System Leadership Team
Meeting No. 24
Chair: Peter Miller
Date: Thursday 21 February 2019
Time: 9.00 – 12:00
Venue: 8th Floor Conference Room, St Johns House, East Street, Leicester, LE1 6NB

Present:	
Peter Miller (PM)	LLR STP Chair, Chief Executive, Leicestershire Partnership Trust
Karen English (KE)	Managing Director, East Leicestershire and Rutland CCG
Azhar Farooqi (AFa)	Clinical Chair, Leicester City CCG
Mayur Lakhani (ML)	Chair, West Leicestershire CCG, GP, Sileby and Chair Clinical Leadership Group
Roz Lindridge (RL)	Locality Director Central Midlands, NHS England
Sue Lock (SL)	Interim LLR STP Lead, Managing Director, Leicester City CCG
Ursula Montgomery (UM)	Chair, East Leicestershire and Rutland CCG and GP
Evan Rees (ER)	Chair, BCT PPI Group
Caroline Trevithick (CT)	Interim Managing Director, West Leicestershire CCG
John Adler (JA)	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
John Sinnott (JS)	Chief Executive, Leicestershire County Council
In Attendance:	
Sarah Prema (SP)	Director of Strategy and Implementation, Leicester City CCG
Richard Morris (RM)	Director of Operations and Corporate Affairs, Leicester City CCG
Tim Sacks (TS)	Chief Operating Officer, Director of (items 19/12 and 19/13 only)
Ruth Lake (RLa)	Director, Adult Social Care and Safeguarding, Social Care and Education, Leicester City Council (items 19/12 and 19/13 only)
Tamsin Hooton (TH)	Director of Service Improvement/CSR (items 19/12 and 19/13 only)
Cheryl Davenport (CD)	Director of Health and Care Integration and SRO Business Intelligence Strategy (for item 19/20)
Jon Adamson (JAd)	Jon Adamson, STP Performance Analyst, MLCSU (for item 19/20)

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Clare Mair	Board Support Officer, Leicester City CCG (Minutes)
Apologies:	
Sue Elcock (SE)	Medical Director, Leicestershire Partnership Trust
Mark Andrews (MA)	Deputy Director for People, Rutland County Council
Ben Holdaway (BH)	Director of Operations, EMAS
Jon Wilson (JW)	Director of Adults and Communities, Leicestershire County Council
Paul Traynor (PT)	Director of Finance, University Hospitals of Leicester NHS Trust

SLT 21/01/02 Welcome and introductions	
Peter Miller, Chief Executive, Leicestershire Partnership Trust welcomed everyone to the meeting. Introductions were made.	
SLT 21/01/03 Apologies for Absence and Quorum	
Apologies were received from Mark Andrews, Ben Holdaway, Sue Elcock, Jon Wilson and Paul Traynor.	
SLT 21/01/04 Declarations of interest on Agenda Topics	
No declarations of interest were noted.	
SLT 21/01/05 Minutes of meeting held on 22 November 2018 (Paper A)	
The minutes of the meetings on 22 November 2018 were approved as a true and accurate record.	
SLT 21/01/06 Action notes of the meeting held on 22 November 2018 (Paper B)	
The action log was reviewed and it was noted all actions were green.	
SLT 21/01/07 LLR SLT Terms of Reference (Paper C)	
Sue Lock presented the revised terms of reference which had been amended to reflect the feedback from discussions at the last SLT meeting and email input outside of the meeting. SL noted the changes and reference had now been made in the ToR to the STP Partnership Group and SLT having sign off prior to any issues being taken to external clinical senates and before commencement of external or system-wide consultation. DHU had been included in future membership and subject to approval today would be invited going forward. A governance pack would be developed and the terms of reference would form part of that. CT asked whether there was merit in future proofing the terms of reference in readiness for primary care representation. SL responded that any reference at this point would need to be vague. Early guidance had stated PCN clinical leads would be on the partnership groups, assuming there was consensus about what was meant by partnership groups. The terms of reference would be reviewed once PCN arrangements were known. JS referred to paragraph 35 on the accountability of the SLT to the HWBs and he felt it would be more technically accurate to use the word 'reporting' to rather than being accountable to. SL undertook to amend that. MP noted the SLT chair role in paragraph 17 may be subject to change as the ICS took on	

different chair arrangements. SL was satisfied the terms of reference reflected the current arrangement and undertook to make the review period for the terms of reference more prominent.

