Trust Board paper Q

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

Trust Board Bulletin – 5 October 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:-

- **Trust sealings quarterly report (June – September 2017)** – Lead contact point Mr S Ward, Director of Corporate and Legal Affairs (0116 258 8615) – **paper 1**
- **System Leadership Team minutes (20 July 2017)** – Lead contact point Mr J Adler, Chief Executive (0116 258 8940) – **paper 2**
- **Trust Board meetings 2018** – Lead contact point Mr S Ward, Director of Corporate and Legal Affairs (0116 258 8615) – **paper 3**

It is intended that this paper will not be discussed at the formal Trust Board meeting on 5 October 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.

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

DATE: **5 OCTOBER 2017**

REPORT BY: **DIRECTOR OF CORPORATE AND LEGAL AFFAIRS**

SUBJECT: **SEALING OF DOCUMENTS**

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1. The Trust's Standing Orders (Standing Order 12) set out the approved arrangements for custody of the Trust's seal and the sealing of documents.

2. Appended to this report is a table setting out details of the Trust sealings for the 2017-18 financial year to date (by quarter).

3. The Trust Board is invited to receive and note this information.

4. Reports on Trust sealings will continue to be submitted to the Trust Board on a quarterly basis.

Stephen Ward
Director of Corporate and Legal Affairs

List of Trust Sealings for Quarter 2, 2017/18

There were no Trust Sealings for Quarter 2.

System Leadership Team

Chair: Toby Sanders

Date: 17th August 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
Adrian Childs (AC)	Chief Nurse, Deputy Chief Executive, Leicestershire Partnership Trust
Karen English (KE)	Chief Executive, University Hospitals of Leicester NHS Trust
Steven Forbes (SF)	Strategic Director for Adult Social Care, Leicester City Council
Andrew Furlong (AF)	Medical Director, University Hospitals of Leicester NHS Trust
Azhar Farooqi (AFa)	Clinical Chair, Leicester City Clinical Commissioning Group
Satheesh Kumar (SK)	Medical Director, Leicestershire Partnership Trust, Co-Chair, Clinical Leadership Group
Mayur Lakhani (ML)	Chair, West Leicestershire CCG, 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
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
Paul Traynor (PT)	Chief Financial Officer, University Hospitals of Leicester NHS Trust
Jon Wilson (JW)	Director of Adult and Communities, Leicestershire County Council
Apologies	
John Adler (JA)	Chief Executive, University Hospitals of Leicester NHS Trust
Nicola Bridge (NB)	Finance Director and Deputy Programme Director, BCT
Helen Briggs (HB)	Chief Executive, Rutland County Council
Richard Henderson (RH)	Deputy Chief Executive, Rutland County Council
Peter Miller (PM)	Chief Executive, Leicestershire Partnership Trust
John Sinnott (JS)	Chief Executive, Leicestershire County Council

In attendance	
Shelpa Chauhan (SC)	Office Manager, BCT
Janice Richardson (JR)	Project and Admin Support, BCT

2. Conflicts of interest handling	
Nothing noted at this time.	

3. Minutes of last meeting 20th July, 2017	
Minutes were approved as an accurate record.	

4. Review of action log	
TS acknowledged the public presence outside St John's House, and gave his response to their press statement, confirming that key decisions on hospitals and services are made by the statutory bodies who hold that responsibility and not SLT. Going forward to improve relationships and transparency the SLT papers will be shared with the BCT PPI group. PPI lead ER is a member of SLT supporting the group's transparency and public role. TS advised that the action log has been updated; the amber actions are on-going and will be brought back to subsequent meetings. Action 170518/9-Home First service model for non-acute, community will be discussed within agenda item 6.	

