Committee on the Sustainability and Transformation Plan 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 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

14:00	**Friday, 10 March 2017**	**King Edmund Chamber, Endeavour House, Russell Road, Ipswich, IP1 2BX,**

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.

Part 1

(During consideration of these items the meeting is likely to be open to the press and public)

		Pages
1	**Election of Chairman**	
2	**Election of Vice Chairman**	
3	**Draft Terms of Reference** To agree the ToR of the Joint Committee	5 - 14
4	**Identification of Items Involving Public Speaking** To note where members of the public are speaking on an agenda item. These items may be brought forward on the agenda.	
5	**Apologies for Absence**	
6	**Declarations of Interest** To note any declarations of interest to be made by Members in accordance with the Members' Code of Conduct	
7	**NHS Sustainability and Transformation Plan fro North East Essex, Ipswich and East Suffolk and West Suffolk**	15 - 28
8	**Urgent Business** To consider any matter which in the opinion of the Chairman should be considered in public by reason of special circumstances (to be specified) as a matter of urgency.	
9	**Date of Next Meeting** Members of the Joint Committee are requested to bring their diaries with them to the meeting	

Exempt Items

(During consideration of these items the meeting is not likely to be open to the press and public)

To consider whether the press and public should be excluded from the meeting during consideration of an agenda item on the grounds that it involves the likely disclosure of exempt information as specified in Part I of Schedule 12A of the Local Government Act 1972 or it being confidential for the purposes of Section 100A(2) of that Act.

In each case, Members are asked to decide whether, in all the circumstances, the public interest in maintaining the exemption (and discussing the matter in private) outweighs the public interest in disclosing the information.

Suffolk County Council

Essex County Council

Agenda Item 3

Essex and Suffolk Joint Health Scrutiny Committee

10 March 2017

Draft Terms of Reference

Summary

1. This report provides the reasons for the establishment of the Joint Committee, and sets out draft terms of reference for the operation of the Committee.

Objective

2. The Committee is asked to consider and agree the Terms of Reference, attached at Appendix 1.

Contact details

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Background

3. Sustainability and transformation plans (STPs) were announced in NHS planning guidance published in December 2015. NHS organisations and local authorities were asked to come together to develop 'place-based plans' for the future of health and care services in their area, covering three headline issues: improving quality and developing new models of care; improving health and wellbeing; and improving efficiency of services.

4. STPs are long-term plans (2016-2021) covering all aspects of NHS spending, as well as focusing on better integration with social care and other local authority services.

5. STPs reflect a growing consensus within the NHS that more integrated models of care are required to meet the changing needs of the population and to bring the system back to a financially sustainable position. In practice, this means different parts of the NHS and the social care system working together to provide more co-ordinated services to patients and represents a significant change to the planning and delivery of health and care services.

6. The Suffolk and North East Essex STP Implementation Plan was published in November 2016. The information it provides reflects a high level shared vision and priorities for action over the next five years. The detailed proposals and timescales for changes to services resulting from the STP will take time to develop and implement.

7. Under the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013, NHS bodies are required to consult local authority health scrutiny arrangements on any "substantial variations or developments to services". The requirement is separate, and in addition, to the duty of the NHS to consult and engage with patients and the public.

8. What constitutes a "substantial variation or development" is not defined in Regulations, but guidance suggests it should be a matter for local discussion and agreement, taking into consideration factors such as the extent to which the proposed change may impact upon patients, for example in terms of access to services, whether the change represents a reduction or closure of a service, the numbers of patients affected, the extent to which the public and patients have been involved and consulted on the development of the proposals, the extent of the impact and local feeling.

9. 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 substantial development proposal.

10. For the purpose of scrutiny of the Suffolk and North East Essex STP, Essex Health Overview and Scrutiny Committee and Suffolk Health Scrutiny Committee have agreed to establish a joint scrutiny committee, on a task and finish basis. The joint committee will focus on activities taking place under the banner of the STP which are likely to impact upon patients from both counties. There may be other aspects of the STP work for which scrutiny by the "home" local authority Committee would be more appropriate.