JS asked why it had been decided that chairs of provider trusts would not be members of SLT but commissioning chairs would. JA responded that provider chairs did not have an executive role and he felt the UHL Chair would not feel it appropriate to a member of SLT. ML understood why some local authority chairs may challenge that decision but commissioning chairs were a hybrid role of executive leadership and clinical leadership.

JA noted the current shared leadership model and once a single AO/CEO was appointed there would need to be a further collective review about STP leadership and the associated chairing of this group. The last SLT meeting, at which Paul Traynor had been present, had discussed the STP role in relation to the single AO role. RM had discussed with NHSE the need to have clear water between the AO role and STP role, held by the same person, but if there was to be a change in ICS governance the two would need to be extricated.

It was RESOLVED

- To accept the revised terms of reference, subject to some minor amendments requested above.

SLT 21/01/08 Partnership Terms of Reference (Paper D)

Peter Miller presented the LLR STP Partnership Group terms of reference, who as a group would provide an oversight function in order that statutory organisations receive common and shared assurance on the development of the LLR STP. It was noted the reference to confidential items was to be removed. An independent chair would be appointed on a yearly basis. The role of the independent chair and some high-level bullet points on the role had been added to the terms of reference. A job description and person specification would be developed. The chair role would include holding the system to account and behaviours.

JS asked how selecting one representative from the voluntary sector would be achieved given the many voluntary organisations and that they did not represent each other. JS also noted the difference between infrastructure providers and direct providers. ER suggested approaching the voluntary sector for a view on how someone could be mandated as a representative on behalf of the sector.

JA noted each LA would have a representative and then the HWBs were mentioned separately, however he thought the LA representatives would be the HWB chairs. JS said he too read the Terms of Reference as the LA having both an officer and elected member, however SF interpreted had it as one representative. It was agreed the positions would be taken up by the HWB chairs.

RL asked if Healthwatch would have a place on the partnership group. JA explained Healthwatch wanted to keep a distance from the structure and therefore had not been included. SL agreed nothing had changed in terms of Healthwatch's intention to keep a distance and undertake a scrutiny role. JA felt it would be courteous however to ask Healthwatch and he would take the opportunity to do that when meeting with them later today.

JS asked whether lessons learned from the BCT partnership group had been considered in drawing up these terms of reference as he felt the remits were similar. PM agreed wider group engagement had failed but the opportunity presented in how the group would be used to make the difference going forward.

PM would speak with the universities (DeMontfort, Leicester and Loughborough) to see whether this was the right forum for them.

It was RESOLVED

- To agree to the terms of reference, subject to the changes agreed today
- To devise the chair JD and PS.
- To invite applications for the partnership group chair role.

SLT 21/01/09 LLR Estates Forum Update (Paper E)

Karen English provided an update on the estates strategy. The LLR estates strategy had been submitted and NHSE/I indicated it was satisfactory and had asked for a number of actions to be followed through. There were specific actions for people who manage and own the estate such as being rigorous about potential disposals and maximising opportunity. LPT undertook a comprehensive disposal exercise 3-5 years ago and that was outside of this monitoring timeline. UHL also has a very comprehensive strategy. KE noted the percentage of estates underutilisation was quite high and not particularly limited to one place or one provider. The next step was to pull together a comprehensive primary care strategy and some additional money had been identified to start a 6 facet survey on the primary care estate. That would inform the amount of available estate for left shift work and the PCN footprints. KE would ensure the strategy was regularly refreshed as the system moved forward and that any associated costs were current.

ER commented that the question of estates disposal had been raised at a number of engagement events and asked that the issues being faced and intentions were articulated. PM said that would be subject to consultation when clear plans were available.

A further update would be received by SLT in July 2019.

It was RESOLVED

- To receive the update report from the LLR Joint Estates Forum (23 January 2019) and to note the actions agreed.

