Suffolk & North East Essex STP Board
Meeting held on Friday 11 January 2019 from 09:30 – 12:30
at Conference Room West, West Suffolk House

CAN DO HEALTH & CARE

DRAFT Notes and Actions

Nick Hulme (Chair)	NH	STP Lead
Ed Garratt	EG	Ipswich & East Suffolk CCG & West Suffolk CCG
Hasan Chowhan	HC	North East Essex CCG
Patrick Higgs *(Representing)*	PH	Essex County Council
Hasan Chowhan	HC	Suffolk County Council
Stephen Dunn	SD	West Suffolk Hospital
Shane Gordon	SG	East Suffolk & North Essex NHS Foundation Trust
APOLOGIES	NM	East Suffolk & North Essex NHS Foundation Trust
Antek Lejk	AL	Norfolk & Suffolk NHS Foundation Trust
Andy Brogan	AB	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
Richard West	RW	Suffolk LMC
Vaiyapuri Raja *(Representing)*	VR	North Essex LMC
APOLOGIES	IG	Suffolk District & Borough Councils
Anastasia Simpson *(Representing)*	AS	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
Saffron Rolph-Wills *(Representing)*	SR-W	Health Education East of England
Amanda Jones	AJ	Public Health
Carole Theobald	CT	NHS England
Ruth Forbes	RF	NHS Improvement
APOLOGIES	LL	STP Clinical Lead
APOLOGIES	SC	STP Chairs Group
Mark Shenton	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:

Lynda Bradford	LB	Suffolk County Council
Eddie Olla	EO	NHS England
Caroline Taylor	CTr	Essex Community Foundation
Stephen Singleton	SS	Suffolk Community Foundation
Simon Morgan	SM	STP Delivery Support Unit
Victoria Fennell	VF	STP Delivery Support Unit
Kate Walker	KWr	STP Delivery Support Unit
Caroline Proctor	CP	STP Delivery Support Unit
Keith Wood	KWd	STP Delivery Support Unit

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Ref	Item	Action
221	**Welcome, introductions and apologies** The Chair, Nick Hulme, welcomed all to the meeting and apologies were noted. The minutes of the meeting held on the 14 December 2018 were reviewed and accepted as a true and accurate record of the meeting. **Matters Arising** **Brexit** EG said there has been a lot of work going on. The supply chain is the biggest risk we have. Chair said there is not much guidance centrally. SH added that there is a workshop on Monday which Glenn Young and Amanda Lyes would be attending. AH asked if we need to consider putting out a message to patients and carers as there is some concern. Chair responded that if we had some clarity we could do so but at the present time we are not in a position to give any reassurance to patients and staff. RW said we must remember incidents from the past like petrol shortages, which actually created panic which caused problems with the supply chain. We do need to ensure we are giving the message that it is business as usual, there is no need to stockpile as otherwise we will create the disaster that wouldn't have happened in the first place. PH commented that the council are doing a similar exercise so at some point we need to get together on this. **Long Term Plan (LTP)** Chair said we don't have the LTP on the agenda but it should be discussed. It is a bit disappointing with regard to higher ambitions but there is nothing in it which would stop us with the some of the ambitions we are creating locally. There is not much there which will accelerate this either. - SD said he had attended an advisory board the day before. There are inevitably a series of compromises nationally. It gives a clear vision as to the future direction of health services as opposed to health and care, there are challenges around how the health service integrates with social and care and voluntary networks of provision. There are key areas of the workforce that remain to be addressed but the plan is very strong and reinforces the direction of travel for STPs which is in line with what we are doing. There is a new focus on preventative programmes and revised NHS financial architecture. The key question is how we implement the LTP which should be part of a future discussion at the STP Board. There is a desire for the government to remove some of the competition rules which currently hinder collaboration. This information is not for tweeting but it is thought that CCGs will, over time, merge to become ICSs. SD was pleased with the LTP but there are big questions. It is really important that leaders engage with this agenda and get behind it whatever our personal views may be. We are already doing or are on the way to doing most of that contained in the LTP. Not sure that what in the plan will alleviate the year on year increases that have been seen. Some of that is acknowledged in the modelling which underpins the LTP because they make an assumption the bed base needed will reflect current trends and not models of care that it refers to implementing in the plan which will be a benefit for the system. It means that we may move out of deficit but it will be still be challenging going forward. - EG said we have needed to wait for the LTP but we can now get on with it and I see it as an endorsement of the mandate to move forward. - Chair said that for the next meeting we will look at the LTP and link our ambition alongside to see if there are some areas where we need to adjust our plan. - SA said there was emphasis on GPs doing more social prescribing and gave a word of caution that if our commissioners jump on the band wagon of supporting social prescribing per se there is a danger that small voluntary activity may go by the wayside because all the trendy funding is going to the social prescribers when really it is only a matter of awareness, promotion, training to know	

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	where to signpost people. Everyone does social prescribing in their own daily lives. Please support the small voluntary sector organisations rather than this trendy new social prescribing. - Chair said that we are working through the plan and we need to think about what it means locally. We need to be careful not to just jump onto the next new thing. We will look at who is best to lead on that. - SD said there is operational guidance coming out. Operational plans put together by individual organisations need to be pulled together for the STP. - Chair said date of submission is in February so that piece of work will have to be done outside of the normal process as a Board. **ACTION:** Identify who will lead on implementation of the LTP to look at how it links with our ambition and bring it to a future Board.	**SH**