11. 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.

12. The joint committee will meet to scrutinise matters arising from the STP, or to receive formal consultation from the NHS as appropriate. The joint committee's programme of work will need to be developed in light of further information about emerging proposals and detailed timescales for decision making. This will be particularly important where the joint committee is being formally consulted as the Regulations require timescales to be provided to health scrutiny and published. This includes the date by which the NHS body requires comments in response to consultation and the date by which it intends to make a decision as to whether to proceed with the proposal. This is so that local patients and communities are

aware of the timescales that are being followed. Ongoing constructive dialogue as the plans develop should help ensure that timescales are realistic and achievable.

Main Body of Information

13. The following information has been provided for the Joint Committee's consideration and is attached to this report:

Appendix 1: Draft Terms of Reference for the Joint Committee

Glossary

NHS – National Health Service

STP – Sustainability and Transformation Plan

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

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

Draft 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 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 (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 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.
2.4	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.

5.	**Supporting the Joint HOSC**
5.1	The lead authority will be as decided by negotiation with the participating authorities. 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.

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:- o an explanation of the proposal to which the report relates; o the reasons why the joint committee is not satisfied; o 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; o an explanation of any steps taken to try to reach agreement in relation to the proposal; o evidence to demonstrate that the joint committee has complied with arrangements for appropriate notification of timescales for its decision to refer; o an explanation of the reasons for the making of the report; and o any evidence in support of those reasons. • The joint committee may only refer the matter to the Secretary of State:- o 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. o 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 7

Essex and Suffolk Joint Health Scrutiny Committee

10 March 2017

Sustainability and Transformation Plan (STP) for North East Essex, Ipswich and East Suffolk and West Suffolk

Summary

1. This report provides the joint committee with an overview of the arrangements for taking forward the Sustainability and Transformation Plan for North East Essex, Ipswich and East Suffolk and West Suffolk. It outlines progress made since the Plan was published in November 2016 and deals with issues of finance, governance and arrangements for future public and patient engagement and consultation as the plan progresses.

Objective of Scrutiny

2. The objective of this scrutiny is to provide the joint committee with an opportunity to consider the NHS Sustainability and Transformation Plan (STP) for North East Essex, Ipswich and East and West Suffolk.

Scrutiny Focus

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

   a) What progress has been made on the STP since it was published in November 2016?

   b) What are the next steps and key milestones?

   c) What are the key risks and challenges associated with the delivery of the Plan?

   d) Which elements of the plans within the STP are “footprint wide” (ie likely to result in changes to services for patients in both Essex and Suffolk), as opposed to CCG or local authority based?

Governance:

e) What arrangements are in place to clarify the different levels at which decisions will be made within the STP?

f) To what extent have individual organisations signed up to delivery of the STP?

g) Given that STPs have no legal accountabilities, how will collective decisions be reached?

h) How will organisations be held to account for delivery?

i) How will success be measured?

j) What are the arrangements for transparency, scrutiny and assurance?

Financial

k) What is included within the system-wide financial control total?

l) To what extent does the forecast shortfall take account of wider pressures in the health and care system (eg financial, demographic, population growth)?

m) What are the key risks associated with the savings assumptions set out in the October submission?

n) How will resources be shared and financial flows operate across the STP footprint?

o) What processes are in place to help support and monitor financial integrity and audit the flow of resources in terms of cost and value?

Consultation and engagement:

p) What are the planned arrangements for consultation and engagement?

q) Who is responsible for this?

r) What changes have been made following feedback from stakeholders and the public about the Plan to date?

s) What are the timescales for the production of a consultation and engagement plan?

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

a) consider and comment upon the information provided;

b) make recommendations to the STP Leader and/or relevant STP Senior Responsible Officer;

c) make recommendations to NHS bodies;

d) identify issues which would warrant further scrutiny review;

e) identify changes upon which the Joint Committee would wish to be formally consulted;

f) 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 (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. NHS providers, Clinical Commissioning Groups (CCGs), Local Authorities, and other health and care services were asked to come together to form 'footprints'. The footprint would represent a geographical area within which the various organisations would come together to develop the STP for the local population.