SLT 21/01/10 Developing our Long Term Plan (Paper F)

Sarah Prema explained she had undertaken this work in response to a request for every ICS area to refresh their 5 year plan. The plan included development of this system's ICS model and a move to block arrangements with system controls. The governance for ICS would need to be refreshed and the programmes reviewed against the plans for the next 5 years. There would be a requirement to engage on the changes to the refreshed plan and make some adjustments before final submission in August. As this was quite a challenging date, SP had included an early timetable and asked for views, particularly around the engagement work.

ER was of the view that the timescales for engagement were too late by which time a lot of the plan would have been finalised and people would get a sense of that. PM agreed ideas could be engaged on earlier and the work streams would therefore be required to do that. The engagement could then be evidenced in the plan in terms of 'you told us and we did this'. KE felt it would be useful to make reference in the CSR to that linking into the long term plan and that would help people understand that this work was 'business as usual'.

MP noted the focus on prevention and digital but saw little reference to exercise and lifestyle. Digital, AI and innovation would be key drivers for medicine and the local plan did not yet reflect the ambition in the national plan. MP appreciated the IM&T group work around local systems and sharing records but felt a further digital stream was needed. PM gave assurance that this had been considered and a digital sub group would be established to respond to the long term plan

requirements. SL commented that work streams needed to understand the greater potential they could have with the right IM&T systems and support.

JS commented the long term plan felt like a plan written by the NHS for the NHS and healthcare and whilst the local authority would want to participate in the ICS discussions, it was difficult to see how the LA could sign off a formal plan in Autumn. UM referenced the areas of work in the plan which were non-medical and supported vulnerable and hard to reach groups and that would be an area of integrated work with the local authorities. That link would be made clearer.

SP undertook to establish the inter-dependencies group.

It was RESOLVED

- To receive the plan and proposed timescales, noting the engagement work would be brought forward to inform the plan.

SLT 21/01/11 Draft 2019/20 System Operational Plan (Paper G)

Sarah Prema explained as part of the 2019/20 planning process, NHS organisations had been asked to produce individual organisation plans and also a system plan. The first draft of the system plan had been submitted on 19 February and SP apologised for the late distribution of the draft plan due to the tight timescales. The next iteration was due to be submitted on 4 April which would allow sufficient time for NHSE to feedback and make changes where needed. An alignment tool for finances and activity had been submitted in the previous week and NHSE would also provide comment on that. The financial position and efficiency would shift as contracts and budgets were finalised. Priorities for 2019/20 had been taken from individual operational plans and linked back to BCT plans to ensure they were congruent as a system.

JA remarked this was an impressive document given the short timeframe. JA added a note of caution regarding section 6 (system finance) as it alluded to an outcome of fixed income and expenditure and it might not be as straight forward as that. SP would update that section when a decision had been reached between providers and commissioners on the contracting terms.

JS referred to the key priority areas in section 4 and did not concur with the positive views on CAMHS service quality and responsiveness. However as this had been reflected as a key priority, any sub-optimum areas of service delivery would be addressed.

SP undertook to provide a final draft to the March SLT and if that was not achievable she would seek final agreement outside by the meeting for the 4 April submission. SP requested comments on the draft plan from anytime now.

It was RESOLVED

- To receive the draft operational system plan and note the need for further refinements to be made and agreed to prior to final submission on 4 April 2019.

SLT 21/01/12 Primary Care Networks - Next steps for LLR (Paper H)

Tim Sacks gave an overview on PCNs, the actions to be undertaken in the short term and the impact on the system.

- PCNs will comprise around 30k to 50k patients.
- PCNs will have a clinical accountable director (CAD) for which guidance is awaited on the role description.
- Contracts outside of core GP work will go through a PCN rather than practices and services delivered at PCN level.

- By 15th May PCNs must be mapped out and all practices signed up to a PCN contract. Pictorial maps will show where each PCN sits in LLR and each PCN will need their own bank account.
- In year 1 funding will be available to support practices to sign up and for some additional non-GP staff, such as social prescribing link workers, clinical pharmacists, physicians associates, first contact physios and first contact community responders. PCNs will only receive money to support posts when they have been filled and this is not a 100% contribution. There will be workforce challenges.
- There will be an 'impact fund' and PCNs can gain up to £5 per patient in 5 years for avoiding ED and making prescribing savings and that will be used to fund staff – not a cash benefit.
- EOL and care homes have a need for investment of time and resource and there needs to be a clear strategic direction for all of those in the PCNs.
- More information will come down over the next few weeks and a number of local and national events are taking place.

