North Central London Sustainability and Transformation Plan

MINUTES OF THE NCL STP PROGRAMME DELIVERY BOARD
14:00-16:00 on Friday 17 March 2017
Room 6LM1, 6th Floor, Stephenson House, 75 Hampstead Road, London, NW1 2PL

Members	Role and job title	Attended	Deputy sent	Apologies
Sir David Sloman (DSl)	STP Convenor (Chair) and SRO Lead for Providers; CEO Royal Free London NHS Foundation Trust	✓		
Cathy Gritzner (CG)	Vice Chair and SRO Lead for CCGs; Accountable Officer Barnet CCG	✓		
Mike Cooke (MK)	Vice Chair and SRO Lead for Local Authorities; CEO Camden Council			✓
David Stout (DSt)	STP Senior Programme Director	✓		
Jo Sauvage (JS)	STP Co-Clinical Lead, Chair Islington CCG	✓		
Alison Blair (AB)	SRO Urgent and Emergency Care Workstream and SRO Health and Care Closer to Home Workstream; Accountable Officer, Islington CCG	✓		
Richard Jennings (RJ)	STP Co-Clinical Lead Co-SRO Planned Care Workstream Medical Director, Whittington Health NHS Trust			✓
Caroline Clarke (CC)	Co-SRO Planned Care Workstream Chief Finance Officer, Deputy CEO Royal Free		✓	
Jon Abbey (JA)	SRO Children and Young People Workstream and Director Children's Services Representative; Director Adult & Children Services Haringey Council	✓		
Neil Griffiths (NG)	SRO Digital Workstream; Deputy CEO UCLH	✓		
Dawn Wakeling (DW)	SRO Estates Workstream; DASS Barnet Council			✓
Paul Jenkins (PJ)	SRO Mental Health Workstream; CEO T&P FT	✓		
Tim Jaggard (TJ)	SRO Productivity Workstream; Finance Director UCLH			✓
Maria Kane (MK)	SRO Workforce Workstream; CEO BEH NHS Trust		✓	
Kathy Pritchard-Jones (KPJ)	SRO Cancer Workstream; CMO UCLH Cancer Collaborative			✓
Rachel Lissauer (RL)	SRO Maternity Workstream; Acting Director of Commissioning, Haringey CCG			✓
Julie Billett (JB)	SRO Prevention Workstream; Director of Public Health, Camden and Islington		✓	
Ray James (RJ)	Director Social Services Representative; Director Health, Housing & Adult Social Care (Enfield)			✓
Anita Patel (AP)	NCL GP Federation Lead;			✓
Jonathan Wise (JW)	STP Finance Lead	✓		

Attendees	Job Title	Reason for attendance
James Porter (JP)	Programme Manager	Dep. for Richard Jennings
Simon Goodwin (SG)	Chief Finance & Investment Officer, BEH	Dep. for Maria Kane
George Howard (GH)	Mental Health Lead at HLP	Representing HLP
Tessa Lindfield (TL)	DPH Enfield	Dep. For Julie Billet
Jonathan Fisher (JF)	Programme Manager, NCL STP PMO	Regular Attendee (Minutes)
Gen Ileris (GI)	Communications Lead, NCL STP PMO	Regular Attendee
Sanjay Mackintosh (SM)	STP Programme Lead for NCL Councils	Regular Attendee