- **Part 1 Specific Issues for Discussion**

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222	**Proposed Application For Funding for STP Suicide Prevention Programme** AB introduced this presentation. We have been asked to apply to this second wave of funding. There are two issues:- • Suicide prevention is one of our higher ambitions for mental health • There is no indication at this stage that any funding we can secure would be recurrent or last for any longer than a year, which needs to be considered. It's not entirely clear what the amount will be or when we will be able to give more detail. There are some caveats on the bid as to what we can actually apply for but we do have suicide prevention strategies in both Suffolk and Essex. Part of this is to try to harmonise some of the approaches across the STP foot print. LB spoke about the work Suffolk have been doing on suicide prevention. The main points are:- • We were invited to join a shortlist in mid-December to enable us to bid • We may be the only STP in the East of England shortlisted. • A steering group was formed of people with interest and knowledge about suicide prevention from North East Essex and Suffolk to draft the bid. • The Suffolk Health and Wellbeing Board in Nov 2016 committed to suicide prevention as a system • Much work is already in place; staff training, database set up, community individuals called Suffolk Life Savers are in place, task and finish groups are looking into high risk groups, IT solutions etc. Firstly they looked at what both Essex and Suffolk already had in place in order to harmonise. There are a number of caveats:- • Place based prevention work • Self-harm • Acute hospitals • Primary Care support It is therefore limited with regard to what it can be used for. The steering group looked at what both Suffolk and Essex are doing to come out with an overall plan. There will be a bid for some primary care support around training, focussing on higher suicide risk areas. There will also be a bid for some mental health acute care support, in the form of a product called the Monsenco app. The biggest area is how we support middle aged men to reduce their suicide risk as both Suffolk and North East Essex show that 70% of people who die through suicide in our STP footprint are men and the majority of them are not known to mental health services. One aspect of the bid is to have a community based fund which people can bid into, which is an ask of the voluntary sector. The process is set out in the paper, we	

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	think the money is around £250k, 25p per head of the population of the STP but confirmation of that is still awaited. The Chair then opened this up for questions. • SA said she thought it was really exciting and she can identify some potential organisations that could work with this and she would pass their details on. • Chair said that in Wendy's absence we would ask for her assistance on this. • AL spoke about the danger of the short-termism. As the funding was only for 12 months, it needs to be well thought through in terms of what follows and how the resource is used to build a sustainable and different model of delivery which we then fund appropriately. • Chair said we need to remind ourselves that we have zero suicide as one of our higher ambitions and need to think how it links into that. • AB said his concern with the bid is that it is still service specific, it is about service and suicide prevention is probably less about that than some of the other things we do. It does tie into the higher ambition but it probably won't me a major factor in that. Supporting the service is important but it is much more about the wider determinates and how we can tackle that across the STP. • RW said Suffolk and North East Essex is a rural area and farmers are one of the highest suicide risks yet it seems to be very much based around population settings • LB responded that is not the case. They are looking to target man led community based work around veterans and ex-service personnel, residents in high risk suicide areas, LGBTQ, those at risk of social isolation, routine and manual workers and drug and alcohol users. The agents we want to work with are community agencies and rural community support voluntary sector organisations. • Chair responded that the NFU did a lot of work around this. • LB said Suffolk is very different from Norfolk, which has a much greater problem. Suffolk doesn't show farmers as being a high risk group but we still consider them. Chair asked if everything was covered and AB and LB agreed that it was.	
223	**A Regional Approach to our Longitudinal Health and Care Record (LHCR) Programme** SD introduced this presentation in relation to the LTP in which there is a very clear vision of digitally connected providers and patients and the harnessing of technology to support operational delivery and quality and clinical priorities. It is key in improving quality and safety and integration of our services. There are a series of milestones set out in the plan, one of which is that by 2025 geographies will deliver a longitudinal health and care record platform, linking NHS and local authority organisations, with subsequent areas following. There is a real focus on cyber security and they wish to get all providers to a level of significant digital maturity by 2024. There is a proposal to develop a regional LHCR across a wider geography and because we are seen as one of the most digitally advanced systems in the region, there is an opportunity for us to lead on this work. This would not only let us have a wider system role which may come with some resources, but also will give us the ability to maintain and influence the agenda from our current Secretary of State. KW gave a presentation, the main points:- • LHCR is a group of healthcare partners who are working collaboratively to create an information share environment. • It is a suite of capabilities that connect to allow information to flow. • Why us? Our investment and collaboration and the importance to our partners and patients of shared health records. • From a patient's perspective; example given of a patient who suffered a fatal asthma attack, having been seen 47 times by various medical professionals in different parts of the NHS. Linked records would have allowed doctors to better understand the patient's medical history to treat her differently and perhaps prevent her death.	

- From a manager's perspective; by linking the data together around conditions and relating costs it can give insight into the critical relationships between co-morbidity and costs of care to help form priorities for the development of local integrated care strategy.
- From a healthcare professional's perspective; better understanding of the patient's medical history which would inform decisions made in future treatments leading to a better outcome for the patient.
- From a social care perspective; it would be embedded in practice to refer to these healthcare records to track a patient's location, test results and keep professionally involved. Looking up past medical history will build a picture of a patient to help perform social work assessments, saving time chasing this information from wards. This will free up time to spend with patients to assess their needs and facilitate their discharge from hospital.
- If all clinicians are working from the same healthcare records, it avoids the patient having to tell their story time and time again.
- Avoids waste; duplication.
- Will enable health and social care professionals to manage risk more effectively.
- Enables patients to maintain their independence, eg access to information informs them to make choices, ordering medication online to be delivered home gives independence.

EO said on Monday the Long Term Plan was launched and echoed the points that have been made about the ambition or lack of ambition in the plan but also wanted to acknowledge that this is one of the systems who have generated the best amount of digital investment so far. Taking the points from the LTP, this is a locally led long term plan with digital at the heart of the delivery and partners such as this STP have actually delivered on the technology by creating an ambitious plan which has been followed through by delivery. It is really important to acknowledge that and we learn how to make sure that the LTP delivers the service improvements that we have outlined. Collaboration is the key to making this work. NHS England are just going through that process of collaboration so they are not the experts, this STP is better positioned in terms of Suffolk and North East Essex to take forward the regional aspect of the bid for local health care records. There is acknowledgement of the great input of the third sector and other bodies because collaboration is already happening, I have seen it today, and the key partnership works not just with health but the carer and third sector as well. EO offered support to a locally led but nationally co-ordinated digital programme to achieve the service ambitions as set out in the LTP.

