Trust Board paper T

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

Trust Board Bulletin – 3 August 2017

The following reports are attached to this Bulletin as an item for noting, and are circulated to UHL Trust Board members and recipients of public Trust Board papers accordingly:-

- **System Leadership Team minutes (22 June 2017)** – Lead contact point Mr J Adler, Chief Executive (0116 258 8940) – **paper 1.**

It is intended that this paper will not be discussed at the formal Trust Board meeting on 3 August 2017, unless members wish to raise specific points on the reports.

This approach was agreed by the Trust Board on 10 June 2004 (point 7 of paper Q). Any queries should be directed to the specified lead contact point in the first instance. In the event of any further outstanding issues, these may be raised at the Trust Board meeting with the prior agreement of the Chairman.

System Leadership Team

Chair: Toby Sanders

Date: 22nd June 2017

Time: 9.00 -12.00

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

Present:	
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
Donna Enoux (DE)	Chief Financial Officer, 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
Sue Lock (SL)	Managing Director, Leicester City CCG
Will Legge (WL)	Director of Strategy and Information, East Midlands Ambulance Service NHS Trust
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
Sarah Prema (SP)	Director of Strategy & Implementation, Leicester City CCG
Evan Rees (ER)	Chair, BCT PPI Group
John Sinnott (JS)	Chief Executive, Leicestershire County Council

Apologies	
Helen Briggs (HB)	Chief Executive, Rutland County Council

Karen English (KE)	Managing Director, East Leicestershire and Rutland CCG
Richard Henderson (RH)	Deputy Chief Executive, Rutland County Council

In Attendance	
Martha Milhavy (MM)	Communications and Engagement Manager, BCT
Shelpa Chauhan	Office Manager, BCT
Janice Richardson	Project and Admin support, BCT(Minutes)

1. Apologies and introduction	
Apologies received from Helen Briggs, Karen English and Richard Henderson.	
2. Conflicts of interest handling	
The following conflicts of interest were noted. Item 5 – Prevention. Declarations of interest from Local Authority Officers, UHL, LPT and GPs – declaration only. Item 6 – LMSG – GPs declaration only Item 10 – Tiger Team – declarations from UHL and LPT as the matter concerns provision of beds. Declaration only	
3. Minutes of last meeting, 18th May 2017	
The minutes were approved pending the following amendment: Page 5 – honorary UHL contracts instead of honorary IMT contracts.	
4. Review of action log	
Item no: 170216/15 - Cardio respiratory business case – Red status. TS noted that the issue remains unresolved and therefore re-escalated to June's SLT meeting. TS noted that all other actions were either complete, on track or to be discussed in the agenda.	
5. LLR Prevention	
Mike Sandys (MS), Director of Public Health, Leicester and Rutland County Council and Ruth Tenant (RT), Director of Public Health, Leicester City Council presented Paper C, highlighting the seven key work themes: 1. Making Every Contact Count (MECC) and the Commissioning for Quality and Innovation (CQUIN) Payments. 2. Integrated Lifestyle Servicers to address key risk factors and co-morbidities 3. Early identification and effective management of Long Term Conditions 4. Self-care and better use of current resources 5. Falls prevention 6. Investment upstream to improve health and well-being 7. Reducing anti-microbial resistance. RT advised that prevention work is ongoing in other work streams. LLR has a Prevention Board; this is a large group that will be narrowed down in the future to focus on delivery. It was noted that further work was required on supporting the prevention components of other work streams and the view was that work should happen in those work streams rather than be held in prevention. WL queried the link to Mental Health and said that EMAS would be able to contribute to MECC in terms of providing information or identifying how they can adapt as a service. MS will contact EMAS consultant paramedic, Ian Mursell about providing EMAS representation for the Prevention Board or the Tiger Team. The discussion around referrals also included consensus around ensuring the onward referral process is easy to use and that there is clear communication between services.	

While CQUIN metrics are based around the number of referrals, RT suggested avoiding making referrals the main end point as using MECC would provide opportunities for brief interventions while allowing referrals only for the people who needed further support.

