Trust Board paper W

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

Trust Board Bulletin – 1 June 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 (20 April 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 1 June 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: 20th April 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
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
John Jameson (JJ)	Consultant Surgeon, Deputy Medical Director, UHL
Andy Ker (AK)	Clinical Vice Chair, East Leicestershire and Rutland Clinical Commissioning Group GP, Oakham
Satheesh Kumar (SK)	Medical Director, Leicestershire Partnership NHS Trust, 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
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
Chris Trzcinski (CT)	Deputy Chair, West Leicestershire CCG
Mark Wightman (MW)	Director of Communications, Integration and Engagement, UHL
Apologies	
John Adler (JA)	Chief Executive, University Hospitals of Leicester NHS Trust
Andrew Furlong (AF)	Medical Director, University Hospitals of Leicester NHS Trust

Mayur Lakhani (ML)	Chair, West Leicestershire Clinical Commissioning Group GP, Sileby Co- Chair, Clinical Leadership Group
Richard Henderson (RH)	Deputy Chief Executive, Rutland County Council
Richard Palin (RP)	Chair, East Leicestershire and Rutland CCG

In Attendance

Emma Gillespie	Project and Admin support, BCT(Minutes)
Martha Milhavy (MM)	Communication and Engagement Manager, BCT
Martin Pope (MP)	Service Director, Midlands and Lancashire CSU

1. Apologies and introduction	
Apologies noted as follows. • Mayur Lakhani – Chris Trzcinski to deputise • Andrew Furlong – John Jameson to deputise • John Adler – Mark Wightman to deputise • Richard Palin – Andy Ker to deputise • Richard Henderson – Will Legge to deputise It was noted that Martha Milhavy (MM), Communication and Engagement Manager, BCT will be in attendance at SLT meetings to capture key messages for public communication. Martin Pope (MP), Service Director Midlands and Lancashire CSU joined the meeting to scope support they can provide as the new contracted CSU taking over from Arden Gem.	
2. Conflicts of interest handling	
TS declared an interest in agenda item 5 – STP Lead Appointment.	
3. Minutes of last meeting, 16th March 2017	
Minutes were agreed as an accurate record with the following exception. Agenda item 3 – Review of the Action Log. 170119/8 should read The Cancer Alliance are holding a stocktake day on 24th March at Leicester General Hospital.	
4. Review of action log	
AK queried due dates and status (RAG). TS suggested reviewing this at next SLT. Ongoing pieces of work will be removed from the action log.	
5. STP Lead Appointment	
SL presented Paper C outlining the STP Lead Appointment and noted that the 5YFV publication sets out the governance arrangements which state that where it has not already occurred, can appoint or reappoint an STP leader, subject to ratification by NHSE/I. Finance will be available to each STP area on a non-recurrent basis for this financial year to support STP leader and Programme costs.	
SL will oversee the process for the appointment of STP lead which is being proposed as an open process for all CEOs in the system and will give the lead legitimacy and support from the system. An assessment panel will include CCG Clinical Chairs with NHSE/I involvement. Dr Paul Watson, Regional Director NHSE informed TS and NHSI they are happy with the proposal for a local process with a local job description. There have been no objections from NHSI. TS to confirm with Elliot Howard-Jones, Director of Commissioning Operations, NHSE that they are in support of the proposal from a local level. Any strong views or concerns should be reported back to SL by end of Monday. A permanent lead can then take the STP forward.	SL TS
KE queried who will write the local job description. TS to ascertain from NHSE when a national Job Description for the position of STP lead will be available. Alternatively Sue	TS/SL