KW said they were asking for support of the Board to lead this as a system on behalf of the region.
Chair thanked everyone for their input and asked for questions:-

- SG said this is hugely exciting and is the tipping point for our ambitions as this information underlies every aspect of our aspirations. There is some complexity and challenge leading six STPs, some of who are a long way away from the level of integration we have. We need to think about the resources we put in collaboratively for the centralised effort as KW is fabulous and works all hours but there is only one of her. Also, we are only going to make progress with integration if everyone is moving towards it. Not every organisation can invest at the same level but some organisations are not investing at all, not necessarily in this STP but in others and it can create the dialogue that says you have to be making progress and commit resources every year to take the next steps as it happens with five to ten years of sustained investment.
- Chair said there is a really important role for the region as we have limited, if any, influence as an STP so there needs to be a conversation with INE and the regional regarding what support and levers they may potentially use and cash tends to be quite strong.
- MS spoke on behalf of the Chairs' Group who welcomed this and felt that they have been listened to regionally when this Board said that just our own STP footprint was not going to be enough. The digital is advanced but we are not using it as effectively as we could be and it is patchy. We will have leaders and followers and luddites so we have got to make it really relevant, not only for practitioners but also for patients. We know it's not going to be a panacea to the demand but it is a real enabler to help decision making, patient and clinical, and is recognisable for safety. We know GP extended hours indemnity cost is higher if they do not have access to clinical records and there

	was a potential problem of them not being indemnified if they couldn't access the clinical records of the patient in front of them. Cross system working could reduce cost and it will reduce risk. It can also link to systems enabling to us to audit and improve outcomes for patients but it also, through patient access, give potential for patients to release their own ability to change the way they are using services and manage their own lives. A vital part of the system. How do we use the leverage of the system size we have to push the current providers, who may not be as responsive as they could be, given their positon in the market. Hopefully by opening up the market we will get new IT providers providing us with something truly revolutionary. - Chair said we are hoping for leverage and the purse string power that allows us to take control of the providers role. - EG said it is exciting to be doing something across the East of England. Do we need to think about the leadership skills. The branding may need to be considered as in West Essex they have something called My Care Records and we are using the Longitudinal Health and Care Records which really loses people so we need consistent branding. - AJ said she is very supportive but system outcomes are the key thing here and information equity could be a risk due to the fact that the things we are talking about can really improve patient outcomes so we need to keep an eye to information equity both in terms of groups and geography. - VR said it is really good progress. Only fear is around GDPR regulations. Practices are responsible for holding all the records in primary care and there is a cost involved in looking after data protection. Would those practices still be the data control officer. - Chair commented that the resource implications need to be carefully considered so we don't create an unnecessary burden of resource in any part of the system. - KW responded that there is an expectation that the journey of travel is very much per person, the patient themselves can control their consent without reliance on the individual practitioner but that is a journey of travel that we will get to. - EO said the concerns raised are being discussed at a national level, specifically around the fact that we are making a commitment to opening up the records to the patient and we have a work stream for this. - Chair said that it is usually the healthcare professional who is more protective about the patient's records that the patients are themselves. Once the patient recognises the advantages of sharing, they are much more willing. With all the different organisations having their own development ideas around where they want to invest in terms of technology, how do we ensure that organisations aren't developing their own systems that won't integrate with one another. - KW responded that it is important to get a position of standards that we can work towards collectively which allow innovation and integration. The leadership is very much emerging as guiding principles rather than a command, because there needs to be connection up, across and down. - Chair said that as the group develops, is there the possibility to require that any investment in technology must be signed off by the STP/ICS. It's not about controlling it is just about being absolutely sure that future developments will link in. Can SD and his team think about this issue and bring it back to the Board. - SD agreed there must be a way of doing that collaboratively. - PH said following on from this point, thinking about the East of England and the complexities, there may be an opportunity to take this presentation into the ADAS regional group as there would probably be buy-in around that commonality and understanding. - HC said as well as looking at the integration ability we also need to consider the quality of data held within those systems as there is no standardisation. - The Chair gave his thanks to those who presented. **ACTION:** SD to come back to the Board with an outline of how we ensure that any investment in technology is signed off by the Board to ensure that technology integrates with other systems being used. **ACTION:** SD to look into the link with ADAS.	 **SD** **SD**

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224	**Proposals for Estates and Technology Transformation Fund (ETTF)** EG introduced this saying this is around new investment in general practice in terms of estates and facilities. KW gave a short presentation. The ETTF comes from NHS England. In June 2018 we agreed our STP digital priorities and building blocks of enabling the practitioner, empowering the person and accelerating our digitalisation. We want to show the schemes developed to work in primary care, focussing on those core building blocks, enabling the practitioner and freeing up time to care, so those schemes align to priorities. In summary the focus is on local capabilities in primary care and moving those assets forward so that practitioners have more capacity. The Chair asked the representatives of primary care around the table if they feel they have been involved in this prioritisation. - RW said he was very pleased to see this investment. Within regard to Falsified Medicines Directorate, there hasn't been sight of the IT support to allow that to happen across the full primary care estate. - KW responded that she didn't have the answer to that but would come back. - Chair asked KW to find out. - PD asked how the NHS app fitted in with this. - KW responded that national assets tend to get piloted in some of the more advanced areas, tested and evaluated then rolled out in our various areas. We remain very close in our system toward national asset development so we need to see how that works, how we receive it. It is a case of watch this space. - EO said it plugs into all other applications. - AB asked how accessible IT is to professionals across the whole system as not every nurse or practitioner has direct access to a screen to access emails, online training, webinars etc. Do we know to what extent practitioners have access. - Chair responded that it is about individual organisations. - MM said at the last Board there was a presentation about My Care Choices. This feels like a potential source of funding for that. The Ipswich and East Suffolk End of Life Programme has asked MM to work with Mark Jarman-Howe to come up with a proposal which would be happily shared across the STP footprint. - Chair responded that would be good. We haven't had the costings from Mark yet but we have identified a potential source of funding. **ACTION:** KW to look into the IT support available around the Falsified Medicines Directorate.	**KW**
225	**Focus on Primary Care** Chair said we have quite rightly been challenged about our focus on primary care. Talking to some national leads earlier in the week, it is an issue that most ICSs and STPs are having difficulty with. It is about how can we ensure primary care representation at system planning and delivery level, giving that most people in primary care wear several different hats as a provider, as a commissioner, representing their own practice, representing their members thought the LMC etc. There isn't a system that can say they have nailed this. The request is that we hear from each of the three presentations, the LMC for Suffolk, the CCGs collectively for Suffolk and North East Essex and the local professional networks. RW gave the first presentation for the LMC. The main points were:- • Maintaining the workforce In 2016/17 GP numbers nationally increased by 7, across the whole country, whereas Consultants increased by 1,520, yet primary care provide 80 - 90% of NHS contacts. General Practice has become more and more stressful for individual practitioners and other career opportunities being created, such as GP Plus and GP Screening, are more attractive to GP practitioners. There is real concern amongst GPs with avoiding 'last partner standing' which means you are the last partner left in a practice with all the liabilities in terms of staff redundancies and premises liabilities. Changes in the pension regulations make it more	

attractive to retire from mid-50s onwards, so we need to make it more attractive for them to work into retirement as we desperately need that workforce. Also, Agenda for Change has meant that salaries for staff working in hospitals is higher than for those working in primary care which means they are losing staff into secondary care.

