CAN DO HEALTH & CARE

Suffolk & North East Essex STP Board
Meeting held on Thursday 15th November 2018 from 1400 - 1700
at Training Rooms South, Colchester Hospital

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
Patrick Higgs *(Representing)*	PH	Essex County Council
Anita Farrow (*Representing)*	AF	Suffolk County Council
Stephen Dunn	SD	West Suffolk Hospital
Shane Gordon	SG	East Suffolk & North Essex NHS Foundation Trust
Neill Moloney	NM	East Suffolk & North Essex NHS Foundation Trust
APOLOGIES	AL	Norfolk & Suffolk NHS Foundation Trust
Andy Brogan	AB	Essex Partnership University NHS Foundation Trust
APOLOGIES	DA	East of England Ambulance Trust
APOLOGIES	LW	Anglia Community Enterprise
APOLOGIES	DS	Healthwatch Essex
Andy Yacoub	AY	Healthwatch Suffolk
APOLOGIES	MM	St Elizabeth Hospice on behalf of the three Hospices
Joanne Sunderland (*Representing)*	JS	GP Primary Choice
APOLOGIES	DP	Suffolk GP Federation
APOLOGIES	RW	Suffolk LMC
APOLOGIES	BB	North Essex LMC
APOLOGIES	IG	Suffolk District & Borough Councils
Rory Doyle (*Representing)*	RD	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 Ambitions Group / Patient & Carer Representative
Tania Farrow (*Representing*)	TF	LPN Chairs Group – Suffolk & NE Essex
APOLOGIES	PC	Health Education East of England
APOLOGIES	AJ	Public Health
Joan Skeggs (*Representing*)	JS	NHS England
APOLOGIES	RF	NHS Improvement
APOLOGIES	LL	STP Clinical Lead
Janet Wood (*Representing)*	JW	STP Chairs Group
APOLOGIES	MS	STP Chairs Group
Craig Black (*Representing*)	CB	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:

Simon Morgan	SM	STP Communications Lead
Victoria Fennell	VF	STP Delivery Support Unit
Glenn Young	GY	STP Delivery Support Unit
Kevin Wood	KW	STP Delivery Support Unit
Michelle Grant-Richardson	MG-R	Survivors in Transition
Verena Stocker	VS	NHS England National Transformation Team
Rosie Frankenburg	RF	Suffolk CCG

CAN DO HEALTH & CARE

Ref	Item	Action
196	**Welcome, introductions and apologies** The Chair, Nick Hulme, welcomed all to the meeting and apologies from members of the Board were noted. The minutes of the meeting held on the 12/10/2018 were reviewed and accepted as a true and accurate record of the meeting. The Chair updated:- • The Long Term Plan expected this winter any time up until April but hopefully in the next couple of months. Following the meeting with Paul Watson this morning, who has seen a draft of the long term plan, this absolutely allies to our ambition. • Regional appointments should be announced next week. • Paul Watson assurance meeting took place this morning. Very positive, on track, very pleased we are working with local authorities and the third sector which sets us apart from many of the ICSs. Primary care may be a concern, our thought processes on transformation in this area are excellent but concerns re having primary care round the table and hearing their voices is a concern we have spoken about before. Overall positive meeting. SD – Digital much of which we are doing with sharing of information aligns with and addresses some of the inequalities seen around the systems. Anticipates a strong emphasis on getting more activated. Warm Handover paper is for information following last month's Board. NM spoke about Winter planning. They are addressing risks in the system, engaging with East of England Ambulance Trust. Working with Glenn Young, who has recently joined the SDP on secondment, to draft a paper which was handed round to the Board. Looking to get emergency care STP leads to join with us to work through a more sensible approach to managing risk. Critical to that is engagement of East of England Ambulance Service and Ed Garratt as commissioner for EEAST has offered his support which we would like to take up to get those leads to reach agreement. The Chair commented that the system response last year was an improvement which benefitted from regular meetings. The paper outlines our thoughts for the Board to think about, outlining some of the pressures we have had previously to see what we ought to do. At the end there are some unintended consequences associated to this which we need to work out together. AB asked where mental health fitted in, NM responded that for A&E and the ambulance service there is sometimes a long waiting time and we need to look much more as a system how we support that, particularly for patients who have called an ambulance when an ambulance response unit isn't needed. Also our ability to respond more proactively during the day instead of waiting until the evening when everywhere has ground to a halt. There is a winter room which will go live on 1st December and information on this will be shared.	