JS asked whether primary care welcomed this change. TS commented it felt like people were quite excited and this was probably the biggest fundamental change since GP services became part of the NHS. AF felt this was necessary for the system because primary care needed strengthening, more resources and could enact change at scale. MP welcomed the shift in resource and power.

TS advised a session for primary care was taking place in the afternoon to understand the governance. It was likely LLR would have 25 PCNs. The national contract would be very prescriptive and the challenge would be to manage that locally to deliver a shared direction of travel. It was recognised that PCNs would be bottom up organisations and needed support to grow and develop but at the same time ensure equity of provision by PCNs matched to patient need. A national programme would be on offer to develop leadership skills for PCNs whilst recognising the need for a local programme to bolster that. The CAD would have a place at the ICS.

JA asked if PCNs would replace federations. AF responded that federations were the blueprint for PCNs and in the city the federations could provide umbrella support for back office functions. Federations would remain but have a different role.

It was RESOLVED

- To note PCNs in the context of the LLR ICS development and the national drive for PCNs to be the Neighbourhood/HNN structures.

SLT 21/01/13 Integrated Community Services Programme Stocktake And Community Services Redesign Update (Paper I)

Tamsin Hooton updated on the work of the CSR work stream. The ICB was established with a broad remit of out-of-hospital services and the stocktake captured the work undertaken on care homes, long term conditions, end of life etc. The work was being delivered on the basis of place based structures. TS would lead the primary care board which would absorb a lot of this work. TS and TH would align and work together. A range of community services would be wrapped around the PCNs. The CSR, once implemented, would be an enabler of that.

The CSR set out a high level model and would review three main blocks of care; community nursing teams configured on PCN level, home first for crisis response and reablement and rehabilitation. The review would identify the level of need for pathway 3 beds for reablement commissioned from care homes and the number of community beds required. The transformation programme would take 2-3 yeas to deliver, enabling neighbourhood nursing teams to respond to

same day need, access to therapy reablement and step up/down of support after acute discharge.

The work reports into the Integrated Community Board and commissioning decisions are taken at CCB. There is an implementation group below the Integrated Community Board. Place based governance is recognised and any proposed changes affecting social care teams would be routed through the LAs.

AF had a slight concern that implementation was planned for October and he asked if testing could be done before the winter period to safeguard in case of unintended consequences. TH assured testing was already happening, particularly with home first in the County and it was hoped the locality decision unit would have been established prior to that. TH said the city already had a well-integrated model for care within the first 72 hours of step up/down. A formal management of change process would be required for affected LPT staff.

AF asked how nursing team alignment to PCN footprints would be achieved. TH responded that some locality team configurations were already coterminous with PCNs. Other PCNs would share across to give resilience to same day responses. Further work would be done on identifying a base for the nursing teams and if the provider needed to change their work base. SP noted that district nurses were already aligned to practices but the management of that was at a much higher level. TH commented there might be higher level managers covering 3 to 4 PCNs. PM noted it would be challenging to achieve genuinely integrated locality services across health and social care but if it could be delivered, it would be of great benefit.

MP noted PCNs would be a key driver and whilst there was reference to PCNs employing therapists and pharmacists there was little steer on how they would link with community care. MP commented that functional integration had not worked in the past and the new models of procurement going forward would need to be more defined and include shared employment and shared access to records.

SL asked that further consideration be given to the decision making route as the city did not have integration executives.

UM asked how this work would feed into the estates strategy. TH said the CSR would consider estates requirements for primary care, community hospitals and community nursing team bases. Co-location was very important to delivering the community services redesign along with identifying and delivering on IM&T requirements.

