Paper A
LLR System Leadership Team
18 July 2019

System Leadership Team
Meeting No. 27
Chair: Peter Miller
Date: Thursday 20 June 2019
Time: 9.00 – 12.00
Venue: 4th Floor Conference Room, St Johns House, East Street, Leicester, LE1 6NB

Present:	
Peter Miller (PM)	LLR STP Chair, Chief Executive, Leicestershire Partnership Trust
Andrew Furlong (AF)	Medical Director, University Hospitals of Leicester NHS Trust
Steve Forbes (SF)	Strategic Director for Adult Social Care, Leicester City Council
John Sinnott (JS)	Chief Executive, Leicestershire County Council
Professor Azhar Farooqi (PAF)	Clinical Chair, Leicester City CCG
Professor Mayur Lakhani (ML)	Chair, West Leicestershire CCG and Chair Clinical Leadership Group
Ursula Montgomery (UM)	Chair, East Leicestershire and Rutland CCG and GP
Sue Lock (SL)	Interim LLR STP Lead, Managing Director, Leicester City CCG
Caroline Trevithick (CT)	Interim Managing Director, West Leicestershire CCG
Donna Enoux (DE)	Chief Finance Officer, East Leicestershire and Rutland CCG
Frances Shattock (FS)	Director of Strategic Transformation/Locality, NHS England & Improvement
Stephen Bateman (SB)	DHU CIC
Ben Holdaway (BH)	Director of Operations, EMAS
Evan Rees (ER)	Chair, BCT PPI Group
Mark Wightman (MW)	Director of Strategy and Communications, University Hospitals of Leicester NHS Trust
In Attendance:	
Ket Chudasama (KC)	Director of Performance & Corporate Affairs, West Leicestershire CCG (for item 19/58)
Helen Mather (HM)	Programme Manager, Planned Care, Leicester City CCG (for item 19/58)
Jane Edyvean (JE)	General Manager for Clinical Services Directorate (for item 19/58)
Paul Gibara (PG)	Chief Commissioning and Performance Officer, East Leicestershire and Rutland CCG (for item 19/59)
Sam Leak (SLe)	Director of Operational Improvement, University Hospitals of Leicester NHS Trust (for item 19/59)
Hannah Hutchinson (HH)	Head of Strategy and Implementation and Cancer Commissioning Lead, Leicester City CCG (for item 19/59)
Helen Brooks (HB)	Clinical Lead Cancer Centre, University Hospitals of Leicester NHS Trust (for item 19/59)
Mike Sandys (MS)	Director of Public Health, Leicestershire County Council (for item 19/60)
Ivan Browne (IB)	Director of Public Health, Leicester City Council (for item 19/60)
Vivienne Robbins (VR)	Consultant in Public Health, Leicestershire County Council (for items 19/60 and 61)
Tim Sacks (TS)	Chief Operating Officer, East Leicestershire and Rutland CCG (for item 19/64)
Clare Mair (CM)	Board Support Officer, Leicester City CCG (Minutes)
Apologies:	
John Adler (JA)	Chief Executive, University Hospitals of Leicester NHS Trust
Mark Andrews (MA)	Deputy Director for People, Rutland County Council
Karen English (KE)	Managing Director ELRCCG

SLT 19/52 Welcome and introductions

PM, who was chairing the meeting in JA's absence, welcomed everyone to the meeting.

SLT 19/53 Apologies for Absence and Quorum

Apologies were noted as above. The meeting was quorate.

SLT 19/54 Declarations of interest on Agenda Topics

Declarations of interest were noted for item 19/61 – LLR Making Every Contact Count Plus Project. It was noted UHL and LPT receive 0.25% of their contract value as a CQUIN payment. UHL and LPT attendees made a declaration of interest. It was agreed they could remain for the duration of this item as the purpose of the paper was to approve the approach.

SLT 19/55 Notification of any other business

The Chair was not notified of any other business.

SLT 19/56 Minutes of meeting held on 18 April 2019 (Paper A)

The minutes of the Senior Leadership Team meeting held on 18 April 2019 were approved as an accurate record.

SLT 19/57 Action notes of the meeting held on 18 April 2019 (Paper B)

The action log was reviewed and the following noted:

<u>01/88 – Partnership Terms of Reference/Governance</u>
SL advised the ongoing discussions on the partnership group had delayed the development of a governance pack.