Lock to draft local JD. JS queried local authority involvement in the STP Lead Appointment process. It was agreed Local authorities to be included in the process for appointing an STP Lead. Local authorities to decide who will be involved. PM queried if was legally possible for a non-CCG officer to chair a joint committee of 3 CCGs. TS explained this was explored when AF was appointed to Deputy Chair and it is possible if conflicts of interest are declared. SL added that they would not be able to commit resource but can chair. KE queried the urgency of the appointment. TS considered this a top priority so that it does not cause any further delay in resourcing PMO. MW agreed UHL are keen for an appointment to be made to increase legitimacy.	HB/SF/JS
6. Local STP delivery arrangements: Next Steps	
TS presented Paper D, the STP Lead discussion paper regarding next steps for LLR STP delivery. TS highlighted that the discussion paper was taken to the STP Programme Reporting and Governance Arrangements meeting with SROs yesterday. Feedback on the overall LLR system approach was that it had a sense of merit and mileage. TS suggested local focus needs to be on workstream delivery and progressing the STP rather than designing an accountable care system for the future. TS opened up a discussion for SLT to consider. AK queried MCP contracts and advised that the Integrated Locality Teams workstream need some clarity. TS advised that we need to encourage and support working in a multidisciplinary way but we will not focus on formal MCP contracts in the short term. PM referred to 50% of healthcare systems becoming accountable care systems by 2020 and suggested SLT consider what it would mean for LLR. TS considered this to be the likely longer term direction but noted that LLR is not yet in a position and will need to evolve towards working in a more connected way. TS highlighted the LLR Sustainability and Transformation Partnership and noted the 5YFV publication sets out governance arrangements and discusses implementing ‘support chassis’ which specifies lay or non-exec input. TS suggested formalising the LLR Chairs meeting to have engagement with lay members at the four established board meetings. JS, HB AFa, SL and ER all agreed. JS asked SLT to consider abandoning BCT and removing the logo citing confusion around BCT and STP. SLT discussed the BCT brand and suggested getting a steer from Comms and Engagement. MW was uncomfortable with this from a future branding perspective. WL felt that BCT came out of the local area and should continue. TS agreed that most STPs have a local strapline. MW supported CLG driving clinical models and noted it was important for them to drive rather than be involved. TS added that SROs agreed that CLG be an internal senate and noted the ML and SK wanted to move in that direction. SK noted the challenge of CLG is to not duplicate the workstreams and felt there was a lot of duplication with discussions. TS offered to support CLG Chairs with how to practically drive clinical models forward without duplicating the workstreams. TS presented the workstreams purpose, workstream reporting and accountability which sets out roles and emphasised the importance of accountability to ensure workstreams are progressing adequately. SK suggested that provision is made for an evaluation and improvement function in the	TS / ML / SK

STP framework and noted a meeting is scheduled with LIIPS to build on improvement capacity and would like to bring a paper to SLT in May/June. MW suggested that SLT drive the workstreams and set parameters. TS agreed that there needs to be a clear outcomes framework. JJ considered it important to set parameters without compromising the scope of thinking within clinical workstreams and emphasised there needs to be a balance so that it does not become a barrier to change. JJ also noted that there is not always evidence and some decisions need to be pragmatic. JJ was in favour of patient focussed outcomes and quality improvement. JS queried communications and engagement as a PMO function and suggested workstream leads and programme boards think about this collectively. TS noted this was also raised by SRO's. AK queried if there had been any input directly from the community on UHL reconfiguration. JJ thought it was key for the patient to be at the centre and consider what it feels like for the patient when designing clinical pathways. TS agreed it needs to be about what is best for population and patient. SL queried principles around workstream purpose around local variations and highlighted the need to assess how patients' access services when dealing with a diverse population and suggested existing services are challenged to ensure they are appropriate and evidence based. TS presented the PMO function and highlighted the current arrangements inherited from BCT are inadequate for what is required and highlighted 5 core areas to be rapidly resourced with all partners contributing financially or with staff resource. TS expressed this is a top priority which has been reiterated from SRO's. ER suggested adding a PMO function to ensure workstreams link in with patient representatives which is mapped into the PPI Group and gives another route into the System Leadership Team. ER added that a core PMO function would be to support the PPI Group. KE suggested that the Estates group should be an enabler rather than a workstream. MW advised that UHL would want to be recognised for the current staff resource linked to the reconfiguration work with staff devoting 100% of time. TS proposed a mapping exercise to understand where resource is deployed into STP linked workstreams to sense partnership input. KE felt that all work inputs into the STP and felt it was not possible to disentangle work from the CCG and STP. NB suggested linking this across to key priorities and savings delivery to give some context and proportionality to the resource needed. KE added that the exercise would expose where workstreams are less resourced. TS considered this the purpose of the exercise and not to highlight staff differences. WL noted EMAS are playing into 7 STP's with one person in PMO and managing an internal SIP programme. WL would be happy to discuss resourcing into the PMO and noted EMAS want to be engaged in the STP and drive forward values in LLR. SL noted that it was important to include an ongoing and overarching QIPP monitoring function in Roles and Responsibilities. TS explained this would be in finance and performance. SL wanted clearer definition around establishing a PMO and in what capacity people would contribute. TS explained there was a plea from SRO's to properly resource PMO. Consideration needs to be given to skillset and how to populate.	SK