8. In forming footprints, local areas were asked to take into account:

   a) Geography (including patient flow, travel links and how people use services);

   b) Scale (the ability to generate solutions which would deliver sustainable, transformed health and care which is clinically and financially sound);

   c) Fit with footprints of existing change programmes and relationships;

   d) The financial sustainability of organisations in an area; and

   e) Leadership capacity and capability to support change.

9. On 15 March 2016, NHS England announced the 44 STP footprints across England, which would be responsible for pulling together the plans. The footprints do not align with county boundaries. In Suffolk, the areas covered by Ipswich and East Suffolk CCG and West Suffolk CCG are in a footprint with North East Essex CCG, whilst the Waveney area of Suffolk is in a footprint with Norfolk. Within Essex, there are also footprints covering Mid and South Essex and Hertfordshire with West Essex. This scrutiny will focus upon the North East Essex, Ipswich and East Suffolk and West Suffolk CCG footprint.

10. The first drafts of the plans were required to be submitted to NHS England in June 2016, with final versions being submitted in October 2016.

11. Nationally, the footprints cover an average population size of 1.2 million people (the smallest covers a population of 300,000 and the largest 2.8 million). The North East Essex and Suffolk footprint covers a population of 953,000 people.

12. The scope of STPs is broad. Initial guidance from NHS England and other national NHS bodies set out around 60 questions for local leaders to consider

in their plans, covering three headline issues: improving quality and developing new models of care; improving health and wellbeing; and improving efficiency of services. STP Leaders were asked to identify the key priorities needed for their local area to meet these challenges and deliver financial balance for the NHS. The plans needed to cover all aspects of NHS spending, as well as focusing on better integration with social care and other local authority services.

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

14. This shift reflects a growing consensus within the NHS that more integrated models of care are required to meet the changing needs of the population. In practice, this means 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.

15. It also recognises that growing financial problems in different parts of the NHS cannot be addressed in isolation. Instead, providers and commissioners are being asked to come together to manage the collective resources available for NHS services for their local population. In some cases this has lead to 'system control totals' – in other words, financial targets – being applied to local areas by NHS England and NHS Improvement.

16. The Kings Fund reports that the process of developing STPs has not been easy. The pressures facing local services are significant and growing, and the timescales for developing the plans have been extremely tight. Expectations and timelines for the plans have changed over time, guidance has often arrived late, and there have been inconsistencies in the approaches taken by different national NHS bodies. Leaders have also faced practical challenges to working together on the plans. STP footprints are often large and involve many different organisations, each with its own culture and priorities. Progress made on the plans in different areas has been highly dependent on local context and the history of collaboration between organisations and leaders.

17. The Kings Fund suggests that local leaders have found it difficult to meaningfully involve all parts of the health and care system in developing the plans. The involvement of local authorities has varied widely between STP areas, ranging from strong partnership between the NHS and local government to almost no local government involvement at all. Patients and the public have been largely absent from the initial stages of the planning process.

18. The key priority for STP leaders in the short term is to strengthen involvement in the content of the plans – particularly among clinicians and other frontline staff, local authorities, and patients and the public. Staff will need to be equipped with the skills and resources needed to implement the improvements in care described in the plans.

19. 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/

Main body of evidence

Evidence Set 1 has been provided by Susannah Howard, STP Programme Director; Kirsty Denwood, STP Financial Lead and Isabel Cockayne, STP Communications and Engagement Lead, with support from Simon Morgan (North East Essex CCG) Andy Yacoub (Healthwatch Suffolk) and Thomas Nutt (Healthwatch Essex).