5. Moving towards Accountable Care in LLR: A draft proposal	
SP presented the proposal drafted by PM, TS and SP on moving towards Accountable Care. PM has already spoken to the three CCG leads about the proposal and feedback from the meeting will be incorporated into the paper. SP explained the context of the proposal following the publication of the Next Steps Forward document, noting the clear direction of travel towards Accountable Care System (ACS) and change of language from sustainability plans to sustainability and transformation partnerships. The focus of NHSE and NHSI has moved towards ACS. The design of the system is down to each STP footprint, which has led to a variation in the ACSs that are being developed nationally. SP noted the following key points for consideration: -Purpose and vision – LLR should have a purpose and vision that is worked to -Governance and decision making -Clinical networks –How transformational change is obtained in work streams. -How do we move our integrated locality approach into a much more organisational approach? There was a general consensus from the partners supporting the proposal's direction of travel and shared platform. The clinical networks were considered a good development as patients remain part of the accountable care pathway rather than being discharged from one service to another. SK stated that this would require further work from the Clinical Leadership Group (CLG) team and there should be a clear rationale where integration is not possible. The following points were raised: • less technical language to help people understand what it means to them as a patient; • need for public involvement at an early stage; • a need for substance behind the proposal to enable it to capture this year's contracting round; • sovereignty issues with organisational boards; • clarity on whether the proposal was a single entity or a combination of various elements: a system level, regional level and local level; • additional focus on outcomes; • potential risks that may emerge from other platforms;	

• some associated risks including the public's perception; • clarity on whether the proposal was presenting an ACS or an Accountable Care Organisation (ACO) AF suggested using the cardio-respiratory service as test case to see how an ACS would benefit the service. The mechanism for shifting finances through contractual reform was essential. PT emphasised that finance was not the singular key element however it is pivotal in unlocking other parts of the system. TS proposed to review the contracting and finance elements and options at Septembers SLT meeting. SL referenced the Memorandum of Understanding (MOU) used by other areas. She asked if NHSE and NHSI have signed up to anything that would help with the sovereignty issue with organisational boards. SL also suggested working through implementation in phases. It may be possible to ask for clarity from NHSE and NHSI on how they would work with LLR as an ACS by using an MOU process. The partners agreed on the use of a MOU including a set of questions to be prepared for the boards to receive consistent feedback. CCG Chairs and Clinical Leads met and discussed the options of a formal merger of the CCGs or a single management team. These options were not considered viable. They had agreed to come together to strengthen the Collaborative Commissioning Board as a joint committee of the CCGs and widen its membership to include non-executives. The AO; Chairs and Vice Chairs of the three CCGs are also meeting on a regular basis to support more collaborative working arrangements and work is ongoing to consider functional areas that would benefit from greater collaboration across the three CCGs. . RP noted that the outcomes from this meeting were a movement in ethos and change and its significance should not be underestimated. While discussing whether the paper focused enough on system outcomes, the partners accepted that it is necessary to have the correct foundations in place which would help subsequent discussions to move on faster. However, it was noted that focusing on the design rather than the process increased the risk of missing timelines. WL pointed out the need to consider how the system is held to account and how LLR would work with the system regulatory bodies. TO'N noted that most local people are interested in high quality care and care close to home. Local authority is the key conduit into the local community, so they would need to be involved in the narrative which needs to be correct. The approach made good sense from a local authority perspective and Rutland would continue with the work collaboratively. JW asked for clarity on whether the proposal was for an ACS or ACO, as he felt the paper leaned towards ACO rather than ACS. He also queried the role of the local authority as partner or member of an ACS or ACO. SP suggested that ACS is the natural initial step potentially moving to an ACO at a later stage – this is in line with the Next Steps Five Year Forward View document. JW also asked for clarity around the commissioning of services as the proposal was unclear on what the process would be to get to integrated collaboration of the CCGs. What appeared sound in principle may experience challenges in delivery, making local authorities uncomfortable. Taking into consideration the feedback received, SP and TS to revise the Moving Towards Accountable Care in LLR: A draft proposal on next steps document for the boards to consider in September 2017. TS and SP offered their support to attend Boards if required.	Spencer Gay and Sarah Shuttlewood SP SP
6. Community Services model: scope and approach	
Paul Gibara, Chief Commissioning and Performance Officer (PG) presented Paper D asking the Partners to: • consider this paper and confirm scope / descriptors; aims and approach, providing any	

amendments or suggestions back to the Project Team to finalise and formally commence work;
- confirm the SRO for this work (recommended that this is a member of the STP Leaders);
- nominate the appropriate representative from each Locality to take part in the Task Group;
- nominate the appropriate persons for interviews (covering key providers; CCG and Local Authority; third sector and patient/carer groups) and any wider stakeholders for the concluding workshop;

PG advised this is about Community beds yet is mindful of other services. There is a need to be realistic about what can be achieved in a four to six week period. RP acknowledged the paper as an important piece of work as he felt it was necessary that the various partners all conveyed the same message. A single consistent approach was felt to be beneficial to identify the direction of travel. PG recommended that TS lead on this work, providing a link between the virtual reference group of work stream leads and the SLT.

