System Leadership Team

Chair: Toby Sanders

Date: 16th March 2017

Time: 9.00 -12.00

Venue: 8th Floor Conference Room, St Johns House, East Street, Leicester, LE1 6NB

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1. **Welcome, introductions and apologies**	
Toby Sanders (TS)	LLR STP Lead, Managing Director, West Leicestershire CCG
John Adler (JA)	Chief Executive, University Hospitals of Leicester NHS Trust
Nicola Bridge (NB)	Finance Director and Deputy Programme Director, BCT
Karen English (KE)	Managing Director, East Leicestershire and Rutland CCG
Azhar Farooqi (Afa)	Clinical Chair, Leicester City Clinical Commissioning Group
Steven Forbes (SF)	Strategic Director for Adult Social Care, Leicester City Council
Andrew Furlong (AF)	Medical Director, University Hospitals of Leicester NHS Trust
Satheesh Kumar (SK)	Medical Director, Leicestershire Partnership NHS Trust, Co-Chair, Clinical Leadership Group
Mayur Lakhani (ML)	Chair, West Leicestershire Clinical Commissioning Group GP, Sileby Co- Chair, Clinical Leadership Group
Will Legge (WL)	Director of Strategy and Information, East Midlands Ambulance Service NHS Trust
Sue Lock (SL)	Managing Director, Leicester City CCG
Peter Miller (PM)	Chief Executive, Leicester Partnership Trust
Tim O'Neill (TO'N)	Deputy Chief Executive, Rutland County Council
Richard Palin (RP)	Chair, East Leicestershire and Rutland CCG
Evan Rees (ER)	Chair, BCT PPI Group
Sarah Prema (SP)	Director of Strategy & Implementation, Leicester City CCG
John Sinnott (JS)	Chief Executive, Leicestershire County Council

In attendance	
Emma Gillespie	Project and Admin support, BCT(Minutes)

Declarations of interest on agenda topics	
None	

2. Minutes of last meeting, 19th January 2017 (Paper A)	
The minutes of the last meeting were agreed as an accurate record with the following exception.	

Agenda Item 12 – Pi Care and Health Trak – This should read 'In discussion, WL provided a vote of support and explained that the tool has provided much richer information on patient dispatch for EMAS. SL reported a conflicting opinion which was shared by both City CCG and City Council. SL requested details about how the County had used the PI tool and what decisions it had informed, as they had not had a positive experience in using it on City issues. The CCG support was for 17/18 following which a review was requested before longer term support could be confirmed. SF had stated that City Council support was also on this basis, but that he also received details of how the tool was planned to be used in 17/18'.	
3. Review of the action log (Paper B)	
The following updates were provided. 161215/2 – System Leadership Team DRAFT TOR – TS announced that AF will be taking on the deputy chair role of SLT. 170119/12 – Estates Workstream – KE has convened a meeting with estate leads across local authorities and NHS and has also engaged with NHS Property Services. 170119/12 – STP Delivery - Interdependencies meeting held yesterday. Angela Bright is preparing a briefing paper on Interdependencies for presentation at April SLT. 170119/8 – Cancer – Three groups will take forward the STP work which will comprise a Contractual Performance Group, an STP Work Group and an Implementation Work Group which will include the implementation of work coming out of East Midlands Cancer Alliance Group. The TOR are being revised and this should be set up and established in the next few weeks. It was noted that The Cancer Alliance are holding a stocktake day on 24th March at Leicester General Hospital. 170216/15 – Cardio Respiratory business case – ongoing, SL received briefing papers last week and a date is still to be scheduled to discuss. JA hasn't received this and will chase. Agreed to keep on action log. 170216/14 – Medicine Management – TS met with the Leicestershire Medicine Strategy Group (LMSG) last week and they are very keen to take on extra work to link with the STP. Once ideas are generated they will present to SLT in June.	TS SL SL/JA
4. National policy update (Paper C)	
TS presented Paper C, a national policy update provided for informational purposes only.	
5. Feedback from STP stocktake meeting on 6th March 2017 (Paper D)	
TS noted that there have been no further developments since the STP stocktake meeting on 6th March 2017. TS reported NHS E were positive about the LLR position and did not feel the need to schedule more frequent sessions. TS will follow up in the next few weeks if no further detail emerges regarding the expected national Five Year Forward View delivery plan.	
6. 7. Blueprint for general practice: delivering the general practice five year forward view	
Tim Sacks (TSa) joined the meeting to present Paper E, a publication of the GP forward view, final draft plan and Paper F, the delivery plan publication for a wider system discussion to help shape the final documents. TSa provided background to the draft reports and highlighted that this is the first time the 3 CCGs have worked collaboratively to focus specifically on long term general practice. The GP 5 year forward view highlighted that general practice working in isolation does not help the system and it is key to allow people to work across boundaries and work collaboratively to enable interactions with primary, secondary and mental health services. TSa highlighted four tiers of practice; ways that general practice can work more closely together in a	

