happens again and again • Learning can be poor. For medical professionals there is a lot of fear around complaints and loss of medical reputation. There has been work providing psychiatric support to clinicians who feel a huge amount of stress, sometimes	

resulting in suicide, especially younger clinicians. Finding a way to resolve complaints without them becoming adversarial would be powerful.
TL said the NHS complaints service has been critically reviewed with the findings that the complaints process:-

- is too long
- is not that effective.
- is reliant on phone calls, letters, emails etc
- resolvable complaints go to litigation or the Ombudsman.

The process needs support at the local early resolution stage. Externally applied mediation can save time, energy and cost. It is key that mediation is external to the system, both the hospital and the complainant. The health mediation process is simple. Firstly the mediator meets with each party separately in order to give their perspective, express feelings and vent anger. This is followed by a meeting with all parties, where each person gives an opening statement and moves on to issues identified at the initial meetings. There is then free exchange between the parties, facilitated by the mediator asking useful questions to allow that communication to reach a meaningful resolution. Generally these meetings can be emotional but therapeutic with the complaint is revolved with a positive outcome.
Chair commented that complaints are presently driven by a culture of defensiveness.

CM outlined her experience as an Orthopaedic Surgeon and Clinical Director dealing with many complaints. People want honest communication not bureaucracy but this has not been the case, a situation not helped by the defence organisations who often advise clinicians not to speak. Failure to reach resolution results in litigation and sometimes the Coroners Court and Criminal Justice System. Hospital investigations tend to be poor and unsatisfactory to the complainant who wants the truth. Mediation may give people a voice, getting people together to have honest conversations. At the end the parties may agree to disagree, and money may have to change hands to finance the care needed for whom things have gone wrong but it cuts down the process. As GMC Chair CM will be interested to see if we can support clinicians into safe places where they can have the honest conversations that can resolve complaints and avoid litigation. None of this means that people are not disciplined but it does give clinicians an opportunity to say I made a mistake, I am sorry and I have learnt, which is very powerful.

The Chair asked to open up the conversation and asked if as a system we are willing to support staff, patients and families in a different way when things go wrong with a more formalised mediation approach to those situations that require it, maybe providing support and training.

- AY responded by outlining how their community development manager offered complaint leads a facilitated complaints group linked to a national network. It has worked well, with 19 members and well attended meetings with guest speakers. It provides a safe environment for discussions, supporting those involved and improving the process. This may be a way of taking this forward in Suffolk.
- SD said they have overhauled their complaints system with SD reviewing every patient complaint and signing it off. Patient stories are heard at Board which are very powerful. It is important to give patients space to communicate effectively to get closure. Healthcare is a risky business which does have a profound impact. Following a recent case where a patient was not seen as soon as they should have over a weekend with profound consequences, the surgeon involved and SD visited the family at their home. They wanted answers and to hold us to account but they appreciated precisely the things highlighted by Terry, Clare and Bernard. Be open, honest and unafraid. They would really welcome the opportunity to pilot and explore this.
- CM said if we are going to pilot this we really have to be very clear how we take back the learning back into the system. There would need to be a formal way of recording and reflecting on the learning throughout the organisations.
- SD asked how, as an STP Board, we are going to address this learning being shared in a systematic way.

Chair commented that there are always incidents in our individual organisations where the system has let patients down but seldom is there a system review. We may have looked at what social care did,

	what primary care did etc, but the different organisations haven't come together to meet with the family. - AH agreed with bringing the system together regarding the learning as many patients and families are bounced around the system and let down at certain points. This is a good opportunity as patients tell us they don't necessarily want to complain but want understanding and learning so it doesn't happen again. - DA said having dealt with many significant incidents and complaints, all that has been said rings true. They are one of the first ambulance trusts to have Schwartz rounds and they would be pleased to be part of the system response to this. Is there a certain level of complaint this applies to and is there a follow up wellbeing piece on those that are involved as it brings out a lot of emotion? - TL responded that needs to be decided but from experience dealing with a huge number of complaints which are all important to those involved. Chair responded that maybe one or two of us may want to bring stories to the Board, particularly when they relate to system failure. - LL said that every trust is different and they need to be more collaborative around supporting clinicians and look at how we involve staff as they feel it is their fault. - SC There are two system wide bodies which do formal reviews, the Adult Safeguarding Board and the Children's Safeguarding Board. Cases need to meet a threshold, but for Childrens they do system-wide case reviews focussing on what can be learnt rather than who is to blame. Requests that a connection is made with the two safeguarding Boards. - BJ said we need to transform the meaning of what a complaint it. We think of it as incoming, a threat, problem, being sued, putting the shutters up when what we want is learning. So instead of complaint think learning, maybe it could be called the complaint and learning management group. The challenge is creating a process to embed it in the organisation. We need trust and create safe places that enable people to say sorry for an honest mistake. The Chair thanked visitors to the STP for prompting us to think about this and for the discussion. There is a general sense that we do want to do something different. He asked SD for someone in the STP team to work with the organisations around what we can do to move away from complaints to learning and supporting staff with doing that, involving national bodies and a defence union to see if there is a different way. **ACTION:** Identify someone in the STP to work with all the organisations to see how we can move from complaints to learning and support the staff. **ACTION:** Board members to consider bringing stories to the Board, particularly relating to system failure.	**SH** **ALL**
209	**Suffolk Mental Health and Emotional Wellbeing Strategy** RW outlined the needs assessment presented to the last Board leading on to the next stage outlining the main features of the emerging model. Main points:- • Co-production key – four voluntary organisations involved • This is about mental health and emotional wellbeing in its entirety across East and West Suffolk • How we can support and drive change within our mental health services. Chair commented that this is very Suffolk focussed but all of the issues affect both counties so even if we are not Suffolk based, we can still think about how this impacts on the mental health and emotional wellbeing of all the people we serve. AH summarised points from the previous presentation:- • If we were going to do this, it was important to do it properly. • Make it about people who use services and the people who care for them • Partnership working for system wide transformation. The challenge is to provide system wide change. An example was given about a young person who had to wait a year to be assessed for a service. Having been assessed, they then had to wait a further year and a half to access that service, meaning they had a two and a half year wait. It is important to have services where people need them, as they often feel isolated so it is important to also look after carers and the whole family. There are many different transition points where they may be getting a really good service then they transition to another service and get barely any input.	