- Reducing workload in General Practice
  Using the Boston Consulting Group calculation to work out what capacity is needed, there are 9,501 less appointments available each week to patients. 80% of those patients will end up somewhere else, i.e. A&E, 111 etc.
- Investment in General Practice
  This is about real investment. Funding in general practice has declined from about 9.6% in 2005/6 to 7.9% in 2016/17. Budgets have not gone up enormously in that time which means that in real terms we will have lost about 1%. At the same time, practice expenses have gone up which means the workforce is shrinking rather than growing. When there has been increased funding it has been diverted to other things such the introduction of CQC inspections which are very time consuming and costly, and professional indemnity costs which have really risen to well above inflation. The average annual payment of £152 per person per year is slightly less than the cost of a TV license.
- Focussing the clinical workforce
  There has been an increase in bureaucracy and reduced capacity, although the system always says it will decrease bureaucracy. Lots of the funded students that have come into general practice recently have been non-reoccurring which makes it difficult to employ long term staff. Even if there was capacity, no matter what funding was put in place, there just isn't the workforce available.
- Continuity of care
  Both Kings Fund and BMJ reports say that continuity of care decreases cost to the system, improves outcome for patients and improves satisfaction for the workforce. Therefore we need to try to work into our plans how to retain continuity of care between patients and practitioner in order to try and improve efficiency.
- Closing the cultural and commissioning gap
  Since quite a lot of commissioning has been done, particularly around district nursing, there is a greater gap where district nurses are providing services for patients who are purely housebound while they traditionally did other things such as catheter care etc and now there is nobody commissioned to do mobile care of patients in the community. These are causing gaps in the system with people working purely to a contract instead of doing what they traditionally did. We talk at the STP about the whole patient and holistic care and working together as one clinical community so if we actually as a group could produce leadership in terms of that and get it happen on the ground rather than in meetings.

With regard to IT in general practice, there is a general feeling that it isn't fit for purpose and it is falling behind in lots of ways. It is often very unstable in practices and there is a lot of time spent rebooting machines that don't work, fixing coding errors and systems not integrating properly. It really does need to get sorted and capacity could be increased if the systems would work.

There is a balancing act between NHSE policies that take money away from supply and services on the ground. Changes to infrastructure will fail if core services become unviable. There needs to be a recognition that GP funding reduction is well beyond its capacity to absorb work. More money is needed urgently, the sums are not particularly large but capacity needs to be increased. The failure of a relatively small number of practices will create a cascaded destabilisation effect across the whole local health system and the feeling on the ground is that this is much nearer than anyone feels comfortable with. There have been parts of the country where practices have failed, though this hasn't happened in North Essex and Suffolk.

MS gave a presentation as Chair of Ipswich and East Suffolk on the challenges faced. Main points are:-

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	• There have been practices that have failed and have needed rescuing with support from Suffolk GP Federation. Others have needed high levels of support from the CCG, LMC and GP Federation. • The strategy has been developed from bottom up, not from this board and filtered down. It aligns with what we want to achieve locally and with the GP Five Year Forward Plan. • General practice has constantly evolved and continuing to do so will enable the next steps to become a reality. Our local practice development is aligned to national models and the GP element of the LTP enables primary care to benefit from the attention and financial intention of the five year plan. • General practice has evolved. Historically GPs were sub-contracted by the NHS as they worked from their own homes to give care to local patients and their houses couldn't be nationalised. Group General practice came about in the 1970s, and in the 1990s mergers of single handers and the development of co-ops to deliver out of hours care. Many changes came from general practices themselves to improve safety and continuity of service. From there came the primary care team and the primary care network model. There has been constant evolution rather than revolution, from bottom up not top down, and legislation and contracting has tried to support that development. • CCGs developed their primary care strategies before the five year forward view for general practice was published. They are relevant to neighbourhoods and the population they serve and also relevant to the strategies of the membership that created them. It is important they continue, so having an overarching STP primary care strategy is not the right way forward. • It is aligned to the primary care network and collaborative working, which had a strong emphasis in the plan. Our ambition goes further as it looks to include specialist, mental health and social care teams as well as the voluntary care sector. The voluntary sector will support social prescribing done by everyone, not just GPS. Any of our organisations can do social prescribing which will save some burden on GPs. • Financially we must balance every year. There are issues around a balance of working on our business and in our business as unless we have time to work on our business, we can't work out solutions for ourselves. Innovation comes from those who take joy in their work, not those who are miserable. • Despite the challenges, general practice has good performance against national standards. Having a GP Federation across our footprint has been enabling, supporting general practice in many ways. We need to make working in core general practice as attractive as GP Plus and out of hours. GPs are engaged in developing neighbourhoods, place and systems. Localities are starting to develop and new models of care described in the GP forward view are starting to happen. We are trying to secure maximum investment to improve resilience in general practice. 90 of 102 practices are currently working in a collaborative way. • The practitioner/patient relationship and continuity of care are the most appreciated care by our population. • List based care of our population is most fundamental and is the basis on which the NHS is built. If that foundation is not strong, the rest of it crumples. • We are looking to develop practice enablement in regard to the business model and the delivery model so they can be more sustainable through the high impact changes described in the forward view to increase capacity and get patients to the right place first time. • With good processes, 75% of clinical bureaucracy can be managed by administration teams given the right support. • Working at scale in real self-determined collaborations is important as resources at scale can be more effective across groups of practices rather than individually and Care Closer to Home and integrated neighbourhood teams in the localities are the equivalent of the national model. • Evidence also tells that about 80% of contacts have continuity of practice but not necessarily continuity of GP input. Of practitioner and teams wrapped around the remaining 20% about 18% needs continuity of practitioner and the other 2% requires both. Applying that to our new models of care may change the capacity required. • Young practitioners don't want to just do serial one to one care, they want to be involved in education, training and their own specialisms. Time to think, learn, share and network to	

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broaden horizons is important to them so this presents an opportunity to improve workforce retention.

