East London Health and Care Partnership
Sustainability and Transformation Plan (STP) Board Meeting
Minutes

26th April, 09:00am to 10:30am

Newham CCG, meeting room FO21/FO24, Unex Tower, 4th Floor, Stratford E15 1DA

Present:	**Representing:**
Rob Whiteman	East London Health and Care Partnership (ELHCP) Board Chair
Jason Seez	Director of Strategy, Barking, Havering & Redbridge University Hospital NHS Trust
John Brouder	Chief Executive, North East London NHS Foundation Trust
Marie Price	Director of Corporate Services**,** Barking, Havering & Redbridge Clinical Commissioning Groups
Steve Gilvin	Chief Officer, Newham Clinical Commissioning Group
Paul Haigh	Chief Officer, City & Hackney Clinical Commissioning Groups
Clare Highton	Chair, City & Hackney Clinical Commissioning Group
Sam Everington	Co-Chair, Clinical Senate
Vincent Perry	Mental Health Sector Clinician
Navina Evans	Chief Executive, East London NHS Foundation Trust
Alwen Williams	Chief Executive, Barts Health NHS Trust

Additional Attendees Present	**Representing:**
Ceri Jacobs	Director of Commissioning Operations North Central and East London, NHS England
Cathy Turland	Health Watch Observer
Meradin Peachey	Director of Public Health, Newham – ELHCP Public Health Lead
Henry Black	ELHCP Chief Finance Officer
Ian Jackson	Head of Delivery (North East London) Specialised Commissioning, NHS England (London Region)
Victoria Woodhatch	Delivery & Improvement Director, NHS Improvement
Charlotte Williams	Chief of Staff, UCL Partners
Nichola Gardner	ELHCP Programme Director
Nigel Woodcock	ELHCP Director of Provider Collaboration
Ian Tompkins	ELHCP Director of Communications and Engagement
Deodita Fernandes	ELHCP Senior Programme Manager
Joy Ogbonna	ELHCP PMO Programme Officer (Note taker)

Apologies:

Matthew Hopkins	Chief Executive, Barking, Havering, Redbridge University Hospital NHS Trust
Atul Aggarwal	Chair, Havering Clinical Commissioning Group
Nigel Burgess	Head of Workforce Transformation, Health Education England
Conor Burke	Chief Officer, Barking, Havering & Redbridge Clinical Commissioning Groups
Andrew Blake Herbert	Chief Executive, London Borough of Redbridge
Martin Esom	Chief Executive, London Borough of Waltham Forest
Waseem Mohi	Chair, Barking and Dagenham Clinical Commissioning Group
Tracy Fletcher	Chief Executive, Homerton University Hospital NHS Foundation Trust
Jane Milligan	East London Health and Care Partnership (ELHCP) Lead
Terry Huff	Chief Officer, Waltham Forest Clinical Commissioning Group
Simon Hall	Acting Chief Officer, Tower Hamlets Clinical Commissioning Group
Tim Shields	Chief Executive, London Borough of Hackney

Item no.	Name	
1.	**Welcome, introductions and apologies for absence**	
	1.1	**Welcome and introductions** Rob Whiteman, the chair welcomed members to the meeting and led a round of introductions
	1.1.2	**Apologies for absence** Apologies was given for: • Matthew Hopkins, Chief Executive, Barking, Havering, Redbridge University Hospital NHS Trust • Conor Burke, Accountable Officer, Barking, Havering and Redbridge Clinical Commissioning Groups • Atul Aggarwal, Chair, Havering Clinical Commissioning Group • Martin Esom, Chief Executive, London Borough of Waltham Forest • Andrew Blake-Herbert, Chief Executive, London Borough of Redbridge • Waseem Mohi, Chair, Barking and Dagenham Clinical Commissioning Group • Tracy Fletcher, Chief Executive, Homerton University Hospital NHS Foundation Trust • Jane Milligan, East London Health and Care Partnership (ELHCP) Lead • Simon Hall, Acting Chief Officer, Tower Hamlets Clinical Commissioning Group • Tim Shields, Chief Executive, London Borough of Hackney
2.	**Minutes and matters arising**	
	2.1	**Minutes of the meeting 29th March 2017** Ceri Jacobs requested a correction to the minutes, under item 3, **Whipps Cross Strategic Outline Case** in the following lines that were recorded as: Ceri Jacobs highlighted that given the funding constraints and the time it would take to build a new hospital, it was important that the financial benefits were realised before the hospital was built. To be corrected to – Ceri Jacobs highlighted that, given the time it would take to build a new hospital and the immediate need for financial savings, it is possible that the expected financial benefits through service redesign associated with the new hospital could be realised through other routes. The minutes were otherwise approved as accurate.
	2.2	**Matters arising**
	2.2.1	**Capital and Estates Priorities:** Governance arrangements and updated membership for support of the Capital and Estate priorities to be brought to a future ELHCP Board meeting. Action: Henry Black
	2.2.2	**Update on proposal to hold Board meetings in public:** Ian Tompkins reported feedback and comments received from the group had been considered and a proposal to focus the public meetings on sessions where there could be meaningful interaction and questions to the Board was recommended. The public meetings will run as events with topics relevant to the public audience in the months of June, November and March.
	2.2.3	**DECISION:** The East London Health and Care Partnership Board agreed to have three public meetings in the year 2017/18 in the months of June, November and March. No further matters arising were discussed.