No.	Agenda Item	Owner
1.1	**Welcome and Apologies** DSl welcomed attendees to the Programme Delivery Board meeting. Introductions were made and apologies were noted. The meeting was **QUORATE**.	
1.2	**Review of minutes from the previous meeting** The minutes of the previous meeting were **APPROVED** without amendment.	
1.3	**Review of action log** In relation to the outstanding action, DSt advised the delivery board that Helen Pettersen (NCL CCGs' Chief Officer and Accountable Officer from 4 April 2017) had secured agreement to proceed to recruit to four posts to support the Urgent and Emergency Care, Planned Care, Health and Care Closer to Home and Mental Health Workstreams, respectively. He noted that, whilst establishment of the full programme budget still needed to be agreed, this initial tranche would help ensure that these key workstreams maintained their momentum. It was noted that this left a number of workstreams with no support from April, but the overall commitment to support implementation from within existing resource was reiterated. The delivery board **AGREED** that the initial posts should be recruited to and **NOTED** the update on the outstanding action in relation to the programme budget.	
1.4	**Declarations of interest** No new interests were declared.	
2.0	**An update report on key programme activities** DSt provided a brief update on two recent sets of assurance meetings: • The first involved a high-level NHS England review of three of the five[1] NCL CCGs' QIPP plans, alongside the cross-STP acute QIPP initiatives. • The second involved a joint assurance meeting with NHS England and NHS Improvement. The feedback following the meeting had broadly been positive, with some constructive challenge around 1) the need to keep working to close the financial gap 2) the degree of dependence on 'high' and 'very high' risk QIPP; and 3) the lack of a visible collective approach to CIP in providers. In relation to the latter, DSt noted that providers were now starting to share their CIP plans to enable shared learning and a more coordinated approach. He added that there would be a third round of meetings on 24th April which would focus on the finalisation of the plans and the early stages of delivery. The programme delivery board **NOTED** the update.	
3.0	**Final detailed workstream delivery plans**	

[1] Barnet and Islington CCGs were exempted from this process as they were undergoing a separate review by Deloitte

This agenda item involved an in-depth discussion on the four report attachments[2], with a view towards deciding whether to commit to the 2017/18 plans or, if not, to decide what needed to be done to progress them. The following sections summarise the discussion on each of the four attachments, respectively.

- Attachment 1: Finance and Activity Overview

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JW began by explaining that a key focus of the FAM meeting earlier that day was to assess whether the assumed UEC, planned care and HCCH savings figures that had been incorporated into contracts in December 2016 were still valid in light of the more detailed activity and financial modelling that had since been completed. He explained that if the more detailed modelling had suggested a variation of greater than 0.5% against the December estimates, then this would have triggered a renegotiation of the contracts. He noted, however, that the detailed modelling had been within the 0.5% tolerance level and he was therefore pleased to report that the contracts could be taken forward as planned.

JW cautioned, however, that the financial gap would not be closed by the plans and there were a number of risks that could broaden the potential gap. He highlighted that:

- The projected activity impacts were ambitious both individually and collectively (projecting a real reduction in acute activity in some pods), and delivery risks needed to be addressed quickly.

- There was a residual gap in the CCGs' financial plans even if plans were fully delivered, which when combined with delivery risks suggested a gap/risk of c£35m

- Based on the latest operating plans there was a significant gap in the provider position against the control totals issued by NHS Improvement of c£110m, predominantly in Royal Free and North Middlesex. He noted that all Trusts were assuming CIP plans (averaging c4.5%) could be delivered, with an element at high risk. He added that there were also potential 'alignment' / income risks in relation to both within Sector income of £20m and outside (mainly spec comm) of £40m.

DSl thanked FAM for this robust piece of work, noting that while the financial position was far from resolved, it was a substantial accomplishment to have obtained agreement around contract values, which reflected projected changes in activity.

The delivery board **NOTED** the Finance and Activity Overview

- Attachment 1: Plans with Greatest Financial Impact

The delivery board took the approach of hearing detailed feedback from discussions at the Health and Care Cabinet (HCC) and the Finance and Activity Modelling Group (FAM), together with input from workstream leads. The Chair then summarised the key points from the discussion and a course of action was agreed. The following summarises the discussion on each of the three plans in this section:

Urgent and Emergency Care (UEC)

[2] The attachments included 1) a financial and activity overview; 2) plan summaries for those workstreams with the greatest financial impact; 3) plan summaries for those workstreams requiring investment decisions; and 4) plan summaries for other plans. Attendees had also previously been sent the full, unabridged plans to ensure that they were familiar with the detail behind the summaries.

- Feedback from HCC: the HCC had been impressed with the level of analysis underpinning the plan and there had been a high degree of confidence that the assumptions were reasonable and the priorities appropriate. There was a notable discussion on interdependencies between the UEC workstream and enabling workstreams, e.g. mobile digital access to care records and the creation of a new kinds of workforce teams would be required to enable changes in the UEC pathway to be embedded successfully;
- Feedback from FAM: FAM had similarly been impressed by the level of analysis behind the plan and had noted the substantial engagement that had been undertaken with each Acute Trust and with commissioners around the assumptions that underpinned it;
- Feedback from the workstream SRO: AB reiterated the dependence of the UEC workstream on enabling workstreams. She noted that the workstream was currently in a 'good place', with passionate leadership, but that it was 'fragile' as the programme director currently leading the work was leaving at the end of the March. She also highlighted a recent letter from NHSI which meant that some of the delivery timescales might need to be brought forward;
- Chair's summary: DSl concluded that the UEC plan was of a high quality and had the support of HCC and FAM. He stressed the importance of building momentum by **identifying people who would be responsible for delivery**. It was acknowledged that this would be difficult, particularly as not all of the required additional resource had been agreed and, in comparison to workstreams such as Health and Care Closer to Home, there was not a clear group of people in the system who were working on similar things and could be simply redirected to the task.

