Essex and Suffolk Joint Health Scrutiny Committee on the Sustainability and Transformation Partnership for North East Essex, Ipswich and East and West Suffolk

(The quorum will be a minimum of 4 members, with at least 2 from each of the participating authorities)

Essex

Councillor Anne Brown	Essex County Council
Councillor Dave Harris	Essex County Council
Councillor Colin Sargeant	Essex County Council
Councillor Andy Wood	Essex County Council

Suffolk

Councillor Helen Armitage	Suffolk County Council
Councillor Peter Coleman	Suffolk Coastal District Council
Councillor Jessica Fleming	Suffolk County Council
Councillor Elisabeth Gibson- Harries	Mid Suffolk District Council

DATE: Friday, 30 November 2018

PLACE: King Edmund Chamber
Endeavour House
Russell Road
Ipswich
IP1 2BX

TIME: 10.30am

Audio Recording Notice

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For further information on any of the agenda items, please contact Susan Cassedy, Democratic Services Officer, on 01473 264372.

Business to be taken in public

1. **Election of Chairman**

2. **Election of Vice Chairman**

3. **Public Participation Session**

   A member of the public who is resident in, or is on the Register of Electors for Essex or Suffolk, may speak for up to 5 minutes on a matter relating to the following agenda.

   A speaker will need to give written notice of their wish to speak at the meeting using the contact details under 'Public Participation in Meetings' by no later than noon on Monday, 26 November 2018.

   The public participation session will not exceed 20 minutes to enable the Joint Committee to consider its other business.

4. **Apologies for absence and substitutions**

   To note and record any apologies for absence or substitutions received.

5. **Declarations of interest and dispensations**

   To receive any declarations of interests, and the nature of that interest, in respect of any matter to be considered at this meeting.

6. **Minutes of the Previous Meeting** Page 5

   To approve as a correct record, the minutes of the meeting held on Friday 10 March 2017.

7. **Revisions to Terms of Reference and supplementary guidance** Page 13

   To consider revisions to the Terms of Reference for the joint committee and proposed supplementary guidance on working arrangements for the joint committee with the two "home" committees covering Essex and Suffolk.

8. **Update on the Sustainability and Transformation Partnership (STP) for North East Essex, Ipswich and East Suffolk and West Suffolk** Page 23

   To consider an update on the developments taking place under the Sustainability and Transformation Partnership covering North East Essex, Ipswich and East Suffolk and West Suffolk.

9. **Date of Next Meeting**

Members of the Joint Committee are requested to bring their diaries with them to the meeting.

Access to Meetings

Suffolk County Council is committed to open government. The proceedings of this meeting are open to the public, apart from any confidential or exempt items which may have to be considered in the absence of the press and public.

For more information about this meeting, including access arrangements and facilities for people with disabilities, please contact Democratic Services on:

Telephone: 01473 265119;

Email: Committee.Services@suffolk.gov.uk; or by writing to:

Democratic Services, Suffolk County Council, Endeavour House, 8 Russell Road, Ipswich, Suffolk IP1 2BX.

Public Participation in Meetings

Members of the Public from Suffolk or Essex who wish to speak at a Joint Health Scrutiny Committee meeting should contact Democratic Services on 01473 265119 by noon on 26 November 2018.

Further information about arrangements for public participation can be found at: https://www.suffolk.gov.uk/council-and-democracy/the-council-and-its-committees/apply-to-speak-at-a-public-meeting/ (see Guidance for Health Scrutiny Committee)

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www.suffolk.gov.uk/council-and-democracy/the-council-and-its-committees/apply-to-take-part-in-a-public-meeting

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1. Leave the building immediately via a Fire Exit and make your way to the Assembly point (Ipswich Town Football Ground).
2. Follow the signs directing you to Fire Exits at each end of the floor.
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4. Use the stairs, not the lifts.
5. Do not re-enter the building until told it is safe to do so.

Nicola Beach
Chief Executive
Suffolk County Council

Unconfirmed

Minutes of the Essex and Suffolk Joint Health Scrutiny Committee on the Sustainability and Transformation plan for North East Essex, Ipswich and East and West Suffolk Meeting held on 10 March 2017 at 2.00 pm in the King Edmund Chamber, Endeavour House, Ipswich.

Present:

Essex

Councillor Andy Erskine, Essex County Council
Councillor Dave Harris, Essex County Council
Councillor Colin Sargeant, Essex County Council
Councillor Andy Wood, Essex County Council

Suffolk

Councillor Sarah Adams, Suffolk County Council
Councillor Peter Coleman, Suffolk Coastal District Council
Councillor Elisabeth Gibson-Harries, Mid Suffolk District Council
Councillor Michael Ladd, Suffolk County Council

Also present:

Councillor Sian Dawson, Babergh District Council
Councillor Tony Goldson, Cabinet Member for Health, Suffolk County Council
Councillor Inga Lockington, Suffolk County Council

Supporting officers present:

Susan Cassedy, Democratic Services Officer, Suffolk County Council
Theresa Harden, Business Manager, Democratic Services, Suffolk County Council
Graham Hughes, Scrutiny Officer, Essex County Council

1. Election of Chairman

On the proposition of Councillor Dave Harris, seconded by Councillor Sarah Adams it was:

RESOLVED that Councillor Michael Ladd be elected as Chairman

2. Election of Vice Chairman

On the proposition of Councillor Andy Wood, seconded by Councillor Peter Coleman it was:

RESOLVED that Councillor Dave Harris be elected as Vice Chairman

3. Draft Terms of Reference

At Agenda Item 3 the joint committee considered a report setting out the draft Terms of Reference for the operation of the committee.

Decision: The joint committee agreed the Terms of Reference as set out at Appendix 1 of the report.

Reason for Decision: The joint committee considered that the Terms of Reference reflected the purpose of its scrutiny of the Suffolk and North East Essex STP on a task and finish basis.

Alternative options: None considered.

Declarations of interest: None declared.

Dispensations: None reported.

4. Public Participation Session

There were no requests to speak during the public participation session.

5. Apologies for Absence and Substitutions

There were no apologies for absence or substitutions.

6. Declarations of Interest and Dispensations

Councillor Andy Wood declared a non-pecuniary interest in Agenda Item 7 "NHS Sustainability and Transformation Plan for North East Essex, Ipswich and East Suffolk and West Suffolk" as he sat on the Board of Governors of the North East Essex Partnership Foundation Trust.

7. NHS Sustainability and Transformation Plan for North East Essex, Ipswich and East Suffolk and West Suffolk

At Agenda Item 7 the joint committee considered a report which provided an overview of the arrangements for taking forward the Sustainability and Transformation Plan for North East Essex, Ipswich and East Suffolk and West Suffolk.

The joint committee had received written evidence and was joined at the meeting by the following witnesses:

Susannah Howard, STP Programme Director, Suffolk and North East Essex STP

Kirsty Denwood, Chair, STP Finance Director's Group

Paul Scott, Director of Finance and Strategy, Ipswich Hospital NHS Trust

Lisa Llewelyn, Director of Nursing and Quality, North East Essex CCG

Isabel Cockayne, STP Communications and Engagement Lead

Tom Nutt, Chief Executive, Healthwatch Essex

Andy Yacoub, Chief Executive, Healthwatch Suffolk

The joint committee was presented with a short film which had been produced by Healthwatch Essex explaining the Sustainability and Transformation Plan (STP) in simple terms to a young person they called “Healthwatch Harriet”.

The Chairman invited witnesses to comment on the written evidence provided and highlight any key points they considered the joint committee should be aware of.

The Chairman then invited the joint committee to ask questions and comment on both the written evidence and the information provided to them by the witnesses.

The question was raised as to why social care financial plans and assumptions had not been included in the development of the STP. It was noted that in October, the budget for social care was still under development, so it had not been possible to include these figures. It was noted that, culturally, the NHS and social care had very different approaches to planning cycles and budgeting and this was an issue across all STP footprints. It was noted the Clinical Commissioning Groups and Local Authorities had recently met with the Chartered Institute of Public Finance and Accountancy with a view to developing a greater understanding of each other’s budget planning processes and work was taking place to look at opportunities for greater alignment and pooling. More needed to be done but progress was being made. It was confirmed that the STP financial bridge addressed only the healthcare gap for the footprint, of £248m.

Members questioned how this could be the case when reference was made in the STP to various work which would need to take place in collaboration with social care. The joint committee was informed that a lot of this work was already taking place under the banner of health and social care integration and examples of this were provided, which members were acquainted with.

The joint committee heard the STP covered a range of services and there were currently lots of unknowns. The work would therefore be broken down into manageable pieces with clear accountability and scope. Engagement would be ongoing and consultation would be employed when needed to get patient and public views on any specific changes. The biggest area of work was to move from a high level plan, to specifics of implementation. As the technical detail was developed it would test assumptions and would need to be worked through. Existing workstreams were being pulled together and groups established, and the next few years would therefore be a journey.

It was clarified that the STP partners did not have a single financial pot, or “system control total”. The hospitals had a financial control total with NHS Improvement, whereas the Clinical Commissioning Groups had a financial control total with NHS England. This did not allow flexibility to have a single pot. A single pot would also create a question of who would be ultimately accountable for it. Currently each STP partner was individually accountable.

The joint committee put questions to witnesses about governance arrangements and who would be accountable in the event the STP did not work. The joint committee heard that the STP partners were individually accountable for

delivering their own part of the programme and, in the event it did not work, they would all be accountable. A member commented that if all partners were accountable, did this mean no-one was accountable and questioned what would happen if a partner did not wish to take part, or when difficult collective decisions were needed.

Members heard, in the example of the Colchester/Ipswich Hospitals Long Term Partnership, a decision would need to be taken by the two hospital Boards. For the wider STP, a draft Memorandum of Understanding had been developed, based on work done nationally, and the Terms of Reference for the STP Programme Board had been upgraded and these were currently with the partners to look at. Meetings had also taken place with the partners to understand how they wished to be represented across the various STP workstreams.

The joint committee noted that the Chief Executives of Healthwatch Essex and Healthwatch Suffolk sat on the STP Communications and Engagement Advisory Board. The joint committee heard there was a role for Healthwatch in acting as critical friend to the STP partners, helping them to develop communication and engagement plans and ensuring that people understood what the STP was, to enable people to engage and to have their say. Healthwatch was also independently seeking views from the public and patients on the STP and, once the Plan was further developed, there would be a role for Healthwatch in understanding and representing people's lived experience of services and using this information to feed back to the partners to help inform decisions about what services should look like in future.