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

Further information can be found on the Healthwatch Essex website at: http://www.healthwatchessex.org.uk/news/what-are-stps-and-the-success-regime/

Further information can be found on the Healthwatch Suffolk website at: http://www.healthwatchsuffolk.co.uk/neesuffolkstp/

Glossary

CCGs – Clinical Commissioning Groups

CHUFT – Colchester Hospital University Foundation Trust

GP – General Practitioner

IHT – Ipswich Hospital Trust

NEDs – Non-Executive Directors

NHS – National Health Service

NHSE – NHS England

NHSI – NHS Improvement

OBC – Outline Business Case

OOH – Out of Hours Service

SOC – Strategic Outline Case

STP – Sustainability and Transformation Plan

Evidence Set 1

Essex and Suffolk Joint Health Scrutiny Committee

10 March 2017

Local health and care plans for north east Essex and east and west Suffolk

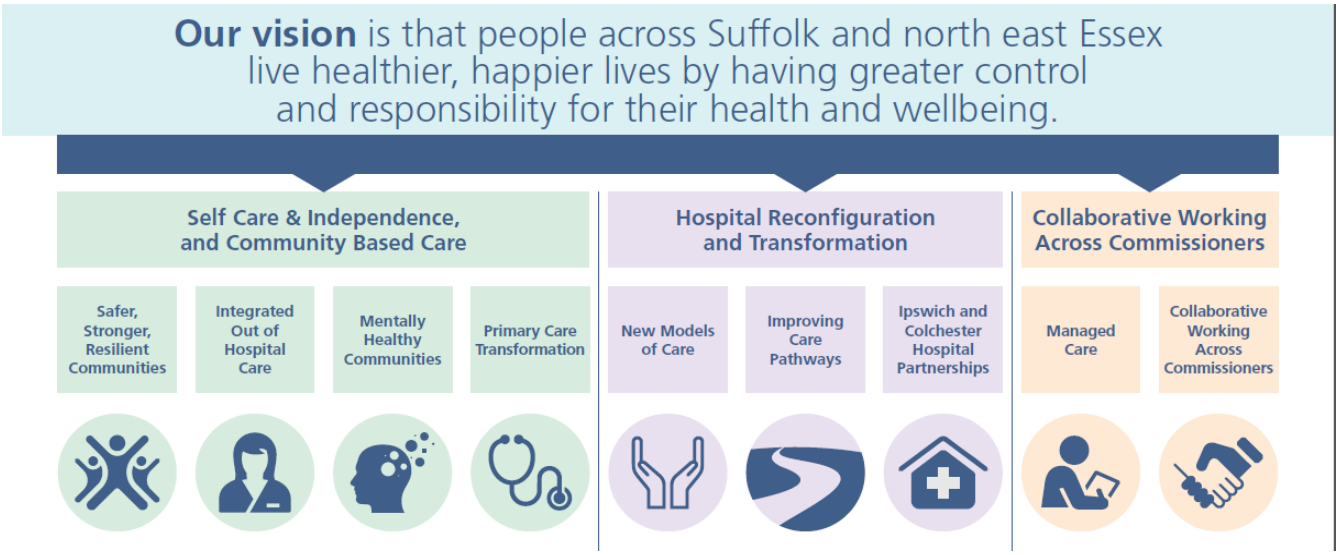
Information in this report was produced on behalf of:	
Lead Officer/s:	Nick Hulme, STP Lead and Chief Executive of Colchester and Ipswich Hospitals
Author:	Susannah Howard, STP Programme Director Kirsty Denwood, STP Financial Lead Isabel Cockayne, STP Communications and Engagement Lead, with support from Simon Morgan, Andy Yacoub and Thomas Nutt.
Date Submitted:	28 February 2017

1.0 Background

NHS England set out ambitions in the Five Year Forward View in 2014 to reduce inequalities in health and care, improve financial sustainability and improve prevention work. No one organisation can do this on its own.

This led to NHS England asking for a proposal from north east Essex and east and west Suffolk for how this might work. This proposal, known as the Sustainability and Transformation Plan (STP), was submitted to NHS England during October 2016.

At its heart is the ambition for NHS and social care organisations to collaborate, not compete. The local system's vision and three programmes, and what makes those up, are set out in the table below.



2.0 Progress

Since the launch on 17 November 2016 of public-facing documents, and feedback from the public and regulators NHS England (NHSE) and NHS Improvement (NHSI) there has been a focus on; strengthening the support team; agreeing two-year contracts; and improving governance.