SK agreed with the use of MECC, stressing the importance of making people understand the changes that are happening and said that prevention/health campaigns tend to have a big impact with the public. SK proposed using the public engagement event in September to find out what public want for mental health prevention. AFa stressed the importance of having a strong evidence base for any actions taken for all groups. He noted that prevention is underpowered in terms of resources as any changes would need to be done on an industrial scale. This in turn would lead to decisions as an STP on investment. TS agreed with AFa, on making practical changes.

PM noted that it is an adult focused paper and noted that children's mental health was on the increase. MS acknowledged that children's isn't referenced as much as it should be.

TO'N stated that further work needs to be done to engage the wider level services. The partners discussed the scope of work and agreed more could be done to engage with other services in a positive way. There is a huge potential scope in the prevention work stream.

ML welcomed the paper and suggested that the outcomes framework needed to be more visible and noted primary care is excluded. RT said that primary care will be picked up by the Tiger Team and that improvement is needed in developing measures of patient activation in long term conditions and prevention.

RT stated that some elements are being looked at by other groups such as health & wellbeing boards and therefore we should avoid overlap of governance.

TS emphasised the purpose of SLT is to ensure that work is progressed in the correct place, the visibility in terms of scope and the areas that required more focus. TS summarised the areas of discussion by the partners:

- Avoidance of duplication;
- Visibility of strands of work to the partners and the public;
- Membership point in terms of work moving forward;
- Interdependencies, particularly integrated teams;
- Scope;
- Primary care;
- Engagement work;
- Outcomes

TS mentioned within key theme 5 – falls prevention the Academic Health Science have been doing work for the whole of the East Midlands. There is a briefing note that will be circulated to partners on the scope of their work. | TS

6. Medicines Optimisation

Caroline Trevithick (CT), Chief Nurse and Quality Lead, West Leicestershire CCG presented paper D based on work completed over the last three to four months with Medicines Management. CT confirmed that engagement was good from all health organisations involved in this plan.

Work was completed to strengthen the Quality Impact Assessment (QIA) to enable a link between STP leads and Pharmacy Leads. CT advised that there is an opportunity for lay-membership into the group in response to ER's enquiry about patient representation on LMSG.

CT stated that Project Management support was still required for the group and asked the partners to consider the need to identify project management support to drive forward the action plan. CT has held discussions with Midlands and Lancashire Commissioning

Support Unit (MLCSU) regarding the resource support.

In terms of the national initiatives regarding pharmacies and medicines optimisation, AF emphasised a need to be sighted on the Carter review. The review mentioned three big schemes, medicines optimisation, work force and hospital pharmacy work that could be incorporated at a system level. AF asked the partners to consider elements that are not done well as a system for instance, medicine safety and IT systems sharing information and said that there was apprehension regarding the capacity to complete the work.

ML made a plea to prioritise this piece of work as it was a key area to the STP to reach efficiencies and suggested the following:

- Bio-similar drugs
- Repeat ordering-wastage
- Drug switching
- Medicine safety
- Linking in with regional and national initiatives.

SL said that the paper highlighted that people are working on organisational priorities regarding QIPP and medicines management and missing opportunities to get wider impact as a system. There are opportunities in terms of transactional procurement between secondary and primary care. RP agreed with SL's comments. TS said that there were opportunities around patient safety as well as financially and the collective scope of combined spend across the system and requested that partners consider what we want to collectively focus on that is best for LLR and what the opportunities are.

CT noted it was viewed by the CCG leads that UHL lead on this piece of work. It was requested that partners provide support to their respective Medicines Team Leads to work across organisational boundaries and collectively as a system.

LMSG to be the vehicle with accountability and direct remit to SLT, proposed by TS. AF and SK stressed the importance of aligning this to the Carter review in terms of governance.

AFa noted that this will require Terms of Reference to be looked at. CT confirmed that a meeting for this is being arranged with the LMSG Chair and Clinical Leads, advising that she and the chair would report back to SLT going forward.