The joint committee received comments from the Chairman of the Suffolk Health and Wellbeing Board. He informed the joint committee that there was no councillor representation on Ipswich Hospital's Governing Body as it was not a Foundation Trust. He also made the point that Colchester Hospital University Foundation Trust did not have an elected representative from Suffolk on its Governing Body despite the hospital receiving patients from Suffolk and he felt these issues needed to be addressed. He noted that Health and Wellbeing Boards were working collaboratively, but highlighted a need for full support for the work of the Boards from the NHS. He hoped that the STP would help to make health and social care easier to navigate. With regard to the future of hospitals, he considered that no hospital would close but there may be changes in how services were delivered for example, from specialist units. He appreciated the challenge brought by the joint committee and would take a number of issues away. Finally, he also highlighted progress being made with blue light collaboration.

Recommendation:

The joint committee:

a) requested further information about the options for the Colchester/Ipswich Hospitals Long Term Partnership, and what these different options would actually mean for patients and the public, as soon as this information became available;

b) requested sight of the full consultation and engagement plan for the various components of the STP as soon as this became available (currently anticipated June 2017);

c) emphasised the key role that staff will play in the success of the STP and encourage the STP partners to engage in early, two way communications and engagement with their staff, to ensure their views were heard and informed the development of the detailed components of the Plan, as these were progressed.

d) urged the STP partners to give consideration to the needs of vulnerable and hard to reach communities in the development of the detailed plans, including as part of the arrangements for consultation and engagement; and

e) requested that further information is provided on the milestones for the development of the primary care strategy in North East Essex. It was acknowledged that accessibility to GP services in North Essex seemed to be particularly challenging at present (exacerbated by GP shortages). *(This could potentially be fed back to Essex HOSC, rather than the joint committee).*

Reason for recommendation:

a) The joint committee noted, with regard to the Colchester/Ipswich Hospitals Long Term Partnership, the evidence stated that there were currently three options being considered, plus a fourth option of doing nothing. A question was raised as to what difference the three options would have for the people receiving services. Members were informed this was currently being worked through and was a question both Boards would wish to see addressed. The joint committee noted a written briefing on the Long-Term Partnership had been provided for both Essex Health Overview and Scrutiny Committee and Suffolk Health Scrutiny Committee which had been included in the published papers for the next meetings of the Committees (see: http://committeeminutes.suffolkcc.gov.uk/LoadDocument.aspx?rID=0900271181f731e7&qry=c_committee%7e%7eHealth+Scrutiny+Committee). The joint committee noted that an Outline Business Case for the future of the hospitals was due to be presented to both hospital Boards in July 2017. The joint committee was informed that engagement with staff and stakeholders would enable the Boards to come to an informed decision about precise options to include in a Full Business Case, which would then go forward for public consultation. It was confirmed that both Healthwatches were involved in developing the communication and engagement plan. The joint committee noted the requirement for NHS bodies to consult with health scrutiny on substantial variations in service, and wished to ensure early and ongoing dialogue took place on the development of these proposals.

b) The joint committee heard that NHS England had informed STP footprints that there was no need to engage on the STP Plan as a whole. However, a plan of consultation and engagement was currently being developed for each of its component parts. Live engagement was currently taking place on mental health services in Essex, and had closed on Urgent Care in North East Essex. It was envisaged that a full plan would be available in June 2017. The joint committee agreed it would wish to see this detail when it became available.

c) A question was raised about what steps were being taken to engage with staff about the STP. The joint committee heard there were workforce challenges nationally and a need to employ agency staff and staff from abroad to help address this. Work was also taking place nationally to understand how many people were being trained. The STP would need to take these national issues on board. The NHS was looking at how skills of staff could be used more effectively and developing career pathways to support this.

STP representatives acknowledged there was a need to make sure staff were on board with the development of the programme. It was reported that conversations had been taking place with a Joint Staff Partnership Board, and the partners were working with Unison and the BMA. Members heard, for the Colchester/Ipswich Hospital Long Term Partnership, a Clinical Reference Group had been established to support the development of this work.

d) A question was raised about how the STP would ensure that the most vulnerable in Suffolk and Essex would not be left behind in the development of services. The point was raised that whole communities could be considered vulnerable and this would need to be taken into account in looking at how and where services should be delivered. It was noted that individual partners' responsibilities towards vulnerable people would remain unaffected. There was also an opportunity for the STP to help address existing gaps in services. The role of Healthwatch in being able to reach out to people through the voluntary and community sector was noted.

e) A member commented that it was not made clear which services were included in the STP for North East Essex. He raised concern that people in the Clacton area had been waiting for information about improved collaboration between GPs and the development of GP hubs. It was confirmed that a Primary Health Care Strategy was being developed. From 1 April 2017, North East Essex CCG would be co-commissioning primary care and work was taking place to hand over some responsibilities from NHS England. The Primary Health Care Strategy would develop different models, but care would be taken to ensure patients could access the services they required. The work was considered to be an element of the STP as it had links with social care and urgent care. It was recognised that access was currently a problem. The member was concerned that NHSE had not been present at sessions to discuss this and asked if the milestones for taking this work forward could be made available.

Alternative options: None considered.

Declarations of interest: Councillor Andy Wood declared a non-pecuniary interest in Agenda Item 7 as he sat on the Board of Governors of the North East Essex Partnership Foundation Trust.

Dispensations: None reported.

8. Urgent Business

There was no urgent business.

9. Date of Next Meeting

The joint committee noted that its programme of work would need to be developed in light of further information about emerging proposals and detailed timescales for decision making at which point a further meeting would be arranged as necessary and published on the participating Council's websites.

The meeting closed at 3.43 pm.

Chairman

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Suffolk County Council

Essex County Council

Agenda Item 7

Essex and Suffolk Joint Health Scrutiny Committee

30 November 2018

Revisions to Terms of Reference and supplementary guidance

Summary

1. This report sets out a draft framework for the working relationship between, and distinguishing roles of, the Essex and Suffolk Joint Health Scrutiny Committee on the Sustainability and Transformation Partnership (STP) and the two "home" health scrutiny committees which cover services within the local authority boundaries of Essex and Suffolk. The report also sets out proposed revisions to the Terms of Reference for the joint committee, which were originally agreed on 10 March 2017.

Objective

2. The joint committee is asked to:-
   a) comment upon the proposed working arrangements for the joint committee with the two "home" committees covering Essex and Suffolk, as set out in the report;
   b) agree the revisions to the Terms of Reference for the joint committee, attached at Appendix 1.

Contact details

Theresa Harden, Business Manager (Democratic Services), Suffolk County Council
Email: Theresa.harden@suffolk.gov.uk; Tel: 01473 260855

Peter Randall, Senior Democratic Services Officer, Essex County Council
Email: peter.randall@essex.gov.uk Tel: 03330136131

Background

1. The first meeting of the Essex and Suffolk Joint Health Scrutiny Committee took place on 10 March 2017, when the joint committee agreed its Terms of Reference. Since its first meeting, members have continued to receive briefings on developments taking place under the STP, and reports and updates have been presented to both the Essex Health Overview, Policy and Scrutiny Committee, the Suffolk Health Scrutiny Committee and the Health and Wellbeing Boards for each county.

2. On 6 September 2018, members of the joint committee met informally with supporting officers to receive an update on progress and consider next steps. Members considered it would be helpful to provide greater clarity about the working relationships between, and distinguishing roles of, the joint committee and the two "home" health scrutiny committees covering the counties of Essex and Suffolk. Members also proposed some minor revisions to the agreed Terms of Reference. These are set out at Appendix 1.

3. Local authorities may appoint a discretionary joint health scrutiny committee to carry out health scrutiny of issues which cross local authority boundaries (Regulation 30). Regulation 30 also requires local authorities to appoint a mandatory joint committee where an NHS body or health service provider consults more than one local authority's health scrutiny function about a proposal for a substantial variation or development in service.

4. Essex Health Overview, Policy and Scrutiny Committee and Suffolk Health Scrutiny Committee agreed to establish a joint scrutiny committee, on a task and finish basis, to scrutinise, on a discretionary basis, activities taking place under the banner of the STP which are likely to impact upon patients from both counties. The joint committee will also act as the mandatory joint committee in the event that an NHS body is required to consult health scrutiny on a substantial variation or development in service as part of the implementation of the STP.

5. It is recognised that consultation on a substantial variation or development in service may need to happen on more than one occasion during the implementation of the STP. The joint committee will continue, on a task and finish basis, whilst the STP implementation continues.

6. Whilst there is an STP process covering Suffolk and North East Essex, the main focus of any cross boundary discussions will be via the joint committee. This arrangement does not preclude the "home" committees from continuing to scrutinise aspects of the STPs individually, where it makes sense to do so.

7. Those matters that are overwhelmingly the responsibility of one Local Authority area should be discussed and led by the respect home health scrutiny committee. These matters may include (but are not exclusively):-

   a) the relocation or reconfiguration of primary care services accessed by patients from within the local authority boundary;

   b) the relocation or reconfiguration of local community services accessed by patients living from within the local authority boundary;

   c) any proposals for changes to the delivery of acute services which only impact upon patients residing within the local authority boundary.

8. The "home" Committee may also exercise an overview role across STPs which cover their local authority area, for example, in scrutinising whether local

communities within the local authority boundary have equality of access to health and care services.

9. Those matters that cut across the whole STP footprint area in terms of location and/or patient pathways should be discussed and led by the joint committee. These matters may include (but are not exclusively):

   a) The overall sustainability of the STP plans, including finance;

   b) Development of an integrated care system across the footprint;

   c) Matters relating to digital integration of health services across local authority boundaries;

   d) Future proposals for acute reconfiguration and/or specialisation/networked services accessed by patients from Suffolk and Essex;

   e) Overarching strategies relevant to the STP footprint, although local implications may be reviewed by the “home” committee;

   f) Ongoing and new public and stakeholder consultation and engagement on the above matters.

10. These principles set out above are intended as guidance only, to supplement the joint committee’s Terms of Reference.