<u>19/29 – SLT Work Programme</u>
SL had discussed with Mark Andrews and Steven Forbes to suggest additions to the work programme to reflect LA work. The recent ½ day session had run out of time to discuss this. JS suggested including troubled families and describing social care activities.

<u>19/33 – Update from STP Meetings</u>
SL had again chased information from Dorset ICS and was yet to receive a response. SL attended a really useful meeting yesterday of Midlands and East AOs and STP/ICS leads. A collaborative forum had been established for information sharing and learning and SL will propose clinical leadership development as a future discussion item.

SLT 19/58 Planned Care Work Stream – presentation (Paper C)

Ket Chudasama, Director of Performance & Corporate Affairs, West Leicestershire CCG, Helen Mather, Programme Manager, Planned Care, Leicester City CCG and Jane Edyvean, General Manager for Clinical Services Directorate attended for this item to present on the Planned Care Work Stream. Key achievements were reported as;

Referral Support Services (RSS) mobilisation had been done with UHL and primary care GPs. Dermatology, ENT and MSK had gone live with the aim to divert 20%-30% of referrals from acute and out of county into primary care and community care settings. Patients, trusts and referring GPs had given positive feedback. Over the first few months the RSS had received over 1000 dermatology referrals; 38% to acute, 33% to community, 33% to primary care and 12% returned to GP with advice that acute intervention was not needed and advice given on management. The numbers were also similarly reflective in MSK and ENT.

RSS were hearing from a number of specialties now wanting to be in the next wave. More challenged

specialities will be selected for wave 2. General surgery and ophthalmology will go next and be live by summer. A confirm and challenge session with UHL was useful to engage with clinicians and speciality managers and ensure all were sighted, had input and were on board. That led to transacting about £5.7m from the UHL contract. An undertaking to share business intelligence in a timely way would ensure an evidence based approach.

A second area of priority was reducing follow up face to face appointments by one third over 5 years. This would be a change in mind set for both established clinical behaviours and changing patient expectations for those used to seeing their consultant every 6 months for their condition. More could be done in a community setting, in primary care and increasing the digital offer. A cohort of patients would still require acute out-patient follow up. The changes would inform the estate size.

In terms of diagnostics, MRI guidelines and pathways had been refreshed to ensure correct use. MRI had seen a 10% year on year increase. The number of tests repeated was not best for patients or resources. A system offer needed to be defined for MRI in terms of planned, emergency and ambulatory and a look at what could be done in PCNs in terms of diagnostics.

Work was being undertaken on outpatients and theatres to address fundamental problems, ensure good core internal processes, understand capacity and know the offer in the system and the consistency of that. Also a consistent standard for clinicians to deliver care. UHL recognises the traditional outpatient model was no longer fit for purpose and required a radical rethink. The size of the estate would be based on patients who really needed to be at UHL and everything else could be done outside of that estate. The delay in the capital programme had allowed for some further work on capacity modelling for the treatment centre to be done. In order to understand capacity a two-way text reminder had been introduced to ensure all clinical slots available were utilised and this had resulted in a reduction of DNAs. Around 800 more patients had been seen and rooms were being used better. This approach would be tried with the Alliance to afford greatest capacity for patients being treated locally. The outpatient optimisation programme in collaboration with planned care partners was putting in place advice and guidance and initially would focus on the ERS clinics. It would be seen what more could be done before moving into the RSS. Consultant job plans were looking to be aligned to maximise capacity and intelligently use what was already there rather than doing more. ERS for outpatients would seek to increase electronic request of tests thereby reducing paper and increasing traceability. Interoperability across the three sites and the Alliance would be required to deliver this. Patient letters would be simplified and electronically communicated in 7 days.

Theatre productivity would be increased by introduction of a two-way text reminder. There was early planning for networking across the East Midlands and the theatre benchmarking project so UHL can learn from best practice.

A further benefit of ERS would be to take costs out by reducing agency staff usage. Waiting lists would be reduced and patients repatriated from the independent sector. The move from transactional to transformation would be difficult with PBR.

A lot of work had been done on reducing health inequalities through looking at pathways and policies. 230 pathways for planned care were now on PRISM. Data was improving but could be better still. The elective transformation plan had been recognised nationally as an exemplar.

A lot of activity was being introduced into primary care and SystmOne community services unit would be in place by the end of July. It was helpful that LPT was also using SystmOne. Interoperability was key. A lot of work had been done with therapy teams.