EG gave a recap on Rosie Frankenberg's presentation from the last Board. Main points:-

- Needs assessment based on physical and mental health, moving away from traditional needs assessment and looking at discreet mental health issues.
- Deprivation. 90% of mental health cases are being treated in primary care and going nowhere near specialist mental health services.
- High level of self-harm, particularly in young people. Very high compared to national trend.
- Personality disorders; c20k in county have diagnosis but there is an additional 60k who do not have support.
- Need clear response to crisis as a system.
- High levels of depression among older people which is going undiagnosed.
- Those with severe mental illness are dying 15-20 years earlier than the general population.

In addition to the engagement events that have taken place, they have had a number of visits to East London Foundation Trust and the Cambridge and Peterborough health economy who are a national vanguard for mental health, so some of these innovative ways of working are being reflected in the Suffolk model.

EG reiterated this is an East and West Suffolk mental health strategy but there are common issues across the STP. The biggest issue is deprivation which is driving poor outcomes which is probably the same across Essex.

ES described the build on the five ways of well-being and the responses required; physical, emotional and environment. Key points:-

- Physical and mental health
- Increased integration
- Focus on severe mental illness
- Need to be clear about our crisis
- Continuation of support the suicide prevention work.
- Need to tackle the broad determinates of health.

The vision and co-produced principles have been worked up as a system. The principles are something we all need to live and breathe.

In terms of the foundation and key principles of the model:

- Geography
- ICS footprint
- Alliance population of c250k/350k in East and West Suffolk
- Locality populations of 50k

That means the 13 integrated care teams are the foundations starting to build mental health with a need to focus on:-

- System-wide leadership and culture. There is a need to look at ourselves and our own organisations to raise the profile of mental health and emotional health and wellbeing.
- Focus on early help with regard to supporting prevention and self-care.
- National drive to develop increasing access to psychological therapies and supporting mental health early.

A key shift of focus of the emerging model is primary care and community mental health services, given that 90% of patients being treated in primary care:-

- Need to upskill primary care
- Address consistency of services on offer across GP practices. Education package has been produced to provide the training and skills needed to support the population.
- Crisis model with regard to the route in with a national drive to make clear how that fits in with the 111 service and the responses needed to bring physical and mental health together and address parity.
- Integrated childrens models. A national requirement for every area to have a childrens' mental health and wellbeing place which needs to be refreshed each year.

In departure from the pyramid of need with universal services at the bottom with specialist at the top of the triangle, the future model is based on four quadrants:-

- Self-Care: individuals being confident to manage their conditions
- Universal Health, Primary Prevention and Care: about what all services do to support patients.

- Access and Brief Community-Based Interventions: additional support required in the community
- Specialist Secondary Mental Health Services.

In relation to the above:-

- There is a lack of a directory of service. There is lots of good work is going on in local community groups and clubs but there isn't one place to go to find them.
- Looking at rolling out digital responses like Living Life to the Full, a website offering information and access wellbeing services.
- There needs to be a very different relationship between GPs, practice staff and mental health wellbeing staff going forward. Consistency needs to be addressed with an education package, which has been developed for all primary care teams.
- Embedding increasing access to psychological therapies and not having a stand-alone well-being service and a stand-alone mental health service.

In the future model:-

- Mental health link workers assigned to each GP practice and very quick access to mental health community clinics
- There is still a requirement for community mental health teams but moving away from these being stand-alone and joining up with all other agencies that are supporting physical and mental health
- The model shows how it will work starting with telephone support.
- Crisis services work in a fragmented way. The model has brought together a range of organisations to work out how it may work. The principles are that:-
  - There will be a crisis team that brings together inpatient wards, psychiatric liaison teams, police triage and serenity intensive monitoring, where police officers are working with the mental health services.
  - They will work in a way that allows mental health issues to flow through the 111 service.
  - Clinical l response to patients and their families with a whole range of options of what that response might be, i.e. using the third sector organisations such as Suffolk Mind, who provide a night owls telephone service for patients with personality disorders, or it may be an urgency response where someone needs support in their home but not in A&E. There is a commitment being made in the strategy to look at alternative ways of working which are not reliant on statutory responses or statutory organisations so we are looking at how we can work with the third sector to support the needs of our population.
- With regard to how the model would work in practice, again there would be a single point in terms of telephony. Exactly how this will work hasn't yet been agreed so there are some options available to us in terms of having a telephone response within the mental health service or a care co-ordination centre working with other organisations which is already in practice.