Glossary

NHS – National Health Service

STP – Sustainability and Transformation Partnership

Supporting Information

Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013

Local Authority Health Scrutiny - Guidance to support Local Authorities and their partners to deliver effective health scrutiny

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Essex and Suffolk Joint Health Scrutiny Committee on the Sustainability and Transformation ~~Plan~~ Partnership (STP) for North East Essex, Ipswich and East and West Suffolk

Revised Terms of Reference

1.	**Legislative basis**
1.1	The National Health Service Act 2006, as amended by the Health and Social Care Act 2012 and the Localism Act 2011 sets out the regulation-making powers of the Secretary of State in relation to health scrutiny. The relevant regulations are the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 which came into force on 1st April 2013.
1.2	Regulation 30 (1) states two or more local authorities may appoint a joint scrutiny committee and arrange for relevant health scrutiny functions in relation to any or all of those authorities to be exercisable by the joint committee, subject to such terms and conditions as the authorities may consider appropriate.
1.3	Where an NHS body consults more than one local authority on a proposal for a substantial development of the health service or a substantial variation in the provision of such a service, those authorities are required to appoint a mandatory joint committee for the purposes of receiving the consultation. Only that joint committee may: • make comments on the proposal to the NHS body; • require the provision of information about the proposal; • require an officer of the NHS body to attend before it to answer questions in connection with the proposal.
1.4	This joint committee has been established, on a task and finish basis, by Essex Health Overview, Policy and Scrutiny Committee and Suffolk Health Scrutiny Committee.
2.	**Purpose**
2.1	The purpose of the joint committee is to scrutinise the implementation of the Suffolk and North East Essex Sustainability and Transformation ~~Plan~~ Partnership (STP) and how the STP is meeting the needs of the local populations in Suffolk and Essex focussing on those matters which may impact upon services provided to patients in both counties.
2.2	The joint committee will also act as the mandatory joint committee in the event that an NHS body is required to consult on a substantial variation or development in service affecting patients in both local authority areas as a result of the implementation of the STP.
2.3	In receiving formal consultation on a substantial variation or development in service, the joint committee will consider: • the extent to which the proposals are in the interests of the health service in

2.4	Suffolk and Essex; • the impact of the proposals on patient and carer experience and outcomes and on their health and well-being; • the quality of the clinical evidence underlying the proposals; • the extent to which the proposals are financially sustainable and will make a response to the relevant NHS body and other appropriate agencies on the proposals, taking into account the date by which the proposal is to be ratified. The joint committee will consider and comment on the extent to which patients and the public have been involved in the development of the proposals and the extent to which their views have been taken into account as well as the adequacy of public and stakeholder engagement in any formal consultation process.
3.	**Membership/chairing**
3.1	The joint committee will consist of 4 members representing Essex and 4 members representing Suffolk, as nominated by the respective health scrutiny committees.
3.2	Each authority may nominate up to 2 substitute members.
3.3	The proportionality requirement will not apply to the joint committee, provided that each authority participating in the joint committee agrees to waive that requirement, in accordance with legal requirements and their own constitutional arrangements.
3.4	Individual authorities will decide whether or not to apply political proportionality to their own members.
3.5	The joint committee will elect a Chairman and Vice-Chairman at its first meeting.
3.6	The joint committee will be asked to agree its Terms of Reference at its first meeting.
3.7	Each member of the joint committee will have one vote.
4.	**Co-option**
4.1	By a simple majority vote, the joint committee may agree to co-opt representatives of organisations with an interest or expertise in the issue being scrutinised as non-voting members, but with all other member rights. This may be for a specific subject area or specified duration.
4.2	Any organisation with a co-opted member will be entitled to nominate a substitute member.
4.3	A standing invitation to attend meetings will be extended to the Chief Executives of Healthwatch Essex and Healthwatch Suffolk.

5.	**Supporting the Joint HOSC**
5.1	The lead authority will provide Chairmanship and officer support to the joint committee. The lead authority role will be shared between ~~as decided by negotiation with~~ the participating authorities, and will be reviewed on an annual basis in July. ~~Suffolk will initially act as the lead authority and this will be reviewed following the May 2017 county council elections.~~
5.2	The lead authority will act as secretary to the joint committee. This will include: • appointing a lead officer to advise and liaise with the Chairman and joint committee members, ensure attendance of witnesses, liaise with the consulting NHS body and other agencies, and produce reports for submission to the health bodies concerned; • providing administrative support; • organising and minuting meetings.
5.3	The lead authority's Constitution will apply in any relevant matter not covered in these terms of reference.
5.4	The lead authority will bear the staffing costs of arranging, supporting and hosting the meetings of the joint committee. Other costs will be apportioned between the authorities. If the joint committee agrees any action which involves significant additional costs, such as obtaining expert advice or legal action, the expenditure will be apportioned between participating authorities. Such expenditure, and the apportionment thereof, would be agreed with the participating authorities before it was incurred.
5.5	The non-lead authority will appoint a link officer to liaise with the lead officer and provide support to the members of the joint committee.
5.6	Meetings shall be held at venues, dates and times agreed between the participating authorities
6.	**Powers**
6.1	In carrying out its function the joint committee may: • require officers of appropriate local NHS bodies to attend and answer questions; • require appropriate local NHS bodies to provide information; • obtain and consider information and evidence from other sources, such as local Healthwatch organisations, patient groups, members of the public, expert advisers, local authorities and other agencies. This could include, for example, inviting witnesses to attend a joint committee meeting; inviting written evidence; site visits; delegating committee members to attend meetings, or meet with interested parties and report back. • make reports and recommendations to the appropriate NHS bodies and other bodies that it determines, including the local authorities which have appointed the joint committee. • consider the NHS bodies' response to its recommendations; • In the event the joint committee is formally consulted upon a substantial

	variation or development in service as a result of the implementation of the STP, refer the proposal to the Secretary of State if the joint committee considers: ➢ it is not satisfied that consultation with the joint committee has been adequate in relation to content, method or time allowed; ➢ it is not satisfied that consultation with public, patients and stakeholders has been adequate in relation to content, method or time allowed; ➢ that the proposal would not be in the interests of the health service in its area.
7.	**Power of Referral**
7.1	The power to make a referral to the Secretary of State will be delegated to the Joint Committee on the basis that the Joint Committee will have received and fully evaluated the evidence presented to it.
7.2	In the event the Joint Committee agrees to make a referral, the participating local authorities will be notified of the intention to refer and the date by which it is proposed to do so.
7.3	The Joint Committee will only make a referral on the basis of a majority vote being taken in favour of this course of action by those members present at the time the vote is taken. The majority will include at least one vote in favour from each participating authority. Where no clear majority is reached, this will be taken as indicating the evidence is not strong enough to support this course of action.
8.	**Public involvement**
8.1	The joint committee will meet in public, and papers will be available at least 5 working days in advance of meetings.
8.2	The participating authorities will arrange for papers relating to the work of the joint committee to be published on their websites, or make links to the papers published on the lead authority's website as appropriate.
8.3	A press release may be circulated to local media at the start of the process and at other times during the scrutiny process at the discretion and direction of the Chairman and Vice Chairman.
8.4	Local media may attend meetings held in public.
8.5	Patient and voluntary organisations and individuals will be positively encouraged to submit evidence and to attend.
8.6	~~Members of the public attending meetings may be invited to speak at the discretion of the Chairman.~~ Members of the public attending meetings may speak in the Public Participation session on a matter relating to the agenda, in line with the arrangements set out in the lead authority's Constitution.
9.	**Press strategy**

9.1	The lead authority will be responsible for issuing press releases on behalf of the joint committee and dealing with press enquiries, unless agreed otherwise by the Committee.
9.2	Press releases made on behalf of the joint committee will be agreed by the Chairman or Vice-Chairman of the joint committee.
9.3	Press releases will be circulated to the link officers.
9.4	These arrangements do not preclude participating local authorities from issuing individual statements to the media provided that it is made clear that these are not made on behalf of the joint committee.
10.	**Report and recommendations**
10.1	The lead authority will prepare draft reports, as necessary, on the deliberations of the joint committee, including comments and recommendations agreed by the committee. Such report(s) will include whether any recommendations contained within it are based on a majority decision of the committee or are unanimous. Draft report(s) will be submitted to the representatives of participating authorities for comment.
10.2	Final versions of report(s) will be agreed by the joint committee Chairman.
10.3	In reaching its conclusions and recommendations, the joint committee should aim to achieve consensus. If consensus cannot be achieved, minority reports may be attached as an appendix to the main report. The minority report/s shall be drafted by the appropriate member(s) or authority concerned.
10.4	Report(s) will include an explanation of the matter reviewed or scrutinised, a summary of the evidence considered, a list of the participants involved in the review or scrutiny; and an explanation of any recommendations on the matter reviewed or scrutinised.
10.5	In addition, in the event the joint committee is formally consulted on a substantial variation or development in service:- • If the joint committee makes recommendations to the NHS body and the NHS body disagrees with these recommendations, such steps will be taken as are "reasonably practicable" to try to reach agreement in relation to the subject of the recommendation. • If the joint committee does not comment on the proposals, or the comments it provides do not include recommendations, the joint committee must inform the NHS body as to whether it intends to exercise its power to refer the matter to the Secretary of State and, if so, the date by which it proposes to do so. • In the event that the joint committee refers a matter to the Secretary of State the relevant report made will include:-

	○ an explanation of the proposal to which the report relates; ○ the reasons why the joint committee is not satisfied; ○ a summary of the evidence considered, including any evidence of the effect or potential effect of the proposal on the sustainability or otherwise of the health service in the area; ○ an explanation of any steps taken to try to reach agreement in relation to the proposal; ○ evidence to demonstrate that the joint committee has complied with arrangements for appropriate notification of timescales for its decision to refer; ○ an explanation of the reasons for the making of the report; and ○ any evidence in support of those reasons. • The joint committee may only refer the matter to the Secretary of State:- ○ in a case where the joint committee has made a recommendation which the NHS body disagrees with, when; ▪ the joint committee is satisfied that all reasonably practicable steps have been taken by the NHS body and the joint committee to reach agreement; or ▪ the joint committee is satisfied that the NHS body has failed to take all reasonably practicable steps to reach agreement. ○ if the requirements regarding notification of the intention to refer above have been adhered to.
11. 11.1	**Quorum for meetings** The quorum will be a minimum of 4 members, with at least 2 from each of the participating authorities. This will include either the Chairman or the Vice-Chairman. Best endeavours will be made in arranging meeting dates to maximise the numbers able to attend from both participating authorities.

Suffolk County Council

Essex County Council

Agenda Item 8

Essex and Suffolk Joint Health Scrutiny Committee

30 November 2018

Update on the Sustainability and Transformation Partnership (STP) for North East Essex, Ipswich and East Suffolk and West Suffolk

Summary

1. This report provides information about the developments taking place under the Sustainability and Transformation Partnership covering North East Essex, Ipswich and East Suffolk and West Suffolk. The report includes information about the work in progress to develop an Integrated Care System covering the STP footprint and also provides an update from the newly formed East Suffolk and North East Essex NHS Foundation Trust, following the merger of Ipswich and Colchester hospitals in July 2018.

Objective of Scrutiny

2. The objective of this scrutiny item is to provide the joint committee with an opportunity to consider and comment upon:

   a) progress, key achievements and challenges;

   b) work in progress to develop an Integrated Care System for Suffolk and North East Essex;

   c) the development of primary care strategy within the STP;

   d) an update from East Suffolk and North Essex NHS Foundation Trust.