SK recognised this work as key prior to the Clinical Senate. SL asked that PG should be given as much priority as possible in order to access existing groups, work streams and programmes.

SL felt that the scope and approach would move LLR forward and noted that although City CCG do not have community hospitals, their patient quotas are still pertinent and should be considered.

It was agreed that non-acute service needed to be considered when discussing community beds. JW queried whether this was specifically in relation to health care or non-health, primary care or planned care. The exam question being asked is what services we will have in place in the community that will support the planned bed base in UHL. As a result some will be bed-based and some will be non-bed based. In the non-bed based how will the community hospitals be used with those beds, those numbers and where. In an attempt to answer that question this work would join up the existing work being done by various work streams. It was agreed that the paper needed to be re-drafted to give more clarity on the scope and to amend the paper to reflect the exam question. PG

While the timing is ambitious; failure to do this work will delay other elements, impacting on the overall consultation timeline. SP emphasised that this work is crucial to the clinical senate, assurance piece and vertical integration.

ER was concerned about separating engagement from the stakeholders and suggested that it would beneficial to involve the BCT PPI Group and Healthwatch. PG acknowledged the existing work being done in terms of patient involvement within the work streams as well as drawing on previous and existing engagement work. It was agreed to redraft the paper including an appropriate title and to invite PG to provide an update to SLT at the September meeting**.** TS

7. GP Medical Workforce Expansion 2020 strategy

AFa explained that there is a requirement from NHSE for an increase in GP numbers as part of the Five Year Forward View. For LLR this is 14% increase in the number of GPs, the full-time equivalent of 76 GPs by 2020. NSHE also require a detailed plan by the end of September showing how this figure will be achieved as well as:

- a workforce survey clarifying the baseline figures;
- a recruitment and retention strategy;
- expansion in training;

AFa acknowledged the challenge to develop a detailed plan by the end of September given the constraints of limited resources and asked the partners to consider how to mobilise resources to accomplish this task.

It was agreed that more GPs are needed. The partners discussed whether to recruit the 76 target or to reduce that figure and to have a comparative skill mix as primary care is offered by a wider team. AF noted that with regards to the wider workforce that UHL have the Physician Assistant school starting later this year and there will be more people joining the workforce over the next few years. The partners discussed local and overseas recruitment. AFa stated that there is a proposal to use the overseas recruitment strategy currently in place in Lincolnshire. KE pointed out that there is a workforce bid and suggested that LLR should do its own overseas recruitment. AF agreed with keeping the overseas recruitment in-house, noting that UHL has a lot of experience in overseas recruitment both inside and outside the EU. UHL would be able to support through portfolio careers working either in hospitals or alongside hospital admissions. RP proposed bringing back GPs who have left general practice and agreed to speak to AFa on this topic. AF pointed out that nursing has experience with bringing people back into the workforce so that should be looked into. It was agreed for the detailed plan to be presented in September SLT meeting prior to NHSE end of September deadline.	AFa/KE
8. Cardio-respiratory service design update	
Sarah Shuttlewood (SS) Associate Director for Contracts and Provider Performance joined the meeting to present Paper F. TS explained that there have been many discussions on this issue and UHL are looking at how they can re-focus resources to enable progress and prevent the loss of work completed at this point. SLT are being asked to: • note the progress made since July • support the risk share approach outlined with UHL to enable the Community; Physician and clinical pharmacist post to be filled to be resourced.; • support the proposal from LPT to enable the service manager post to be filled; • support the proposal for the Tiger Team and Prof. Sally Singh to provide specialist; input to the integration of Pulmonary and Cardiac rehab on behalf of UHL and LPT; PT re-iterated UHL's commitment and are keen to work with the service to get a proposal back to SLT as quickly as possible. PT highlighted a bigger challenge in terms of service; the workforce and capacity rather than finance. AF also cited workforce as the bigger issue, noting: • HEEM criticism about training experience within respiratory and cardiology • More consultant presence is needed on the wards to support Red to Green This all equates to pressure about delivery of in-house service against delivery of the Integrated Cardio-respiratory Community Service (ICCS). It was agreed an additional meeting to be held involving UHL and Leicester City CCG to present a proposal to SLT to progress further. AC queried that if there is no resolution, there is a risk that clinicians may become disengaged. Current challenges may potentially become a continual obstruction if there is no solution.	Angela Bright/PT
9. Capacity update for BCT programme delivery:	
1) PMO structure Andy Pickering, Head of Process Improvement, Midlands & Lancashire CSU and Martin Pope, Director, Midlands & Lancashire CSU presented Paper G on the proposed central PMO model. A hybrid model is being considered for development, this would be an outward-facing PMO that covers monitoring, reporting, provides guidance, advice and support to the projects	