- **Part 1 Specific Issues for Discussion**

Ref	Item	Action
197	**Brexit** EG spoke about Brexit:- • There is no national guidance though there is a national EPRR exercise planned for 1st March. • Local authorities have started to do some work together around their responses and what their plan should be and the local CCGs have been invited to contribute.	

	• Do we want to do something as an ICS? • Issues around workforce, drugs, blood products etc • We need to plan from 1st March and as nothing seems to be coming out centrally should we be doing something and what needs to be done? SD made the point that we need to make EU nationals who work in our area feel welcome, suggesting an STP communication along the lines of valuing, respecting and supporting EU nationals. With regard to supply issues, there is no guidance only warnings not to stockpile. Do we need to do something collective on this in identifying what stock we have collectively and where we are vulnerable. NM responded that at the present time we are not clear where all the risks lie around this or how confident are we around national contingencies. Risks need to be identified through organisational assessment and joint discussion to identify organisational risk. Questions were posed around how patient access to the NHS would change, what do we do if EU nationals come to the hospital for treatment after 1st April. SG said we are about to spend a considerable amount of time mitigating plans locally which should be mitigated centrally. Also, we have to be careful not to be political. EG commented that the carer workforce is huge in its employment of EU nationals. The Chair asked that the comms going out should include local authorities who may be slight more risky regarding the political agenda. The council representative confirmed that there are plans in place which Peter Fairley is dealing with. It was agreed that each organisation identifies a lead on this to share thoughts with Ed Garrett to chair with Simon Morgan and Glenn Young building comms around that. **ACTION:** Board members to advise the STP office the name and contact details of their organisation's representative. **ACTION:** Simon Morgan to put together a form of words for each organisation to put out, including local authorities.	**ALL** **SM**
198	**Suffolk Mental Health** EG began a presentation on mental health around co-production and the effects of deprivation on mental health. At the next Board the second half of the presentation, around the service model and commissioning options, would be presented. AH outlined:- • "A Very Different Conversation" including local authorities, providers and service users. One message. • Changes in the way they were working, now in partnership which proved beneficial and gave way to very different conversations. • Patients across whole systems were asked what they wanted and where they needed them by going to supermarkets, libraries, schools etc. Spoke to around 5,000 people across the entire footprint. • They changed the way they worked. Previously they all worked on their own patch but now worked to cover each other's' patches. This had been difficult but collaborative. • This provided a good base from which to work which was owned by all and was the equal responsibility of everyone • Part drawing up commissioning recommendations. • So successful that this is the way commissioning will be undertaken in the future. AB outlined:- • Healthwatch are co-ordinating a survey from which they are analysing 15,000 individual comments. 7,000 pupils took part. • Looked for repeated themes were which were outlined in the presentation. RF outlined:- • They were looking at providing guidance but more importantly to engage. • Produced an information poster and asked for feedback in order to develop.	

	• Self-harm, suicide and people in crisis as well as deprivation have become big issues. The reasons for this have not been established but they need consideration. • Looking at key issues, 90% of mental health cases were dealt with at GP level. • Links between organisations are not presently clear. • Personality disorder needs are not being met but they are the highest A&E attendees. • Crisis care which have heavy involvement of A&E, the ambulance service, Network Rail Police, GP Surgeries etc has been shown to increase both in the summer and in the evening, when there tend to be the least staff on duty. • Mental and physical health are linked, i.e. long term conditions can lead to depression which in turn means people are less likely to look after things like diabetes, heart conditions etc. • People with severe mental health conditions tend to live 15-20 years shorter than average. • Older people, especially those in care, transgender people and those with drug and alcohol abuse problems often suffer depression and mental health problems. EG reported that self-harming in young females is alarming and has become a real crisis and is a whole system issue. JS asked how we are going to access schools as schools are denying they have a problem and denying access. WH responded that they are developing a programme of working with schools which they are developing and building on and schools are beginning to see the value of it. SD said this work was deeply impressive and gives a better understanding of the challenges. He asked what gaps there are between demand and capacity. We will need to target scare resource. He was very struck by the change in deprivation in Suffolk which outlines the work that needs to be done bringing it together. EG said he would be bringing the service model to the next meeting. There is much work to do in primary care and the wider community. Crisis services are inadequate at present. The point about schools is very relevant. They have had access to Thurston School which is being rolled out to other schools which serves as a very good example of what can be done. SG commended a great presentation outlining hugely complex issues. The traditional mix of services aren't hitting the spot with this group of people. Patient activation models showing that patients feel unable to access mental health care and don't realise they are able to self-care at all at the lowest level. How do we provide staged education for people? Is there a role here for social media? i.e. Facebook activating mental health interest within communities. AH emphasised that this is about a system wide transformation across districts, boroughs, councils, communities. There are some things on social media and internet in there for young people but there seems to be some dichotomy between making conditions worst and engaging them through social media. AB agreed with the points made by SD. Because the system was co-produced, levels of expectation were made very clear from the outset that the system clearly wants to hear from you because it will influence strategic thinking and the way forward. If we continue to co-produce all the way through to the procurement stage, those levels of expectation will remain grounded. By co-producing people understand and prioritise. WH referred to the presentation to the Board had which talked about the causes. Services can only really be short term interventions for a certain amount of time so thinking about long term support is needed. With regard to higher ambitions, we need to continue with this piece of work as deprivation is absolutely a health problem. **ACTION:** Service plan and commissioning for next Board	**EG**
199	**Population Health Management Maturity Matrix** SH apologised and passed round an updated paper to the board, which replaced that already issued, explaining that we are not quite in the place we expected to be when the original paper was written. Verena Stoker explained that as part of the MOU that NHS England signed with us, they asked and we agreed that population health management was a key area of focus NHS England could support us to further develop Support is has been offered in terms of resources as well as a little bit of money. The MOU asked and agreed key areas of focus to develop a matrix to assess improvement and map successes. In developing the matrix they had looked at other areas that had done well and shared	

