System Leadership Team

Chair: Toby Sanders

Date: Thursday 15th February 2018

Time: 9.00 – 10.40

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

Present:	
Toby Sanders (TS)	Chair, 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
Karen English (KE)	Managing Director, East Leicestershire and Rutland CCG
Azhar Farooqi (AFa)	Clinical Chair, Leicester City CCG
Steven Forbes (SF)	Strategic Director for Adult Social Care, Leicester City Council
Mayur Lakhani (ML)	Chair, West Leicestershire CCG, GP, Sileby Co-Chair Clinical Leadership Group
Will Legge (WL)	Director of Strategy & Information, EMAS, NHS Trust
Roz Lindridge (RL)	Locality Director Central Midlands, NHS England
Peter Miller (PM)	Chief Executive, Leicestershire Partnership Trust
Tim O' Neill (TO'N)	Deputy Chief Executive, Rutland County Council
Sarah Prema (SP)	Director of Strategy and Implementation, Leicester City CCG
Evan Rees (ER)	Chair, BCT PPI Group
John Sinnott (JS)	Chief Executive, Leicestershire County Council
Apologies	
Andrew Furlong (AF)	Medical Director, University Hospitals of Leicester NHS Trust
Satheesh Kumar (SK)	Medical Director, Leicestershire Partnership Trust, Co-Chair Clinical Leadership Group
Sue Lock (SL)	Managing Director, Leicester City CCG
Richard Morris (RM)	Director of Corporate Affairs, LCCG SRO Communications and Engagement
Richard Palin (RP)	Chair, East Leicestershire and Rutland CCG
In Attendance	
Shelpa Chauhan (SC)	Office Manager, BCT
Shelly Heap	Board Support, BCT(Minutes)

1. Apologies and introduction	
Apologies received from Andrew Furlong, Richard Morris, Sue Lock, Richard Palin and Satheesh Kumar.	
2. Conflicts of interest handling	
The following two items are of note for this part of the agenda: Item 5, Planning Guidance – NHS organisations and provider agencies have an interest relating to funding levels and contractual arrangements for next year. Item 9, Clinical Leadership arrangements – There may be potential interest from clinicians regarding the proposed roles in the new arrangements.	
3. Minutes of last meeting	
The minutes of the last meeting on the 18 January 2018 were accepted as a true and accurate record.	
4. Review of Action log	
It was noted that all actions have a progress update added to the log and are either ongoing or to be discussed in the agenda.	
5. 2018/19 Planning Guidance	
SP provided an update as outlined in Paper C, to ensure members have a collective understanding of the new planning guidance for 2018/19. RL will help interpret or clarify any elements of the guidance should it be necessary. SP explained that there is a NHSE & NHSI requirement to refresh the 2018/19 plan which was prepared in December 2016. The focus of the update will be on the new contracting arrangements and to make improvements in planning and the management of systems during 2018/19. Some important areas have been selected from the guidance for discussion today. Firstly, the allocation of additional resource amounts of circa £10m, to reflect realistic levels of emergency and elective activity and which is dependent on achieving the mental health investment standard. There is also an opportunity for the removal of the CCG requirement for a 0.5% underspend which will provide an additional circa £6m to be made available for use this year. However, although this funding is a helpful addition to the system there is still a significant gap in the overall financial position. Furthermore, a new Commissioner Sustainability fund is being created for CCGs who are currently in deficit; hence it is unlikely that LLR will qualify for this funding as there is no planned shortfall. However, once the technical guidance is available it will be possible to clarify any implications for LLR. Additional investment into the National Provider Sustainability and Transformation fund has also been made. Locally LPT will have an increase in funding of circa £6 k, however, UHL will not apply as it is unlikely that they can achieve the performance requirements and therefore any funding could be clawed back. JA will ask Paul Traynor to send a briefing note to SLT next week detailing the control total calculation for UHL to make members fully aware of system implications and risk. This information will also assist with the planning process for 2018/19. TS asked the Local Authority members if there was anything to share regarding social care funding levels. JS explained there has been a one-off payment of circa £1.5m for Leicestershire County Council however there are pressures within children's services which will	JA

take priority for funding. Funding levels are circa £0.9m for City and Rutland Councils.