3.	**Capped Expenditure Process**	
	3.1	Henry Black gave an update on the Capped Expenditure Process (CEP). He noted the programme was a national process and acted as the escalation of the assurance process for STP footprints where planning did not meet the control total. In the next two years financial success for the ELHCP would require successful management of a number of risks and dependencies. Henry Black reported that the ELHCP was not in the first phase of the CEP process but was in the second wave. An aligned plan was required to be submitted to NHS England/NHS Improvement by 2 June 2017. The ELHCP financial position was going to be discussed at a review meeting with NHS England and NHS Improvement on 26 April 2017. A small task and finish group was being set up to take forward commissioning decisions and medicines optimisation. Ceri Jacobs added that it was important that the clinical voice was at the forefront in terms of ensuring that services were safe as well as financially sustainable.
	3.1.1	**Discussions included:** Clare Highton highlighted that acute trusts were driven to increase income and unless there was a move away from Payment by Results (PbR) to capitated budgets, the commissioners would not been able to make significant progress in relation to demand management activities.
	3.1.2	Steve Gilvin agreed with Clare Highton and mentioned there were significant risks in meeting the control totals and that these risks would need to be managed. It was important for commissioners and providers to manage the demand within the control totals
	3.1.3	Sam Everington raised the issue that the work done by Transforming Services Together (TST) demonstrated that outpatient appointments could be reduced over a period of six months and proposed that this could be rolled across East London. Although it was acknowledged that it would take 2-3 years to roll out across all specialties in the whole area, taking into consideration other key priorities such as A&E performance improvement. This was especially important as the number of outpatient appointments had increased rapidly over the years.
	3.1.4	John Brouder recommended that there should be a shift of focus from not just responding to demand but to moving to the big transformational priorities which needed to be rolled out across a number of areas i.e. A&E, primary care, digital and workforce. This would have a positive impact on quality and the control totals for the entire health economy in East London.
	3.1.5	Ceri Jacobs highlighted that it was important to de-risk the East London CEP schemes in order to remain within the control totals for 2017/18, but also ensure that the medium and longer term initiatives were worked up by the STP footprint as soon as possible.
	3.1.6	Alwen Williams highlighted that it was important to build an appetite for service redesign and service improvement initiatives that are most likely to be achieved in 2018/19 and 2019/20. It was important to plan for the longer term to meet the challenges across the STP footprint.
	3.1.7	Navina Evans highlighted that the group needed to start a strong debate on the changes that may require a much longer time to achieve. She highlighted that it was important for the group to think strategically about key changes that were needed across the STP footprint. In view of the challenges for the contracting system, the STP footprint could begin work on a payment system that worked and was robust.
	3.1.8	Jason Seez stated that it was important to understand how the ELHCP added value to the footprint. If the ELHCP managed the big transformational changes that needed to happen, and provided a structured framework for these changes, then it would add value to the system.