and programmes that it covers, ensuring that the models and outcomes are being realised. Two thirds of the roles are currently in place however there are key roles that are currently vacant. As a result there are significant gaps in certain functions such as communications and reporting. The model presented works in close association with the work stream piece and it is essential that the gaps in the model are filled for it to work effectively. The partners discussed key roles that were felt to be necessary to the system. RP queried the size and cost of the PMO. TO'N noted that communications should be given consideration in order to clarify the expenditure to the public. PT queried whether the level of spend was appropriate, suggesting that the correct resources may require additional costs as opposed to spending less on something that was unsuitable. The partners came to agreement that it was necessary to progress with filling the key posts and agreed in most cases that secondment would be the best method to fill the posts. AP noted that some substantive resources that could be used more effectively in partnership with the proposed PMO roles: • Programme /Partnership Director The role is based around the original BCT Director post with changes to reflect moving from STP to an ACS which entail additional responsibilities. This role is considered critical and the partners agreed that it would be advantageous to recruit from within to get an individual who already has relationships within the system and understands the politics. Whereas an external candidate would need time to acclimatise themselves. • Head of Communications & Engagement The partners agreed that secondment would be beneficial as that would allow the role to be filled by an individual who knows the partners and has already established relationships. • Head of Partnership Governance The partners agreed that the governance role could be covered by a secondment. Alternatively it was suggested that a Corporate Affairs team may have staff who could contribute their time to the PMO. • Portfolio Analyst MP advised that recruitment was currently taking place; the partners agreed that secondment could provide a short term solution. TS to email proposals to progress with filling the immediate gaps for the following roles in the PMO: - Short term secondment opportunity for the Programme/Partnership Director - Secondment to be arranged for the Communications Function and will liaise with Mark Wightman - Work stream Delivery Support will be straight to recruitment - Short term secondment to be decided Portfolio Analyst PMO structure to be presented for SLT's consideration at September SLT meeting. 2) Work stream resource TS asked the partners to review the STP capacity analysis summary. The STP Work Stream Capacity Analysis summary will be emailed out along with AP's email address to allow propositions to be fed back from the work stream. Accountable Officers/SRO's to review the STP Work stream Capacity Analysis Summary and STP Capacity Analysis by Individual Work stream to: - Review content to confirm that information remains accurate and valid, and that RAG assessment is in keeping with current status.	TS TS AP

- Where RAG assessment is at present not Green, to identify additional or revised plans and actions which will enable RAG status to turn Green	
10. Date, time and venue of next meeting	
Thursday, 9am-12pm, 21st September. 8th Floor Conference Room, St John's House, East Street, Leicester LE1 6NB	

Trust Board meeting dates 2018

The public session of the meeting begins at 9am

Date	Venue
Thursday 4 January 2018	Rooms 2 & 3, Clinical Education Centre, Glenfield Hospital
Thursday 1 February 2018	Board Room, Victoria Building, LRI
Thursday 1 March 2018	Rooms A & B, Education Centre, Leicester General Hospital
Thursday 5 April 2018	Board Room, Victoria Building, LRI
Thursday 3 May 2018	Rooms 2 & 3, Clinical Education Centre, Glenfield Hospital
Thursday 7 June 2018	Rooms A & B, Education Centre, Leicester General Hospital
Thursday 5 July 2018	Rooms 2 & 3, Clinical Education Centre, Glenfield Hospital
Thursday 2 August 2018	Board Room, Victoria Building, LRI
Thursday 6 September 2018	Rooms A & B, Education Centre, Leicester General Hospital
Thursday 4 October 2018	Rooms 2 & 3, Clinical Education Centre, Glenfield Hospital
Thursday 1 November 2018	Rooms A & B, Education Centre, Leicester General Hospital
Thursday 6 December 2018	Board Room, Victoria Building, LRI