7. Update on national policy position following STP Leads meeting and NHS Confederation 2017

TS gave an update on a recent meeting of 44 STP leads meeting that he attended and the NHS Confederation Conference last week. He summarised the key points:

- STPs are here to stay. The focus is now more on strengthening through partnerships instead of plans
- National bodies are continuing to review blurring commissioning and provider lines within the NHS.
- There is unlikely to be policy/legislative top down change, which provides opportunities at a local level to continue with the work done through partnership arrangements.
- There is a strong expectation for STP partnerships to work together collectively rather than through informal partnerships
- Announcements made last week on the first eight parts of the country that are being formally described as Accountable Care Systems (ACS). There are clear expectations that we will need to work on this area. TS pointed out that there were different approaches which reflected the variation in geography, size, population and relationship with local organisations.
- While there are no major changes regarding resourcing an announcement is expected on capital funding in July and a further announcement in the autumn.
- NHSE Improvement spoke about how their role needs to change within the

system on how they hold organisations to account. • Dale Bywater, NHSE Improvement Regional Director will take on a new role, a dual leadership of Oversight and Assurance of the LLR Systems. JA confirmed that the Regional Chief Executive meeting held on 21 June covered similar ground to the STP Leads meeting. The Strategy Director of NHS Improvement also spoke about ACS at the meeting. ML said that it was an important meeting and the meeting set a clear direction around ASC in terms of health and care, which needed to be explored further. He re-iterated that no major legislative changes are expected. ML met with several GP chairs and advised that there is a big change around primary care and the majority of the presentations were around transformation. There was clear direction from the meeting of sharing background functions to deliver efficiencies. ML found the conference hopeful as Jim Mackie, Chief Executive of NHSE Improvement and Simon Stevens, Chief Executive of NHSE were thankful as financial control totals were met and transformation changes managed during a period of austerity. TS suggested that SLT needed to focus on moving forward with the STP and looking at issues around finance and shared resource. TS proposed looking at successful schemes, initiatives that we can take learnings from. TS proposed a stakeholder event should be arranged to further discuss the STP and the national direction. TS will email the partners suggesting suitable dates and requested the partner's flexibility in terms of availability. JS raised the lack of understanding regarding ACS among local authorities colleagues and said that the direction of travel is good, however the local politicians and their varied views would need to be considered before and during the design of future delivery models. JA said it was apparent at the Regional Chief Executive meeting that although STP was toned down, there was a focus on accountable care systems. JA added the revenue of resource in health and social care was not mentioned to support with the delivery and this could impact accountable care.	TS
8. Draft STP engagement report	
Sue Venables (SV), Communication and Engagement Manager, West Leicestershire CCG and Martha Milhavy (MM), Communications and Engagement Manager, BCT, presented an overview of Paper E. *Engagement since November:* • There has been a period of general STP engagement since the publication of the STP in November • This follows extensive engagement on Better Care Together • Engagement with patients, public, carers, stakeholders, staff and clinicians • Feedback received via email, social media and at events • 10 public events held across LLR by the three CCGs • Paper pulls together the key themes emerging from STP engagement • Alongside this work streams have also been engaging on more detailed proposals *Key messages from feedback:* • More detail is needed on plans • Support for Home First but concern about delivery within available resources • Worry about change from a hospital based model to one largely based in their home – particularly in rural areas • Sense from Rutland stakeholders that they are bearing the brunt of changes	