A programme director, Susannah Howard and independent chairman, Alan Burns have been appointed to support the STP lead, Nick Hulme (Chief Executive of Colchester and Ipswich hospitals). These two further posts are being jointly-funded with the money the system already has and are specifically aimed at making sure of its success through good data collection, planning and peer-to-peer challenge to drive change.

The relationships already developed have given significant advantages. For example, in December north east Essex and west and east Suffolk were the first systems to agree two-year contracts, giving greater stability to the system. Previously one year contracts were agreed with providers in January and February every year. The collaborative relationships also saw much improved integration over the busiest winter months (December, January and February) which is when more people access services.

A list of other key actions are here:

- Ipswich and Colchester hospitals' Long Term Partnership – Strategic Outline Case (SOC) agreed, moving to next phase Outline Business Case (OBC) and including engagement with a number of reference groups to support;
- Joint Alliances in east and west Suffolk and north east Essex (NEE) have been formed and a Memorandum of Understanding prepared for sign off. The two Suffolk Alliances are currently further progressed than NEE, given their longer history of collaborative working;
- North East Essex Accountable Care System Chief Executives' Group established:
- Development of the GP Five Year Forward View for the system submitted to NHS England;
- Three events have been organised for: Project Management Officers; Voluntary Sector; Non-Executive Directors (NEDs) and Chairs in March to support the development of next steps within the system;
- Developed new terms of reference for new governance structures;
- Chief Executive Senior Responsible Officers for the three programme boards identified;
- Renew representation for all organisations across new STP governance structures. Finalise dates and venues for all meetings;
- Bids for transformation funds developed and submitted to NHS England;
- Dates for new Programme Board meetings planned for 2017;
- Finalise arrangements for STP/Health and Wellbeing Boards Link Group;
- Finalise template for monthly delivery workstream highlight reports;
- Collate first delivery workstream highlight reports in March 2017 and produce first delivery programme board dashboards.

2.1 Governance:

At the time of writing, a meeting is scheduled for 9 March 2017, which will give greater clarity on governance, partnership working, next steps and key milestones. An update will be provided for the joint committee at the meeting on 10 March 2017.

2.2 Key risks:

- Capacity of senior staff to deliver both organisational and system leadership roles;
- Identification of project resources to ensure comprehensive delivery of STP workstreams;
- Local authority elections in May 2017 will impact on joint working for a period of time.

2.3 Key challenges:

- Links with county and local borough councils need to be strengthened.
- There have been some requests for system representatives to join regional networks, such as the Cancer Alliance and Local Maternity System. This needs to be agreed and organised, or there is a risk we are not represented.
- Each programme lead has the responsibility to ensure that the communications and engagement planning is robust and coordinated.

2.4 Elements affecting both north east Essex, west and east Suffolk

The two programmes dealing with hospital reconfiguration and transformation and working across commissioners have the elements which affect both north east Essex and east and west Suffolk.

No changes are being proposed at the moment. Ideas to develop proposals for public engagement will be developed with patients.

Colchester Hospital University NHS Foundation Trust and Ipswich Hospital NHS Trust announced in January that their boards had agreed three options. Engagement with patients and hearing their feedback will be vital to the formation of the outline business case which will be given to the boards in July.

There are some elements of the collaborative commissioning programme which might affect patients and the public. For example, there is a suggestion that the re-procurement of the NHS 111 and out of hours services will be done by the three CCGs covering this system.

3.0 Finances

a) What is included within the system-wide financial control total?