	examples. She asked for feedback on the matrix and for the board to work with her to develop priorities. There were no comments and the Chair said we recognise the importance of the work and thanked Verena.	
200	**Kings Fund Programme – determining our future ICS Structure, Governance and Leadership** SH gave apologies that this document was late being circulated but the document had to be updated following the workshop which took place after circulation of board papers. She made the following points:- • The document had been built up layer by layer, following regular conference calls, by a smaller panel of ten people chaired by Matthew Kershaw of the Kings Fund. • It is a first stage document outlining the principles of governance. It will later be built upon, starting with the governance then outlining further issues such as what functions might sit where in the ICS, what the leadership arrangements will be, how we make decisions etc. • SH emphasised that this is a draft first stage document which is not to be circulated more widely at the present time. Following discussion at the Chairs' group yesterday, SH will be providing a cover sheet explaining the purpose of this document and the next stages, before it can shared. • Want to be open with the work done so far in producing a reasonable draft, which we will hopefully agree on today, so it can be more widely circulated for discussion and feedback, whilst at the same time starting work on the second stage and the next layer of detail and some more specific proposals. • Once the cover sheet is in place, SH will share the document more widely and it can then be shared. She asked that Board members move quickly once the document was issued. Whilst that feedback was coming in, the panel would be working on the second stage and hopefully would be able to give the December board an idea of the emerging second layer of detail. The Chairs' group did not want to set deadlines, they see is as a dynamic process. JW said the Chairs' Group were very supportive of the principles and direction. It is a fast process and they want to see it moved forward quickly. The group are very supportive. The Chair asked for comments and made the point that the Nolan Principles of Public Life have been in existence since 1995 and are still as relevant today as they were then. CB spoke about the finance directors' awayday and the Shared System Control Total (SSCT). It was almost impossible to manage this without governance structure in place, particularly in relation to independent oversight in order to deal with any issues. In respect of the SSCT, if one organisation is coming adrift from the SSCT, how that would be dealt with particularly in relation to individual organisations and their statutory responsibilities, especially where they are relating to geography. There are also issues with county councils potentially subsidising other organisations in difficulty but also with GGCs being able to use money allocated to them for specific geographic areas. This can only be done with independent oversight bringing organisations to account. With regard to governance for the SSCT, we cannot do one without the other. The Chair responded that in the long term plan there will be a very clear expectation that ICS can demonstrate a degree of independence. Unless we are prepared to share, we are not a system. It was absolutely right that without finance governance the Department of Health won't give us any money so we may need to get to a position where we have some governance around finance in advance of the overall governance for the ICS otherwise we will not be given the £3m for the people we serve. SH said that we need to move to a close alliance with DoFs. At present they are more separate than we would like. The independent chair would be defined at level 2. We are moving quickly and the System Control Total would be included. **ACTION:** The Stage 1 document to be widely distributed with the cover sheet. **ACTION:** Update at December board regarding progress with Stage 2. **ACTION:** Feedback on document to SH	**SH** **SH** **All**
201	**Winter Comms Plan** We need a collaborative approach giving a consistent message on the website including the councils, the voluntary sector and mental health. • It is working well across patch with all parties. • There is a surprising amount of deprivation. • All partners are working well together.	

