Cambridgeshire and Peterborough
Sustainability and Transformation Partnership

Meeting Minutes – FOR APPROVAL - STP Board Conference Call –IN PUBLIC	
Meeting:	**Sustainability and Transformation Partnership (STP) Board**
Date and Time:	**23 NOVEMBER 2020**
Venue:	**Conference Call (COVID-19)**

Attending Members:		
Caroline Walker (CW)	Chief Executive	North West Anglia NHS FT
Cllr Anna Bailey (AB)	Chair of Adults Committee	Cambridgeshire County Council
Alex Gimson (AG)	Chair	Clinical Communities Forum
Gary Howsam (GH)	Clinical Chair	Cambridgeshire and Peterborough Clinical Commissioning Group
James Morrow (JM)	GP/Co-Chair South Alliance	Granta
Jan Thomas (JT)	Accountable Officer	Cambridgeshire and Peterborough Clinical Commissioning Group
Julie Spence (JS)	Chair	Cambridgeshire and Peterborough NHS FT
Katie Bramall-Stainer (KB)	Chief Executive	Cambridgeshire Local Medical Committee
Liz Robin (LR)	Director of Public Health	Cambridgeshire & Peterborough
Louis Kamfer (LK)	Chief of Finance	Cambridgeshire and Peterborough Clinical Commissioning Group
Mandy Nagra (MN)	Executive System Delivery Director	Cambridgeshire and Peterborough STP/ICS
Mary Elford (ME)	Chair	Cambridgeshire Community Services NHS Trust
Matthew Winn (MW)	Chief Executive	Cambridgeshire Community Services NHS Trust
Michael More (MM)	Fixed Term Non-Executive Chair	
Neil Modha (NM)	GP/ Co-Chair North Alliance	Greater Peterborough Network
Rob Hughes (RH)	Chair	North West Anglia NHS FT
Roland Sinker (RS)	STP Accountable Officer	
Stephen Posey (SP)	Chief Executive	Royal Papworth Hospital NHS FT
Tracy Dowling (TD)	Chief Executive	Cambridgeshire and Peterborough NHS FT
Charlotte Black, *deputising for Wendi Ogle-Welbourn*	Director	Cambridgeshire County Council and Peterborough City Council

Jessica Watts (JW)	Delegated Executive Director	East of England Ambulance Service
Arshiya Khan (AK)	Co-Chair	North Alliance
Carolan Davidge (CD)	Non Exec Director	East of England Ambulance Service
Prof John Wallwork (JW)	Chairman	Royal Papworth Hospital NHS Foundation Trust
In attendance:		
Alison Ives (AI)	System Governance and Business Manager	System Delivery Unit
John Peberdy JP)	Service Director - Children and Young People's Health Services	Cambridgeshire Community Services NHS Trust
Nicola Curley (NC)	Assistant Director Children's Services	Cambridgeshire County Council and Peterborough City Council
Helen Freeman (HF)	Children's commissioner	Cambridgeshire County Council
Apologies:		
Cllr Wayne Fitzgerald (WF)	Deputy Leader and Cabinet Member	Integrated Adult Social Care and Health, Peterborough City Council
Chess Denman (CD)	Chair	Joint Clinical Group
Wendi Ogle-Welbourn (WO-W)	Corporate Director	Cambridgeshire County Council and Peterborough City Council

DRAFT Meeting Minutes - STP Board Conference Call – 22 NOVEMBER 2020 (PUBLIC)		
	Agenda item	**Action**
	Welcome and introductions The Chair welcomed everyone to the meeting.	
	Apologies for absence: As above. Declarations of interest: None declared. Notification of Any Other Business: None declared.	
	The minutes from the previous meeting were **approved.**	
1.	**Covid update (Verbal)- Jan Thomas**	
	JT opened the item by highlighting the huge amount, of excellent work that was continuing to be carried out by District Council colleagues, driving local community engagement. It was noted that the work the community leaders had done with the District and County Council colleagues had put us where we are with our health numbers. Though our numbers were relatively good in comparison to other areas, our focus must remain on keeping the transmission down. Challenges: • When we do see increases in numbers, we must keep areas of Health care separated, in order to keep infection down, in order to minimise disruption to other services. • Staffing sickness numbers, fluctuating across all organisations, health and care. • Balancing all the above whilst dealing with regional and national, as well as local services. LR provided some analysis on COVID-19 data, as well as noting that C&P residents have made positive differences to our COVID-19 figures by responding accordingly to communication. JT highlighted that there is a System Co-ordinating group that meets 3x a week that looks at data analysis and it is now focused on how we come out of lockdown, keeping numbers stable and manageable. The imminent departures and returns of large volumes of students for Christmas break was discussed and the risk of spikes and turbulence in the infection rate figures. LR noted that PHE are working closely with Cambridge University, meeting with them every day for updates, they are screening all students asymptomatically, last week there were 50 cases and prior to that it was 234, it is coming down. Similarly, ARU, have much lower amount of cases, are using lateral flow testing. JM raised that Primary Care appreciated the efforts of Acute and Community service colleagues, allowing them to maintain 'normal' referral rates. Primary Care was also stretching itself; figures show GPs were operating at 156% of normal activity to maintain normality. The message to the public must be that the NHS was open as normal, dealing with COVID, but we must keep normal services continuing to maintain health and wellbeing of the population.	
2.	**Communications update – Alison Ives**	
	The Board **noted** the paper on the Communication (Comms) Plan update, being jointly led by the Comms cell Team, made up of all partners, including Health Watch to build on the good comms work. Priorities for the next 6 months were shared: • Brand creation – Clarity around acronyms as well as what an Integrated Care System (ICS) is (will no longer be using STP after we gain ICS status); • Website – case studies of good work we are doing;	