No formal system wide control has been agreed. The STP sets out the savings required for the system to be balanced by 2020/21. It does not include the speed at which those savings will be delivered. The operational planning control totals that have been issued for the NHS organisations, once agreed, will determine the speed of recovery. The 2017/18 and 2018/19 planning round for health is not yet complete so a health control total for these two years is not yet available. The final operational plans submission date is anticipated to be 27 March 2017. Once these plans are finalised the STP organisations will need to determine whether they would like to apply for a system control total on which to be monitored. This however is not a mandatory requirement.

b) *To what extent does the forecast shortfall take account of wider pressures in the health and care system (eg financial, demographic, population growth)?*

The STP shows the 'do nothing' position and has been built based on individual organisational plans all of which include assumptions around demographic growth, activity growth, price inflation and additional mandated investments. Therefore, the shortfall takes into account all known variants.

c) *What are the key risks associated with the savings assumptions set out in the October submission?*

The main risks included in the October submission regarding savings opportunities were as follows:

- Savings opportunities may under-deliver against plan – therefore there is a risk that sustainability may not be achieved in the timescales set out.
- Savings opportunities may have been double counted – many of the STP solutions cross over different organisations and service delivery models. Therefore, there is a risk that some of the solutions may be counting the same savings opportunity.
- System control totals may not match the financial bridge assumptions – this is already apparent in that the latest operational plan control totals will challenge the system more in the early years of the STP than had previously been anticipated. There is a risk that the system cannot accelerate the STP solutions proposed to keep in time with the control total requirements.
- Social care plans and assumptions have an impact on health and have not been included and vice versa – there is a clear need for both health and care plans to be shared to ensure that what might be considered a positive solution to one party actually has a negative impact on the system position as a whole.

d) *How will resources be shared and financial flows operate across the STP footprint?*

At present NHSE and NHSI are working to their own control totals and therefore resource sharing in control total form is not allowable. Where possible, plans are beginning to be progressed around risk sharing and where else pooled budgets may be appropriate across health and social care. It is likely that some staff resources will be shared as organisations start to work more collaboratively and there will be some funding available to make STP-wide appointments. The financial flows will remain as present within the remit and control of the different statutory bodies that are part of the STP.

e) *What processes are in place to help support and monitor financial integrity and audit the flow of resources in terms of cost and value?*

All organisations are accountable bodies with their own statutory requirements. This has not changed and financial control lies within the accountable organisation and is audited as at present. The STP is being managed as a programme and the governance of this clearly leaves financial responsibility with the individual organisations. A wider sharing of financial information will be encouraged as part of working more collaboratively.

4.0 Consultation and engagement

The first submission of the draft local health and care plan was based on more than 40 pieces of engagement, which were used to develop strategies for urgent care, hospital improvements, housing, mental health, including learning disabilities, primary care, end of life, maternity, cancer and hospital plans.

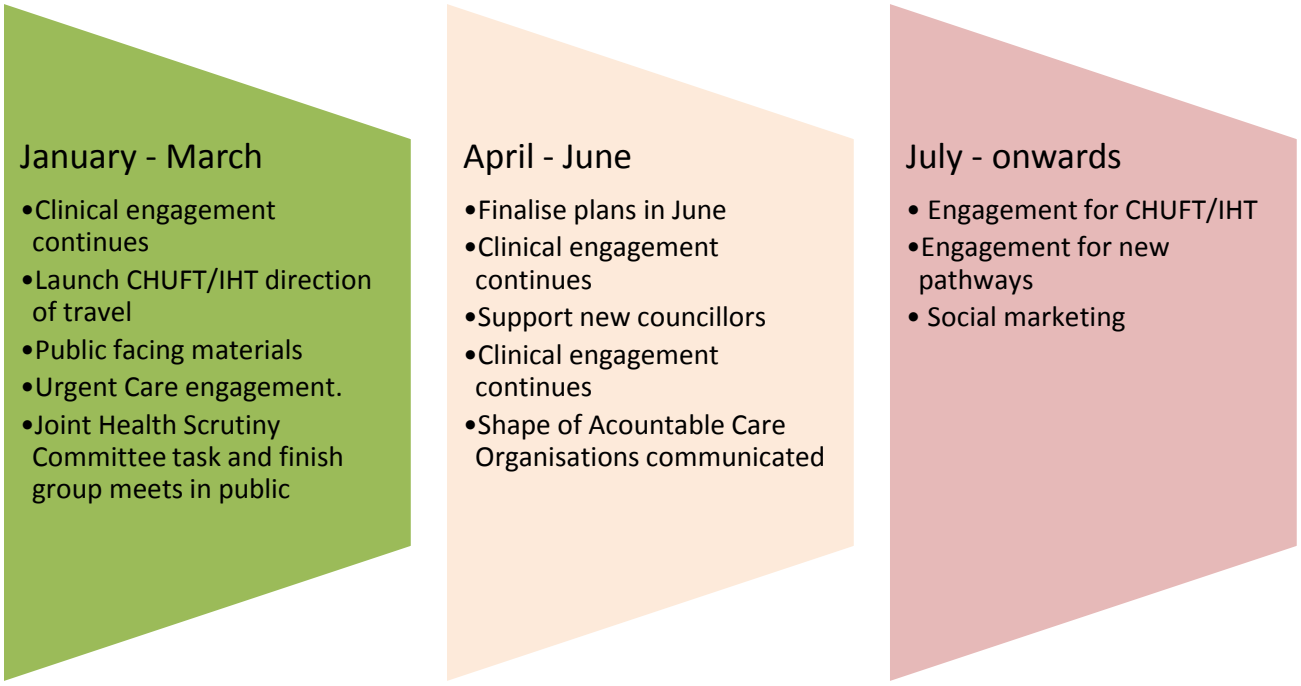
It also included feedback from health focused annual events, such as Supporting Lives, Connecting Communities, Patient Revolution and Feet on the Street, the Health and Care Review 2014 in Suffolk, The Big Care Debate and Urgent Care Review in north east Essex and Healthwatch Essex and Suffolk reports on 111/Out of Hours (OOH) and ambulance services and lived experience of health.