PM asked to understand what SLT could do to help before moving into Q&As.

KE cited money and the current contract form as a key risk. A useful workshop had been held during the week with partners on the future of the Alliance as a provider of elective care. The idea that came out of the workshop was to have a single pot of money and a workforce with a defined notion of having an LLR passport so that clinicians and managers could move across sectors, to deliver the level of change required. PAF was pleased with the progress made. He felt it was important that providers in future had a network to discuss these things. PAF did not think primary care had a reliant and consistent offer and required skills, a suitable environment/estate and capacity and commitment to get there. PCNs would offer an ideal opportunity and plans should be put in place now to get primary care engaged. ML felt this was an exciting programme for LLR and was pleased to see the progress. He suggested PCNs having an additional arm for outpatients and gave the example of Birmingham where primary care had in place core and extended GP work and an outpatient arm through which most dermatology work was provided by GPs. ML felt the digital plan to send electronic letters in 7 days was not ambitious enough. PAF felt this provided huge scope for ambition but the system needed to be resourced to do this, particularly when moving activity out to primary care. AF felt it was difficult to achieve 14 day letters and there needed to be some realism about what was practical. SL commented on the potential but felt already there was better working together. SL asked what the patient view of RSS was and their expectation of seeing a consultant. HM responded there hadn't been any negative feedback yet, that patients had been involved in a steering group from the beginning and practices were quick to advise if there was a problem. HM said the patient letter content was important so that expectations were not raised and that patients were then communicated with again following a contact to keep them informed. HM recognised there was still more to do and the patient partners were key to driving that forward. MW said himself and Ms Prema had been considering resource and capacity and at present there was not enough resource and what was there was not being used in the best way. He did not feel the work streams as they were currently constructed made sense, such as the separation of emergency admissions and LTC and it would be worthwhile reviewing to see if more bandwidth could be put into the programmes. FS referred to the first risk on the slide regarding stakeholder and organisational incentives not being aligned to delivery objectives and asked if there were any specifics this group needed to discuss. PM commented that the system, when developing the ICS, needed to consider and facilitate resource so as not to leave individual organisations with individual risks. MH felt there were lots of good things but things happening separately in the local authorities and it needed to be seen where these could and should be replicated as a system. SF advised a post had been funded by Leicester City Council to comprehensively map information and advice for service users to access and he undertook to share that with County and Rutland colleagues. It was RESOLVED - To receive the presentation.	**SF**
SLT 19/59 Cancer Work Stream – presentation (Paper D)	
Paul Gibara, Chief Commissioning and Performance Officer, East Leicestershire and Rutland CCG, Sam Leak, Director of Operational Improvement, University Hospitals of Leicester NHS Trust, Hannah Hutchinson, Head of Strategy and Implementation and Cancer Commissioning Lead, Leicester City CCG and Mrs Helen Brooks, Clinical Lead Cancer Centre, University Hospitals of Leicester NHS Trust	

attended for this item to present on the Cancer Work Stream.

PG spoke about the Cancer Board being relatively new and the work undertaken to put some structure around it, to develop a programme management approach, linking performance, investment and outcomes together, to interact with the health economy, to link to the East Midlands Cancer Alliance and seek external validation on its governance structures to ensure it was fit for purpose.

HB reported on the two pathways that had undergone clinician supported change; national optimal lung cancer pathway had seen improvement in the 62 day wait since January and from March to May had both improved and sustained. Patients were receiving faster diagnosis and coming back for appointments less often. The prostate pathway had been changed to ensure sustainability and robustness in the process and pre-MRI had reduced the pathway by 10 days. Those with cancer have seen improved quality and have a health needs assessment and plan and can access a Macmillan course which had been rolled out from UHL into the community.

HH spoke of FIT that had been introduced as part of the bowel cancer pathway to offer a test at home, for suitable patients, instead of a 2ww referral. That had resulted in 70% of tests being negative and saving a number of 2ww referrals. For the first time cervical screening recording for ages 29-45 had dropped to under 60%. The #dontfearthesmear campaign had seen a positive impact in more women booking into their practice or attending a UHL drop in session for smear tests. Events and social media had been used to target and raise awareness in postcode areas LE1-LE5.

The LLR Cancer Strategy included four pillars with an SRO for each; Prevention, Earlier Diagnosis, Access to Treatment of Excellence, Personalised Care Agenda with robust governance in place. The Strategy would be signed off and go to boards in July.