	• Monthly newsletter; and • Recruit Comms cell partner to work on delivery of becoming an ICS. ME asked will there be examples of where being an ICS will be the resolution to issues, to highlight why being an ICS matters? AI agreed this would be an important aspect and there is a need to highlight the benefit. MM asked if AI needs any support from STP Board, in terms of comms in their organisations asking if they feel supported and have endorsement across all sectors? AI responded that there was support and they had very much engaged and welcomed the change. LH noted they would like to start to test our materials, be useful to know if what we come up with is answering the questions in the way we would expect and from the organisational and public perspective. JT noted pleased to see Healthwatch were involved in the Comms cell. The language needs to be very accessible, so that all comms is at a patient accessible level. RS said there will be times when there are radically different views about the language we should be using, what the priorities are, how it relates back to a range of different partners. What is the process? LH said they were working on a partnership basis will all comms cell members, language needs to always comes down to patient level but we will have things to work through in private before we publicise them. We will be driven on a topic basis on items that are brought to the Board, to give us outline, but it will be about having good relationships, managing expectations, negotiation, and partnership MM asked the Chief Executives and Chairs to be sharing the information and comms, within the organisations and networks. He said the more we do the greater the impact and we need to get better at this. **** Action – Julie and Laura to meet and pick up the communications within the Voluntary sector****	**LH**
3.	**Diabetes**	
	The STP Board **noted** the paper on Diabetes. AG introduced the Diabetes paper, noting that it reviewed the overall Diabetes Strategy – highlighting its links with the Health Inequalities Strategy and therefore its importance. The Diabetes clinical community, led by Dr Jessica Randall-Carrick was made up of GPs, community, and secondary care Diabetologists, community and practice nurses and the British Diabetics Association. AG highlighted 3 areas: • **Early adopter Primary Care Networks** (PCN) – rational behind selection and what they are doing e.g. meeting regularly and using Eclipse IT system to identify Patient's outside of their treatment target and agreeing a common approach, all but one PCN has improved their targets. • **Digital diabetes** – main conclusion was it is not very important for managing diabetes, need to get the basics right before apps/digital can assist. Many diabetic patients with some of the	

	worse outcomes were not digitally connected. This Programme had significant benefits to practices that were involved, some came together for the first time ever to discuss clinical cases/management. This was an important message to the ICS that the way to foster PCN coherence is through discussing patients and clinical management, this was what they are enthusiastic about. • **BMI can do it**- An initiative around low carb diet management, for early onset diabetes. Repatriating tier 3 and 4 obesity management. Discussion continued around measuring the uptake and the equality of support across the population. It was also noted that this was the first time weighted funding had happened to ensure that we understood where the inequality sits and how we get the resources to those who had the biggest need and where it would have the greatest impact. There was further discussion about upscaling the plan and expanding it to other PCNs. The CCG was looking at how we can create space for rolling it out across the board, with the financial implications. It was agreed that a paper from Rob Murphy and Dr Jessica Randall-Carrick about the financial implications and how they would roll it out would be useful. ****Action to bring to the STP Board Outcome Measure data to demonstrates the difference being made and a paper on the financial implications of wider roll out****	**AG**
4.	**Update on Early Help/Older Children/Vulnerable Adolescents/Mental Health**	
	The STP Board **noted** the paper on the Best Start strategy. NC noted that Phase 3 of the strategy should have commenced in the spring, but pilots were now being introduced, currently undertaking multiagency workshops. There are 3 core elements: • Early help; • Adolescent; and • Mental Health. The plan was to produce clear recommendations and an implementation strategy for Early Help Strategic Board early 2021. It was noted that there had been lots of previous initiatives/strategies but the difference this time was that this looks to work at a System level, gaining agreement across the System to make sure a long-term plan was established. Lots of lessons had been learnt and built on for this strategy, this time the aim was for cross-system commitment and cross organisational strategy, which was written locally. HF highlighted to the Board the new challenges they were facing that needed to be considered in the strategy going forward, such as seeing families with needs for the first time, that do not know how or what services were available e.g. how they access a Foodbank.	
5.	**AOB**	
	None declared.	
6.	**Questions from the Public**	

1. Why does your website describe Mike More as “Independent Chair” - I am sure you don’t intend to mislead the public so will you correct this?