	• Emergencies through Careline • Social workers are aware of the programme and how we can be flexible. • Surprising how well we can work flexibly and well together. • Need to be careful how we frame our message with the emphasis on staying healthy to avoid hospital, not that hospital is a horrible place to be. • There should be just one message across all organisations. The Chair commented that hospitals are not good places to be and that in order to stay healthy, avoid hospital, not because of infection but due to emotional, social and physical effects on the patient. People should only be in hospital of they need clinical care. This is great but there needs to be more of that in the messages, there is not enough in there. **ACTION:** SM to get message out	**SM**
202	**STP DoFs Group/Investment Committee Proposed ToR** CB Within ToR for DoFs for financial investment process, the DoFs group will be the group within the STP who will consider proposals for the money coming into the STP, prior to them being brought to the Board. Key sums of money to have come in so far are around cancer, digital and the £3.3m for STP. The proposal is for the DoFs group to provide scrutiny around the proposals to spend that money and bring recommendations to the Board. EG commented this is like the tail wagging the dog. It is for the Board to make the decisions on how money is spent. CB responded that they scrutinise and recommend, they don't make the decisions, which would be for the Board. The Chair asked for clarity that the criteria is to be set by the Board. How to get from business case approach and into the wider issues that may need to be discussed. Also, predominately, representatives are statutory sector and is that the right thing in the spirit of what we are trying to do in the STP. CB responded that the criteria is set externally to the STP, for example the cancer and digital money came with set objectives. DoFs are purely making sure business cases meet the set criteria before going to board. If that criteria is not already set, it would be done by the Board. Within DoFs there can be co-opted members to make membership wider. The Chair said there needs to be independent overview of which there was none on DoFs. There needs to be an independent Chair of DoFs. CB responded that when considering the SSCT oversight if we really get the three alliances working together, with devolution from the GCC into those alliances, that would provide the oversight, therefore Jane and Kirsty as independents would be able to provide that oversight. The Chair asked what the local authorities thought as the money is not just for healthcare and the £3.3m needs to be used innovatively. County Council representative on the DoFs group said we have done that within the alliances and the transformation fund in Suffolk has been used more broadly than in just health services. There has been discussion at the DoFs group. JW said the Chairs' Group had the same concerns as Nick regarding the predominance of the larger organisations and the voice of the smaller organisations but this seems to have been addressed. Also regarding the lay membership, not sure how that works so needs reflection on that as a Chairs' group. SH said she attends the DoFs meetings which are predominately attended by NHS directors of finance. Although occasionally there are representatives from local government, she had never seen the voluntary sector, primary care contractors etc represented. It is one of the least representative groups of the STP. We need to establish what an assurance of the process is. Is it an assurance that we have followed a process or is it an assurance of the business cases. As an ICS, patient/clinical leadership is the focus, so we need to ensure that any decisions made are guided by that type of process. This should be part of the Stage 2 detail and work needs to be done on it. CB responded that we do need to agree the ToR under which the DoFs group is working. If this isn't right we can change it in the future, dependent on any further governance proposals but at the moment this is the remit under which the DoFs group is working. We need group agreement. SH said we need to agree on how some money will be spent in the short term and the intention is for it to be broader to include the voluntary sector, primary care etc and ensure that leadership from those	

	sectors have a say in how we invest money. What forum should be created in the short term for these decisions to be made. CB responded that the assumption is that if money comes in then someone in authority comes up with proposals on how that money is spent. The DoFs group doesn't do that but it considers those proposals against a criteria to assure the process. EG said that £3.3m of national money needs discussion. This Board makes the recommendations that the DoFs group then picks up and returns back to them, not starting the other way round. Also, the money should not go to the NHS but to the voluntary sector and these are the conversations that should be taking place. NM asked if these ToR could support us until the end of the financial year then be reviewed. SA commented that on page 5 of the document it should not be North East Essex CBST but Tendring CBST. Lady in navy next to Andy Yacoub said that with regard to intermittent attendance at DoFs, if it was clearer what the agenda covered they would get better attendance. The Chair responded that he kind of agreed but it wasn't right for people to turn up only if there were funds to bid for but also didn't want people wasting their time. WH said if money was moved around the whole system, this group could provide some comfort around the rigorous management of that money if it was outside the health sector, not necessarily what it did but around the mechanisms, where the money was held, to give assurance. SH said this would be picked up as part of Stage 2 of the Integrated Care System detail. It was **AGREED** this should be signed off for now and reviewed at stage two and the end of the financial year and it would be a Board decision on how the £3.3m would be spent. **ACTION:** To be included in Stage 2 ICS Governance **ACTION:** Re-circulate the DoFs group members list to see if other people wish to join that group.	 **SH** **KD**