HH spoke about the engagement with patients and communities across all of LLR based on the activities for the four pillars. For the personalised care agenda pillar a survey was out to seek views on what people would want to see from cancer services, if they or a family member had need of that. Over 20 Let's Talk About Cancer events had taken place to provide a face to face opportunity to gather patient views.

PG commented on the fragility nationally of the workforce, particularly in specialised commissioning areas, and a regional view was being taken to see how head and neck could be supported. The Cancer Alliance had set up a workforce development committee.

PG highlighted key risks and issues as having a support framework in place to deliver things at pace and clinicians having time to undertake the increasing amount of work. Some of the Cancer Alliance funding could be utilised for that. The cancer standards were challenging and the 62 day target was not being met due to a significant increase in 2ww. The one year cancer survival was progressively improving and was now at 74%. Patient satisfaction was good. The referral to diagnostics performance was broadly there. PG advised the cancer standards were likely to change following national clinical review.

SLe reported on 2ww demand seeing a 15.9% increase and conversion rate increase by 24.4%. This varied across the different tumour sites. Lung cancer diagnosis was at a 40% conversion which was positive in terms of earlier presentation and treatment but posed a capacity issue. 2ww was achieved for April with the exception of breast with all three patients choosing to have treatment after the 14 days.

SL commented the month end position was good news however the real good news story would come when patients went through the system in a timely way and late presentations to ED were no longer seen. SL recognised this was complicated with the commissioning of screening programmes through

NHSE and specialised commissioning having responsibility for oncology and she had mentioned to Roz Lindridge, Director for Specialised Commissioning about the need to link more consistently with the CCG on planning and resources. PG said that was a helpful observation.

ML said the FIT test was excellent and as a GP he regularly used it in line with the guidance. He felt plans for earlier diagnosis could be stronger and more was needed than fast track. Referral was easy if a patient presented with a lump or bleeding but people with vague symptoms tended to end up in ED with Stage 4. PG responded that LLR would bid for a multidisciplinary diagnostic centre (MDC) and early PCN discussion on how an MDC could work for LLR was needed in terms of front loading to support the impact on primary care, knowing what to do with patient test results and how to link into expertise. MDCs were presently based on the London model. PAF agreed that correctly supporting patients with a vague diagnosis was important because often these patients were not identified. The City PLT had a long discussion about 2ww and it was felt primary care was not engaged enough. PAF gave an example of the lung cancer pathway and there being a good mechanism if a patient had an abnormal scan to get into the MDT but the GPs were told they still needed to make a 2ww referral and he queried why that was the case if the patient was already in the system. AF said the GPs had not been consulted on the changes to the gynaecology pathway and some GPs did not feel they had the skills to do the physical checks. PAF suggested a PCN forum across LLR to highlight such issues.

ER asked for more to be included on communications because he had not been aware of the cancer questionnaire and it had not been through the PPI group or added to the website. PG responded that the communications team had been charged to do that and whilst the slides had reported on activities undertaken, it was not yet a coherent approach.

FS noted the slides highlighted programme support and clinical time as areas of risk and asked if a request was being made to this group. SLe advised EMCA funding had been received last year and was due for the current year but had not yet been released. The funding had been aligned to the 4 pillars. More resource was needed to deliver at a faster pace. The funding was non recurrent and that impacted on how the posts were filled. Posts were seconded to and then backfilled. A project manager worked with a virtual team. SL asked if EMCA expected a report back on how funding had been spent in 2018/19 and she understood there had been some underspend. SLe responded the 2018/19 funding underspend had been aligned to this year's pathways and the 2019/20 funding had not been released yet.

PM summarised it had been good to hear about the progress and positive work, the involvement of the public and the provider alliances and the development of networks. He spoke of the need to resource the infrastructure to support large quality improvements. PM encouraged the Cancer work stream to identify the resource it needed and to work with the LLR systems and processes to understand how that could be put in place.

It was RESOLVED

- To receive the presentation.

SLT 19/60 Prevention and Inequalities Work Stream – presentation (Paper E)

Mike Sandys, Director of Public Health, Leicestershire County Council and Ivan Browne, Director of Public Health, Leicester City Council attended for this item to present on the Prevention and Inequalities Work Stream.