SK suggested creating capacity for improvement expertise in the PMO function and noted significant evidence where organisations and systems that have invested in QI have seen significant benefits particularly with CQC inspections.	
JS supported a mapping exercise and stated that it was important to support SRO's.	All
TS concluded that work will continue over the next few months to develop a PMO structure and resource. TS asked partners to map resource and to scope first line involvement in leading delivery of workstream areas. TS noted that Midlands Lancashire CSU may be able to support with mapping.	TS/MP
7. Timeline for finalising STP	
SP presented Paper E and noted the paper was written prior to the capacity plan and reconfiguration update and would need to ensure alignment to this. SP is aiming for a refreshed final document in July. The narrative has been out to be refreshed but hasn't been out for acute reconfiguration, most chapters have come back. SP noted this was circulated before the 5YFV publication and needs to check the rework reflects this. JS commented on the role of the Local Authorities in the 5YFV publication and queried the role of Local Authorities for sign off of the STP. TS confirmed that any reference to Local Authorities has been removed and now only refers to NHS organisations. TS noted that locally we would want to discuss the extent of local authority involvement and thinks it would be a missed opportunity, if we don't reflect for the public or wider partners, the involvement of local authorities in this programme.	
8. Workstreams	
TS presented Paper F and noted the report is a first attempt to draw out what is happening in the work streams. In particular, TS drew attention to the Executive Summary which highlights inconsistencies and gaps across the programme. TS noted that discussions have taken place with MP around CSU potential input on software and tools to support a fully populated reporting process. TS highlighted that the Interdependencies workstream is seeking support from SLT and have proposed a 'it's not you, it's me' group which will be an informal group across SRO's to look at interdependencies with a clear route back to SLT. TS asked SLT to consider the proposal for a new group which will need to be branded under a different name. SL noted that Cancer was not listed in interdependencies. TS explained the group was initially small but would need to be broader. MW reported that the interdependencies workbook was a good first cast but noted he would want to look at a workstream and critical delivery in each year and map across from other projects. MW felt this was too high level to do that and does not create the map that he was hoping for. TS suspects this is an issue relating to workstreams not being in a position to set out interdependencies yet. AK considered resource was the reason for the Executive Summary highlighting missing information and supported the idea of mapping resource. KE defended work streams and noted the Estates workbook had been completed but it was still showing as missing. Other areas that are red were due to annual leave over Easter and short timescales. KE felt that work was happening and there was an administration issue. SL advised that planned care was marked as red as they want to escalate to SLT for discussion. JS noted that there will be a presentation from Home First at SLT in May and asked to defer renaming the group until then which was agreed.	

9. AOB	
SP presented key work taking place over the next few weeks and asked SLT for partner support. • Ophthalmology, triage and assessment will be taken to CCG's and needs to be turned around in May and June. • SP noted there are issues around Ear Nose and Throat (ENT) services and lack of clinical engagement. • There is a follow up plan going through UHL Executive Board and noted a plea to support this. • From a CCG point of view SP noted the need to continue pushing using PRISM system for advice and guidance for GP's which will help to support £7.2m already identified and £3.3m unidentified from a financial perspective. All representatives on planned care delivery know where they are. TS noted the importance for work streams to bring particular issues to SLT and felt there should be space on the agenda for a hot topic point for work streams to flag issues that do not need a standalone paper. TS concluded that the highlight report is work in progress and will be fully iterated at next SLT and noted that not all content has been reflected. There is a need to look at capacity and support SRO's with a wider group looking more in depth at interdependencies. Midlands Lancashire CSU to scope what support can be provided to PMO.	TS/NB/MP
10. Date and Time of next meeting	
Date: 18th May 2017, Time: 9.00 -12.00, Venue: 8th Floor Conference Room, St Johns House, East Street, Leicester, LE1 6NB	