- IT can improve capacity and efficiency enhances collaboration. Avatar technology can improve capacity for GPS IT. It is an enabler that improves access to patient records and practitioner effectiveness allowing for mobile working. Suffolk GP Federation are looking into how access to the records can give a different offer to practitioners who wish to work from home, supporting other practices with telephone and bureaucratic demand from a clinical perspective.
- The risk that we hold in general in terms of mortgages, estate or as leaseholders does need to be sorted out. Suffolk Primary Care have developed new solutions for partners to manage that better, creating funding and avoiding the last man standing issue. In addition, working with alliance partners like Suffolk County Council and putting money into estate development gives much better value for money for the NHS generally.
- Closing commissioner gaps through strong relationships between practices and community teams will better enable them to manage the workload and improve quality of care, close to home, for patients.
- GP is a pivotal pillar which is vitally important and the foundation of our system. It is financially efficient and adaptable which needs to be a priority for investment as without it working optimally the rest of the system will fail. However there is bottom-up strategy which is all aligned, we know we can evolve and that we are aligned to the national model and are in a position to draw in the investment associated with that.

There is a request the Board to consider how general practice engages with the rest of the system through their localities to ensure that your teams make themselves available to it and amenable to what needs to be done to reduce the workload of general practice specifically but for all of us overall, and a call to our voluntary sector to say we do want to work with you as we know you can help us. It needs to be community first not practitioner first. Any consideration of investment in primary care is given the height of priority.

HC said he agreed with everything RW and MS have said. Having qualified in 2007 he applied for over 100 GP jobs and now, ten years later, if a GP vacancy is advertised the chances of an application being received is virtually nil. At the moment all we are looking at is stealing GPs from our colleagues. North East Essex are doing a couple of things, out of necessity rather than desire:-

- Working at scale; doesn't give any more appointments but it does allow for trying out different models such as telephone triage, care allocation etc, working with the system to try to bring other skilled practitioners within the practice, working at a bigger scale. This also addresses the problem of shortages in the professions such as physiotherapists, occupational therapists, psychiatrists etc.
- Access; when looking at systems and drivers to provide more appointments such as out of hours, we are still looking at the same workforce, there isn't a bigger workforce, so extending the workforce into those extended hours leaves gaps elsewhere.
- Estates; trying to address the last man standing issues. Senior partners, whose pensions are a factor are having to drop their sessions otherwise they will have to pay a hefty tax bill. Doctors are wanting to work but financially aren't able to.
- Training and education; upskilling our GPs and primary care workforce.

Chair said it is important to bring in the views of North Essex LMC. As Brian Balmer was unable to attend, his email was read out to the Board:-

"As you know I am unable to attend the January meeting and I am therefore unable to express to the meeting the concerns of North Essex LMC about this STP. We have expressed our disquiet on a regular basis for many months and have yet to have any positive discussions with the STP leadership.
We support the work of the CCG in developing a community based health and care system based on localities (Primary Care Networks) and supported by a CCG wide Alliance. We have no confidence in the current hasty approach to integration above this level.

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Primary care in NE Essex bears little resemblance to that provided by our colleagues in Suffolk which makes the production of a single presentation potentially confusing. There is no reason within Primary care for the three areas to be further integrated and there is a clear risk that a focus on wider integration towards the formation of an ICS will merely take attention away from the very significant problems in our sector. To describe the situation as "fragile" could be seen as an attempt to trivialise the very real issues facing practices and patients.
I would be grateful if you could remove my name from the presentation and if our views can be once again made known to the Board."

- Dr Raj commented that BB has made it very clear in his email. While RW mentions a 14% deficit in Suffolk, the analysis of that is tougher in Essex but it is probably closer to a 20% deficit in terms of providing actual patient appointments and it could be more than that. Working at scale also means that you integrate everyone together but that does not bring in additional appointments. Bringing more practitioners into general practice, as has been highlighted by some of my doctor colleagues here, we are pinching people from other systems to work in general practice. What everyone is forgetting is that funding for those practitioners should not be allowed to come from the global sum of general practice. But that is where the problem lies, these practitioners should be funded possibly by the STP as part of the NHS system, they should be included as additional funding, not for a one or two year contract but recurrent funding to fund these practitioners long term. That is the way you will see a significant difference in how general practice works. We are looking at a system we were are actually working at 150% capacity and that 50% is not even being addressed. It is those additional appointments and additional demand that is actually making general practice the fire fighter for the whole system. General practice is not firefighting, it is not acute medicine, it is preventative medicine. The system has been driven into the ground to such an extent that GPs are being asked to look at acute patients and being blamed for patients becoming acutely ill. That is not what general practice is. If GPs were being given adequate time to practice properly, funded properly, whole system funded, you will then see a difference in what we call public health.

Chair thanked VR for his comments. He said he was sure we would get the opportunity to talk about workforce, clearly it doesn't matter how much money you throw at a system, if there are no people prepared to do those jobs, it doesn't make the slightest bit of difference but we will pick that up.

PD then gave a presentation. The main points are:-

- As described by the two previous presentations, the current system is not really sustainable and needs transformation. The NHS website defines primary care as "*Primary care services provide the first point of contact in the healthcare system – entry contact points*"
- Primary care consists of four independent contractor groups; general practice, dentists, pharmacists and optometrists, which have all been kept as very separate groups with different funding arrangements and different contracts.
- Looking at estates, GP practices account for less than 20% of primary care access points and we spend an awful lot of time and effort focussing on that 20%. Any management theory would advise us to focus on the 80% but clearly the NHS has a different approach to that.
- Due to the different funding mechanisms, general practice had to fund their premises within their contract. All the other three groups use other elements, i.e. private or retails elements, to actually make sure they can fund their businesses as they operate as a business.
- An objective is to increase the number of pharmacists working in GP practices which means squeezing those services into that 20% and still ignoring the other 80% instead of working out how to use that 80% more effectively.
- When looking at the four different professional groups, pharmacists are probably the most commonly visited.
- With regard to dentists and optometrists, because their see their patients regularly but not so often, they are able to notice changes which are not so obvious when dealing with a patient frequently. There are lots of good examples of this which can be fed back into the system.
- When looking at the four different contractors, there are four key sorts of activities done on a day to day basis, and the work we do naturally fits with these four areas. We therefore need

to think about how we can share the work in a better way, thinking about consistent messages and pathways. We also need to ensure the right people are doing the right things and not always going to the main focal point which is the GP practice.