RW summarised that the main take home from this. We want a very different conversation with all of you across Suffolk and North East in terms of taking responsibility around this agenda and how we can make big steps integrating our local service provision across physical, mental and social care. We have made big leaps in terms of physical health and social care. Mental health is next to be integrated through our ICS locality approach. The two big changes in terms of the model usually described is the primary care element. There is a huge amount of work to do collectively in terms of enabling and supporting primary care to meet that demand. Investment is needed with a change to resource allocation towards that link worker role and in terms of teams wrapped around primary care and the crisis model. It is early days but we need to crack through work as a system. We have agreement on a way forward but there is more work to do to take it forward. We are taking this out on a further roadshow for six weeks to really to understand from our community and staff that what we are saying is responding in the right way. Healthwatch will do a further survey to garner response to the strategy. As part of the road show we are happy to come to any of the Board members' individual forums. The next key decision point is at the end of January for the two CCG governing bodies and Council's Cabinet in terms of taking this forward and how to commission.

AH emphasised that it was a very different conversation which is ongoing and will continue to be ongoing. Partnership is really important, a lot of things have been learnt along the way, but we are part of that decision making and that is a key change but please do tell us about anything that it missing as it is a genuine conversation we wish to have.

The Chair commented that this is about turning the draft into reality and is every organisations opportunity to be involved, make comment and shape the strategy going forward.

- AG said he welcomed and commended the strategy. The bottom up approach and the extensive consultation is really impressive. AG outlined his experience in a previous role where they embarked on something more limited that this but with very common themes, particularly around creating a thriving voluntary sector, aligning mental health and primary care and really focussing on physical as well as mental health and closing that shocking gap in mortality. About three years in, it's been really successful. Some useful is that it took huge investment from the third sector, the mental health trust itself, and in particular primary care. It was led by a very able and committed GP. For secondary mental health and primary care there was a capacity issue, so it went from "we can just about manage this business" to developing new relationships, sharing more cases and working together. It took time for primary care to have the confidence to take back some quite long term cases and start to recreate that capacity. It was well worth it. Service users got a better deal, the outcomes are very good and feedback from GPs in particular was very, very positive.
- EG that is really helpful and having worked in that area it will be interesting to speak with them.
- DA commented that he particularly liked the single point of access. He asked how they could become part of that prevention so they can start to make every contact count.
- SG said it is encouraging to use the outcomes based accountability. There is anxiety around the dependence of integration on integrated information which we know is particularly challenging between mental and physical health. That should give us focus as we move to use integrated information that we remember the mental health needs of our patients.
- RW responded that they wanted to take the output based approach that started with community services in the alliances. There are million KPIs around this agenda and it doesn't necessarily tell us if we are delivering for our local community. So we do want co-produce what those outcomes need to be. This is a 5-10 year piece of work, we are not going to deliver this overnight.
- AL commented that it is clearly a world problem and this is an attempt to start something different. The big challenge with be that it is easy to enthuse and collect around it at a table like this but everybody needs to think how they behave differently and do that jointly with service users so it is not just a professional model. My only thought in terms of wrapping it around primary care, there are groups like the homeless who don't engage with primary care so we need to make ensure we are supporting them as well, actually reaching out rather than waiting for people to reach in.
- AH responded that it is about basing it where the people who need the service are going to be so, for example, for young people that might be in schools. It is a valid point and we are on it.
- SD said we are all aware of the need to provide additional investment and support in mental health services. We need to think how we focus and target some of the high level messages, such as the focus on deprivation and primary care. The real prize is if we can start to break down the barriers between physical and mental health and get staff on board across all our services. Just keeping people emotionally stable helps the workforce, helps us deliver care so we can all have a role not only in promoting physical health but also promoting mental health in our workforce and I wonder if that is something we could also bring out. A key thing that needs to be explored is what level of investment will be required as we need to make that commitment collectively and rebalance. We do know that there is additional money from the government over the next five years, so how are we going to divert some of that to underpin the turnaround in mental health services. We will have to be very clear on that in the next phase.
- AL agreed but said we also need to recognise the invest to save element of mental health support as it is very expensive supporting a system that doesn't work and not to spend money failing.
- SD added that as providers we can also do more in the mental health and there are lessons to be learnt around our own governance and quality systems which will also help improve the quality of care.