• Questions over impact of going from 3-2 • Desire for better access to GPs – particularly out of hours • Challenges with using NHS 111 services • Voluntary sector colleagues want greater input into the direction of the STP – and more information *Proposed next steps:* • Engagement report to be embedded into each work stream with clear feedback given on how it will feed in to plans • Public summary of engagement to be produced to share more widely – setting out how we have listened and what is happening as a result of the feedback • Monthly STP update to go out after SLT meeting to keep public and partners informed of progress – including an update from two or three work streams • New conversation started when the updated STP is published JS said that this was strong link for the next steps to the agenda item 5, Overview of the Implementation Plan (Paper F). RP acknowledged that the report gave an accurate summary of the situation in Rutland and Lutterworth. ER noted that PPI feedback is along similar lines. Some areas are positive; others are more sensitive. It was recognised that people require clear facts. PM suggested focusing on the delivery of the plans so far. The public generally agree fundamentally with the move to a more community based primary care focus and struggle to understand the details. PPI perspective was for a clear statement on what STP is and how everything connects.ER confirmed that PPI feedback showed that people did not know what STP is. While they understood some of the individual initiatives they are unable to see how everything joins up. As a result people have questioned the strategy and the background data. TS said that the headline message is that the STP is a partnership not a plan and there is a need to highlight the areas that are being progressed as a partnership. TO'N noted that public wanted honest, upfront and direct conversation on delivery. There is a lack of confidence on the delivery of some items in the plan; therefore a collective agreement is needed on how that gap is managed with a clear narrative. ML proposed that clinical ambassadors should front the messages on a monthly basis and offered his support in this. It was agreed that more emphasis should be given to positive achievements. In terms of the next steps, the following actions were agreed: Feedback from engagement events and report to be shared with work streams by communications leads. Case studies of progress that has already been made to be fed back to the PMO. STP update to be developed to be shared with stakeholders. Highlight the work of BCT partnership and focus on progress that is being made.	Communications Leads All TS and MM
i) Plan finalisation: Overview of Implementation Plan **ii) Evolving our vision, goals and values**	
i) Overview of Implementation Plan SP presented Paper F and noted that The Implementation Plan format is based on the draft format provided by NHS E. She confirmed that no formal request has been made to	

submit the plan however it does provide a useful overview of what actions the work streams are taking over the next four years. NHSE indicated a national move from plan to partnership. SP noted that there are a lot of deliverables in this year's plan.

Following the refresh in July, any agreed consultation would require senate and business case approval. There were discussions around the lack of national guidance, the consultation process and the feasibility of producing and agreeing on the next draft of the plan. TS suggested keeping NHSE informed on what is being done. TS will ask Dale Bywater about the consultation timelines in their next meeting.

JS mentioned that the lack of guidance/timeline may delay sign off of the next draft of the STP plan by the local authorities. TS suggested a shift away from the STP being a plan and a greater focus on partnership.

JA suggested focus on the action plan with enablers behind this may be a way to overcome the idea that little is happening with the STP, emphasising what is going on and keeping people updated on what is being achieved. TS suggested that there is still a need to produce an updated plan and agreed with JA on a shift of focus onto implementation. SP agreed that focus is needed on delivery and the issues around configuration will become clearer as more is heard about capital availability and timescales.

The partners agreed on focussing on the implementation within the BCT partnership.

It was agreed that a clear message was needed to partners, stakeholders and workforce on where we are going next.

Next steps, PMO to create performance reporting to monitor progress against deliverables. PMO will work with work streams to refine and prioritise key deliverables identified

ii) Evolving our vision, goals and values

Item deferred to next SLT meeting.

9. Tiger Team report

TS prefaced the report as a good summary of issues and ideas that came out of the last Clinical Leadership Group (CLG) meeting about the Tiger Team stating that the next critical step was routing the issues and feedback into the respective work streams.

SK identified key points, knowledge, skills and confidence as barriers which prevent people from doing the right thing, in community and hospital settings.

ML drew attention to how the programme and the partnership is working, noting a lack of co-ordination, lack of agreement on priorities, overlap and duplication which is common in large transformation plans. ML suggested that the partners should note this and take urgent action in response. ML said some questions have been posed for the system and asked if they can be built into the action plans.

AF said that the key message is that there is a lot going on but that it is not joined up and if clinicians do not know about it or feel confident about it then it may not be used as a result.

TS suggested thinking about collective responsibility. He gave the example of the draft implementation plan and questioned whether it gives the CLG the time/space to do what it is in place for.

TS suggested working on interdependencies rather than redesigning work streams. TS also proposed establishing a frequent checkpoint with AF, ML and SK.