It was RESOLVED

- To note the update on the work of the Integrated Community programme and Community Services Redesign
- To note that the remit of the ICB is under review in the light of the NHS Long Term Plan and the workstream arrangements for developing Primary Care Networks
- To approve the proposed future responsibilities of the Integrated Community Board and the Primary Care Board as described in sections 12 and 13
- To note progress on the Community Services Redesign work and next steps
- To approve the governance arrangements of the Community Services Redesign described in this paper

SLT 21/01/14 BCT Communications and Engagement (Paper J)

John Adler and Richard Morris presented a summary of the activities undertaken in 2018/19 to engage with communities in LLR. JA thanked Sue Venables and Richard Morris for their work on communications and engagement and Evan Rees for his engagement support.

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RM gave the key headlines; BCT communications and engagement over the past 12 months had been better but there was more to be done. As well as a summary of activities undertaken there was also a forward look to the focus on work for 2019/20 of which some areas would require significant engagement and formal engagement requirements such as CSR. It was planned to increase the volume of communications to ensure BCT and SLT messages were resonating more widely with the public. Patients, public and stakeholders were not always recognising the communication work if it was not badged as BCT, including elected members. It was therefore clear that different approaches to engagement and consultation were needed across the CCGs and other NHS partners in LLR. RM, Evan and Sue Venables intended to update the current PPI structures and would form a PPI assurance group, with a mandate from the SLT, to ensure consultation and engagement was appropriate and met legislation. A citizens' panel would be formed to build on existing arrangements.

CT felt it would be good to see some visibility around the engagement plans. JS asked what was envisaged in the short term about communicating with the public and elected members. RM recognised the stakeholder bulletins had been sporadic towards the end of the year and going forward there would be a commitment to getting these out on a monthly basis, coinciding with this meeting, to report on what was happening across the system. The communications functions of each organisation were being relied on to disseminate this information down and RM was not clear whether elected members were not recalling seeing the bulletins or whether they had not been received. RM was asking for assurance on how these were being cascaded down.

RM advised nine public engagement events had taken place for CSR or BCT and attendance had been good. JA felt it would be worthwhile mapping who the key stakeholders are and stating how those different constituencies would be kept up to date because some information would be different and some would be common.

UM welcomed the citizens' panel, especially the remit to reach into schools and colleges.

Appendix A listed the identified engagement and consultation for LLR in 2019/20. RM said there was potential to simplify and bring elements of engagement and consultation together and bring the long term plan into that narrative where possible. ER commented that the structure of the PPI group was irrelevant and the key point was holding the work streams to account and ensuring opportunities for co-design were built in early on. ER said the question should not be did you involve, but when did you involve. JA asked whether a template was needed to ask those questions of the work streams. RM responded that SROs were being offered training and development to ensure they understood the engagement requirements and legalities of consultation. RM said SROs were both held to account to deliver transformation programmes with a financial saving and to also meet the statutory requirements of engagement and consultation and taking those views into account for service redesign. RM said the CEOs needed to recognise those opposing requirements and to reiterate the message about early consultation.

It was RESOLVED

- To agree the direction of travel in creating an integrated and consistent approach to communications, engagement and where necessary consultation.
- To agree to the work programme

SLT 21/01/15 Integrated working – Feedback from LLR STP Development Session & Maturity Matrix (Paper K)

Peter Miller fed back on the outputs from the SLT development sessions in September 2018 and

January 2019 at which work had taken place to populate the maturity matrix and identify required actions to progress to an ICS. PM had also produced a document setting out the purpose, principles, behaviours and values for BCT that would form part of the governance pack. The independent chair role would hold the system to account. AF welcomed the useful summary.

KE advised the CCGs had been asked to undertake a Commissioning Capability Programme for a period of 12 weeks and would then come back to the system and report on what the CCG's had learnt and whether the maturity would shift to the right.

SL was of the view that the workshops had been really useful and thanked PM for the work to identify next steps. SL felt it would be useful to go through what was every day work, what was best done through collective ownership and use a workshop style, where needed, to work through some of these elements.

JA noted the system had marked itself quite low on the maturity matrix because it did not have some of the building blocks in place, however he believed it would not be too difficult to address that and there was a danger of under-playing the current situation and the resultant impact on the image of the system. JA encouraged the view of maturity to be moved to the right sooner rather than later, provided that could be substantiated. JS was in agreement with JA's view but questioned how that would be achieved and whether that came back to the issue of programme support. PM and SP would continue to lead on this piece of work.

