System Leadership Team
Meeting No. 33
Chair: Andy Williams
Date: Thursday 19 December 2019
Time: 9.00am – 12.00noon
Venue: Conference Room, 4th Floor, St Johns House, 30 East Street, Leicester LE1 6NB

Present:		
Andy Williams	(AW)	Accountable Officer (LLR CCGs) and LLR STP Lead
Stephen Bateman	(SB)	Chief Executive Officer, Derbyshire Health Care (DHU)
Stephen Forbes	(SF)	Strategic Director for Adult Social Care, Leicester City Council
Donna Briggs	(DB)	Deputy MD & CFO, East Leicestershire & Rutland CCG
Andrew Furlong	(AFu)	Medical Director, University Hospitals of Leicester NHS Trust (UHL)
Ben Holdaway	(BH)	Director of Operations, East Midlands Ambulance Service (EMAS)
Mayur Lakhani	(ML)	Clinical Chair, West Leicestershire CCG
Ursula Montgomery	(UM)	Clinical Chair, East Leicestershire & Rutland CCG
Richard Morris	(RM)	Director of Corporate Affairs, Leicester City CCG
Sarah Prema	(SP)	Director of Strategy & Implementation, Leicester City CCG
Evan Rees	(ER)	Chair, BCT PPI Group
Frances Shattock	(FS)	Director of Strategic Transformation/ Locality, NHS England and Improvement
Mark Wightman	(MW)	Director of Communications, University Hospitals of Leicester NHS Trust (UHL)

In Attendance:	
Matt Archer (MA)	Head of Operations, University Hospitals of Leicester NHS Trust (UHL)
Lynne Cook (LC)	Head of Therapy Services, University Hospitals of Leicester NHS Trust (UHL)
Stephanie O Connell (SOC)	CHS Lead Therapist, Leicestershire Partnership NHS Trust (LPT)
Simon Pizzey (SPi)	Head of Planning & Strategic Commissioning, LLR CCGs
Judi Vernau (JV)	Executive Assistant, West Leicestershire CCG

Apologies:	
John Adler (JA)	Chief Executive, University Hospitals of Leicester NHS Trust (UHL)
Mark Andrews (MA)	Strategic Director of People, Rutland County Council
Sue Elcock (SE)	Medical Director, Leicestershire Partnership NHS Trust (LPT)
Azhar Farooqi (AFa)	Clinical Chair, Leicester City CCG

SLT 19/134 Welcome and introductions

AW welcomed everyone to the meeting.

SLT 19/135 Apologies for Absence and Quorum

Apologies were noted as above.

It was noted that meeting was not quorate as there were only 2 CCG Chairs in attendance.

SLT 19/136 Declarations of interest on Agenda Topics

The papers had been reviewed by a CCG Governance Officer and conflicts of interest had been identified as follows:

Better care together
Leicester, Leicestershire & Rutland health and social care

SLT/19/140 - Therapies (Occupational & Physiotherapy) Update:
Paper to approve recommendations. It was noted that UHL & LPT representatives could remain in meeting for this discussion but were excluded from any decision.

SLT/19/141 - LLR Joint Estates Forum Update:
Paper to note. UHL & LPT members to declare any conflict of interest but no exclusion from meeting required.

SLT/19/142 - Proposal to change the LLR System Governance:
Paper to approve recommendations. All parties to make a declaration of interest but no exclusions required.

SLT 19/137 Notification of any other business

The Chair was not notified of any other items of business.

SLT 19/138 Minutes of meeting held on 21 November 2019 (Paper A)

The minutes from the System Leadership Team held on 21 November 2019 were taken as an accurate record of the meeting.

SLT 19/139 Action notes of the meeting held on 21 November 2019 (Paper B)

The action log was reviewed and the following noted;

SL/21/01/09: Partnership Terms of Reference:
AW proposed to close this action as it would be would be superseded by an item on today's agenda. The action to be marked as green/complete and removed from action log.

SLT/19/32: Frailty End of Life Programme Report:
AW noted that JA had sent apologies to today's meeting so there would be no update in relation to this action.

SLT/19/76: Integrated Community Teams:
AW noted that Caroline Trevithick was not present at today's meeting and so there would be no update in relation to this action.

SLT/19/92: Urgent & Emergency Care and Transformation Plan:
It was noted that there was nothing further to update on this action.

SLT/19/105: Long Term Plan:
SP confirmed this action had been completed and as such could be marked as green/complete and removed from action log.

SLT/19/131: IM&T Workstream Update:
AW confirmed that this action had been picked up at yesterday's AEDB and noted that Richard Henderson, CEO EMAS would be taking the action away to complete. It was therefore agreed that this action could be marked as green/complete and removed from action log.

SLT 19/140 Therapies (Occupational & Physiotherapy) Update (Paper C)

MW invited the Therapies team to join the meeting to present the Therapies Update to SLT and introductions were made; Stephanie O Connell (LPT) and Lynne Cooke (UHL) as the twin pillars of Therapy Community alongside Simon Pizzey who was assisting the team with putting together of information.

SOC noted there being two main health providers of therapy services, UHL and LPT, and highlighted that today's paper concerned physiotherapy and occupational therapy services, along with two discrete services i.e. adult musculoskeletal (MSK) out-patient and rehabilitation pathways.