Scrutiny Focus

3. The scope of this scrutiny has been developed to provide the joint committee with an opportunity to consider the following key areas for investigation:

   a) What are the key achievements in delivering the aims of the STP to date?

   b) What are the key challenges?

   c) What progress has been made towards the development of an Integrated Care System (ICS)?

d) What is the role of the Kings Fund in supporting the development of the ICS and what has been achieved by this work to date?

e) What further work is planned and what are the timescales associated with this?

f) What progress has been made on the development of metrics for the ICS?

g) How are primary care services engaging with the delivery of the STP?

h) Following the formation of the East Suffolk and North Essex Foundation Trust on 1 July 2018, what have been the key achievements and challenges for the new Trust in the first six months and what are the next steps and timescales?

4. Having considered the information, the Committee may wish to:

a) consider and comment upon the information provided;

b) provide feedback on the ICS Stage 1 Draft document (Evidence Set 1);

c) make recommendations to the STP Board;

d) make recommendations to NHS bodies;

e) make recommendations to the Chief Executive of ESNEFT;

f) seek to influence partner organisations;

g) identify any emerging developments in service upon which the joint committee would wish to be formally consulted;

h) seek further information.

Contact details

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Background

5. In December 2015, the NHS published "Delivering the Forward View: NHS Planning Guidance 2016/17-20/21. The guidance asked every local health and care system in England to come together to create a local plan for accelerating the implementation of the NHS Five Year Forward View.

6. These plans, called Sustainability and Transformation Plans *(later "Partnerships")* (STPs), were required to be place-based, multi-year plans built around the needs of the local population and designed to help drive sustainable transformation in health and care between 2016 and 2021.

7. STPs represented a shift in the way that the NHS in England planned its services. While the Health and Social Care Act 2012 sought to strengthen the role of competition within the health system, NHS organisations were now being told to collaborate rather than compete, to respond to the challenges facing their local systems.

8. This shift reflected a growing consensus within the NHS that more integrated models of care were required to meet the changing needs of the population. In practice, this meant different parts of the NHS and social care system working together to provide more co-ordinated services to patients – for example, by GPs working more closely with hospital specialists, district nurses and social workers to improve care for people with long-term conditions.

9. It also recognised that the growing financial problems in different parts of the NHS could not be addressed in isolation. Instead, providers and commissioners were being asked to come together to manage the collective resources available for NHS services for their local population.

10. NHS England's decision to mandate that initial plans be created behind closed doors attracted considerable negative media attention and the pressure to publish was substantial. On 17 November 2016, the STP Implementation Plan for Suffolk and North East Essex STP was published. A copy of the plan and associated documents can be found at: https://www.westsuffolkccg.nhs.uk/health-care-working-together-differently/

11. Following publication of the Plan, on 10 March 2017, the joint committee met formally for the first time, to consider an overview of the arrangements for taking forward the STP. The Committee acknowledged that the STP Implementation Plan currently represented a high level document, in its very early stages of development. The Committee explored what progress had been made with implementation to date, risks and challenges associated with the plan, proposals for developing governance and decision making arrangements, financial forecasts associated with the plan and proposals for wider consultation and engagement. The joint committee made a number of recommendations relating to future plans for communication and engagement (including with hard to reach groups) and requested further information about the merger of Colchester and Ipswich hospitals as a specific strand of work the joint committee would wish to be kept informed of, due to its potential to have implications for both Suffolk and Essex residents.

12. Following this, in July 2017, the STP partners published "A healthier long term future", the STP delivery guide, which provided information in a more digestible form for a wider audience and set out what the STP might mean for local people, including activities, priorities and proposals for consultation and engagement.

Background to hospitals merger

13. On 13 December 2017, Essex Health Overview, Policy and Scrutiny Committee received a report setting out an overview of the planned merger of Ipswich and Colchester Hospitals. This report was presented to Suffolk Health Scrutiny Committee on 24 January 2018. The report included information on the driving forces behind the merger, the anticipated outcomes, progress with the merger to date, the planned timetable for formalisation of the merger, and plans for the future of acute health care in the area.

14. The report confirmed that no major service changes were anticipated as part of the merger process itself, as the main thrust would be to create a new organisation with robust governance structures, more sustainable finances and the most modern systems, technology and logistics.

15. The Full Business Case for the merger of the hospitals was published on 22 March 2018, and, at the conclusion of due process, East Suffolk and North

Essex NHS Foundation Trust (ESNEFT) was formed on 1 July 2018 through the merger of Colchester Hospital University NHS Foundation Trust and The Ipswich Hospital NHS Trust.

16. The joint committee will act as the mechanism for receiving consultation on any major service change emerging from the hospitals merger, if and when this is required.

Development of Integrated Care System

17. In May 2018, Suffolk and North East Essex STP was named as one of four areas across the country to join the development of integrated care across health, social care and the voluntary sector. The announcement signalled the start of a journey to introduce an Integrated Care System across the region.

18. An Integrated Care System joins up all parts of the health and care system including GPs, hospitals, community care and social care as well as physical and mental health services. Integrated care systems have evolved from STPs in other areas of the country and take the lead in planning and commissioning care for their populations. One of the key aspects of an Integrated Care System is for the local system to provide support or care closer to people's homes and to make services easier for people to access when they do need them.

19. In Suffolk and North East Essex, three locality alliances will be at the heart of the Integrated Care System – Ipswich and East Suffolk, West Suffolk and North East Essex. Each alliance, which comprises NHS, local government, voluntary and community sector and primary care representation, is currently developing a delivery plan for each of their areas.

20. By working with partners in an integrated way, the aim is to achieve higher ambitions for the local health and care system, focusing on a small number of additional local priorities. As a first step towards this, on 20 April 2018, leaders from across the local health and care system came together to identify these higher ambitions. The output from this event was an initial very 'raw' initial set of potential ambitions. Further information can be found by following the links under the Supporting Information Section at the end of this report.

21. The Suffolk and North East Essex shadow Integrated Care System (ICS) includes all NHS organisations within the STP footprint, local government, other health sector bodies, local hospices, ambulance service and other community and voluntary sector organisations. The leadership for the ICS is drawn from across these local stakeholders.

22. The Kings Fund was commissioned by NHS England to provide support to the four national second wave ICS areas. This support builds on similar work that the Kings Fund provided to the ten first wave ICS areas last year, which was reported in "A year of integrated care systems - reviewing the journey so far". The STP Chairs Group and subsequently the STP Board agreed in July 2018 that this offer could provide useful support to STP leaders in finalising the future structure, governance and leadership arrangements for Suffolk and North East Essex as an Integrated Care System (ICS). A programme of support involving senior leaders from the Kings Fund commenced in Autumn 2018.

23. Development of this work is by its nature through a 'dynamic process'. A small design panel, working with support from the Kings Fund have developed a Stage 1 draft document setting out potential future ICS arrangements and

principles of working. This document is work in progress and will continue to be refined in response to feedback as the work progresses. The Stage 1 draft is attached as Evidence Set 1. Feedback to the design panel should be addressed to susannah.howard2@nhs.net and should be sent as soon as possible recognising that further drafts of the paper will be considered by the STP Board in mid-December and early January 2018.

Main body of evidence

Evidence Set 1 - **DRAFT** Stage One Governance Framework for Suffolk and North East Essex Integrated Care System (*Note: Feedback on this draft document may be submitted to the Integrated Care Design Panel via: Susannah Howard, STP Programme Director, susannah.howard2@nhs.net by* ***5.00pm*** *on* ***Tuesday 4 December 2018)***

Evidence Set 2 - East Suffolk and North Essex NHS Foundation Trust (ESNEFT) update to Joint Health Overview and Scrutiny Committee

Representatives from primary care in Suffolk and North East Essex have been invited to attend the meeting provide views to the Committee.

Supporting information

December 2015; Delivering the Forward View: NHS Planning Guidance 2016/17 - 2020/21; Available from: https://www.england.nhs.uk/wp-content/uploads/2015/12/planning-guid-16-17-20-21.pdf

Suffolk and North East Essex STP Implementation Plan : 20 October 2016; Available from: https://www.westsuffolkccg.nhs.uk/health-care-working-together-differently/

Five Year Forward View 2016-21 – A guide to the local health and care plan for north east Essex, west and east Suffolk; Available from: https://www.westsuffolkccg.nhs.uk/wp-content/uploads/2016/11/5YearPlan.pdf

Suffolk Health Scrutiny Committee (24 January 2018) Agenda Item 6 Colchester and Ipswich Hospital Merger

Full Business Case for the Merger of Ipswich and Colchester Hospitals

Suffolk Health and Wellbeing Board (12 July 2018) – see Agenda Item 07a Appendix A - A Higher Ambition for Health and Care in Suffolk and North East Essex and Agenda Item 07a Appendix B - Achieving Improved Outcomes

A year of Integrated Care Systems - reviewing the journey so far (20 September 2018)

Essex Health and Wellbeing Board

Essex Health Overview Policy and Scrutiny Committee

Suffolk Health and Wellbeing Board

Suffolk Health Scrutiny Committee

Kings Fund (2014) The Reconfiguration of Clinical Services: What's the evidence

Glossary

A&E – Accident and Emergency

CCG – Clinical Commissioning Groups

CEO – Chief Executive Officer

CHUFT – Colchester Hospital University NHS Foundation Trust

CQC – Care Quality Commission

DPP – Diabetes Prevention Programme

ED – Emergency Department

ESNEFT – East Suffolk and North Essex NHS Foundation Trust

FYFV – Five Year Forward View

HOSC – Health Overview and Scrutiny Committee

HWB – Health and Wellbeing Board

ICS – Integrated Care System

IHT – Ipswich Hospital Trust

JHOSC – Joint Health Overview and Scrutiny Committee

NED – Non Executive Director

NHSE – National Health Service England

OBA – Outcomes Based Accountability

QOF – Quality and Outcomes Framework

SNEE – Suffolk and North East Essex

STP – Sustainability and Transformation Partnership

DRAFT Stage One Governance Framework for Suffolk and North East Essex Integrated Care System (ICS)

IMPORTANT – PLEASE READ

The attached paper contains an early draft of work currently being undertaken to develop the future governance and leadership arrangements for an Integrated Care System (ICS) in Suffolk and North East Essex.

This work is being undertaken by a small design panel working with independent support from the Kings Fund who have experience working with other ICS sites around the country.

Development of this work is by its nature through a 'dynamic process'. As such this paper will continue to be refined as we go forward and does not yet include all of the detail that will eventually be included.

The paper attached summarises stage one of potential future governance and leadership arrangements which includes an outline of potential future ICS arrangements and the principles and ways of working that this might involve. This paper has been reviewed in several forums so far including the STP Board and STP Chairs group. However we know that it will likely be of interest more widely and we would like it to be shared with other forums including Alliances, Health and Wellbeing Boards etc.

Meanwhile a stage two paper is in preparation that will build on the content of the stage one paper and describe proposals in more detail including the functions that will sit at each level, how decisions will be made in different parts of the ICS and proposals to ensure independent leadership for the ICS.