Health and Care Closer to Home (HCCH)

- Feedback from HCC – JS reported that the HCC had been supportive of the plan and its priorities (particularly as this was the platform on which many other initiatives were predicated), but had highlighted critical dependencies on enabling workstreams such as Digital and Workforce. DSt added that there had also been some discussion around whether the expected impact on activity in the acute care pathway was overly-optimistic, noting however that the cabinet had concluded that this should not prevent investment and that impact during 17/18 should be closely monitored;
- Feedback from FAM: JW noted that whereas the UEC finance and activity modelling had been underpinned by a central dataset, the CCH modelling had been developed from the 'bottom up' and was based on analysis undertaken at a borough-level. This had given rise to some inconsistent assumptions around impact and some related concerns that the anticipated scale and speed of savings could be overly-optimistic;
- Feedback from the workstream SRO:
  AB noted that
  1) the chosen approach had been to focus on developing ownership at a borough level with the trade-off being the variation highlighted above. She therefore agreed with the need for further testing and review of the assumptions around impact;
  2) the workstream shared a number of dependencies with other workstreams and additional work was required to ensure that the HCCH plan captured these interdependencies and was in synch with the plans of linked workstreams;
  3) unlike UEC, the HCCH workstream already had some infrastructure in place to deliver the work. She explained that each CCG had established teams whose focus was primary care development and that each had taken on a leadership role on one aspect of the HCCH plan. She cautioned however that provider federations were critical to delivery of the plan and that one of the key workstream risks was around building the capacity of these federations to deliver primary care elements at scale.

  DSt added that governance within these multiagency collaborations was not straightforward and that letting the agencies operate in 5 different ways might not be optimal. He suggested that a balance needed to be struck between local flexibility and

having a consistent framework. A discussion followed around how to allow for a strategic approach and variability in light of the dependencies with other workstreams.

Chair's summary: The Chair summarised the additional work that was required in order to give the delivery board additional confidence in the plan, i.e. **testing and reviewing the impact assumptions**, **ensuring interdependencies are clear and that the plan is in synch with those of linked/enabling workstreams**, and **obtaining the next level of planning granularity**.

Planned Care

- Feedback from HCC – The HCC felt that the plan had come a long way in terms of establishing a clear framework for assessing and prioritising initiatives and was in agreement around the emphasis on the Musculoskeletal and Dermatology pathways as immediate priorities. The HCC had not had access to the granular data underpinning some of the assumptions and so felt that their understanding of impact and pathway changes needed further development. DSt noted that there had also been a debate around whether to focus on a small number of initiatives or to work on a large number of areas simultaneously;
- Feedback from FAM – FAM highlighted that a number of areas in groups 1-6 were already being done / planned and that the expected savings were therefore largely comprised of existing CCG QIPP plans. If fully delivered, the plans would deliver additional savings of c. £16m, materialising in the second half of 2017/18, however FAM had felt that the plans seemed ambitious and more confidence was needed that delivery plans were realistic;
- Discussion and conclusion: A detailed discussion followed wherein it was agreed that 1) the **savings model should be aligned with the Carter GIRFT data set** and 2) the **workstream should undertake a review of the readiness of each of the schemes** in terms of work already completed and what infrastructure was already in place, to test that it matched the scale of the expected savings.

The delivery board **AGREED** that above plans should proceed to delivery, starting with the identification and deployment of management capacity from within the system.