- **Part 2 – System Transformation Programme**

Ref	Item	Action
203	**STP Diabetes Programme** SG brought to the Board work done on the diabetes programme to share thinking on implementing ways of working. The outcomes based accountability model was used in deciding what needs to achieved for the population and what is being done to change it. You cannot hold anyone to account on what you are doing for your population as it is a community effort. There is a need to know that what is being done individually and as a partnership is making a difference to our population. This has been simplified down to two outcomes; what can be done to prevent people getting diabetes and how to provide the best possible care to those who have diabetes. It is easy to measure the number of people who have diabetes but the number of new diabetes cases each year needs to be measured as one of our alliances has stopped increasing the number of new cases for the last year or two but there is no explanation why. The diabetes programmes in Ipswich and East Suffolk and North Essex have just won national awards for their diabetes care and the whole STP has been very highly commended by Diabetes UK for the quality of care. So how well cared for and self cared for are patients? We congratulate ourselves on 90% of people hitting their blood pressure targets, 80% for cholesterol etc, but when added up across people who have diabetes, there are only 25% of cases getting all the right care. So we may be doing really well with blood pressure for one group of patients, foot care in another, cholesterol in another, but overall we are not doing as well as we think. So it is not about the measure of success in individual things but ensuring all patients with diabetes get all of the best care. There are vast variances of outcomes in different practices, with 10% of diabetes patients getting all the right care, whilst in others it is 40%. It is not about deprivation rather about the way healthcare and the community support those patients to get the best care. The role of the STP is not to go and fix all the problems but to prompt us to ask the interesting questions such as why some of the most deprived areas have the best diabetes care. Activation and engagement of the community may have a bigger role to play in this than medical care. With regard to data, most diabetes data is a year out of date. We would like to see it updated month on month or week on week. Access to more up-to-date data is crucial in helping us to move forward	

	and a critical tool for change. Investment in updating data would help us to know if what we are doing is working and help us to prove our effectiveness as an STP. JS said Rightcare have the same data and suggested pharmacy engagement as a good opportunity. SG agreed it is the whole community that needs to be pushing for the same outcomes in their different ways. Population data is so vital as there is so much we don't know about our populations and this highlights what can be done with good data. SD commented that it was a good, well thought through paper. How do we focus on areas and localities that need it? SG there is a lot of investment coming in but it is all targeted at a national programme we have no control over. As an STP, there is about £40m spend on diabetes and it is about how we use the vast resource we have to drive improvement from a different approach and the data is what will drive it. The considerable improvement seen in North East Essex can largely be attributed to the change from hospitals being completely separate to GP practices to clinicians in hospitals going out to GP practices and working with them. SD asked about the existing executive schemes and payment schemes, are they appropriately used? SG responded that national targets the single organ or single indicator model and that is not as good as targeting an holistic model and we don't have a lot of attitude to change that but there is some local funding in North East Essex which is given to the provider to incentivise the population which is targeted at the practices. That is a bit of extra funding from the CCG so there is a question about affordability. AY said it is good to see Gerry Rayman involved and asked about patient diabetes passports. SG responded that HSLI investment gives us the opportunity to access the Health Information Exchange which allows any person caring for that patient to access all records for that patient across multiple providers which effectively is the Diabetes passport. PH North East Essex has looked at the way their resources are directed and a lot of money has been spent on consequences rather than causes. How to we bring in from a metrics perspective how we are tackling the causes and causes of the causes SG so the looking at outcomes for people which is the consequence and the work done to try and change that so we need to look at the outputs and that is why we need whole community involvement regarding activity, diet etc. What we do know is that 90% of diabetes is preventable or reversible with a change of lifestyle and its things like access to green space, walking for thirty minutes, five a day, cutting down on alcohol etc that makes the difference. We have an awayday next Friday which is focussed not on the medical model but on community activation to establish how to do this as a diabetes strategy. For the STP that will be the next thing to come out of this workstream. SH we will be looking at how we can use this same concept on other worksteams in the STP. **ACTION:** SM to get messages out.	**SM**
204	**Update on Higher Ambitions** AH • Partnership working takes time, sometimes a long time. • We need to involve both people using the service and their carers. • We need to get going on higher ambitions. • Healthcare can't do it all. The third sector is doing well but needs our funding. WW • There are tiny pockets of deprivation and deterioration but methodology is assisting. Things are getting worse, as shown with the increase in food parcels and we need to do something sooner rather than later. • Suggests we need to learn by doing as it is complicated. The Chair commented that there would have to be a very good reason not to use the £3.3m for the third sector. AH asserted we should just get on with it. This will increase the understanding of what the STP is. There are three things Anne asks everyone to do:- • Provide names and contact details of any service user/carer organisations or individuals that they currently work with • Provide name and contact details of the person responsible for transformation or partnership in their organisation	