Whilst the design panel continues with developing stage two they would welcome feedback on this stage one paper, recognising that they need to continue to work at pace. Feedback to the design panel should be addressed to susannah.howard2@nhs.net and should be sent as soon as possible recognising that further drafts of this paper will be considered by the STP Board in mid-December and early January 2018.

DRAFT Stage One Governance Framework for Suffolk and North East Essex Integrated Care System (ICS)

1. Introduction

This document sets out the first stage of proposals for an integrated governance framework for the Suffolk and North East Essex (SNEE) Integrated Care System (ICS). It describes the context for changing the way that we work and sets out our ambitions for an integrated approach which is expected to evolve over time as the system develops new integrated ways of working. This paper has been developed by a small panel of 10 people with the support of an independent chair from the Kings Fund (see appendix 2).

In summary in developing our future governance for the ICS what we **want** to do is to:

- make a difference to the issues that matter to people, that we are collectively responsible for which and we can only change by working together;
- work more flexibly across our sector and organisational boundaries. Striving to be efficient, simpler, joined up and accountable;
- adopt a common set of principles and leadership behaviours;
- develop an approach which is right for now whilst working in a progressive environment which may see this change over time;
- add value!

What we **don't want** to do is to:

- add extra layers or complexity to our already complex system;
- create rigid long-term structures;
- undermine the governance and statutory responsibilities of our individual organisations.

We want the governance arrangements for our ICS to enable partners to work at an integrated system level rather than as individual health and care organisations, coming together to meet the needs of patients and citizens. Our proposed governance framework is therefore built on a system leadership model which addresses the balance between a broad range of partners and maintains a clear sense of collective responsibility when developing collective solutions.

As there is no statutory basis for the ICS, a system-wide governance structure needs to be developed which ensures public accountability of the whole health and care system for the outcomes that are collectively achieved, works with and alongside existing accountabilities and structures, aligning with the roles and accountabilities of the NHS, Local Government, Health and Well Being Boards and Overview and Scrutiny Committees.

Whilst there is a commissioner and provider split due to statutory legislation, the spirit of integrated working will mean this split becomes less and less visible, as NHS commissioners and providers work in partnership together for the benefit of the population.

Robust mechanisms need to be developed as part of the governance arrangements which provide scrutiny and hold the collective leadership to account and legitimise decisions by bringing in elected members, NEDs and lay people.

Whilst the ICS needs effective governance to support system-wide decision making and accountability, form should follow function. Governance should be the servant not the master to ensure action and movement as a system.

2. How we need to work as an ICS

2.1 Uniting Principles

Our ICS will bring together the full spectrum of partners responsible for planning and delivering health and care to the one million people who live in Suffolk and North East Essex. Although it often seems that as partners we have different perspectives, we also have much more in common in planning and delivering local health and care services than we realise.

The seven principles of public life, which are intended to apply to anyone who delivers public services, focus on behaviour and culture rather than processes. In applying these principles, the ICS can ensure it is delivering integrated plans which spend public money wisely and deliver services that meet the needs of the local population. The seven principles for public life are set out below and will underpin the governance framework for our Integrated Care System (ICS).

The Seven Principles for Public Life

1. Selflessness - Holders of public office should act solely in terms of the public interest.

2. Integrity - Holders of public office must avoid placing themselves under any obligation to people or organisations that might try inappropriately to influence them in their work. They should not act or take decisions in order to gain financial or other material benefits for themselves, their family, or their friends. They must declare and resolve any interests and relationships.

3. Objectivity - Holders of public office must act and take decisions impartially, fairly and on merit, using the best evidence and without discrimination or bias.

4. Accountability - Holders of public office are accountable to the public for their decisions and actions and must submit themselves to the scrutiny necessary to ensure this.

5. Openness - Holders of public office should act and take decisions in an open and transparent manner. Information should not be withheld from the public unless there are clear and lawful reasons for so doing.

6. Honesty - Holders of public office should be truthful.

7. Leadership - Holders of public office should exhibit these principles in their own behaviour. They should actively promote and robustly support the principles and be willing to challenge poor behaviour wherever it occurs.

Committee on Standards in Public Life,
31 May 1995

2.2 How we will work as an ICS

Based on these overarching principles we propose that the way that we should work as an ICS going forward should be as follows:

Seven Principles of Public Life	How we will work as an Integrated Care System
Selflessness	• We take collective accountability for achieving the outcomes that matter for our whole population; • We put the interests of the people we serve ahead of the interests of ourselves as individuals or organisations
Integrity	• When we say whole system, we mean it – our ICS genuinely collaborates across all sectors purchaser/provider, health/social care, primary/secondary care, statutory/non-statutory, patient/service; • We respect the sovereignty, governance and statutory responsibilities of every organisation; • We are all responsible for creating an environment that enables openness, clarity and fair discussion about organisational and individual interests.
Objectivity	• We always start with 'why?' before 'how' and then 'what'; • We use the discipline of a core methodology for our collaboration to ensure we succeed; • We use evidence and data to drive our decisions within a population health management framework; • We continue to develop our learning and thinking by collaborating as a system – at local, regional, national and international level.
Accountability	• We will devolve decision making as locally as possible, developing solutions for different natural populations flexibly as required at local, neighbourhood, place and system level; • We work closely with patient and carer groups, NEDs and democratically elected representatives and forums (including HWBs and HOSCs) to ensure that we are accountable to the population that we serve.
Openness	• We share our work with the public; • We will share and make the data that we have available and genuinely accessible to all; • We will use a variety of structured and unstructured techniques to engage the public in dialogue about what matters to them.
Honesty	• We have mutual accountability for creating the cultural conditions for system working to succeed; • We hold one another to account for ensuring that as individuals and organisations our behaviours and the way that we organise our resources genuinely support system working.
Leadership	• Leadership within the ICS includes clinical leadership, non-clinical leadership, patient and carer leadership, and non-executive leadership, ensuring genuine coproduction across all sectors; • We support one another to meet shared objectives; • We set ourselves measurable ambitions to make a difference to the things that really matter to people.

2.3 Benefits

By changing the way that we organise ourselves and designing services based on integration rather than organisation, we can provide the following benefits:

- Delivery of person-centred, family-centred and community-centred care
- Enabling communities to lever local assets and develop health and care strategies using technology and information
- Measuring performance and demonstrate real improvements in services and outcomes
- Using consistent standards and outcome measures when taking collective action
- Using our collective workforce resources more wisely
- Improving how we share records and information
- Supporting leaders and staff to develop skills in system working
- Sharing skills, knowledge, resources and expertise when integrating care across organisations
- Reducing waste and duplication of efforts
- Developing stronger links and relationships between partner organisations
- Unlocking efficiencies by aligning incentives across the system
- Promoting financial stability, while holding the system to account for effective delivery
- Improving our approach to assurance through delegated powers from the constituent organisations

3. Measurement and accountability

3.1 Our opportunity as an ICS

Transition to an Integrated Care System (ICS) is an opportunity to collectively raise our ambition for the one million people living in Suffolk and North East Essex who we serve. There are many areas where we all want to see measurable improvements for our communities. However we also know that achieving change will require sustained, concerted action and effective partnership working across organisations and systems. Working as an Integrated Care System (ICS) gives us an opportunity to take a different approach and collectively reinvigorate our efforts in relation to these important priorities.

3.2 A core methodology for change

In order to be successful we will need to adopt an evidence based methodology to ensure discipline in how we work together around complex issues going forward. Outcomes Based Accountability (OBA) is a tool that has been demonstrated to work elsewhere and within our ICS will help us to create a common language that clearly defines core concepts such as *'outcome,* provides a structured approach that brings stakeholders together and provides a framework for more effective discussions about how to improve outcomes and manage performance.

3.3 Population outcomes

Key to an OBA approach is the identification of true population outcomes. These should be set at a large population level. They are the outcomes or the conditions of well-being that we want for our citizens and communities, such as a safe neighbourhood or a clean environment. These outcomes are population outcomes as they refer to whole populations of a region, country – or an ICS. By their very nature, these outcomes will be quite broad and multi-faceted in nature, and cannot be achieved by a single organisation, service or programme working in isolation. Rather, it takes sustained and concerted action from many organisations and programmes and can only be delivered through effective partnership working across key stakeholders.

Across both our Health and Well-being Boards in Essex and Suffolk and the strategies for our individual organisations there is remarkable consistency in the outcomes that we want to achieve for the population that we serve across Suffolk and North East Essex. The ICS should have a key role in delivering these outcomes.

Linked to each of these high level outcomes we then need to add a broader description of what matters to people. This is what they would experience if we were achieving these outcomes. A common framework of population based outcomes for the whole ICS **could** therefore be as follows:

POPULATION BASED OUTCOMES Every one of the one million people in Suffolk and North East Essex……	WHAT MATTERS TO PEOPLE…. WHAT WE WOULD SEE IF WE WERE ACHIEVING THIS If we were achieving this everyone would…..
….is able to live as healthy a life as possible	• live as long as possible no matter where they lived • live as well as possible in terms of their physical, mental & social health • avoid preventable illness
….has access to the help and treatment that they need in the right time and the right place	• have access to primary care, social care, screening, secondary care, support in a crisis • have access to the range of support they need • have access to effective pathways e.g. stroke • experience seamless transition between different agencies and services
….has good outcomes and experience of the care that they receive	• receive the best possible service quality, efficiency and clinical outcomes • access services that are safe and do no harm to those that use them • have the best possible experience as patients and families – kindness, compassion and respectful of peoples time and the complexities of the lives that they lead • have choice and control of care
….has a good start in life	• have a healthy birth • experience good physical health; good mental health • have a safe and supportive environment • be able to fully realise all of their aspirations and goals
….has a good experience of ageing	• not feel vulnerable • experience limited impact from age related conditions • be able to maintain their independence for as long as possible • be able to avoid loneliness and social isolation • be supported as carers
…has a good experience at the end of their life	• make an informed choice about the place of their death • have access to the full range of services help and support that they need • be treated with dignity, respect and sensitivity • have the support they would want for their family and carers

NB – this framework is a draft and would be subject to consultation

3.4 Population accountability versus performance accountability

It is essential that within our ICS there is clarity about the nature and purpose of the monitoring and accountability arrangements we put in place. Fidelity in implementation of OBA identifies the need

for two kinds of accountability – population accountability (outcomes and indicators) as opposed to performance accountability (performance measures).