	- SJ said they are very supportive of the strategy from a general perspective and is sure that the very mention of the mental health link workers and crisis support team will be absolute music to colleagues' ears. Being pragmatic there are resource constraints in general practice however it is very clear this is critical and needs to be achieved. - SC speaking on behalf of the Chairs' Group welcomes this brilliant report but there is a sense of urgency given some of the issues around our mental health services and there is a need to turn this into a service to be delivered and bring real change. If ever there was a case for transformation and urgency around it, I think this is it. - Chair responded that it needs and urgency balanced with the investment of time to get it right. It is always a difficult one. - WH said that links with the voluntary sector are absolutely key. In regard to homelessness, the CAB are on there, dementia services all of those things. There is an issue if we signpost to that, we need to consider resources, especially in the current environment, for example the CAB having their funding cut. They saw 22,000 people last year with 75,000 issues which is enormous. This is great, really amazing but we need to consider when things go wrong. - Chair said we need to start to resolve that collectively. - ES said this isn't a strategy that is going to sit on the shelf and not be used so although we are going through the engagement process we have got to make a decision in January. We are starting to put some of this in place with immediate support work with NFST. Some of this is national must do so which has been worked on for some time anyway. We also have an opportunity with the transformation funds, of which mental health were major elements, of that so we have already started investing in quite a lot of different schemes with the DCS sector and statutory partners around this agenda. Also, EG is keen to pilot this and look at the primary care element of this model in one of our localities in the East and another in the West to actually start to test this out as this is potentially a big investment of time, energy and resource. - EG agreed we need to invest but recruiting staff is an investment in culture as much as it is new services or operational things. - PD said that when we are talking about primary care we are talking about the wider primary care, particularly the upskilling element of this. - Chair responded this is a Suffolk presentation but it is about the whole system. - LL said we do need to go quickly but we need mental health awareness training for all staff across the STP and also the onus is on us all to look after our own staff and we can all do that now. - Chair concluded that zero suicide is something we have set as a higher ambition. Most important if that is concentrated on specifically it improved mental health services across the patch. The point about staffing is absolutely crucial. I did a blog on world mental health day for our organisation to talk about my own battle with depression and alcoholism in my thirties and I was struck but the tens and tens and tens of staff who contacted me to say this is my lived experience or working, I haven't spoken to anyone about this, not even my family, people on high levels of medication, so we as leaders need to talk about this issue, be open about it and encouraging these conversations amongst our workforce who are suffering. He thanked those involved for the work they are doing and looks forward to the strategy getting signed off. The point about Essex is really important so this is taking the great work we are doing in Suffolk and spreading that across the river. - LL there is an Essex strategy as well. - Chair said don't spend a lot of time as it won't be that much different the other side of the river. - SH John Spence at the Chairs' group yesterday specifically raised how much interest there was from Essex County Council in looking at this piece of work.	
210	**Apprenticeship Levy Update** PC gave a presentation on the apprenticeship levy and explained that they were asking the Board for agreement in principle to support the gifting option of between 10 and 25%. The main points:- • Organisations with a pay bill over £3m annually who pay the levy are able to gift 10% to other organisations who can't currently access that. • For providers who presently pay the apprenticeship levy within our STP footprint, this amounts to £10m, which enables us to gift between £1m and £2.5m per year collectively to those who currently cannot access apprenticeship levy funding.	

	• Need agreement around the table that those organisation who are paying the £10m would agree, where possible if they do not have plans to use their full levy, they can gift to other providers within our footprint. Chair said that this is a very clear question, are we prepared, if we are not using all of our levy, to keep the money local rather than giving is back to the taxman. Asked if PC would be pulling it together PC responded that there is a working group within the LWAB who will be working on the mechanisms around it and learning from others but this is a good opportunity potentially to gift £2.5m across the system which, considering an apprenticeship is c£3k/£4k, this gives us plenty of opportunity. Chair this opportunity will enable us to support people specifically, particularly in those areas where we need to build the workforce and build a pipeline workforce for the future. Thanked PC for his work on this.	
211	**Primary Care Choices** MJ-H and KC gave a presentation. Main points:- • Project is working well in their area and they wish to share across the whole STP area. • Primary Care Choices is an electronic palliative care co-ordination system that has been in place since 2013. • More than just a register but a working example of an integrated information system which shares key information about peoples choices and what is important to them in their last year of life across a whole range of partners in the health system. • Cuts across primary, community and acute services and integrated with the hospice and mental health. Also the ambulance service and 111 and ESNEFT are using this as part of their operations. • Very effective population health management service which identifies a cohort within our population and uses it to segment based on where a person is on their journey and the level of risk. • Moving away from being a register of last year of life to a register of choice. • Just launched a new phase of the My Care Choices register, moving from an off the shelf web based solution to actually designing a fully bespoke solution. • Provides one system instead of obtaining information from different systems. • 38 local practices have signed up to this. • More than a software solution but a change of culture around promoting early conversations regarding end of life care in primary care and building on it with other providers and opening conversations with the patient on what their priorities are and their wishes. • 3000 people presently on their register. • Opened it up so it wasn't just about those in their last year of life but also a register of choice for those people with moderate frailty and those with a diagnosis of dementia. • Choices can be accessed by providers so if it is found that a person is in the wrong place, they can be turned around pretty quickly. • For those registered on My Care Choices, only 25% die in hospital which compared to a local average of 46%. • Transforming end of life experience for people, their carers and loved ones. • Building on success, learning from others. MJ-H said they would really like to share our learning with colleagues in Suffolk as we believe it would be a really cost effective roll out across Suffolk and North East Essex and we would be more than happy to assist colleagues to make this happen. - MM said three elements are needed to make this work, one being the register and identification, the second being co-ordination of services and their third being a system of actually not getting people into hospital. So across the three alliances we are strong on one of these so joining together is a positive. - AJ said there is good work going on in bits of Suffolk and the previous DPH focussed on end of life care in his annual report. This looks really good, 25% of deaths in hospital where every survey says 70% want to die at home if they can and we are nowhere near that so that says a lot for this register. The other point is that it still is a difficult subject and we have a cultural issue around talking about	