	• In order to engage with the voluntary sector to improve outcomes on deprivation, please put money on the table for deprivation WH said they had charitable partners in GP surgeries for social prescribing work as many people visiting GP surgeries may be suffering from depression for all sorts of things such as losing their house or their marriage breaking up or their children suffering sexual abuse and the people who can help with that are in the voluntary sector. People in the industry sector are giving support. It is not necessarily about what is being done but how it is being done by engagement with their neighbours. SA wanted to emphasise the importance of retaining, growing and building on the voluntary sector. There is an insistence on the voluntary sector merging with just one organisation to deal with yet within small organisations there is trust and comfort in peoples' own community. One big voluntary sector won't work. The Chair said it would be good to step back. Local authorities, who have been significant funders of the voluntary sector have had a cut of 40% of their funding meaning they have to concentrate on their statutory responsibilities. However, a small amount of investment in the third sector could make a significant difference with the services patients are using. With regard to Anne's request to put money on the table, we hear you but we can't just put money on the table to deal with deprivation. With the support of the board, some of the £3.3m has been spent with but what resource is left the Board could set a criteria for support and encourage the voluntary sector to put together some cases. There will have to be a governance process but it has been recognised that we will need to take some risks and do something different. Agreement to Anne's first and second request for contact details of service user/carer organisation and transformation leads. With regard to putting some money on the table it is difficult to respond to that without any specifics. At the December board we will come back with some proposals of how we will spend the £3.3m before we lose it. The voluntary sector works in a very different way and the money needs to be used to grow the assets they already have. **ACTION:** Provide contact details requested to Susannah Howard	**ALL**

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

Ref	Item	Action
205	**Update from Suffolk Health and Wellbeing Board** SH explained that the Essex Health and Wellbeing Board meeting had not yet taken place so there was only an update from the Suffolk Health and Wellbeing Board. Ed Garratt reported that a lot of the content of that board was the same as that going on at the STP Board. There needs to be a conversation about rationalising some of these boards and clearer roles between the two of them. Much the same content though the conversation was different. The conversation today has been excellent in a way that it wasn't last week.	
206	**Finance Dashboard** Chair advised that this is for information. No comments were made.	
207	**Key STP Delivery Programme Reports** There were no comments on the Programme Reports. The issue of SDP SROs can't be resolved until we have different governance. The posts are for full Board members only. The SRO roles which need to be filled are Prevention, Cancer, Primary Care and Estates. There is an agreed process for these appointments. Asking members of the board for nominations with oversight of Chairs' Group. Primary Care may change in that presently it is overseen by one person but in future the role may be shared by three people. Amanda Lyes will be asking for nominations to include directors of public health board members.	
207	**Any Other Business** WH brought up that Suffolk County Council have taken the decision to cut the core funding of the Citizens Advice Bureau of £75k. They do have bolt on funding for things like debt advisors but without the core funding it is difficult to see how they will survive. This is a health issue as the CAB take a huge number of calls from people facing deprivation, it is way of signposting to foodbanks as well we many other services. They are a crucial partner and due to the impact on health partners it may be something we need to talk about.	

	We could ask what the local authorities are looking to do, as it also involves community transport in rural areas, education phycology etc. The Chair responded that this is an unintended consequence of changes in the system. How do we manage this? This is a matter worthy of a wider conversation and development of a system quality impact assessment. We need to think of how we do this as a system and ask everyone to take this away and bring their thoughts back to the next meeting. Write to Gavin and Nicola, the Chief Executives of both Essex and Suffolk, asking to meet with them to set up information sharing to start with. Healthcare organisation are very closely scrutinised when they wish to make any changes but there isn't the same for local authorities. **ACTION:** The Chair to write to Chief Executives ***Meeting closed at 16:50***	**Chair**