An example of the difference between the measurement of population outcomes compared to performance outputs for diabetes might be as follows:

		Measured by…….. (examples)
<u>Why?</u> Population outcome **If we were achieving this everyone would…..**	Every one of the one million people in Suffolk and North East Essex……is able to live as healthy a life as possible • live as long as possible no matter where they lived • live as well as possible in terms of their physical, mental & social health • avoid preventable illness	Population measures 'outcomes' might include: • QOF Prevalence of diabetes • Estimated prevalence of diabetes (undiagnosed and diagnosed) aged 16 and over • Percentage of people with type 2 diabetes under the age of 40
<u>How</u>? <u>What</u>?	• People at risk of diabetes will be identified as early as possible and offered support to reduce their risk • People diagnosed with diabetes will be supported to manage their condition well and continue to live a healthy and independent life	Performance measures 'outputs' might include • Numbers of patient attending DPPP • People with diabetes who receive all 8 care processes • Number of people with diabetes attending structured education programme

Thinking in this way helps to provide clarity within our ICS about:

<u>Why</u> we need to work together…	…to make a difference to the outcomes and issues that matter to people that we are collectively responsible for which we can only change by working together;
<u>How</u> we will work together…	…to achieve better outcomes in different ways in local neighbourhoods and alliances by working more flexibly across our sector and organisational boundaries;
<u>What</u> we will deliver together…	…real innovation in the way that health and care is delivered in local communities and neighbourhoods.

As partners in the ICS we are collectively accountable for achieving population outcomes as no single organisation can achieve them on their own. Measurement of these outcomes is complex and requires the use of a broad range of population measures. Also the range of measures used must be informed by working with patients and the public through health and wellbeing boards, patient groups and other means so that we can ensure that as an ICS;

- we continue to learn by listening to people about what matters to them; and
- we are collectively accountable to the people we serve for the outcomes we achieve.

We will need an objective and consistent way to do this across the ICS. Also as these population indicators vary across different parts of Suffolk and North East Essex it is essential that the measures we use are accessible and usable by all at neighbourhood, place and whole system level. Open and consistent accessibility of this data will also begin to enable all partners and all sectors in the ICS to

develop a population health management approach that informs how we work together at neighbourhood, alliance and system level – or even as individual organisations.

This approach can also inform the definition of measurable improvements or 'Higher Ambitions' for different elements of our ICS going forward by providing a consistent approach that underpins the definition of key local priorities for alliances and neighbourhoods in terms of specific, measurable outcomes for a defined population within a set period of time.

By contrast, ongoing monitoring of performance measures or 'outputs' would continue to be part of commissioning and contract oversight arrangements for alliances or individual organisations.

4. Our evolving ICS

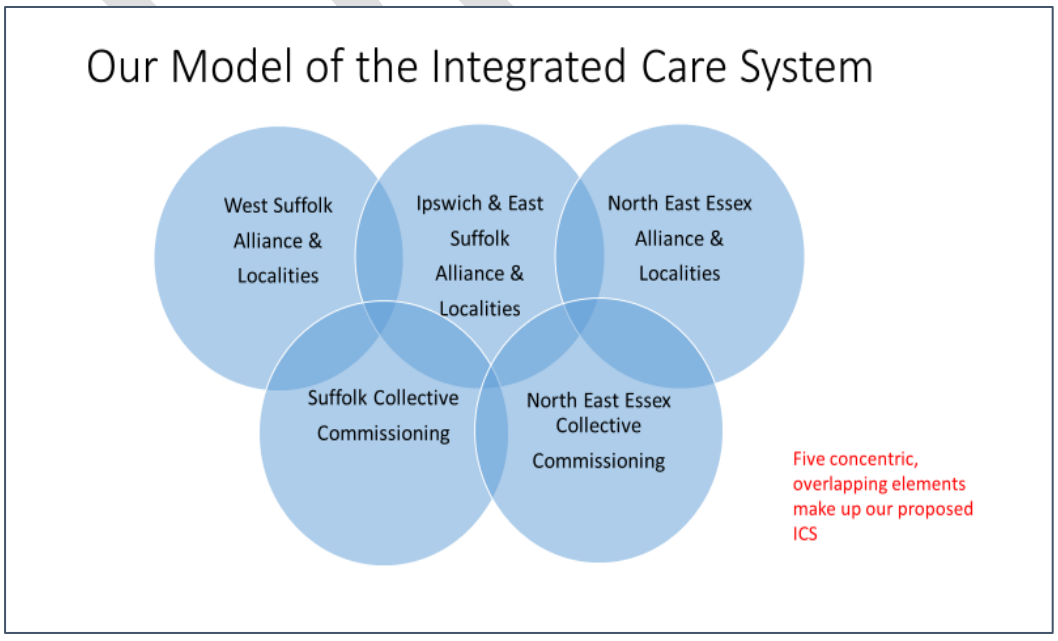
4.1 Our model

We want to avoid a hierarchical approach to governance for our Integrated Care System (ICS) so that it can work more as an ecosystem that can adapt and flex to meet the needs of the population. Indeed, the ICS is an inversion of a hierarchy with the system serving the neighbourhoods and alliances. This network of interconnected resources requires leadership across all sectors and organisations, according to the developing needs of the population, in order that it can design more locally applicable integrated models of care.

The ICS, as a coalition of the willing, will exist through a conscious decision of Alliances, localities, and sovereign organisations to pool resources and efforts to achieve common goals when it makes sense to do so in the interests of the local population.

This way of working will enable communities to shape their priorities and release the assets which contribute to their wellbeing, care and health, within a common set of standards which reduce unnecessary variations in performance and outcomes. By working with people in our communities we can develop trust and understanding with stakeholders about what matters. Consequently, they will own and deliver good outcomes.

In keeping with our commitment to devolve resources to as local a level as possible within our ICS, and our emphasis on neighbourhood and alliance level working, we are committed to continuing to operate with as light touch as possible at system level going forward as an ICS. Roles and functions across the whole ICS footprint will only be created where there is an identified requirement for functionality at this level.



5. Localities and neighbourhoods

5.1 The importance of local 'neighbourhood' working in the ICS

Neighbourhoods provide a focus for smaller, identifiable geographies and communities within Alliances. Without the need to meet the requirements of a fixed size or model, different areas can find different solutions.

These neighbourhoods might be based around GP catchment areas or local authority ward boundaries, with local partners working together in networks, responding to the characteristics and needs of the local population. Equally neighbourhoods may act in a three-dimensional way being defined by a school community or a virtual community meeting needs through the use of social media.

5.2 What we need to do in neighbourhoods

Public Involvement
- Leverage relationships with local population and community partners
- Ensure patient/individual and family centre care design and delivery
- Capture feedback from people to celebrate successes and learn from challenges
- Ensure community involvement

Continuous Improvement/Innovation
- Use innovation including digital solutions to enable system change and improve outcomes for the local population
- Stimulate pilot schemes and new initiatives

Reducing Inequalities/Population Health/Planning
- Develop local population and risk stratification
- Design and deliver asset-based community support and promotion of self-care
- Design and deliver targeted programmes for vulnerable patients, individuals and families

Delivery
- Ensure delivery of the neighbourhood share of Alliance targets and expectations
- Deliver health promotion and wellbeing services
- Operate care coordination and case planning and management
- Provide alternatives to hospital/care requirement and admission
- Operate patient/person tracking and follow up systems

Integration
- Deliver integrated, multi-disciplinary services within each locality

Financial/Contracting
- Deliver demand management and resource allocation as appropriate

6. Alliances

6.1 The importance of 'place-based' Alliances in the ICS

Local 'place-based' systems of care involve multiple partnerships, including NHS organisations and the local authority, working together to provide integrated care across organisational boundaries to improve the health and wellbeing of their populations. In Suffolk and North East Essex ICS there are three 'place-based' systems of care called Alliances. These are North East Essex, West Suffolk and Ipswich and East Suffolk, with each defined by the footprint of local health and care partners as well

as natural geography, developing differently according to local circumstances. As in neighbourhoods, Alliances need to act as a three-dimensional model interpreting need in many ways. Maybe, for example, a boundary being defined by a school community or a virtual community meeting needs through the use of social media and it not always being about geographical boundaries.

The Alliances provide the focus for planning and delivering meaningful integrated care and services to the local population with partners working closely with the voluntary and community sector, independent sector organisations and communities. Alliances will provide the focus for:

- System and service transformation
- Securing and delivering integration
- Ensuring clinical engagement
- Relationship development and management
- Ensuring the principles of good governance are embedded
- Reducing inequalities across the Alliance
- Producing and resourcing a detailed plan to deliver the overarching strategy
- Ensuring public involvement in the planning, development, design, priority setting and decision making
- Demonstrating accountability to Alliance members, local people, stakeholders, and regulators
- Ensuring continuous improvement and innovation in the quality and delivery of services.
- Ensuring the delivery of high quality, safe and caring services
- Ensuring good financial management, financial governance and value for money

6.2 What we need to do in Alliances

Governance

- Local assurance and performance improvement
- Determine and implement the governance arrangements required to deliver on functions
- Approve and sign off business cases in line with scheme of delegation
- Ensure non-executive scrutiny of governance
- Make recommendations to ICS Board
- Own and maintain alliance level risk registers
- Agree a single, local operating and investment plan and managing local financial controls

Public Involvement

Work with citizens to:

- understand the wellbeing, social and healthcare needs of the local population
- create, grow and develop solutions to improve outcomes for the local population
- co-produce outcomes to reflect the lived experience

Continuous Improvement/Innovation

- Review and redesign local services
- Work collectively to shape and deliver improvements collectively
- Use innovation including digital solutions to enable system change and improve outcomes for the local population

Reducing Inequalities/Population Health/Planning

- Assess the wellbeing, social and healthcare needs of the local population
- Conduct strategic planning across local population; identifying opportunities for transformation and improvement
- Develop and implement delivery plans

Delivery

- Responsibility for local service provision. Those defined as Specialised Services may be commissioned at system level, but delivery will remain at provider-led alliance level.

Integration
- Work with system partners to align and integrate service delivery to create efficiencies in practice and improve outcomes for the local population
- Build and manage relationships across the Alliance network
- Work as part of the ICS to inform and deliver systems ambitions

Financial/Contracting
- Undertake procurement where required, and manage ongoing contractual arrangements
- Local financial management

6.3 Alliance Governance Plans so far

Whilst each of the three Alliances have developed some governance arrangements these are in varying levels of detail. They can be viewed in each of the Alliance Strategies in the Appendices.

7. Collective Commissioning

7.1 Our vision for commissioning in the ICS

Commissioning in the ICS is much more than just the procurement and contracting process. Commissioning for integrated care is about wrapping around all elements of the system in an integrated manner using co-design to work with communities on ways to respond to the needs of a defined population irrespective of size. Our Integrated Care System in Suffolk and North East Essex requires that we take much more decisive action on prevention and population health, investing in new, more integrated, more efficient and more locally applicable models of health and care.