- We need to change the thinking around access points, for example we think about dentists looking after teeth, but they are more likely to support oral, head and neck cancers. Optometrists we think of as looking after eye disease, but because they are looking at primary blood vessels, they would also be the first to be able to diagnose diabetes, hypertension and vascular diseases. Pharmacy deal with problems with medication, what is actually causing symptoms or problems.
- PD showed slides showing examples of support the four contractors can provide and the initiatives currently taking place at the moment.
- Pharmacists are now being trained in additional skills to look at minor illnesses in a systematic manner, identifying where key risk areas are, what sort of safety advice is needed etc. This equips pharmacists to deal with minor illness giving the rest of the system assurance that pharmacists are capable and competent at doing this.
- There is a challenge for us working as individual silos. There is a benefit to all working together with diagnosis and treatment, looking at what are the most appropriate pathways in place, could we do more fast track referrals and having a system that allows the pharmacists to be able to do their job competently.
- There need to be better pathways to ensure patients are seen at the right time, at the right place and reducing the burden on general practitioners.

To summarise, we have a real opportunity to create an integrated primary care system, making sure we are really utilising all those applications and places. How do we redesign services around patients and make sure they know how to access the most appropriate practitioners working for them and support GPs in their important role of primary care gatekeepers.

Chair thanked everyone for their excellent presentations.

- WH said it is really interesting for someone outside the health service to hear those presentations which makes us think about why we are here together and what we can do together but also what we can do differently. Our higher ambitions are really important as to how we treat people and how we can serve people in the communities to help to address some of these issues. Workforce is something we can't help with, but the other things we can.
- ED said they were great presentations and the point about 80/20 is fascinating. A presentation recently spoke about a general practice in Lowestoft where they were talking about social prescribing and they had reduced consultations and people actually going into their practices by 40%, putting a lot of resources into social prescribing. Whilst our primary care strategy is localised, is there work we could do in a joined up way around line management in primary care that would make a difference.
- RW responded that in his own practice he was asked by an administrator at a hospital to do a blood form for a patient and then three weeks later asked if he could send the result of the blood test to her, whereas if she had just sent the blood forms to the patient in the first place, it wouldn't have involved him at all. So people need to give a bit a thought about what they could actually do themselves without involving someone else, if it produced the same outcome. There are incidents like this in his practice maybe two or three times a day and that amounts a lot of time.
- Chair said that there are at least two opportunities to manage demand, one is professional demand and the other is patient demand. Perhaps we should have a much wider discussion around social prescribing with some outside people. Increasingly we could use some of these sessions as more of a seminar.
- MS responded that in Suffolk it is called the Connect model with teams that are the statutory professional part of managing the demand of a neighbourhood and the connect is, what can we do below that level to manage the map which is social prescribing led. The top 100 people who use our services have anxiety, will be lonely and isolated. If we can release some of the social assets that help them then we could be reducing demand elsewhere.

- HC said that notwithstanding BB's comments about Suffolk primary care being different to North East Essex, there are similar issues with reliance on social prescribing. Although outwardly challenges may be different in individual patches, collectively across both the challenges are broadly the same. The solutions may be tailored slightly differently but that is where by coming together we might be able to come up with better integrated solutions than working in silo.
- Chair said that MS made the point that each alliance or CCG have drawn up their own strategy which has been welcome at a place level, but there will be advantages, even if it is just sharing the learning and recognising that clearly the demand may be different in different parts depending on lifestyle, demographics and other issues, but some of the solutions may be the same.
- SD said these were three very informative and helpful presentations which convey the quality and commitment we have currently in primary care across the whole of the STP and also conveyed the very real challenges faced of that increasing demand and gap. There are significant workforce challenges and we need to think how we can support primary care even more in facing future challenges. The long term plan does signal a rebalancing of the investment into primary and community care and we need to think how we make that a reality in the context that has been outlined today and how we facilitate that. We should probably start thinking early about how we will invest and support and change the balance of our system. There are so many places people can go but they always go to primary care first. There are two things that we really need to think about:-
  - The strategic vision and how we deal with some of the challenges that have surfaced again today
  - What the workforce implications are

- Chair responded that was really helpful. We are in an area of moderate growth and it is about the difficult decisions we need to make based on the needs of the population in terms of where we invest and how we invest. There will be difficult conversations going forward about those areas with greater need which will need greater investment which is really tricky.
- MM said the diagnosis is spot on but less sure about the prognosis. Whilst understanding there is a lot going on in regional alliances and CCGs, we are moving the conversation between general practice and primary and anything that is not in the hospital, but workforce is a problem, not just in general practice but generally so we have to think how we best deploy the workforce. How we make joining that workforce and staying in it more attractive. The barriers are the complexity of the different contractual arrangements and their nature so we need to work out what the barriers are and how well we are helping with this, particularly thinking about the third sector as there is not so much third sector involvement in primary care and there may be some potential opportunity there.
- SA responded that they work in general surgeries.
- SG said the Secretary of State's pet theme around digital was missing from the discussion. Was that because it was completely irrelevant or were we missing something. There is a lot of good effort going on to relieve the position. It feels like evolution rather than revolution and if we started with a blank piece paper how would we want that to look and is there anything we can do at this level that helps move from where we are.
- Chair said we seem to have a pretty good idea what the problem is but have we started to go out with a primary care strategy. What is it we need to do at ICS level, through the three alliances and what support is required from the ICS, which is about setting direction then supporting the alliances to get there, not about doing it. How do we move this forward?
- MS responded that it is about supporting the business model and delivery model outlined, through building resilience through formal collaboration with others. We aren't able to go to a blank page because there is too much history and evolution has helped along the way. In terms of technology, we are using technology and some of us are doing things differently in terms of the offer to patients.
- RW said the role of the STP is to look at what can be done best at an STP level. Some of it will always have to be at place level where it is really important. We should be able to use the STP to enable funding to come down from other sources. We don't want to do the same thing three times so there is a piece of work which needs to be done. The digital part is double edged in that on the one hand if we engage with digital we have a demand which we need to meet. It will increase