Our collective aim is to generate meaningful insight to shape the planning and delivery of future services, owned by the organisations responsible for making the decisions. Led by Isabel Cockayne, from Suffolk CCGs, and Healthwatch Essex Chief Executive, Dr Tom Nutt, alongside Simon Morgan from North East Essex CCG and Healthwatch Suffolk Chief Executive, Andy Yacoub, this workstream is informed by experts from all organisations involved. This makes up the Communications and Engagement Advisory Board.

This Advisory Board designed the principles of engagement together, based on the 2016 People and Communities Board "Six principles for engaging people and communities" for use over the next two years. These are:

- Use lived experience and other insights to drive change, putting people at the heart of care.
- We will identify and communicate best practice across the NHS – and also tackle areas of improvement.
- Use a network approach, pooling resources and sharing skills.
- Use social marketing and trusted information to support change in behaviours.

This figure (below) shows a high level plan covering the next few months.



As part of the work to develop improved mandates for the planning purposes, each programme will be asked to deliver communications and engagement updates, or be supported to write them. These will be collected in one overarching public engagement plan, with milestones. It is expected this work will be completed by June 2017. Appendix 1 provides a diagram of how it is envisioned, with some of the examples of ongoing work or planned work highlighted.

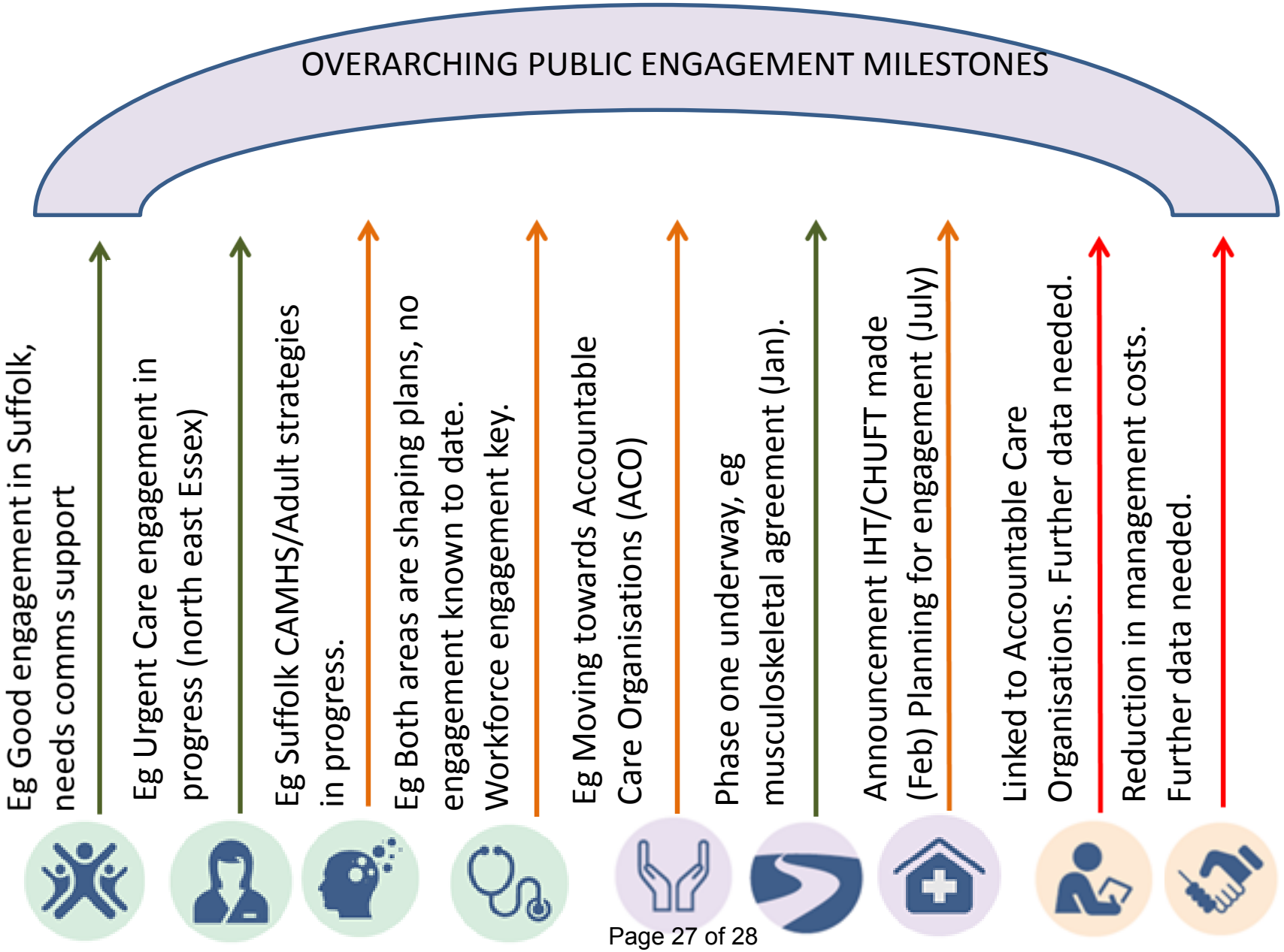
Comments and communications so far