	death and dying, which is very difficult for some people. This work is very important and I support it. - Chair said that in America there is a big national campaign called The Conversation which is being led by the media which I will share with you at a future Board. There is a training programme for relatives on when and how to have the conversation so this is a good point. - SC said this links back into previous discussions around complaints as having dealt with complaints at all levels, some of the most distressing and moving complaints are around when things have gone wrong for people at the end of life. It lives with the relatives long after that person has gone. - Chair said we need to do everything in our power to ensure that the situation you are born into isn't necessarily the situation you die in. - EG said we do have an ICS end of life workstream. Is that vehicle helping us to roll this? - MJ-J said there is really good work happening in the alliances which it is not being pulled together so maybe there is an opportunity to re-visit how it is working in practice so we are all singing from the same song sheet. Maybe some tweaks would help us to make this into practical proposals. - SD asked how this compared to My Care Wishes which they have in Suffolk. From the presentation it seems that some of this is about electronically capturing information which facilities transfer of that information across multiple different health and care providers so we are very clear about what families and people want at end of life stages. Could you clarify that this is the principle benefit of the record as there are also the digital underpinnings that we need to think about so it would be good to think about how much investment has been made in this. - KC said they set an expectation and drove it through with quite hard KPIs and locally enhanced service so they changed the culture of expectation. They didn't say to GPs you can use this tool we said our expectation is that you use this tool and we will measure how you use it and set a target to use it for 50% of people that die over the next year and rewarded primary care for doing so. This meant we acknowledged it was extra work as not only is the conversation time consuming but caring for someone at home takes more resources from primary care when compared to the expense of admissions. We acknowledged that and drove it across primary care over years and kept the funding for that through a grant. - SD said it fulfils the do not resuscitate requirements which can be done just once instead several times which has got to be a real prize for us. - MM So the folder is the old technology that can be used which is great when the paramedic arrives but it's too late then, that's the point. Three elements of this are needed; identify the cohort, proactive co-ordination and case management. Resources and ability are needed to respond when people in the hospital say well its Friday afternoon, they will probably die over the weekend but actually that waits until Monday. The problem with the folder is that it is static. SH this is exactly the sort of population health management approach we want to see in the ICS. It is absolutely fantastic as it unites that user technology with the very human story and actually affects integration, change behaviours and culture. At the moment we are looking at where we can invest in this type of thing and now we have our alliances we can really start to have those conversations locally about how this would be implemented. So if you could share with my the costs we can look to see if we can access some of the offers of support being made around population health management in particular and then get that out to each of the alliances individually to see if that would help in building on what has been done already. Chair we need to be clear about identifying the cost. On my trip to American the best comment was from an Oncologist in the States who said his organisation has moved away from DNR to AND "Allow Natural Death" which is so powers. Asking a family to make a decision not to save their loved ones life rather than allow natural death so it is my ambition across this STP to move to AND. **ACTION:** Costings to be provided in order to access support for this initiative. **ACTION:** Look into how we can move away from DNR to AND	**MJ-H** **SH**
212	**STP Estates Workbook** SH highlighted:- • The paper circulated is the feedback from NHS England on the STP Estates strategy that we submitted. There are 44 STPs in the country, 42 of them submitted an estates strategy and of those 42 only three received the rating of strong, the highest level, which includes ours which is fantastic news.	

	• Both of the wave 4 capital bids submitted recently for the West Suffolk Hospital emergency department and for the ambulance service were both successful. So to add to the previous successes around investment and capital, we now have support to move those developments forward. SH said we are in a position of strength around our capital programme but the announcement of getting the money is only the beginning of a longer journey. She introduced SG to speak about one of the earlier capital schemes to receive funding. SG said the Board agreed in 2016 that a priority in the STP plan was emergency and elective care. We are now in the process of submitting the strategic outline case for the funding that has been allocated to ESNEFT. The first case covers elements that are not likely to be subject to public consultation which are the building of urgent treatment centres and reconfigurations behind the emergency care pathways for both Ipswich and Colchester hospitals, improvements to diagnostic equipment imaging at Ipswich hospital and the rationalisation of estates at both hospitals and the Carter programme. As part of that process the regulators require an indication of support from the STP Board and so we are asking today if the STP Board is still supportive of that programme of work that was in the strategy two years ago. Chair said this was a conflict of interest for him but said that the Board has seen the strategy and asked if they were still supportive of that strategy which was agreed two years ago. This was **agreed** by all. **ACTION:** Minutes of this agreement to be sent to the regulators for their assurance processes.	**SG**
	BREAK	