Public Health recognised lifestyle services and wider determinants of health as being the 'day job' and the workstream focus was on what prevention activities the NHS needed to upscale. MECC Plus and the Long Term Plan health prevention activities had been identified as priorities. UHL and LPT were being supported through the development of a MECC toolkit to help embed alcohol and smoking

advice. A consistent pathway was in place in primary care for healthy hearts/atrial fibrillation and looking at the number of deaths saved by CVD through consistent prescribing. The local authorities had increased the profile of healthy workforce development and had in place a healthy workplace toolkit. The Prevention board was being refocused to provide some system leadership for social prescribing and resourcing link networks. MS recognised PCNs had sovereignty but did not want to miss the opportunity for posts such as social prescribing to provide real value and consistency of offer. The work done by Mark Pierce on risk stratification and identifying cohorts with 5 to 7 conditions had been very useful but there was a conversation about whether that constituted care or prevention and maybe the prevention focus needed to shift to patients with 2 to 3 conditions. The prevention board had looked at smoking cessation services and there needing to be one approach for both community and acute inpatient activity. The Integrated Care Board had asked this work stream to lead on self-care management, for example the diabetes education programmes like DESMOND or assisted technologies used in adult social care. The Joint Health and Wellbeing strategies would be refreshed.

ER commented on the voluntary sector being a key partner in the prevention agenda and he had not seen that come out of the presentation. MS recognised social prescribing would need to utilise the assets in the community and build capacity in that sector.

ML felt it was difficult for primary care to access information and programmes for patients around smoking cessation, alcohol and other healthy lifestyles. VR felt that was an interesting point because there were services available across different geographies and MECC plus would pull that together.

SB commented there would need to be major investment in predictive analytic systems to capture every contact for MECC. SL advised the current risk stratification tool drilled down to very specific levels. SB asked if that included information to advise had a contact been made some months before whether 'x' could have been avoided. SL responded that the tool stated the predicted impact for each intervention.

It was RESOLVED

- To receive the presentation.

SLT 19/61 LLR Making Every Contact Count (MECC) Plus Project update (Paper F)

Vivienne Robbins, Consultant in Public Health, Leicestershire County Council attended to seek guidance and commitment from the SLT on the scale, pace and level of ambition for the MECC Plus project, due to the resource needed for staff to embed the approach.

MECC is a behaviour change approach to embed prevention as a core activity for all professionals for both clinical and non-clinical interventions. PCNs will have a specific role in the link workers actively signposting patients. It was being proposed to increase the scope and ambition and pace of the project to widen out to more partners and increase the 'plus' element to offer signposting on life style, smoking and alcohol cessation and housing and debt advice. Some elements would be system based and some place based however the important factor was to message in a consistent way at population level to have the greater impact and staff would be supported to have those conversations. Prevention offers would need to be different across the places. The local authority would be prepared to resource the on-line and face to face element of training. If MECC was up-scaled then demand on prevention services would increase which whilst positive would require capacity in the system to meet that demand. Some of the pathways are cumbersome and may need some technological solutions.

The LA had identified some funding for the core element of the train the trainer approach and then each organisation would take that back to disseminate. The online training could be part of new starter or appraisal processes. CQUINs were already in place to incentivise UHL and LPT. The progress would be reviewed across the system on an annual basis, led through the LLR prevention

board.

SL supported the principle of MECC plus and wanted to understand the expected number of people to be trained and expected number of contacts to be made. VR said that was dependent on the size and scale being supported. The online package could be opened up to anyone. A half a day per week had been allocated in public health for the MECC training and more could be commissioned if that was needed. IB said Leicester City LA had put in dedicated resource to the public health team to answer the question on investment, scale and capacity. He gave an example of the housing and neighbourhoods team considering what they felt they could do on top of the day job.

UM felt this was a hearts and minds campaign and in terms of the 'mind' was the training sufficient and to engage an entire population people needed to understand the wider determinants of health. UM questioned whether MECC should be wider still and include police, fire, teachers etc.

MW asked how this would link to population risk management stratification, for example how would it connect to smoking or alcohol or result in a contact intervention to prevent people increasing in number of co-morbidities. IB said MECC would impact at the bottom part of the triangle before patients had any or a number of morbidities.

VR advised the County LA would include a chapter in the JSNA on multi-morbidities to determine which cohort of people needed to be care coordinated through a case management approach.