Fundamentally, we also need a totally different relationship with our communities to enable them to shape the priorities and release the natural assets which will contribute to their wellbeing, care and health. We are responsible for making the best use of the resources we have in our system and more effective commissioning has a major part to play in this. Over time we aim to see a greater emphasis on efficiency coming from wider system improvements.

Statutory commissioning bodies responsible for health, care and wellbeing will need to take every opportunity to work with partner organisations/groups/bodies to think outside our current paradigm of what a health and social care system is to have maximum influence on the causes of causes/wider determinants of health. This must include finding new ways to maximise the added value of voluntary and non-statutory resources that exist in the health, care and wellbeing sectors. Our approach to commissioning must also be driven by the latest evidence, insights and intelligence.

To achieve the changes required, all current commissioning and provider organisations in Suffolk and North East Essex are seeking to find a new locally relevant, less hierarchical way of organising and delivering our wellbeing, care and health system. The proposals in this framework will continue to evolve as changes are made to policy directives and legislation but our commitment to support ‘place based’ commissioning and delivery at neighbourhood and alliance level is intended to be a fundamental building block of any future system in Suffolk and North East Essex.

7.2 Issues for CCGs

CCGs need to “lead and cede”. They are now evolving their governance to drive integrated care in the localities, alliances and at the ICS level. CCGs will create new forms of shared decision making with providers and partners in pursuit of a vision of integrated care delivery within the context of legal duties. It is important to ensure clinical and managerial leadership support these integrated care models in the context of the health of the population and support transformation on a collective scale. CCGs will sustain the best examples of community involvement.

Fundamental to this will be the engagement of CCG member practices is to making the ICS work.

The CCGs will work with county and borough/district councils to support locality alliances and the strategic commissioner to serve the distinct populations of Suffolk and North East Essex.
CCGs will develop shared decision-making by agreeing the services and priorities which need a collective approach and explore options for how this could be done.

7.3 Key issues for Local Authorities

Local authorities will therefore similarly need to ‘”lead and cede”.

They build on a long history of supporting the people and the communities they serve to thrive, and on a long history of creating the conditions for health and wellbeing. Local authorities see themselves as integral to the ICS and all its parts.

The ICS covers two county councils and a number of district and borough councils. Different councils will need to be present in different parts of the ICS according to function, locality and responsibilities. This includes commissioning. The principle of subsidiarity will need to be considered both in the ICS and alliance footprints and across and between the wider Local authority footprint linkages where necessary and relevant.

As with the CCGS the County Councils will create new forms of shared decision making with partners in pursuit of integrated care delivery within the context of their legal duties and their democratic accountability. They will pursue shared decision making for those service areas and priorities which require a collective approach.

A fundamental issue is that the taxes paid by residents, and the decisions made by politicians regarding those taxes, pertain to the delivery of services in their relevant geographical patch and this cannot be compromised. The structure of three alliances within the ICS support and enable this condition.

We will, together, also need to find an effective and transparent way that the statutory health and wellbeing boards will continue to exercise their strategic leadership and oversight for promoting health outcomes and reducing inequalities within the county council areas in the context of the emerging ICS plans.

Any arrangements that we co-design and ways in which we collectively change for the better will need to take account of the fact that health services are free at the point of delivery and some local authority services are means tested or chargeable.

The county councils, in particular, have a specific role in contributing to decision making and impact through their public health function and it will be important that this actively contributes to all parts of the functioning of the ICS.

The county councils will adapt and redesign their commissioning, leadership, management and service delivery arrangements in partnership and always in the pursuit of efficiency and better services for residents.

It is important to recognise that in forming our ICS we have can determine locally how both Essex and Suffolk County Councils as Local Authorities will align with the ICS and alliances. The true vibrancy of the ICS and Alliances will be dependent on all partners and everyone has responsibility for influencing how this happens. Elected members recognise the opportunity that the ICS brings as to influence and deliver their objectives.

7.4 Collective Commissioning across the ICS

As an ICS the health and care system in Suffolk and North East Essex has the potential to operate more autonomously and develop a different relationship with regulators including NHS England. An effective collective commissioning function across the ICS will be essential in creating an environment in which our locality Alliances can flourish and the benefits of integrated care at every level can be fully realised.

In addition to managing some strategic functions across the whole ICS, a collective commissioner will also help to ensure that a broad range of funding opportunities are accessible to the all Alliance and neighbourhood partner tiers. It should also be able to leverage the combined scale of the ICS to ensure that Suffolk and North East Essex remains influential in national policy and other forums.

Governance

- Maintain ICS oversight enabling mutual accountability between system, place and neighbourhood to deliver required improvements to wellbeing, care and health
- Discuss with regulators and arms-length bodies how we ca operate a 'system oversight' relationship for ICS performance monitoring, recognising the different accountability relationships for the NHS and Local Government
- Develop and agree protocols for escalation to national bodies

Public Involvement

- Ensure system wide engagement and consultation is carried out when significant service changes are proposed

Continuous Improvement/Innovation

- Support individual Alliances and/or partners who may need performance improvement capacity/capability
- Support Alliances with enabling developments such as workforce, estates, digital where it adds value
- Facilitate networks across the ICS to share good practice and drive engagement in the ICS ambitions and priorities

Reducing Inequalities/Population Health/Planning

- Undertake population health and social needs assessments to identify inequalities the ICS
- Use the insight and levers from population health and social needs assessment to work with Alliances to set strategic ambitions, priorities and performance metrics to address inequalities and improve outcomes over the medium to long term

Delivery

- Assume the maximum permitted delegated responsibility for NHSE commissioned services and for collective commissioning across the ICS where there is identified need at scale or deemed specialist provision that cannot be commissioned at Alliance level
- Operate a system level transformation support and oversight of delivery of FYFV and other agreed programmes within the Alliances

7.5 System control total

Before developing the technical aspects of how a system control total might work within the ICS, we first need to develop vision and principles for how this will add value. Work by the STP Directors of Finance Group on development of how a system control total might work needs to sit within the wider principles and context for the ICS.

Key issues to be considered will need to include:

- The incentives there are for the system to work this way. The opportunity this brings to have different type of conversations
- The desire in Alliances to do something differently – how the ICS can help drive change, improvement and innovate. Process could be to set out amounts in each locality when SCT comes in then look at the total amounts in the system.
- How we can have a common sense approach that supports the freedom of the ICS and is regulator light.
- Rules of engagement – what if an individual organisation under or over performs, how will that be reconciled as part of the system? Would the ICS commit to reallocating or rescuing locally and reduce role of regulator?
- The complexities of local authority boundaries. How local authorites can be involved.
- The meaning of a system control total in light of local guaranteed income contracts
- What are the process and timescales to make the shift to this new way of working? Further develop plans as part of our 5 year plan once the guidance is available later this year. There be some National architecture and an expectation about how this might develop over time.

8. The emerging wider context

8.1 NHS 10 Year Plan

Following the government announcing increases in NHS funding over five years, beginning in 2019/20, the NHS and the Government are working together to produce a Green Paper which will set out the direction of travel for the NHS 10 Year Plan. This is expected to be published in late December 2018.

It is anticipated that the 10 Year Plan will focus on improving population health, reducing health inequalities and integrating care in the context of the development of Integrated Care Systems. NHS England have consulted on key themes, such as maternal and child health, staying healthy and ageing well, workforce and innovation as well as clinical priorities such as cancer, cardiovascular and respiratory, learning disability, autism and mental health.

The 10-year workforce strategy [issued as a consultation in December 2017] will now also be published alongside the plan itself.

8.2 Changes in policy and legislation

Changes in policy and legislation are required to remove financial, regulatory and other barriers to the development of ICSs including:

- Align the statutory framework with ICSs through the development of regulatory changes including the development of formal powers and accountabilities;
- Changing the role of regulators to achieve closer alignment with the emphasis on system working;
- Redesigning financial architecture to provide incentives for integration;

- Reviewing the law relating to procurement.

9. Next Steps

This document sets out a broad framework to underpin the further development of governance and leadership arrangements for the Suffolk and North East Essex ICS. Building on this stage one document, a stage two document will be developed setting out the next level of detail for proposals for future governance of the ICS.

The editorial process for further development of both these stage one and stage two governance documents will need to be managed to ensure that the process continues to move forward. Editorial decisions will be made through the Integrated Care Design Panel (see appendix 2) who will continue to meet weekly.

Discussion and comments on the content of this document is invited from STP Board, STP Chairs Group, Joint Health Overview and Scrutiny Committee (JHOSC), Health and Well-being Boards, Alliances, individual organisation boards and other forums.

Comments on this document should be submitted to the Integrated Care Design Panel via: Susannah Howard, STP Programme Director, susannah.howard2@nhs.net

A further version of this document will be considered by the STP Board at their meeting in December – therefore the deadline for comments to be considered in the version of this document is strictly **5.00pm** on **Tuesday 4 December 2018.**

Appendices

Appendix 1 - Glossary of terms

Integrated Care System (ICS) – the whole system that we are seeking to create across SNEE (commissioners, statutory and non-statutory providers, partners and regulators) to support circa 1 million population
Place based commissioning – commissioners and providers organising themselves so that they collaborate together to address the challenges and improve the wellbeing, care and health of the local population within each Alliance geographic area utilising the common resources available
Collective Commissioning – commissioning (wellbeing, care and health) collaboratively across the whole geography of SNEE where this adds benefit
Alliances – sub SNEE level systems i.e. North East Essex, Ipswich and East Suffolk and West Suffolk alliance of partners that work together to commission and deliver services to their local population of circa 250-350k
Localities – sub Alliance area level systems e.g. 6 in West Suffolk, 8 in Ipswich and East Suffolk and 4 in North East Essex of circa 50k population size
Systems Leadership - leadership across organisational boundaries, beyond individual professional disciplines, within a range of organisational and stakeholder cultures, and often without managerial control.

Appendix 2 - Panel Membership and Chair

The Integrated Care Design Panel has included the following members, chaired by Matthew Kershaw, Senior Fellow at The Kings Fund.

- Ed Garratt, Suffolk CCGs
- Sue Cook, Suffolk County Council
- Peter Fairley, Essex County Council
- Antek Lejk, Norfolk & Suffolk NHS Foundation Trust
- Sheila Childerhouse, W Suffolk Hospital
- Neill Moloney, East Suffolk and North Essex NHS Foundation Trust
- Mark Jarman-Howe, St. Helena Hospice / NE Essex Alliance
- Mark Shenton, GP & Ipswich & East Suffolk CCG Chair
- Susannah Howard, STP Programme Director
- Kirsty Denwood, North Essex Essex CCG / STP Directors of Finance Group

East Suffolk and North Essex NHS Foundation Trust

East Suffolk and North Essex NHS Foundation Trust (ESNEFT) update to Joint Health Overview and Scrutiny Committee

1. Overview

The Joint Health Overview and Scrutiny Committee for Suffolk and Essex requested an update on the achievements and main challenges since the new organisation was created on 1 July this year as a result of the merger of the trusts that ran Colchester and Ipswich Hospitals.