- **Part 2 – System Transformation Programme**

Ref	Item	Action
	The Chair resumed the meeting. BJ addressed the Board before he left to give his thanks and express how impressed he was with such team spirit and on behalf of all local MPs gave sincere thanks for all the work being done which is tremendous.	
213	**Population Health Management** DS gave a brief outline of the two papers provided. Key points regarding Terms of Reference:- • Multi-disciplinary team talking about the skills we have in our system to start to understand how we are using that resource and how we may use it differently. • ToR would form part of the STP governance. DS is chair of that group. • Draft work plan to ensure the group are spending their time on the right areas. • Working with NHS England and attending the Community of Practice meetings around population health management drawing upon the expertise of national colleagues. • Maturity matrix to understand where we are in the system around population health management. • Although some areas are using data in a really good way to understand how we are improving population health, this is not universal. • Work plan to take matrix and identify the areas to focus on to ensure adequate resource is provided and developed and also link back to key priorities around cancer, obesity and suicide. Chair said if we cannot show that we have made a difference to population health, what is the point of the STP. It is the key aspect. - PC said he would be very keen if the workforce data sets could be used with this to help move forward. - DS said that recommendations for a member would be very welcome. - SC said there needs to be balance between having a very large and inclusive group but also the need to move dynamically. - DS said they want to ensure they don't end up with lots of little groups with progress happening in silos because one of the good things about conversations in the forum so far is being able to share knowledge and experience. We need to be able to move nimbly and with the right people progressing so the forum is about how the group are delivering rather than having a conversation on what to do. We need to get the right balance to sure we are not excluding people with skills and experience which are valuable.	

	- SD said it would good to make a link with digital transformation boards as there is a core overlap. Digital representation could do with more clinical engagement through that forum and for population health management you have heavy clinical involvement so this is an opportunity to join that up. - DS said that the intent was not to duplicate things that are already happening elsewhere across the STP but the maturity matrix is an assessment around the actual infrastructure, the actual intelligence and what is actually being done with it. Where there is already infrastructure to look at things like development of digital architecture, we wouldn't be duplicating that but seeking to ensure we have the assurance we are not going in different directions. - SD said there should be some people on the population health board that also sit on the digital group to increase cross-fertilisation. DS then moved onto the second paper. Main points:- • Suffolk County Council, who are part of the population health management group, shared a piece of work done previously looking at skills particularly around informatics teams and intelligence and how they use and manage those skills. • Proposing to undertake a formal analytical skills audit, with agreement from the Board, to encourage teams to share the skills they have. • Will take the form of a questionnaire to gather intelligence to understand how we can better use the skills we have in the system in a more co-ordinated programmed approach. • Will also help identify where investment and change is needed. • At present we are not co-ordinated enough to help prioritise all of those things across the system. • Outcome of skills audit can be brought back to the Board in April 2019 where agreement can be sought to supplement this work if there are skills gaps or confirm that we are able to deliver what is suggested in the work plan. - SG said this is very welcome and a sensible system wide approach which is to be commended. A challenge of analytics is having a combination of understanding the business to ask the right questions and the analytics tools to provide sensible answers. Addresses the analytical end but do we need to think about the literacy of our key workforce in what analytics can offer and the kind of questions it can answer. - DS responded that this is where the Community of Practice and support from NHS England is key. They have been discussing working with a particular partner who will support us to ensure that as we are developing our skills and our plan that we have the capability as a system to take hold of population health management. We have good intent and lots of varying skills and knowledge but we haven't necessarily got the most structured way of getting to that end point as quickly as possible. Via NHS England we are identifying a supplier to work with us on this and accelerate our delivery. - SH said in addition to this there may be capacity locally. It would be good if there are any organisations that would like to be part of this they would be welcome to do so. Chair confirmed that everyone was happy to **agree**.	
214	**Development of ICS Governance with the Kings Fund** Chair said the NHS Long Term Plan now will not be published until January which means we are not waiting, there is lots of work still going on. SH said that work is continuing with the small panel led by Matthew Kershaw by way of con calls every Thursday evening. The stage one paper discussed at the last Board is a partial draft of an eventual governance paper. There have been opportunities for discussion of that at lots of different forum, i.e. joint HOSC, Suffolk CC informal cabinet, Essex Health and Wellbeing Board and wide variety of Boards and other forums for individual organisations. In addition, individual responses have been received which are being collated for discussion by the panel. Presently developing different elements, for example how we may work more closely with Health and Wellbeing Boards, the system control total, planning guidance etc. We are also awaiting publication of the long term plan which we understand will include specifics of the expectations of ICSs, including independent oversight, although work is carrying on until it is published. In January there will be a new draft paper for discussion at a second	