10. PMO arrangements and work stream resource

Andy Pickering, Head of Process Improvement, Midlands & Lancashire CSU and Debbie Thwaites, Business Improvement Director, Midlands & Lancashire CSU joined the meeting to give Midlands and Lancashire presentation on STP PMO Review.

AP explained the three key elements of the scope of work.

- Sense checking the current resources assigned to STP activities.
- Look at existing PMO arrangements
- Procurement of PMO software (CSU is in the process of doing at this time)

AP explained the approach to the review and gave key findings. AP noted that some good work is being done and progress being made, referring to the shared learning event in September. The report re-iterated points made earlier in the meeting regarding issues of duplication and overlap.

The partners discussed the review findings agreeing that across the 19 work streams the STP appeared to be fragmented and there was a disparity of resources. Strategic opportunities were identified along with some short term opportunities to redeploy resources effectively.

None of the roles are 100% dedicated to the STP which is an issue as there is an impact on work being done. The partners were asked to consider giving high impact work streams dedicated roles.

AP reviewed the contracting resource across CCGs and cited examples of using resource to help move the plan forward.

The partners discussed whether it is possible to have an informal arrangement without having a formal ACS.

MLCSU are able to provide further assistance if needed in the development of PMO, linking with other STPs.

When discussing putting resource behind the PMO and using a strategical approach; JA pointed out that a bolt on PMO is neither affordable nor practical on top of a fragmented system. JA said affordable changes are needed and also suggested looking at collaborative working on CCG and providers side.

The partners discussed priorities across the 19 work streams. There are some things that do not add as much value that may need to be looked at. SP noted that there may be some low value elements that have to be done as a statutory obligation.

DE noted that QIPP was raised as an issue as it is an example of collaborative working. DE also noted that it does require provider involvement. AP pointed out the current QIPP arrangement does create duplication so may require an Operations Lead. RP noted that ELRCCG has been complimented on the handling of QIPP by NHSE.

PM said that focus is needed on what is going to delivered with adequate reporting mechanisms. PM emphasised that the right resources are placed in the right

workstreams to ensure delivery as planned. PM noted that a way of supporting clinical teams to test intervention must be found. SK suggested that in terms of allocating resource for the implementation plan, the current WTE by workstream and funding can be used as identified by MLCSU, with a review of milestones over the next six months. SK questioned where the synergy was in the day to day and BCT work. AFa noted that there is a large resource. We would need to agree a PMO and then re-organise resource behind it. JS said that it was essential to validate what resource was in place in each work stream against the implementation plan to identify the priorities of resource required. TS mentioned the requirement of a centralised PMO. It was agreed for consideration to be given to what the immediate priorities are across the programme. Resource can then be directed towards priorities.	
11. Cardio-respiratory service redesign implication issues	
Louise Young, Head of Service Improvement and Delivery LTC LLR, West Leicestershire CCG joined meeting to present Paper H**.** TS explained the reason for bringing this back to SLT. This as an example of collaborative working that requires review in order to take the scheme forward. The partners discussed whether the service could be taken forward collectively. JA agreed the service started positively and believes that we should continue but noted that it will be difficult to resolve due to financial and contractual constraints. TS proposed development of a test case on how you would work through this collectively despite financial constraints within the system. It was noted that there are other areas that are likely to hit similar issues when the work reaches a similar level of detail. TS will pick up with LY and Angela Bright to develop a test case report. It was agreed to arrange a test case meeting to take this forward. AFa suggested continuing as the STP is a five year plan where a solution may be achieved further down the line to resolve current issues. Rebalancing expenditure within various parts of the health economy has previously been discussed. LY pointed out that this service was part of the five year transformation plan rather than a short term QIPP change. ML asked if it external expertise is needed to help find a solution. TS agreed that an external view was key.	JA and Angela Bright
12. Date and Time of next meeting	
9.00 – 12.00, Thursday 20th July 2017 8th Floor Conference Room, St Johns House, East Street, Leicester, LE1 6NB	