geographical boundary, provide joint home visits, offer joint clinics or provide joint evening and weekend appointments to provide real access to complex patients to avoid admissions. With regards to the delivery plan TSa highlighted the following immediate priorities: • Summary record 2 to ensure all systems have access to records whether health or social care. • The state of readiness; where are individual neighbourhoods and federations? • How to align finances slightly differently from a CCG perspective • How to work jointly as 3 CCGs and link with SLT AFa commented that this was a necessary piece of work and thinks that once the framework has been set GP practices should shape how to take primary care forward from a bottom up approach. AFa advised that GP practices have been asked to come up with their own 5 year forward view and this will be where UHL and LPT can link in to start looking at innovative ways for how to deliver services. JA queried the solution to address the workforce problem and also the direction of travel for the employment model. TSa referred to the Multispecialty Community Provider (MCP) model which allows practices to work collaboratively to offer joint services whilst retaining their own contracts and will make some employment elements easier. Practices will be able to take on the new MCP GP contracts from April 2017 to come together as one special interest company. TSa advised that funding has been received to identify employment gaps and identify what workforce is needed to deliver a different model of care which should be mapped out by September. This will ascertain current staffing, demand activity and capacity and how general practice functions. WL was interested in the future model and next steps with regards to e-consultation across LLR and how EMAS will interact with it to help make decisions about complex patients as well as how bringing in specialist skillset can interact with future work models for EMAS. WL was also supportive of the IM&T work especially with access to records and linking real time information of patients. TSa welcomed involvement from EMAS. PM thanked TSa on behalf of the workforce group. PM queried the long term financial implication and projected budgets. TSa explained that in general LLR practices are relatively funded well when compared nationally. Work is required to ensure the right pathways for patients are in place which will then allow the funding to follow the care of the patient. AFa suggested a separate funding graph is required to align with STP proposals in terms of left shift. SL added that each business case will need to acknowledge an increase in primary care. TS suggested that it would be helpful for the final draft to capture the investment from a wider out of hospital setting and not just core primary care. ML emphasised that the plan is integral to the STP and is the heart of the STP as general practice is the hub of integration and the coordinators of care. It is really key that this should be in the narrative. ML suggested promoting hubs should be a priority and this also fits with the message from the Minister of Health for the future of 1500 hubs. ER suggesting linking in with the PPI group. TS concluded that it was a good draft plan and suggested presenting to forums that would be interested in the agenda, with particular involvement from City Council. TS noted that a discussion will be held at CCB to discuss resource to take forward. TSa thanked everyone for involvement so far and advised that in terms of driving forward patients will be engaged to co-design next stages.	TSa
8. Home first scope and progress update – Paper G	
Jon Wilson (JW) joined the meeting to present Paper G, a highlight report for the Home First Programme Board. JW highlighted that the main issues and risks are freeing up capacity within organisations to	