SP confirmed that the capital estates bid is ready for submission, however the disposal strategy is not yet completed. KE is working on this along with NHS property services. There was a discussion regarding the capital bid being contingent on a compelling plan and alternative funding. KE advised that Paul Traynor is currently exploring options for alternative funding for the Pre Consultation Business Case (PCBC). TS asked whether this work will be ready in time for the Assurance Panel scheduled on the 15th April 2018 and requested an update on progress with the PCBC at the March SLT meeting.

There is no change to the national tariff and work is ongoing to consider what changes need to be made to current contracts. Further work is underway regarding the move away from the current traditional way of contracting to a new methodology.

The planning assumptions for determining our growth figures are outlined as follows:

- 2.3% - non-elective admissions
- 1.1% - A&E attendance
- 4.9% - Outpatient
- 3.6% - elective admissions
- 0.8% - GP referrals

These numbers are very similar to the National growth rate figures. The assurance template was submitted to NHSE yesterday and it is expected that they will come back with some challenges and questions over the next few days.

There was a discussion regarding SLT sign off for the refreshed NHS plan for 2018/19 so that members can agree local growth activity. Due to the tight timescale for the beginning of the submission process of 8th March 2018, it was highlighted that the March SLT meeting will be too late, therefore it was agreed that TS and SP will look at the timeline to consider which forum can be used to review the document prior to NHSE sign off. RL confirmed that there is an explicit expectation for SLT members to agree the refreshed document prior to submission. In addition the final document will come to the March SLT meeting as an information only item.

It is expected that the aggregate A&E performance against the four-hour target should reach 90% for September 2018, with the majority of providers achieving 95% for March 2019 and a return to overall adherence to the 95% standard during 2019. Referral to treatment time waiting lists should be reduced so that March 2018 level is not exceeded in March 2019.

There will be further opportunities for LLR to voluntarily become an integrated care system (formally known as accountable care system). However, LLR is not actively pursuing this now due to the financial position. NHSE & NHSI may be able to offer a support package to help with this and will provide further information; therefore it will be kept under review for the time being.

Providers and Commissioners will be expected to work together on stranded (7 day) and super stranded (21 day) patients to release capacity for patients waiting for a bed. The members discussed a new local incentive scheme whereby savings from acute excess bed day costs can be reinvested to expand community and intermediate care services and it was agreed to look at this in further detail to access if the system can pursue it. RL advised the group that DTOC is an area of scrutiny at the moment the focus will move to these patients.

TS summarised that LLR levels of growth demand and costs will cause a financial dilemma for the system in the next financial year. RL pointed out that bringing forward GP access to October 2018 will also have an impact and cause particular pressure to improve winter support

in 2018/19. ML referred to the clinical priorities in appendix one which will raise challenges for primary care, mental health, planned care and cancer. ML requested feedback relating to the 10 multi diagnostic centres for rapid cancer assessment which RL advised was being piloted for the East Midlands at Kettering General Hospital (KGH). ML told the members about the new bowel cancer test which has just been launched to aid earlier diagnosis and reduce referral delay which LLR should be proud of. SP highlighted that the winter planning for 2018/19 should be completed by April 2018. It was agreed that SP will clarify areas within the 2018/19 planning guidance relating to STP capital and estates to come back to March SLT meeting.	SP
6. Business Intelligence update	
Helen Seth (HS), Interim Director of Health and Care, UHL attended the meeting to provide an update on Business Intelligence (BI) as outlined in Paper D. The update is to focus on emerging priority areas and to give SLT an opportunity to contribute to the development of the BI strategy as well as to check there is nothing missing. The first BI strategy workshop held on 19 January 2018 involved all participant organisations and there was a good skill and role mix. Each organisation shared their respective BI strategy so that they could be compared and contrasted to build on good practice. The session focussed on what is working well that should be built on, such as good routine data to support planning and commissioning, standardised data sets, skilled in house teams, use of interactive dashboards and support and recognition for BI from Senior Managers. Areas for improvement included recruitment and retention, fragmented teams, data quality, how to interpret data to provide strategic transformation and the need for a consistent LLR information governance (IG) approach. Outcomes to be prioritised, which will form key strands of the strategy, are as follows: • People – the recruitment and retention of staff, succession planning, skills audit and training to support the workforce to meet key priorities and deliver objectives. • Process – development of IT systems, strategic and tactical information sharing, mapping data requirements and Information governance • Technology – exploiting data warehouses, reviewing current systems/tools and data integration tools SLT were asked to provide feedback at the thematic level and to identify any gaps as well as to provide a mandate for continued work to build on the enthusiasm and momentum to date. There is a second workshop scheduled in February 2018. TS requested clarification concerning the overlap between IT and BI, the use of common platforms for access to records and information sharing as well as whether there is a coherent BI strategic direction from the collective groups. PM explained that there was now considerable progress being made in the IMT workstream which has overcome many challenges recently. JA informed the members that discussions are underway with the system one provider for primary care, mental and community health to use the same system. Once approved this will mean 95% of primary care will be using one solution. A business case is in the process of being worked through for this which is likely to be accepted. In addition, better interfaces between other systems will be investigated. There is likely to be a new national funding stream for digitalisation for which LLR can bid, however, it won't be sufficient funding for EPR but will help. Once this work has been completed a more robust and coherent plan will be ready to come back to SLT in a couple of months. There was a discussion between HS and members regarding cross over between BI and IT, however, as these are aspects of the same thing both need to be included in the strategy. It	