	3.1.9	Steve Gilvin mentioned that the ELHCP needed to review the payment approach and establish a common system across the patch. PbR was not the right system and ELHCP needed to move to a different payment mechanism.
	3.1.10	A Clinical Strategy was needed to underpin all transformational and redesign work across the STP. It was important that timelines were realistic to achieve not only the immediate 2017/18 initiatives but also the medium and longer term sustainability benefits. Ceri Jacobs pledged support from NHS England to the STP both in terms of help in writing the bids for funding and supporting ways to make funding available through the London Region for STP footprints in London. It was also recommended that the Local Authorities need to be a part of the conversation in relation to the big transformational and strategic issues in order to achieve both better joint integrated commissioning and the best possible clinical outcomes.
	3.1.11	**ACTION: Rob Whiteman to contact LA leads to encourage their attendance at the ELHCP Board meetings.**
	3.1.12	It was important to have the difficult conversations about the number of CCGs and the shape and form of providers in the future in order to have a sustainable health and care system.
	3.1.13	Rob Whiteman recommended a consultation needed to take place on how to replace PbR and noted that there was focus currently on reviewing the work of the three Accountable Care Systems and that there was a forum for the seven CCGs to meet.
	3.1.14	**ACTION: An ELHCP initiative to develop and consult on the payment regime and devise new payment mechanisms was important and was needed to be established**. **The Finance Strategy group will take this work forward: Henry Black**
4.	**Strategy Debate:** **Digital Enablement**	
	4.1	Luke Readman tabled the Digital Enablement paper which summarised the digital strategy for ELHCP. The paper focused on three themes namely: • Developing a single system approach to information sharing that starts locally and builds collaboratively around patient care, rather than being driven top down, priorities, issues and proposed actions • Making the best use of the data the footprint has across the STP safely • Promote connectedness to ensure the information that the STP gives to any health or care professional is recorded properly and shared
	4.2	**Discussions from the Board included:** Clare Highton reported that there were key opportunities to review Information technology (IT) systems already in place and shift into encouraging patients take a more active role in their own health and wellbeing by using digital technology more effectively. She recommended working with the Local Authorities as they had been at the forefront of moving services online to provide a better experience to their stakeholders.
	4.3	Sam Everington recommended that patients should be encouraged to have their consultations online. He advised that ELHCP should focus on human interactions between patients, GP and consultants rather than just infrastructure and information technology. The footprint needed to collaborate and allow parts of the footprint to lead on pieces of work to ensure better clinical outcomes were achieved and rolled out across the system.
	4.4	John Brouder mentioned that the licence for RiO would run out in a couple of years. This provided an opportunity to review and get a better IT solution for these services. Overall, consumer empowerment was needed to drive the strategy and it needed to be across the health and social care system.
	4.5	Steve Gilvin recommended that an Equality Impact Assessment (EIA) needed to be in place for the digital strategy and that it was also necessary to have a good understanding of what the future

		investments priorities were for East London and link the transformation funding to it. He recommended that ELCHP should focus on working on parts of the footprint that had challenging CQC outcomes.
	4.6	Meradin Peachey recommended it was important to incorporate messaging and to signpost patients towards accessing of data and other digital innovations (i.e. apps etc.).
	4.7	Clare Highton noted that the transparent dashboards across primary and secondary care could be used to drive clinical improvement. The IT technology enabled the clinical teams to ascertain what the outcomes were for certain services such as the urgent care (111 response) and to improve clinical outcomes.
	4.8	Sam Everington proposed that Clinical effectiveness group (CEG) be rolled out across the whole sector. The East London Health and Care Partnership Board **noted** the paper.
5.	**Communication:**	
	5.1	East London Health and Care Partnership Launch event
	5.1.1	Ian Tompkins gave an update on the ELHCP Launch for the 3rd July 2017 at Stratford Town Hall which would be followed by a Community group meeting on the 4th July 2017. The draft agenda for the event was circulated to all and he informed all that key representatives from Partnership member organisations, members of the Partnership governance groups and workstreams and other key stakeholder and partners have been invited to the launch.
	5.1.2	The PMO team would be sending an invite to all relevant stakeholders for the event with further information on the event. The East London Health and Care Partnership Board **noted** the paper.
6.	**Any Other Business**	
	6.1	A request was made by Sam Everington to bring Workforce as an agenda item to a future Board meeting.
	6.2	**ACTION: Workforce to be scheduled as an agenda item at a future board meeting in either June or July – Nichola Gardner**
7.	**Date of next meeting**	
	7.1	The date and time for the next meeting was agreed for 24th May, 15:30pm to 17:00pm, Newham CCG, meeting room FO21, Unex Tower, 4th Floor, Stratford E15 1DA

The Chair closed the meeting at 10:35am

Summary of Actions:				
Ref	**Action**	**Owner**	**Due Date**	**Status**
2.2.1	Capital and Estates Priorities: Governance arrangements and updated membership for support of the Capital and Estate priorities to be brought to a future ELHCP Board meeting.	Henry Black	24th May	Scheduled for May Board
3.1.11	Rob Whiteman to contact LA leads to encourage their attendance at the ELHCP Board meetings.	Rob Whiteman	24th May	In Progress
3.1.14	**Capped Expenditure Programme:** An ELHCP initiative to develop and consult on the payment regime and devise new payment mechanisms was important and was needed to be established. The Finance Strategy group will take this work forward.	Henry Black	TBC	In Progress
6.2	Workforce to be brought to a future meeting as an agenda item **- PMO**	Nichola Gardner	July Board	Scheduled for July Board

Summary of decisions:		
2.2.3	**Update on proposal to hold Board meetings in public:**	**DECISION:** The East London Health and Care Partnership Board agreed to have three public meetings in the year 17/18 in the months, June, November and March.