	demand which may not be necessary as there are those who want more healthcare that maybe don't need it. We need to play the digital part very carefully and deal with it on a more strategic level to ensure we improve our capacity without increasing demand. - Chair said we do have a primary care work stream with a vacancy in the SRO role which Susannah will speak about later in the meeting. Suggest we use the mechanism we have which is a substream of the ICS to work with the alliances, recognising and hearing all the great work of this morning and coming back to a future Board when those conversations have taken place. Thank you to the contributors, both speakers and questions. **ACTION:** Organise a session on social prescribing, including outside speakers. **ACTION:** Primary Care and Workforce to report back to the Board at a future date on progress.	 **SH** **SH**

- **Part 2 – System Transformation Programme**

Ref	Item	Action
226	**'Realising Ambition' Funding Programme – Role of the Community Foundations** Chair welcomed Caroline Taylor, CEO of Essex Community Foundation and Stephen Singleton CEO of Suffolk Community Foundations who have been invited to the Board to outline the work they do and how they will work together with the STP Board. SS outlined what Community Foundations are. There are 46 across the UK and over the last 30 years have moved to the fifth largest grant funder to the voluntary sector. They are behind the Wellcome Trust, the Sainsbury Trust, the Lottery and others and last year they were responsible for £100m of aid going to the voluntary sector. They are not a trust but a live foundation which is continually growing. Suffolk was one of the last community foundations to be formed. It would seem that most foundations are in quite affluent areas, so the need wasn't seen whereas is it just masked by affluence. They are seen as one of the major authorities on deprivation. The money comes in from three areas:- • Philanthropy – working with high net worth individuals, creating endowment funds designated for the voluntary sector which meets the causes they wish to support. • Working with other trusts and foundations, i.e. Comic Relief, who find it very difficult to penetrate grass root charities on the ground. • Public sector, in the last few years alone they have handled £11m of funding for the voluntary sector which comes from health, local authorities and the police and crime commission and central government. The other important area which is really relevant for this initiative is how robust are we. On a day to day level we operate under strict quality accreditation guidelines originally formed in collaboration with the Charities Commission which is managed by an external organisation and aligns our operations needs as well. That, coupled with the endowment we look after means we are very robust from a governance level and our balance sheet is strong for the size of organisations we are. With our balance sheet increasing we will be around in the long term. As our balance sheet increases so the amount of help we can give to the voluntary sector also increases. Another source of income is legacy planning which is significant as a person can specify what they wish to do with their fund and over time they can keep their name alive as a memorial fund. With regard to the voluntary sector, it is one of the most fantastic systems to operate but is also one of the most hectic. There are lot of them and whilst at a high level of power it has been suggested only having one charity, we think very differently. The more we have the healthier we are as a society. In Suffolk there are 3,000 registered charities and 2,000 community groups, so 5,000. In Essex there are twice as many. They do wonderful work, often under the radar, which means we can find them for	

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investors. They have a very wide remit from the environment to education for their grant making, but 80% goes into health and wellbeing.

With regard to volunteering, is it volunteer or is it paid? A lot of people are paid but 52% of the voluntary organisations have an income of under £10,000 and do extraordinary things and those organisations are run totally on volunteers, paying for lighting and utilities, some equipment and accounting. The rest employ varying levels of people. In the case of Suffolk Foundation, they have about 150 volunteers with a core of about 15 staff.

CTr then talked about the realising ambition programme. One of the strengths of the model is their experience of translating the requirements of their donors into meeting the needs of their communities. In Essex about £7m of public sector funding, from the fire service, police, county council aligns to the overall objectives of that local authority. So a starting point of developing a programme of work across North Essex and Suffolk.

The intention is to develop a consistent programme so there are commonalities across the patch, allowing for solutions to be tailored and developed locally. They will be working with the alliances to develop a programme of work based on the some of the higher ambitions the STP has already set, so that over time they will be able to show the difference being made. They will look at the overarching impact to be achieved by looking at outcomes then the outputs that lead to those outcomes. It is important to look at co-production, involving local people and voluntary organisations in having a say on some of the issues they are facing in their communities which will be brought into the design of this programme. They are the people on the ground who have a vast knowledge of what is going on and it brings a sense of belonging that they are able to influence and start to shape how some of the funding is spent.

Another benefit of the community foundation model is leverage, their ability to use other funds and grant managers to align with any application received. In Essex they manage around 150 different charitable funds and we'll match their funding needs to the most appropriate managed fund but also leverage other money from other managed funds from other donors and other trusts to compliment that work. Both community foundations are strongly networked with other networks of funders in Essex. They have an understanding of where money is coming into their counties which helps to make better decisions about where to invest those funds. Some of the smaller grass roots organisations don't have the capacity to handle large amounts of money but are doing really valuable preventative work so the more strategic grant making can be complimented by smaller grant programme so they can carry on with what they are doing. It is important to think about how we measure success, by building in an evaluation and monitoring model that is light touch but robust enough to tell us what we want to know. This is a really exciting moment in time, having a framework to guide our giving without it being set in stone giving the ability to be responsive and flexible to the needs to the voluntary sector as well.