Channels of feedback were set up on 20 November 2016 and responses to the requests for information have been collected through the local Healthwatch, as well as statutory communications and engagement teams, such as Patient Advice and Liaison Services, and other partners. The main questions asked have been around the governance of the process, which the joint scrutiny committee will have an update on following the meeting on 9 March 2017.

NHS England has confirmed that there is no need to consult on the proposals as a whole. However, it is clear that there is a need for each of its component parts, particularly where it affects patients and the public, which will require careful planning and engagement. The Senior Responsible Officers are clear that they each have a responsibility to support this element of the plan. The milestones of each of the organisation's plans for engagement will be collected in the overarching communications and engagement plan to reduce confusion of what is being asked of the public and when. As stated earlier, this plan will be developed by the end of June 2017.

Another part of the communications and engagement work included a film, developed by Healthwatch Essex, which received national attention following its launch in February 2017. Healthwatch Harriet raised awareness in an accessible way, and has been watched by more than 1000 people. (see: http://www.healthwatchessex.org.uk/news/healthwatch-harriet-grills-nhs-bosses/)

Coverage of the bids for money has also appeared in the last few weeks in the local media, outlining plans for the future of diabetes and improving access to psychological therapies.



Note: Each of the images relate to the workstreams set out on page one of this report. These are examples only.