AF commented that MECC was a huge change programme for staff and public and asked whether the output and difference was understood and where was the effector behind that so that each time a MECC conversation took place in a clinic, it was a simple process to do the right thing. AF said that would require more than e-learning to achieve. UHL was spending £1.5m on a change programme in UHL and the MECC programme had identified £30k resource. Therefore if the resource was scare, there needed to be a focus on where the greatest difference could be affected. VR advised it was for each organisation to decide on their required approach and who was key to receiving the training. For UHL it was about getting staff to direct patients to services in the community. The referrals can be tracked and the outcomes understood, if the clinician was minded to know.

AF felt the required approach was to look at best practice and scale that up as a consistent offer across LLR. As a clinician AF said he would need a constant reminder of what he should be doing and receiving an affirmation of his actions.

CT noted there would be a national training programme for social prescribers and she was concerned that would not fit the local offer.

FS asked if there was sufficient capacity to cope with increased demand and whether some modelling had been undertaken. VR advised that was currently underway and was dependent on the size and scale being supported. FS said it was important to ensure that if the offer was scaled up there was sufficient follow up activity otherwise it would be difficult to get people on board a second time if there had been missed opportunities.

PM noted the support for this work and the conversations to be had in terms of how wide to take the approach and target those that use the greatest resource. In terms of MECC plus he sensed there was more work to be done. AF noted the huge behaviour change and training required for referrers and whether CQUIN would be a sufficient lever against the sophisticated implementation that would be required. PM wanted to be clear about the resource needed rather than working to the resource available to ensure it could be done sustainably across the system. SL suggested health and wellbeing board level discussions as a next step.

It was RESOLVED
- To note the aspirations of MECC plus.
- To note that further work would be undertaken on scale, reach and resource for the MECC plus model.

SLT 19/62 LLR End of Life Programme 2019/20 Briefing Paper (Paper G)

Professor Mayur Lakhani, Chair West Leicestershire CCG presented a briefing paper on the LLR End of Life Programme 2019/20 as at May 2019. A more recent update on actions was provided to the chair in advance of the meeting. ML reported the programme had good leadership and a task force met each month. The working group had focussed on quick wins and practical solutions that were quality focussed. A standardised care planning tool for ReSPECT led by Jon Jamieson at UHL was being developed and was due for roll out by January 2020. There was a focus on quality standards for end of life care, particularly in primary care.

ML spoke of two risks: engagement with the emergency services needed to develop. Engagement with DHU was very good and more work would be done with EMAS. The other risk was due to the lack of capacity in the CSU communications team. **SL undertook to take that back to Richard Morris and advise Rachna Vyas and Carole Ribbins there was a communications function in the PMO that could provide support.** UM praised the work the UHL communications team had recently done on 'dying matters'. UM asked if there could be some joint support from UHL who were good at running twitter campaigns. MW noted the UHL communications team had been asked to provide some support but was unable to do so until September due to workload.

MW said he had listened to an interview on Radio 4 regarding a local case of an older person who'd had numerous hospital admissions to different wards and providers, and discharges followed quickly by readmissions during which time no conversations about end of life had happened with the patient or their family. MW had heard from colleagues in the USA that certain states viewed patients who had longer LOS than necessary were classed as an SI. He suggested that if a patient with a SCR or advanced care record died within 24 hours of admission at UHL they could be flagged as an SI for a review and learning. ML commented that 40% of patients on an end of life register who were admitted to hospital had no medical need to be there and the majority of patients at end of life did not have an enhanced SCR in primary care. AF was concerned that an SI process could disengage staff.

SL was conscious of how many people employed in LLR also lived locally and had experience of where services were performing well. SL had recently spoken with a member of the public health team whose centenarian grandmother had been a resident in a city care home for 20 years and became unwell and was observed as being at end of life. EMAS and the care home were very risk averse and wanted to convey her to hospital and it was only when a close relative, who was a GP, telephoned that the conveyance was stopped. **SL suggested hearing that patient story.**

SB noted the STP plans were being refreshed and questioned whether the EOL profile within that was high enough to meet the system needs.

It was RESOLVED
- To receive the update on the EOL programme.
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SLT 19/63 LLR Joint Estates Forum Update (Paper H)

Donna Enoux, Chief Finance Officer, East Leicestershire and Rutland CCG provided an update from the LLR Joint Estates Forum which met on 9 May 2019. DE had now picked up the lead for estates. A holding update on the estates strategy would be made to NHSE/I on 18 July and delegation to CEOs for sign off on 10 July was requested.