was highlighted that it has not been set out clearly how the tools can help strategic clinical commissioning and planning.

Feedback was provided by ML, AFa, TS, SF and TON and SLT with a clear mandate to continue with this important piece of work with a focus on prioritising those areas that add value and provide the greatest benefit such as integrated care planning, GP services, access to patient records etc. Also with a focus on meaningful intelligence to provide support to targeted cohorts of patients which align to clinical interventions as this has been identified as a weakness within the system.

It was agreed that PM will advise the BCT office when the completed document is ready to be presented so that it can be tabled at a future SLT meeting. TS requested the inclusion of recommendations and suggestions.

7. Refreshing the Urgent and Emergency Care priorities for LLR

JA provided an update to SLT regarding the Urgent and Emergency Care refresh of the LLR priorities as outlined in Paper E. The refresh will be formally signed off at the Accident and Emergency Delivery Board (AEDB) meeting next week.

The items of particular interest to SLT were highlighted as follows:

The AEDB have refreshed priorities and have also considered board structural changes aimed at making the board more effective in delivering its function and more forensic in relation to challenging and questioning. There have been two sessions to review how the board can improve its approach to planning and the delivery of strategic priorities in relation to both the STP work and the immediate high impact work and therefore there will be one single precise plan for the AEDB rather that the current two. This will act as both the developmental STP workstream plan as well as the more immediate plan for in-year performance improvement.

Work has been underway to ensure there is a focus on the right priorities. Precise details of specific key actions such as inflow, flow, outflow and discharges along with priority delivery areas are outlined in the draft plan (Appendix one) although this still requires fleshing out as it is currently a work in progress. However, in broad terms, the inflow has been the most successful area of work for the AEDB, for example the delivery of out of hours GPs and the rising trend in emergency admissions which are now under control. There are particular issues around flow within UHL internal processes which are currently being looked at and good progress is being made.

In relation to discharge, the DTOC numbers are good in comparison with national figures, although at the individual patient level there have been delays in the system due to internal processes and other agencies. There are also issues relating to stranded patients who have been in hospital for a long time. Both are reflected in the plan for priority focus to reduce delays and increase flow for medical beds which are chronically short.

JA welcomed feedback and comments from the members:

TS asked for clarification on the scope of the A&E delivery board in the proposed structural changes and whether it will include emergency activity delivery performance outcomes and financial implications. There was further discussion between TS, JA, SP, NB and AFa and the members with a consensus that activity and performance can't be divorced and that clinical workstreams should be accountable for performance and managing the finances but not for contract management as this would not be appropriate. It was suggested that an A&E sub group for this purpose might be a helpful way forward and agreed that JA, SP and Tamsin Hooton will discuss this further.

There was also a discussion regarding primary care representation on the A&E Delivery Board. JA responded that Dick Hurwood is a member of the board, however, it was noted that Dick is a retired GP and therefore members recommended that in addition a practicing GP input would be of benefit. It was agreed that a request is to be taken to Collaborative Commissioning Board to consider the additional GP provider attendance on the A&E Delivery Board.