SP advised early discussions would be needed on the ICS development to frame and develop the new five year plan for the Autumn. SF reminded members that there were local elections in May 2019.

PM undertook to circulate a revised proposal. Tim Whitworth and Bernie Brooks from the Leadership Centre were waiting to put dates into their diaries. It was agreed SLT would continue to use the support of the Leadership Centre.

It was RESOLVED

- To receive the summary of outputs from the LLR STP development session in January 2019 and the ICS maturity matrix.

SLT 21/01/16 Outline OD and leadership support 2019 (Paper L)

Peter Miller advised resources for developing OD were available, subject to a successful bid. PM proposed every third SLT could be used for a collective OD session rather than a business meeting and the leadership centre would provide support. The next OD session could bring a broader set of leaders and elected members together to develop that shared purpose. JA supported the mixed economy approach but felt the content needed some more work and there was repetition of work already done. JA felt there was the opportunity to make more progress and sign off some of the maturity matrix. JS felt a larger session in May would be too soon to organise the materials and get invites out and suggested a further SLT session prior to that.

It was RESOLVED

- To receive an outline timetable for SLT OD sessions in 2019/20, to be supported by the Leadership Centre.

SLT 21/01/17 SLT Programme Arrangements (Paper M)

Sarah Prema advised a desk top review had taken place on the back of conversations at the January SLT development session regarding local priorities and in response to the publication of the Long Term Plan. SP advised the work stream arrangements and LT plan mapped across

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well. SP had not marked the area of health inequalities as green because that was not yet implicit in the prevention work stream or other work streams, which all had a duty to reduce health inequalities. SP felt personally the current work streams were still valid in light of the LT plan but there was merit in discussion around these and some adjustments would be needed. ICS was being developed as a leadership group and the CCP work was being undertaken as part of the CCG reorganisation. The proposed changes made by Tasmin and Tim to their work streams (CSR and PC) needed to be reflected. SP proposed to ask the Health Prevention Board to help develop the work on health inequalities. As the ICS developed, more conversations would be needed about contracting methodology.

SP proposed to keep the work streams fairly unchanged and request that SROs revise their Terms of Reference and bring those back to SLT. In response to the proposal;

- AF commented the GB GPs could become more involved in the work streams because PCNs would be clinically led.
- Estates work steam to be added as an enabling work stream.
- JA fed back that the frailty the task force had made good progress recently and SLT would receive a report in March. The remaining actions were mainstream and needed to go into the relevant work streams. Therefore JA proposed winding up the frailty task force.
- JA questioned the logic of end of life being part of the community services work stream. It was agreed to have a time limited end of life task force, to be chaired by Mayur Lakhani and an executive lead to be identified.

SP would re-establish the interdependencies group to ensure there was integration between the work streams.

It was RESOLVED

- To approve the programme arrangements set out in paragraph 5 and the changes outlined in paragraph 3.

SLT21/01/18 Learning Disabilities and/or Autism (Transforming Care) Workstream Proposal

Steven Forbes, Leicester City Council reported work had been underway during the past 18 months on the transforming care programme and to move the local system out of recovery. The system remained away from trajectory and it would be a challenge to achieve by Q4 the required reduction in inpatient beds for both adults and children. The step down from specialised commissioning was particularly challenging. The LA identified that focussing on only the programme elements would not be sufficient to keep those in crisis in the community, therefore a new governance and accountability structure had been developed at LLR level. The system would not achieve drafting a single LD strategy because the County and City had taken two different routes on that but would retain an overarching direction of travel. A resource commitment to posts after 2019/20 was needed. It was not clear whether Ministry of Justice initiated placements would be counted in the system numbers.

RL suggested further conversations take place with specialised commissioning.

SP asked SLT members to note specialised commissioning would be setting up a local board and representation would be requested in due course.