ER noted previous versions of the NHS estates strategy had been received by SLT on the confidential

agenda and he asked how patients and the public were being engaged with. DE responded there had been no discussion yet about communications and engagement. ER asked whether this was being handled through the work stream or the strategy board. SL said there was limited resource and the current commitment was that a refresh would be possible with the level of resource available and a stocktake of what was needed.

It was RESOLVED

- To receive the update report from the LLR Joint Estates Forum (9 May) and additional information.
- To note the capacity issues highlighted in Section 7 above to complete the LLR Estates Strategy template.
- To approve that the SLT delegates responsibility for sign off of the LLR Estates Strategy template submission to the Chief Officer Forum on 10 July 2019.

SLT 19/64 Primary Care Strategy (Paper I)

Tim Sacks, Chief Operating Officer, East Leicestershire and Rutland CCG attended for this item to present the LLR Primary Care Strategy 2019/20 to 2023/24. The strategy had been put together within a short time frame of 5 weeks and TS described the resultant document as a plan for a plan that gave a high level view of key areas being worked on, ambitions for general practice, the role that primary care and PCNs would play over the years, the system support of urgent care, personalised care and an integrated health and social care system. Given the timeframe public engagement had not been possible but the working group had comprised health and local authority partners. The LLR Primary Care Strategy 2019/20 to 2023/24 would be submitted to NHSE/I today. Engagement with practices, stakeholders and patients would then follow. TS advised NHSE/I required a specific format and a version would now be created that was more public facing.

MW commented this was a good document. He referred to page 31 where it stated that LLR had been an urgent and emergency care vanguard since 2015 and noted the seamless care for patients entering the urgent care system. MW felt this was overstated given the conversation today about a patient who had been moved to a number of settings at end of life. TS duly noted the comment and would amend.

ER appreciated the position on engagement issues and the changes in primary care, particularly about PCNs. He said that Richard Morris had recently given the PPI group some assurances but those messages needed to go out more widely to give reassurance.

JS asked what NHSE were expected to do with the document. TS considered whether it was intended to provide some focus on specific areas of delivery, such as PCN workforce requirements. FS offered to follow up to understand the process and find out when the strategy would be in the public domain. FS agreed the timeframe had been difficult and expected that NHSE/I would now work with the CCG to see what more was needed. TS advised feedback would be received by next Tuesday with a further submission date of the Thursday that week. FS said NHSE/I were trying to move to a relationship of less assurance and providing more practical support on areas to progress and what would be needed to achieve that.

SL commented this was not the only strategy that CCGs had been asked to provide at short notice. Non-elective, planned care, urgent care were all in the long term plan and an absolute focus of Simon Stevens.

ML commented on the unwarranted variation there was across 138 practices in LLR and the need to address that to ensure primary care, as a point of first care, was of high and consistent quality. ML asked for the strategy to include a reference to the Transferring Care Safely Group about transfers of care and integration and how that would be further embedded in PCNs.

UM said the team had delivered excellent work over 5 weeks but the product had not created a vision for 5 years as there had not been time to talk to partners and be visionary and so UM noted it as a starting point but as chair of the Primary Care Board she wanted to grow an amazing vision to underpin and boost LLR. TS said the last paragraph on page 6 stated the strategy set out a direction and framework on which to build.

SL noted page 43 stated one of the roles of the primary care board as being to align and form a joint commissioning and contracting function for primary care service design and delivery and said that needed to be agreed as part of the structure and governance. TS responded it was part of the aspiration for how across LLR business was transacted and the primary care board was clear about the sovereignty of each CCG. SL said it was important to manage conflicts of interest in commissioning and PCNs would become providers in their own right which might be through provider networks. Where the contracting function sits will need to be decided.

SB asked what role GP federations would have. TS responded that federations had been mentioned in relation to PCNs as they may have a role as umbrella organisations to some PCNs but it would wait to be seen how the provider function developed.

The SLT welcomed the opportunity to receive and discuss the strategy and noted it would now go to the CCB for sign off.

It was RESOLVED

- To comment on and provide approval for the Leicester, Leicestershire and Rutland 2019/20-2023/24 Primary Care Strategy prior to its submission to NHSE on 20 June 2019.

SLT19/65 Integrated Care System Maturity Matrix and Action Plan (Paper J)

Mark Wightman, Director of Strategy and Communications, University Hospitals of Leicester NHS Trust presented the latest version of the ICS maturity matrix and action plan. The NHS long term plan required the STP to mature into an ICS by April 2021. Following the SLT workshops himself and Sarah Prema had rated the STP against the characteristics of an ICS and felt LLR was somewhere between emerging and developing with some way to go before becoming a maturing ICS. The document had been tested with SL and JA as joint leads and today presented an opportunity to comment on the content and any additions to be made.