It was recognised that the frailty agenda is a priority area which needs to be specifically targeted after the issues that have arisen over this winter when respiratory difficulties meant that many patients were too ill to go home. The interface needs to be improved and capacity created to deal with it, as well as to find ways to keep patients from being admitted to hospital in the first place.

8. Feedback from National STP Executive/Clinical Leads meeting

Most feedback from the National STP Executive meeting has already been covered in the planning guidance item. However, of note is that there will be more national joint sessions planned in future. In addition there will be opportunities to look at practice in other parts of the county and particularly in ACS and vanguard areas so that ideas for good practice can be shared.

9. Progress on STP Clinical Leadership arrangements

ML provided a brief update on progress with the STP Clinical Leadership arrangements as outlined in paper F along with recommendations for consideration.

The Clinical Leadership Group (CLG) is proposing a robust devolved leadership model.

Recommendation 1:
To appoint four STP level clinical leads as follows:

- General Practice Leader
- Nursing Leader
- Allied Health Professional Leader
- Secondary Care Medical Leader

The roles will be to provide clinical leadership with particular focus on the implementation of the STP vision and objectives. The expected time commitment will be up to two days per week and the roles will be accountable to the STP lead. Further details such as job descriptions have yet to be scoped.

Recommendation 2:
To reshape the CLG to include wider membership of clinical workstream leads and other relevant influencers. It will become a supportive oversight reference group with a framework for holding the four new posts and positional leaders in member organisations to account for STP implementation. It is proposed to rename it the Clinical Oversight Group.

Feedback was requested from the members.

WL asked if the workstreams will remain the same. ML clarified that reviewing the existing arrangement would be a key role for the new clinical leads, however it is not expected to make unnecessary changes where workstreams are working well, but some may need to be rationalised.

ER requested clarity in relation to the inclusion of a clinical social care professional. ML advised that further consideration is needed as to how this could be incorporated in practice. Dialogue with the three Local Authorities about this point was welcomed, however, it was recognised that there is very strong social care representation within the workstreams. ER

also raised concern about the patient voice and whether there will be mapping of clinical leadership against the various engagement routes within the workstreams. ML responded that Eric Charlesworth from BCT PPI is also a CLG member and that at the workstream level there is PPI involvement to capture the patient view, consequently, it is envisaged that this will be an adequate level of engagement. Additionally ER's expressed the view that leadership support to the workstreams should continue to be provided by the Accountable Officer's as they have a direct route into SLT and raised concerns that any changes to this arrangement might cause confusion. ML explained that the clinical leads will be supported into the new roles, provided with necessary training and development and would be matched with the appropriate Senior Responsible Officer (SRO) which should eliminate any such concerns. There was discussion regarding positional and clinical leaders' accountability to SLT and CLG. There was consensus to review these aspects and the inclusion of social care alongside the review of the wider governance arrangements. It was acknowledged that the interaction between the new posts and existing leaders should be clarified. It was noted that there is good work being carried out on the frailty multi morbidity pathway and a report is currently underway. SP asked for clarification regarding funding for the additional posts which is yet to be agreed. TS provided feedback from Professor Aly Rashid, Medical Director, NHSE, whom he spoke to at a national event in London recently. NHSE are supportive of STPs appointing to clinical roles to build the additional capacity require to be able to progress plans and provide oversight across activity. Some STPs have already recruited to similar new positions for the same reason. There are some example job descriptions available which may be helpful when scoping the posts. JS advised that it is important to have a social care role in the proposal and pointed out that there is disproportionate resourcing across the workstreams, therefore suggested the review will be a good opportunity to take stock in the context of governance and resourcing. Furthermore, it was clarified that the new posts will be at a senior level and JS suggested that it would be sensible to match them with similar level professional leads for social care and public health. To progress work further, Clinical Leadership Group leads, to look at Job Descriptions for clinical leads to scope roles in detail and this will form part of the wider discussion regarding Governance. ML raised a point of note (not connected to the proposal) that frailty has been identified as a critical priority to ensure that there is joined up work and that there will be a dedicated meeting to review it in depth.	CLG
10. Date, time and venue of next meeting	
9am-12pm Thursday, 22nd March 2018, 8th Floor Conference Room, St John's House	