take work forward particularly within the work stream sub groups that are being set up. The first group is an integrated discharge workshop to integrate five discharge teams into one with a clear integrated process. Since writing the paper, managerial/clinical support capacity has increased however LPT is an area of concern as time is extremely limited. JW explained that a team should be put together by next week. The second group will be a commissioning group to assess the impact of how LLR commission services, funding flows and mechanisms in place. The third group will be supporting care homes to see how we can look at deteriorating conditions to avoid admissions, and build trust and confidence between clinical/professional teams. JW explained that in the medium term they will be looking at integrated therapies and step up step down services. JS noted that Carmel O'Brien, Joint Home First SRO would have mentioned a third risk of duplicated work which was discussed at the Interdependencies meeting and identified as crucial in terms of resolving. JW commented that they have identified where interdependencies are and duplications of work and there have been discussions on how to take forward. JA noted there was an obvious overlap with work however it was the view of the A&E delivery board that Home First will provide the overall structure and will link in with discharge. TS confirmed that Angela Bright will be presenting a paper for SLT in April. TS noted that a primary task is to identify what sits within Home First and the Discharge workstream to ensure nothing is left unaccounted for. TS thanked JW for the important work and concluded that all partners were comfortable with the scope. TS queried timing and pace particularly with regards to resource. JW advised that there should be recommendations for an integrated discharge team by the end of Q1. Wider issues around bed numbers will be geared towards medium term work by October. It was agreed that Home First be invited to present an update to SLT in May to check on progress and to see how interdependences can input. JW asked SLT to consider if the name Home First should be described differently however it was decided to retain the name and be clear on the scope of the workstream.	JW/PM JS/JW
9. End of life business case	
The following people joined the meeting. • Caroline Trevithick (CT), Chief Nurse and Quality Lead, WLCCG • Luke Feathers (LF), Palliative Medicine Consultant, LOROS • Rosie Bronnert (RB), Palliative Medicine Consultant, UHL • Jude Smith (JS), Head of Nursing, LPT CT presented Paper H, a report for Community Integrated Palliative Care Team to provide SLT with progress to date on the development of the Integrated Palliative Care Service for LLR. It sets out the need for a Health Needs Assessment (HNA) and recommendations, key issues to be addressed and proposals. AFa agreed that this is the right thing to be doing and welcomed the work. AFa queried how the role of the GP would change. CT confirmed that the business case was to support the role of the GP and district nurses who currently deliver care for end of life. AFa asked about equality impact assessments have been carried out. CT said that this needs to be picked up. RP was supportive of the clinical business case but queried why there was no finance detailed in the paper. CT clarified that information provided was for SLT to support the clinical model and that finance would be dealt with in the full business case to be presented at CCB. RP wanted to see the return on investment and potential risk of double counting in terms of forecast impact. SL confirmed that double counting issues had been addressed at MDs and adjustments made. SK was in support of the clinical model and emphasised that it was vital to understand any	CT

unwanted side effects. SK was in favour of seeing if the model works and then addressing the contractual element. AF queried potentially conflicting workforce detail. RB explained that there was investment for extra consultants but teams would need to be freed up to work in an integrated way. Judi added that there is uncertainty on exact capacity but that there are lots of people with frailty that could be considered. CT and AF agreed that there would be crossovers on some patients. WL made a plea to keep the process simple and stated that a different process at night compared to day would cause confusion. WL emphasised it was crucial to have clear criteria and a clear message. JA was supportive of the plan but queried why UHL was not included with the proposed team model. RB clarified that the business case related to work out in the community rather than support provided from a hospital setting. CT will take back the suggestion of having one team comprising acute and communities. TS concluded that there was strong support for the work and direction, there was scope to take the discussion back around internal investment, structure around phasing and contractually. SL added that she had absolute support for the group and following on from discussion at MDs support has to be around understanding the detailed numbers.	CT
10. Dementia	
KE presented Paper I, a report to inform and seek approval from SLT to enhance the governance process of the Dementia Delivery Group. SLT was asked to: - note the contents of the report, - agree that dementia and its associated work-stream is considered a clinical work-stream in its own right and accordingly the dementia delivery group as part of the STP process is enhanced into a programme board. - ensure that appropriate resource is made available to support he work stream KE explained that dementia was previously a subset of the BCT frailty elderly workstream however it sits outside of this work stream as dementia doesn't just affect frail elderly. TS queried if the workstream is already resourced in its own right. KE confirmed that the work stream is already supported and resourced and would just need an SRO. SP advised that the workstream had been discussed at the interdependencies workshop and the general consensus was that it could be added to mental health. SK noted that mental health also had high priorities which could compromise the work and was in support of a Dementia workstream in its own right. PM was supportive of a Dementia workstream as long as interdependencies were noted. SP said that if an SRO was allocated they would link with the interdependencies work. RP supported a Dementia workstream and highlighted that NHS E have quarterly checkpoints around dementia and thought it important to treat it separately. PM noted that research around dementia is considered critical nationally and suggested the workstream considers the academic environment. In conclusion, it was agreed to keep Dementia as a work stream in its own right subject to reviewing interdependencies. Karen English to consider the academic environment of	

dementia and enhance research. It was agreed that KE would be the SLT sponsor for Dementia with an SRO to be identified.	KE
11. Proposed PMO delivery arrangements	
TS will be circulating a proposed PMO structure in the next few days. SLT discussed the proposed relocation of Better Care Together to County Hall.	
12. Proposed cover front sheet for consideration	
TS presented Paper J, a proposed front cover sheet for SLT briefing papers to ensure consistency. SLT agreed the front cover sheet needs more detail adding. JA to circulate the front sheet form UHL as an example. Additional detail to be incorporated and signed off for future use.	TS/JA
13. Any other business	
None	
14. Date, time and venue of next meeting	
9.00 – 12.00, Thursday 20th April 2017. 8th Floor Conference Room, St Johns House, East Street, Leicester, LE1 6NB	