It was RESOLVED

- To agree the need to expand the remit and focus of the Learning Disabilities and Autism Workstream, from Transforming Care to the proposed 5 – 6 priority areas.
- To approve development of an LLR Learning Disability and Autism Strategy across health

and social care system, and to receive a draft proposal in March 2019.
- To commit resource to develop the Strategy and Workstreams, for delivery from April 2019
- To confirm named leads for the 5 – 6 priority areas.
- To consider longer term commitment of resources for delivery of the Workstream.

SLT21/01/19 Update from STP Leads meeting

Sue Lock reported on key messages from the recent leadership forum;

- NHSE/I restructuring was discussed. Senior management level appointments had been made with Dale Bywater appointed as the Regional Director for Midlands and East.
- PHSE will become a member of the regional executive board.
- A health and social care green paper will be considered on 6 March.
- Consideration would be given to PCNs and governance and clinical director representation on the ICS partnership board.
- Cancer Alliance footprints are not currently in keeping with STP or ICS footprint and may be made smaller.
- Regarding ICS it was noted the maturity matrix was being updated (4 levels and 5 themes) and it was not clear when that would be released.
- Approval processes for ICS would be done in waves and would be conducted at regional level. There had been mention that organisations would have up to two years to become an ICS and concern was raised that ICS status was based on attainment rather than impending timescales.
- The importance of digital and IM&T to underpin the priorities of both clinical and medical work was discussed. Shared records were a first step in this process.

SLT21/01/20 LLR Dashboard and Tools for ICS and BCT (Paper O)

Cheryl Davenport and Jon Adamson provided a briefing paper on strategic direction and progress across three of the four IMT and BI priority areas (Analytics, tools and workforce, Population profiling and risk stratification, Data Integration and Warehousing).

SLT was sighted on how each dashboard was being developed, including over the next year a fully formed jigsaw of business intelligence. Nationally and locally a number of dashboards were available, but there were three main ones;

- STP care and outcomes tool - produced by NHS England on a quarterly basis and reports on five main themes.
- Integrated Operational Report (IOR) - produced by NHS England on a monthly basis. The national performance and health development dashboard was being rolled out for wave 1 ICS.
- BCT Outcomes Framework – developed by MLCSU pulls together a range of different metrics and an STP dashboard, using the Aristotle data tool. This has a high degree of functionality for finance and contracting and the addition of frailty and mental health had been discussed and ultimately the BCT outcomes framework could be hosted on that. These local developments have the benefit of reporting on local priorities in a more timely way than the national data can deliver.

The BI strategy is considering how LA data sets and metrics can be included. ACG data will be developed for locality teams and include public health and social care data where possible. A local data integration and warehousing tool will be required to enable and allow data to be in one place for health and social care; provider, commissioner and social care. It is intended to implement this in 2019. The IMT Board held in February recommended this approach to the Partnership. The warehousing was possible due to getting a data sharing agreement from NHS Digital.

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No one tool will be able to perform all of the purposes and there will be a requirement to have a combination of tools going forward. UM was encouraged by the progress with national tools and noted the new GP contract talked about having to get data from a national dashboard. MP asked for reassurance that Aristotle was the right tool as GPs were not using it. The BCT Outcomes Framework would continue to be used, through excel or Aristotle, recognising the work undertaken to identify local priorities. There would be an opportunity to review this as other dashboards were further developed. The ACG tool cannot be linked to the integrated warehousing tool because guidance prevents that. The cost of £103k to deliver integrated data across the partnership was noted and JMT would consider that request. It was RESOLVED - To note the stage of development of the national and local system tools that will form the foundation of Business Intelligence for health and social care across LLR as outlined in this report and provide any feedback or further direction needed. - To support the roll-out of the MLCSU-developed STP Dashboard in Aristotle for LLR. - To support the development of the Outline Business Case for the integrated data warehousing solution, as a key enabler to Better Care Together and the journey to becoming an ICS - To note that the SLT will receive this Outline Business Case for consideration and approval (via the IM&T Board) in Spring 2019.	
SLT21/01/21 IM&T Update	
The IM&T Update report was received for information.	
SLT 21/01/22 Notification of Any Other Business	
There was no other business raised.	
Date, time and venue of next meeting	
9am-12pm Thursday 21 March 2019, 8th Floor Conference Room, St John's House	

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