- SA congratulated the Board on making the decision to provide funding to the voluntary sector and choosing the community foundations, who have a very strong track record of making a huge impact in the voluntary sector. They make the application process very accessible to both grass roots and larger organisations as they take responsibility for the checks and balances which some of those smaller groups may not be able to put in place. The CVS work well in Essex in helping some of the lower quality applications which wouldn't otherwise be processed. SS wanted to reassure the Board that the Community Foundations are robust organisations, very open to ideas, focussing on the impact they are creating.
- Chair commented that KD and her fellow DoFs had put the community foundations through their paces to get assurance around the governance structures and have been well assured.
- EG said this resource will do great things for local people and it would be good if they could revert back to us in 3-4 months' time to show how directly it aligns.
- WH said that she has said many times over that the voluntary sector needs money to do the good work they do and it is an opportunity to wake people up. Going back to the presentation on GPs,

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	not all of us can help statutory systems but we can all get more involved in supporting the voluntary sector which takes us to self-care and thinking differently. - SS said the impact will be the sea change as we are very good at measuring what is happening with the money being spent and what effect it is having. We can arrange visits and get people to come and present to the Board so we can all be part of the journey. - Chair said it would be good if we are able to do that with the money we are investing and able to hear in a year, two years' time. - AY said he has worked in Essex and Suffolk and has worked with both foundations over the years and knows we have the right people for the right job. The decision this STP Board has made will hopefully have a magnetic effect, causing others to have the same conversations to add to what we are investing now, as it is a relatively small sum and there is potential elsewhere. - CT said there are good examples in Essex of models of cross public sector contribution to endowed funds and it was pretty ground breaking in that Essex County Council put in money that was potentially going to be spent in other authorities, district councils put in money that would be spent in other districts as well, so there are good examples that public sector organisations can work together for the benefit of the community. It also helps with the digital aspect as they are working with some funding from Provide on how to improve the digital intelligence within the voluntary sector and data sharing. For example, how much does it cost when someone has a fall and how interventions do actually save money. We need to be clever about how we measure it. Chair thanked CTr and SS for their time and for all the work they and their volunteers do every day which makes such a difference.	
227	**Public Engagement** EG said we have seen some funding nationally for public engagement. The proposals are in the paper so Susannah will give a bit more information but what is quite exciting is the cultural audit to do with workforce to see what shifts we need there. More resources going into the voluntary sector to build capacity and also working with the support of Suffolk and Essex Healthwatch. SH said the paper is based on discussions with a number of colleagues who joined us for a meeting after the last STP Board. Particularly important from those discussions were the principles we should adopt in terms of underpinning this. There is a strong sense of needing to build on work already done and following discussions at the last Board regarding the Suffolk Mental Health Review and the strong learning from that, we need to take into account what had worked well and what we could do more of in terms of this type of work. There was also a strong sense that we should invest locally making sure we build capacity that can be further developed and leverage so we have a more routine role for partners already in the system to help us improve our engagement with the public. The paper sets out some indicative amounts on how we could distribute that £70k to some key partners in our local health and care system. The paper deliberately doesn't set out any more detail of those specific pieces of work as we want to enable those partners to decide how they could best make use of it and bring those back. This is a start point to get some clarity about what is available as it is a drop in the ocean compared to what we would like to be able to do. In trying to build up some momentum and really make sure we have a space for detailed discussion about this work to ensure we focus on public engagement as opposed to communications and a role for someone to really take a lead on that engagement aspect going forward. - Chair said that at ESNEFT there was going to be some quite significant engagement and consultation around clinical prefiguration between the two acute sites. How do we make sure that all of the engagement/consultation work we do is linked together. We won't be able to answer that now but we need to ensure that the public and communities are getting a single message about direction for health and social care from the two counties and we always link those together. - SH responded that the first of the items is that the two Healthwatches undertook some mapping of engagement consultation which would look to refresh with this and the other aspect is to try and have better co-ordination and more focus on public engagement.	

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	- EG said they had a session with colleagues and the advice was don't just consult on specific services and place it in the context of the whole ICS. - DA said he really supports the paper and keeping it around the workforce is something we have looked at before between ourselves and the acutes particularly but also other workforce across the system in relation to why is that culture across the system and how do we prove that.	

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

Ref	Item	Action
228	**Appointment of SROs** SH said we have four vacancies. The closing date for applications was 9 January and we have received applications for all four vacancies and more than one application for two of those vacancies. In terms of next steps, I will go back to those people who have applied to let them know if they are a single applicant or one of two and what they want to do in that context. Where we have more than one applicant, if they wish to proceed on that basis, then we will need to find a process around that. The STP Chairs' will oversee assurance at their next meeting in February and then come back to the next Board on the 8th.	
229	**Update from Health and Wellbeing Boards** There were no updates from either Health and Wellbeing Boards as they haven't taken place yet.	
230	**Finance Dashboard – Month 8** No comment.	
231	**Approval of Proposals for STP Investment** Everyone **agreed** the investment proposals for the Community Foundations and ETTF.	
232	**Key STP Delivery Programme Reports** SG said the data wasn't actually in the pack but they have just got the diabetes national data for last year which hasn't been looked at in detail yet but there was a need to flag up that there is a continued fairly large deterioration in diabetes care in West Suffolk. Admissions are up nearly 30% in the last two years from 22% improvement in other areas and treatment targets for type two are now the worst, the STP having had the best two years ago. It is a concern but at the present time I don't know the detail behind it. SD said they had made a lot of progress as they were very poor and they have worked very closely with primary care. SG responded that this was 17/18 data. AH said that on the Mental Health Dashboard, we agreed last time that we would add the outcome of CQC inspections to risks and issues not on there. **ACTION:** Ensure the outcome of CQC inspections is included in future.	 **SH**
233	**Any Other Business** Chair said when we have coalition of the willing as we have in an ICS, the leadership of that ICS is dependent on the support and the confidence of its members and it has been made clear to me again today that that support is no longer there for me to lead the ICS so I will be stepping down at the end of the meeting on 15th March. So the process will be that the Kings Fund are currently doing a piece of work around the governance of the ICS going forward and it is part of the LTP that we have an independent non-executive Chair. So what I am asking of Susannah and the rest of the people working with the Kings Fund, and I am not part of that group, is to come up with a plan around the early appointment of an independent Chair and then to work with that individual around leadership going forward. That is not for me to decide as I won't be part of the group as I am standing down from the board as well and it will be either Shane or Neill who will represent ESNEFT going forward. So just to let you know that. Please don't tweet it yet as I haven't informed NHS England yet or my Board so if you can just keep it within this room, but I think it is important that you hear it from me first rather	

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	than rumours and gossip and it is not for any other reason except that the confidence is no longer there so it is the right time for me to exit. I will chair the next two meetings on 8 February and 15 March and then step down. The Chair expressed his thanks and wished everyone a good weekend. ***12.40pm Meeting Closed.***	

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