	workshop for those involved on 1st February. We aim to bring a stage two governance paper to the Board in February.	
215	**Realising Ambition Funding Programme**	
	The Chair spoke about trust and how we work together. He also spoke about how much risk we were prepared to take and how brave we are prepared to be. Traditionally if we get funding from the centre we split it up on a rota and give it to the CCGs but as a system we are at a very different stage of maturity from that and have been for some years which is to be celebrated. Nationally we are recognised as having a very mature relationship around how we allocate resource for the needs of local people and not necessary the sustainability of organisations. However, there is no organisation represented in the room that isn't facing some sort of financial challenge at the moment but we have committed to do things differently so the proposal for the allocation of £3.34m, given because of our success and as recognition of us being a mature system, will be to do something a bit different. It is important to have an honest and open conversation around this to ensure that people aren't leaving feeling unsatisfied. If we always do what we always did we will always get what we always got. SH explained that the paper sets out how money will be allocated across the system, particularly across the three alliances. The sum of £3.34m was allocated as part of the package as we move toward being an integrated care system. The purpose of the funding is to assist us in the delivery our memorandum of understand which has 14 things we agreed to do as a system across the ICS. The proposal is to use the majority of funds to support two of those 14 areas for development which are continuing to support the three locality alliances, including involving primary care in particular and also delivering against our higher ambitions. Principles for the funding programme are drawn from the principles used in drawing up our governance at the moment. The funding will be delivered through the alliances but through two different routes:- • Primary care via CCGs to support the development of local primary care networks across GPs but other primary care providers such as community pharmacists, optometrists and dentists. • Via community foundations to enable the voluntary and community sector to become more involved in local neighbourhood projects and initiatives alongside other partners in the ICS. The paper sets out how the funding should be managed in those two sectors. Money will be distributed using a weighted capitation approach with the ratings used for CCG allocations this year to allow £1 per head for primary care. The remaining allocation will go to the community and voluntary sector based on those ratings. This resource needs to be used by the end of this financial year. - LL asked for clarification that the community foundation are as engaged in this process in Essex as much as they are in Suffolk and is that the appropriate route. In terms of the allocation of funding and after hearing about my care choices, and listening to what you are asking the community foundations to do, should it be turned around the other way and splitting the money a bit more 50/50 but asking primary care to become engaged, in other words creating a hook for them to become better engaged in this process. LL clarified that the allocation should be more 50/50 between primary care and the community foundations for the North East Essex Alliance. - WH explained how the community foundations worked together. They are grant makers, connecting those with money who want to make a difference with the local voluntary sector on the ground who are operating in whichever county. There are 46 community foundations, all independent charities in their own right with their own trustee boards and all accredited at the highest levels with the Charity Commission given the amount of money they hold and pass out. Overall, the 46 community foundations make around £98m worth of grants and are one of the biggest grant making networks who are growing fast. This is about bringing money together from three different sources:- • Local philanthropists i.e. wealthy businesses or individuals who wish their money to make a difference locally. • National charities such as Comic Relief, helping them to get the money where it is needed amongst small community groups. • Public sector partners redistributing funds from County Councils, CCGs, Police and Crime Commissions etc	

	- It is that collective working that gives them the power to talk to people like Mark Carney at the Bank of England and the government nationally about assets that can be used charitably and also connect to those groups on the ground. If we are going to make a difference it will be by activating and supporting all of those people and engaging people to get involved. Although we raise funds and distribute in our own counties, we all work really collectively so that regional funding which needs to work across boundaries can be done really well. - The Chair asked if that gave reassurance which LL confirmed it did. - SA said she would take that reassurance back to the alliance and added that the paper was presented to the North East Essex Alliance leaders and there were a number of questions arising:- • SA asked will the money be spent in time?; KD responded that as long as it is committed that should suffice • SA said some had asked if that was the right channel?; SA wholeheartedly supports the community foundation to deliver this programme as they have been in existence in Essex since 1996. They are one of the strongest community foundations in the UK and they have all the quality assurances and track record who SA is very happy to work with. The Chair said that was probably why there was more comfort in Suffolk as they already have the relationship with their community foundation. WH said there are two questions around this:- • How can we get the most impact with this money to help and support the voluntary sector. There is a trust issue but when we say everybody we mean everybody. Everyone reads our emails as they have money behind them. • Additionally. We need to bring other philanthropic money to this agenda as although you have lots of money it is not going to be enough looking at what we have to do. - SH said there is also something about the reach as well. The community foundations are not sector specific and if you look at our ambitions they go right across all sectors and community foundations have existing processes, systems, track records of doing just this, more than any other partner around the table. - The Chair asked if the DoFs group have discussed this and their views. - KD responded that they had the community foundation coming to DoFs next week. - The Chair asked that means we cannot make a decision today. - KD responded that it would be process rather than contractual so was not a problem. - The Chair asked if everyone had had sufficient assurance around this from WH and SA. - SA said she would like to commend Susannah on the paper which is transformational, ambitious, innovative and more. It will put the STP/ICS on the national map. - EG agreed with SA. It is helpful to make a decision between the strategic and mechanical elements so as a group do we support the finance going into local communities and primary care via public sector, and then do we agree the mechanism to get that money into the communities. The community foundation are amazing as an organisation and their culture but they also multiply the money and generally match fund it so money put in here can potentially double. Asked that the weightings used in the paper could be checked by the DoFs group as they are very surprising. - SD responded that it takes into account age profile as well. - SH said that if the link in the paper is followed, it shows the weighting is correct and it has been double checked. - KD confirmed that she would verify the weighting at the DoFs group on Thursday. - AY said that much of the transformation money was coming our way because of the STP and is there to be used in the short term every time and the voluntary and community sector desperately needs longer term commitment, so if the money is moved to the foundation could it be extended beyond the three months within which it would have to be used if kept by NHS bodies. - KD responded that we would be able to move it all in this year and as far as the NHS is concerned we have committed it so the answer is yes. - SH said the other thing under discussion is whether or not we would pursue other routes of investment we haven't tapped into yet, i.e. Big Lottery Funding, saying that collectively we have a really big plan as a health and care system.	**KD**