➢ Attachment 3: Plans needing further investment decisions

In discussing the plans requiring further investment decisions, the delivery board took the approach of hearing high-level feedback from the discussions at the Health and Care Cabinet (HCC) and the Finance and Activity Modelling Group (FAM), together with input from workstream leads. This was followed by a general discussion around the merits of investment and the agreement of actions. The following section summarises the discussion the two plans covered in this section

Mental health

- Feedback from HCC – The HCC had felt that this was a good, well-developed plan with sensible priorities. JS noted that the discussion at HCC had focused on the difficulty in providing an evidence base around the impact of primary care mental health services; interdependencies with Health and Care Closer to Home, Urgent and Emergency Care, Digital and Workforce; and the funding gap which, if not addressed, would mean that some important priorities would not be delivered;
- Feedback from FAM – JW advised that there had been no focus on the plan at FAM other than to note the plan and confirm the funding gap;
- Discussion and conclusion:

At the outset of the discussion, it was agreed that the elements of the plan that are already funded should proceed to implementation.
Following a detailed discussion around the funding shortfall and the degree to which this might be met by STF funding, as well as the interdependencies with other workstreams, the delivery board agreed a suggested approach by PJ that he bring a revised plan to the April PDB meeting that clarified STF funding expectations and set out a plan for how a further £1.5m investment (over and above the current parity of esteem funding) could be deployed that would maintain momentum, align with other workstreams requirements and deliver some of the areas which would make the biggest difference.

Prevention

- Feedback from HCC – The prevention plan had not been reviewed by HCC.
- Feedback from FAM – JW advised the delivery board that FAM had concluded that the initiatives were important but that investment should occur once financial balance was achieved as otherwise it would not be affordable;
- Discussion and conclusion – A detailed discussion followed around the importance of prevention as a key tenet of the STP vision for transforming services within NCL. It was acknowledged that preventative approaches and 'shifting care upstream' underpinned a number of workstream plans, but that there could be a perception that prevention was not being taken as seriously as it should be if the decision was made not to invest in this area at this time. A further argument made in favour of investment was that if the plans were realistic then, by not investing in 2017/18, the NCL financial position would be made worse in the following financial year. As a consequence, the programme delivery board agreed that a **scaled back plan focusing on a smaller number of initiatives (e.g. falls and A&E liaison)** should be brought back to the next meeting for review.

The delivery board **AGREED** that the elements of the Mental Health Plan that were already funded should proceed to implementation.
The delivery board **DID NOT APPROVE** the unfunded elements of the Mental Health plan or the Prevention plan, but **AGREED** that revised plans should be brought back to the next meeting.

➢ Attachment 4: Other Plans

There was a detailed discussion on resourcing issues within the remaining workstreams (particularly digital and workforce) and the knock-on effects that this could have on workstreams discussed in previous sections.

It was **AGREED** that at the next meeting there should be a **more detailed review of each of the remaining workstreams in the same format as done for the above workstreams.** — **SMc**

AB/CC & RJ

Actions:

1) **The report on the potential impact of the delivery plans on social care is to be presented at the April PDB meeting;**
2) **The Urgent & Emergency Care plan, Health & Care Closer to Home and Planned Care plans should proceed to delivery, starting with the identification and deployment of management capacity from within the system, taking account of the detailed comments from the Programme Delivery Board discussion summarised in these notes;** — **PJ** / **JB**
3) **The elements of the Mental Health plan that have identified funding should proceed to implementation. A revised mental health delivery plan to brought to the next meeting;** — **DSt**
4) **TL / Julie Billet is to bring a revised prevention delivery plan to the next meeting for approval ;**

	5) Plan summaries for workstreams other than UEC, HCCH, Planned Care, Mental Health and Prevention are to be included for review at the next meeting.	
4.0	**Overarching STP EIA report** TL presented the findings of a recent high-level Equalities Impact Assessment for the STP, concluding that all workstreams had been found to have either no equality impact or a positive impact. She reminded attendees that the findings represented a point in time and would need to be refreshed periodically to ensure that this remained valid. DS thanked TL (and, in absentia, JB) for the report and stressed its importance given that a core aim of the STP was to reduce variation and improve clinical outcomes for all existing and potential service users. The delivery board **AGREED** the contents of the report.	
5.0	**Any Other Business** CG reminded attendees that this was her final attendance of the delivery board and she thanked everyone for their help and support. DS wished her good luck for the future and, on behalf of those present, thanked her for her valuable contribution as SRO for CCGs.	
CLOSE: The meeting was closed at 3:58pm		