2. Background to the merger

2015: The Trust that ran Colchester Hospital (CHUFT) was placed in special measures by the Care Quality Commission (CQC). There were significant financial, performance and staff recruitment issues at both Colchester and Ipswich (IHT) trusts. As medium-sized district general hospitals covering populations of around less than 400,000 each, neither trust was sustainable, and many residents had to travel outside the region for specialist care.

2016: Nick Hulme, and David White, respectively CEO and Chair of IHT, were appointed to look after CHUFT. Move to partnership working began. Boards agreed to formal merger.

2017: Merger process and scrutiny began in earnest. A&E performance improved and CQC upgraded CHUFT, lifting it out of special measures.

2018: CQC confirmed IHT still providing 'Good' quality care. The national NHS awarded the combined trusts £69.3m to improve buildings and facilities at both hospitals in support of the upcoming merger. Merger approved in March 2018 and occurred on time, with ESNEFT officially beginning work on 1 July.

3. Since merger

We had a smooth merger, on time and no disruption to staff, services or patients. It was our aim that patients should experience no change at the point of merger, and we believe we achieved this.

Our A&E performance has remained positive so far, including through summer which at times was busier than last winter with the exceptionally hot weather.

Staffing levels have improved, with vacancy and turnover rates reduced and our leadership is involved at national level in developing NHS strategy.

We have begun to articulate trust ambition and objectives and our clinicians and colleagues have begun to develop our clinical approach.

Our scale

ESNEFT is one of the largest of the 140 NHS trusts in England, and we are the largest NHS employer in the region, with around 9,500 staff to look after over 750,000 residents.

As ESNEFT, we have six services in the top 20 nationally for the overall number of patients we see. These include: general surgery (third busiest in the country); cancer services (sixth) and orthopaedics (10th).

Developing our ambition and objectives

Our full business case for merger stated that our objectives for merger were:

- Improve recruitment and retention of staff
- Create larger, more sustainable clinical services with more range
- Create sustainable partnerships with community services
- Invest in innovation, research and technology to transform services
- Adapt flexibly and attract investment to meet the changing needs of the population

Since July we have begun developing the ambition and objectives that will take us into the future. At this point, our draft articulation of these is as follows:

Our ambition

We offer the best in

- Care and experience
- Leadership and as a partner in our community
- Achieving the potential of all our staff
- Daring to be different through innovation and technology

Our objectives

Offer the best care and experience

We will minimise stress for patients and carers through:

- improving access and customer service
- getting care right-first-time.

We will improve clinical outcomes through:

- further developing our clinical centres of excellence
- continuous improvement
- excelling in training and education.

Achieve the potential of all our staff

We will achieve the potential of our staff through:

- trusting our teams to do things differently
- enabling staff to fully use their skills
- supporting and recruiting staff who have ambition
- offering the best training, education and research opportunities

Lead and develop partnership in the community

We will take a leading role in the integration of services through:

- working with partners
- breaking down barriers through good communication
- playing an active & positive role in the community, beyond health care

Drive innovation and technology

We will be daring in our use of innovation and technology to offer the best to our patients, staff and communities. This means we:

- will invest in technology to improve experience and quality of care
- support those who want to innovate and improve quality.

We will continue to develop the clinical strategy and wider approach that sits beneath this.

3. Key challenges

We have a number of challenges which we plan to overcome through our overarching corporate strategy, which includes our approach to providing clinical services.

This strategy and our approach to clinical services are shaped by the context in which we operate. This context, and our design principles for services, are briefly summarised below.

a) National context

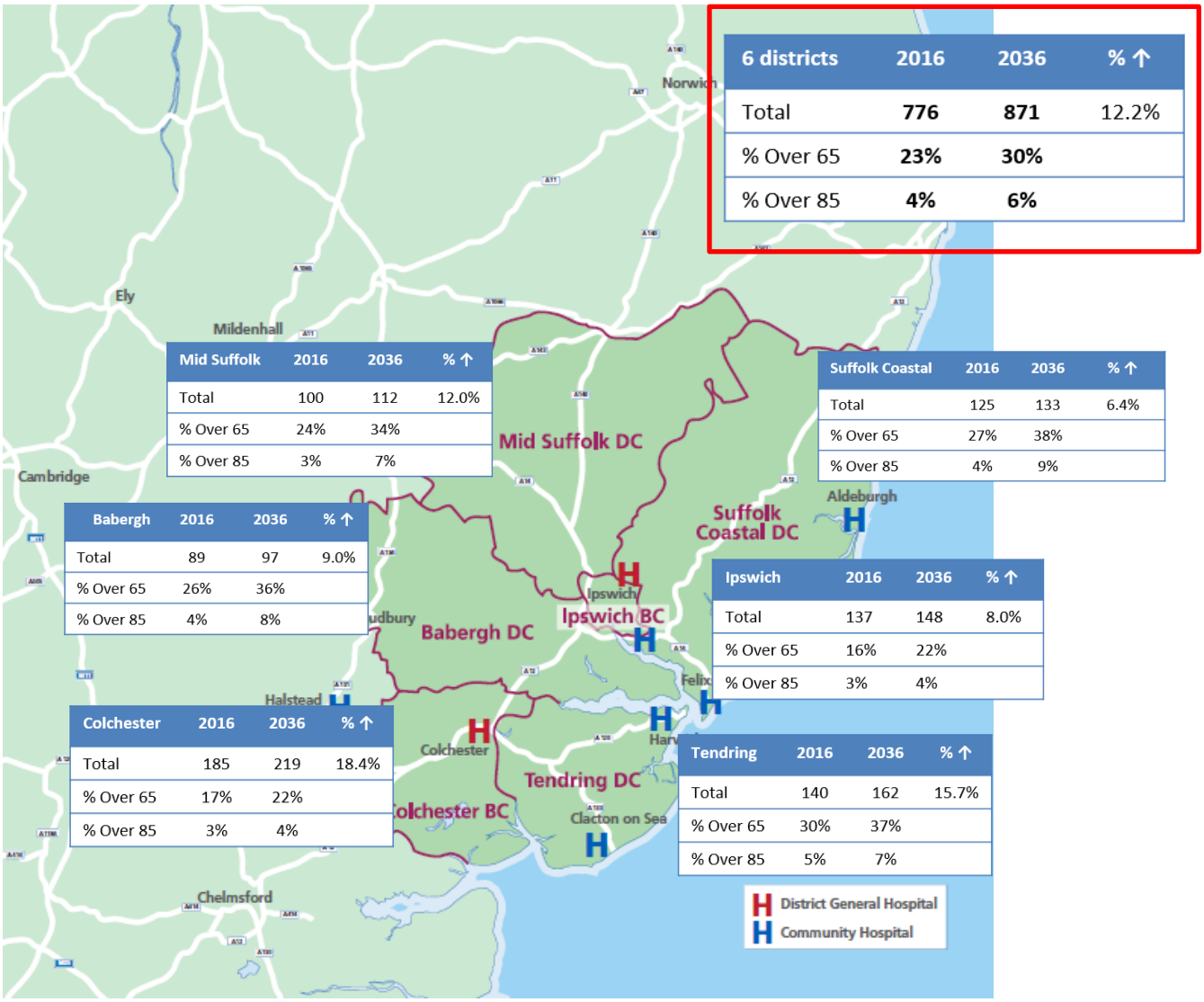
Any NHS strategy should be compliant with, for example: national service specifications and commissioning frameworks; professional and service standards and Get It Right First Time best practice. It should also be informed by expert and independent publications, such as the Kings Fund report *The Reconfiguration of clinical services: What's the evidence?* (2014).

b) Local context

Our strategy needs to support the aims of our sustainability and transformation partnership (STP) and be aware of the possibilities offered by the ability to take a whole-population approach to health care offered by the new wave of independent care systems.

Our hospital services will of course be shaped around the three fixed points agreed pre-merger. This means Colchester and Ipswich hospitals will retain 24/7 accident and emergency departments; consultant-led maternity services and; 24/7 emergency admissions on both sites.

The population that we cover is predicted to rise by an average of 12.2% by 2036.



6 districts	2016	2036	% ↑
Total	776	871	12.2%
% Over 65	23%	30%	
% Over 85	4%	6%	

Mid Suffolk	2016	2036	% ↑
Total	100	112	12.0%
% Over 65	24%	34%	
% Over 85	3%	7%	

Suffolk Coastal	2016	2036	% ↑
Total	125	133	6.4%
% Over 65	27%	38%	
% Over 85	4%	9%	

Babergh	2016	2036	% ↑
Total	89	97	9.0%
% Over 65	26%	36%	
% Over 85	4%	8%	

Ipswich	2016	2036	% ↑
Total	137	148	8.0%
% Over 65	16%	22%	
% Over 85	3%	4%	

Colchester	2016	2036	% ↑
Total	185	219	18.4%
% Over 65	17%	22%	
% Over 85	3%	4%	

Tendring	2016	2036	% ↑
Total	140	162	15.7%
% Over 65	30%	37%	
% Over 85	5%	7%	

c) Service redesign considerations

The aim of course is for the NHS to prevent illness, and provide as much care as possible locally for our population. Local can be in a hospital, but also in local communities, in residents' homes and increasingly in people's hands, through new technology.

Some considerations which will shape our corporate strategy and clinical approach include:

Care should be delivered as conveniently for patients as possible, subject to all the following criteria being met:

- Care should be delivered in a clinically safe environment, including at home and by telephone, video and remote monitoring
- there is a critical mass of patients able to use the service to meet quality standards and with the right levels of staffing
- specialist diagnostic and treatment equipment and staff can be efficiently and economically provided.

Services will be located at both hospital sites where one or more of the following apply:

- There is a direct service dependency with one or more of the three core services (24/7 ED, 24/7 obstetrics and 24/7 medical take) using the South East Coast Clinical Senate criteria
- there is a significant volume of activity that is delivered on an elective ambulatory care basis**.**

Services may be concentrated on one hospital site where one or more of the following apply:

- Peer-reviewed evidence and professional standards supports the centralisation of services on the grounds of improved clinical outcomes or patient safety
- duplicating high cost equipment in more than one place does not provide good value
- the volume of patients needed to meet externally validated accreditation standards can only be met by being provided at one site
- where specialist skills cannot be available at both sites 24/7.

4. Next steps

Now - December:	internal work to determine clinical approach
January:	further engagement with JHOSC to discuss our clinical approach
January:	Trust Board – approval for wider engagement on Trust strategy, including clinical approach
Feb-March:	public and stakeholder engagement conversations on emerging strategy
March:	anticipate Board ratifies strategy for implementation.