JS said a fundamental question was what was meant by 'system'. He referred to action 1, where the system included health and social care but actions 10, 11 and 15 were health care system specific. SL said that was a fair challenge and the remit for each needed to be defined. PAF said there may need to be a two-stage approach with health initially before local authority joined into the wider system work. AF noted the various risks for work streams and asked whether there was confidence that high-level statements would address issues and support progress. SL said it was envisaged that the identified leads would produce a more detailed implementation plan for each area, highlighting the key challenges.

FS noted action 15 to transition oversight from the regulators to the LLR ICS had a commencement date of December 2019. FS advised NHSE/I wanted to do that more quickly and whilst full delegation would not be achieved by December, they wanted to start to change the way they interacted with providers and commissioners in the next few months. The STP had an agreed set of behaviours and MOU in place to support the work. FS said the process for STPs to put themselves forward for shadow ICS status had not received much interest and therefore the national readiness for the April 2021 deadline was being questioned. STPs would be asked to do a diagnostic self-assessment and NHSE/I would then determine the support needed. SL said that would be very welcome and she'd had an early discussion when Roz Lindridge, who had attended SLT, about the commissioning

capability programme informing the ICS preparation.

JS had attended the local government conference and heard from speakers (Kings Fund and Dominic Hardy, Director of Primary Care Delivery at NHSE/I) that no one was able to define what an ICS was. He felt ICS had merit but needed to be local and needed some clear governance about engaging with local authorities. JS said there was more progress to be made on the integration of some of the things discussed at the away day rather than becoming too stuck on the governance. SL felt there was merit in doing both and she felt there were some excellent things in place and more in the pipeline but an eye needed to be kept on governance. PM agreed there were some excellent examples of collective working.

CT said the OD plan needed to be up front and centre, the clinical leadership strategy needed focus and a QI approach to system change to ensure clinicians were resourced to deliver the change. CT noted that the high level actions were mostly attributed to CCG leads.

JS commented that he expected an outcome of the last SLT development session would be to have had some recommendations put forward. JS said given previous experience of the NHS presenting to the elected members on system changes, he suggested they firstly receive a paper defining ICS and the resourcing before an invitation was made. SL said there had been an invitation of the potential members likely to join the partnership group and ICS and what role that partnership group might play and the chairing arrangements. SL said the feedback of how members felt was very important. SL agreed that something would be provided in writing. JS said he had been feeding back to cabinet on ICS so it was a wider audience than health and social care. SB commented that the ICS work felt very health driven and it was important to have all partners at the table for the development work.

PM summarised that good quality background information would be needed ensure everyone was briefed.

It was RESOLVED
- To approve the ICS Maturity Matrix and the Action Plan
- To approve the principles outlined in paragraph 8.

SLT19/66 Updated SLT Portfolios (Paper K)

Sue Lock, Managing Director LCCCG presented updates to the SLT portfolios, in light of PM's retirement the CEOs had worked through leads for each area. The leads would change again when Andy Williams took up post as LLR CCG AO and Angela Hillary commenced as LPT CEO. **SL undertook to add the Prevention work stream with Steven Forbes as lead.** ML noted some leads were executive and some were clinical chairs. SL clarified it listed the SLT link not the chair of each work stream/area.

It was RESOLVED
- To note the SLT lead portfolios

SLT 19/67 Update from STP Meetings

SL noted there had been a number of Midlands leadership events and the next ICS event would take place on 18 July.

SLT/19/68 IM&T Update

The update was noted and attention brought to paragraph 1.11 whereby STPs had been asked to prepare to submit funding agreements and updated analysis value documents. **DE to ensure SLT were already sighted on this.**

SLT/19/69 Any Other Business

There were no other items of business.	
Date, time and venue of next meeting	
9am-12pm Thursday 18 July 2019, 4th Floor Conference Room, St John's House. Apologies were noted in advance from Donna Enoux, Ursula Montgomery and Sue Lock. Nominated representatives would attend on their behalf. Apologies for absence from Donna Enoux, John Sinnott, Azhar Farooqi and Mayur Lakhani were noted from the 22 August SLT meeting.	