	- AH is fully in support of this. Having worked with the Suffolk Community Foundation they have really robust processes which enabled them to be brave and try out some different things which have now become mainstream. - SD said he is very supportive of the approach. Wanted to clarify how the primary care monies would be spent as we heard today about My Care Choices and that would seem like a great opportunity for fast tracking this. There may be other pots of money that can be tapped into for that but just a suggestion. - EG responded that each alliance needs to decide how money is best spent in local primary care and best not to have an ICS approach. - The Chair said the one question we haven't resolved is LL's question regarding the split in funding. - LL responded if that applied with the alliances taking the decision that addresses it. The Chair concluded that had been a very helpful discussion and thanked everyone.	

- **Part 3 – Oversight of STP Delivery Programmes**

Ref	Item	Action
216	**Update from Health and Wellbeing Boards** SH said that PF was unwell but she did attend the Essex Health and Wellbeing Board and one of the things discussed was the governance which was very positive. There was also a detailed discussion of the value of working with parish councils, talking about the contribution in very local communities that could be made and maybe that is something we can think about. The Chair commented that is the most local form of democracy. The Suffolk Health and Wellbeing Board has not yet taken place so there is nothing to report.	
217	**Finance Dashboard – Month 7** KD said the dashboard shows a £10m variance year to date. A significant amount of this is to do with PSF where there are some issues with not having the PSF to date and that can be recovered. Another element is that there is slippage on the savings plan year to date. However we are forecasting that we will recover that position. Commentary refers to ESNEFTs £14m which has now reduced to £8.5m due to their recovery plan. There has not been a change in forecast position to any of the regulators. The national team asked what we were doing about being behind track and I did go back to ask if they were monitoring this as a system as at present we are not in a system control total as if we were there would be a £7m additional surplus from the CCGs. As a system we have quite a bit of risk but collectively we are managing that and are looking at it in the STP DoFs group. EG mentioned that the Norfolk and Waveney STP didn't receive any PSF because they lost control of their finances as a system so there was a consequence for non-delivery which means the population misses out. The Chair responded that the fact we are only one of the three STPs with strong capital estates plans as a system, benefits not the organisations that we serve but the million people that we serve.	
218	**Approval of Proposals for STP Investment** The Chair outlined the process at the moment is for the DoFs to assess bids, business cases etc around the money which is targeted to specific pieces of development growth and improvement as an ICS. They are not a decision making group but they are bringing to us the proposals, with recommendations. KD said the STP DoFs have an investment advisory group which has a wider representation. They check the process, asking the relevant questions and checking that the financials are robust and that there are no hidden future revenue consequences. It is an assurance process to give this Board comfort that the process has been gone through to get the bids to where they are. As part of that they confirm that the statutory bodies that are impacted by the bids have taken it through an approvals process and agreed it as well. It then allows this Board to make the decision. The group have convened three times and taken the LWAB, cancer and digital schemes through, all of which are detailed in the paper and which are all recommended for approval. The Chair asked if there were any questions. No questions were asked so KD was asked to take back to the DoFs group that this is really good work.	

219	**Key STP Delivery Programme Reports** SG said that for diabetes they now had new care improvement for all the three alliance areas over the last year which is really encouraging given the challenges in primary care in those areas. AH said under the mental health dashboard, there is no mental health outcome form NFST as a key risk and it is affecting the whole system at the moment. EG said the HSJ information isn't always accurate. They had a league table around early diagnosis of cancer with which systems had deteriorated the most and North East Essex and East Suffolk were both on that list so it feels like we are going backwards not forward. The Chair responded there should be a conversation around this at a future Board.	
220	**Any Other Business** SH spoke about the LHCR (Local Health Care Records) bid. The last bid was done by the Eastern Academic Health Sciences Network which wasn't successful. We have gone back to the table regarding the footprint used for that bid. There was consensus amongst all the digital work streams that it would be better for us to join together as six STPs for the next round of LHCR to develop our proposals. There was also consensus that there should be a lead STP out of the six and it was proposed and we agreed that Suffolk and North East Essex would lead that process. SD has agreed to support us to extend our digital programme in that way. Also Essex County Council have been spoken to about this as they have had concerns for some time about the need to connect up digitally across the whole of Essex. We are taking this forward, trying to work out what this means. We will be given some additional resource from NHS England for the programme and our CCGs would be the vehicle for the funding to come through as well. We are developing this and will bring back a proposal to the next meet. SH announced that £173 had been raised for Save the Children by wearing Christmas jumpers to the Board meeting. The Chair said that for the first time, every single member round the table had made a contribution and thanked everyone for that. It had been a really good meeting. He wishes everyone and their families a wonderful Christmas. ***12.40pm Meeting Closed.***	