Dr Gary Howsam provided the following response:
There is no intention to mislead the public, it is an error on the old website that we are seeking to rectify with the new website, it will be updated and corrected with the Chair’s correct title.

2. In your strategic plans you place great emphasis on developing local GP services to move more procedures/diagnostics into the community. The Lincolnshire STP has a similar emphasis. Despite this the three NHS organisations covering Stamford’s GP services seem unable to agree on the obvious solution which is to develop the Stamford Hospital site as a modern healthcare campus for the people of Stamford. What are the Board’s plans for the development of GP services in Stamford and can they assure me that alternative uses for the site will not simply benefit PCH’s budget rather than the people of Stamford?

Rob Hughes, Chair, NWAngliaFT provided the following response:
GP services for Stamford are managed by Lincolnshire CCG, they would be best placed to answer about development of GP services in Stamford. NWAFT are committed to investing in providing the services of the Stamford Hospital site to the delivery of a Community Hub based care, combination of Primary, Secondary and Community care, continuing to engage all stakeholders, partners and public to implement the vision.

3. You provided me with a list of projects to show what you had achieved at the last meeting. Surely these should have been listed in a way that allows a member of the public which strategic objectives they were supporting? Pulling together a list of projects when a member of the public has the temerity to as what you’ve done does not suggest a professional planning process?

Caroline Walker, Chief Executive, NWAngliaFT provided the following response:

The last meeting gave examples of excellent things we have been doing as an STP, even today, we have given examples, the Diabetes and Best Start initiatives. However, we also acknowledged we are not always great at communication, which we must get better at, today we have confirmed, in the Communication item that we will spend more time on getting the communication right. The examples given at the last meeting do meet our strategic priorities, e.g. Integrated Neighborhood Development- Examples of what we have been doing in the North and South, key examples of Transforming Pathways. We did not tag them against the priority they met but I think they were clearly in line with them and helping to deliver the priorities across the County.
4. I asked questions at the last meeting about strokes and Covid - in each case you explained that you had the data but did not provide it to me - am I supposed to trawl through the websites of your individual organisations? Surely it is your duty as a strategic public body to make such data available?

Mike More, Chair Cambridgeshire and Peterborough STP provided the following response:
Alison Ives has now sent out Stroke Data and Jan Thomas reiterated that we do have all of this information and it will be picked up outside of the meeting if what has been sent is insufficient.
5. In the September minutes it was reported that LR said that the Peterborough Covid cases "look to be declining but this coincided with the national direction to stop walk in appointments for testing. There had been a good system in place for Peterborough and she was worried that people were not able to access testing via the national system". After the debacle in Leicester, when the local public health team had not been told of the rising Pillar 2 infections, I thought that it had been agreed that data obtained from the privately run Pillar 2 test would be made immediately available to the local teams in order to enable them to do local contact tracing and support those who should self-isolate. However, in August a member of the CCG informed me that this was still not happening. At the beginning of the pandemic local councillors in Ceredigion, Wales, devised their own TAT system

	partly because their corporate director had been a biology teacher and he had grasped the essence of infectious disease control and the importance of local contract tracing and support. www.mirror.co.uk/news/uk-news/how-one-british-town-managed-22147 Local public health teams had previously managed outbreaks of infectious diseases with 'shoe leather epidemiology'. ***Liz Robin, Director of Public Health provided the following response:*** *We are working in partnership with the National Test and Trace system, which has scale and resilience but doesn't work for everyone, we come in with our local knowledge and resources to make sure it works across our population.* *We do get data from Test and Trace about local residents who have been tested or are a contact. The testing issues in Central Peterborough, is a good example of how we worked together - We asked national Test and Trace to put a local test center in central Peterborough, primarily for booked appointment but it also accommodate some walk-ins, this addressed the problem that we were seeing in early September.* *Another concern with the National Test and Trace system is that it is not able to contact and follow up all cases, 20% are not followed up by the National system. In August we did a pilot in Peterborough, whereby we narrowed down those cases that the National System could not contact and very successfully we were able to contact 83% of them. Last Thursday we launched the same system in Cambridge, to follow up locally and we are hopeful that we will see a similar success rate. Now we have this 'follow up' infrastructure across C&P. The next priority that we are working on is using our local Epidemiology and knowledge to establish 'Backwards contact tracing', which aims to find the source of clusters of community cases, by asking more detailed questions.* *Mike More added that he has been meeting with other chairs of STP's up and down the country and have been discussing getting the right balance between nationally and locally led, the view we put to the Department of Health is that they're not quite getting the balance right, they are understating the importance of local provision to deliver much of this, we have been saying this for the last 6-7 months.*	

Meeting closed at: 14.51

Date of next meeting: 7 December 2020

Author: Alison Ives, System Governance and Business Manager, SDU.