SOC explained that a shared vision was being developed and the collaborative actions undertaken/underway were outlined to SLT:

- Setting up of an AHP Council in 2019 which brought together all the AHP's across LLR to work jointly on workforce matters and development of roles.
- Work on a joint service specification for MSK to deliver the self-referral pathways for the service.
- Development of a First Contact Practitioner (FCP) model with funding available next year to enable primary care and GP surgeries to employ FCPs and thus reduce GP workload.
- Development of a business case for the combined physical and physiological approach to low back pain; using the start back tool and grading the levels of back pain for better and more appropriate management of cohorts of patients.
- Review of MSK system workforce and development of a training plan.
- Setting up of a Breakfast Club to facilitate clinical conversations in relation to Rehabilitation pathways; the interface between UHL therapists, Community therapists and Social Care therapists. Work on how pathways could be improved was on-going.
- Involvement in Home First implementation.
- Work undertaken with regards to referral form and the community clinical model.

SOC pointed out the difficulties and blockages experienced with this collaborative approach to system working in terms of there being differing infrastructures, IT systems and payment arrangements and pointed out assistance might be needed from SLT in terms of getting a resolution to these issues.

LC outlined the next steps to SLT:

- Detailed mapping of existing LLR therapies workforce (Rehab & MSK).
- Revisiting community and inpatient therapy benchmarking work
- Completing a system wide acute and community therapies demand and capacity model (Rehab & MSK)
- Developing a joint therapies workforce pipeline and training plan
- Developing/reviewing LLR community and acute therapy clinical outcomes and key performance indicators
- Developing a governance and contractual framework for the new acute and community models of Therapy care (MSK)
- Developing a single community and acute based therapies workforce plan (MSK & Rehab)
- Developing a budget for R&D within MSK, community and acute therapies
- Developing a shared Information Communication Technology infrastructure plan.

LC then outlined the support which would be requisite for successful accomplishment of those next steps:

- Support with shared IT infrastructure.
- Support with implementation for First Contact Practitioner (FCP) and CPPP across LLR.
- Governance, contractual and financial structures to support the clinical pathways being worked on
- Recognition of the potential system savings through FCP and CPPP
- Financial framework to support the redistribution of funds across the STP
- Support for training and research funds.

SLT membership then put forward their comments and questions:

UM noted that funding for the PCNs would be released on 1st April i.e. 70% funding for a physio and enquired as to what PCNs were thinking in terms of feasibility of this model. SOC thought that where discussed with PCNs there was real positivity in terms of the clinical model but there was questioning of the finance arrangements. UM suggested that increasing this offer was something that SLT should consider to prevent system disconnect. SPi noted the paper would be taken through to January agenda of the Commissioning Collaborative Group for further discussion.

ML enquired as to integration with other providers in the system e.g. PCNs and highlighted the importance of colocation responsiveness. LC explained the aim was to reduce referrals to secondary care, move therapies out and relocate staff, with the rehab therapists being aligned with the district nurses hub.

ER expressed concern that next steps didn't seem to include patient stakeholder engagement and noted that in general there was a need for patient engagement to be included in much earlier stages of any proposed change.

AFu agreed with ER's point and highlighted the vision statement asking what it meant in terms of the patient, clinician, PCN etc. AFu thought there were great initiatives being outlined to take forward but these needed to include those patients with Long Term Conditions (Adults and Children); thus giving scope to have a service that worked across a condition.

LC thought this suggestion was really helpful and agreed that discussions with patient stakeholders needed to take place. LC explained that the Adult work was being given priority at this point in time due to flow pressures and then work would look at paediatrics.

SB thought from the system perspective that the work could be aligned with the Prevention agenda.

AW summed up the item by thanking the team for the good progress in work around therapies and asked for this ambition and appetite to continue.

AW asked MW for a sense of support required; MW thought the achievement of the milestones outlined on page 10 of the report were vital for moving towards delivering NHS therapies in an ICS model.

AW outlined some specific actions:

- To invite colleagues to reflect on scope and scale and vision of the process with stakeholder engagement and a mandate built into the design process
- To take forward the PCNs connectivity issue in terms of nuance and language
- To consider a system offer to close the 30% FCP funding gap but with conditions attached.

It was noted that SOC, LC, SPi and MA left the meeting at 9.47 am.

It was **RESOLVED** to:

- **NOTE** the contents of the report
- **APPROVE** the recommendations within the report

Post item discussion:

MW highlighted learning to be taken from this work in that the difficult discussions concerning ownership, clinical direction and governance needed to happen at the beginning of a change initiative in order to prevent project blocks/delays.

AW agreed it was important that this approach be applied directly to the 23 programmes about to be initiated and rolled-out across the system.

SLT 19/141 LLR Joint Estates Forum Update (Paper D)

DB gave a brief update of the November meeting of the LLR Joint Estates Forum and highlighted three points to the membership:

1. The Checkpoint submission in July had received positive feedback in October noting that there had been good progress, the Primary Care strategy had been well answered and the areas for future focus should be disposals, running costs and backlog maintenance.

2. The estates strategies for both UHL and LPT were being refreshed.

3. The feedback on Wave 1-4 updates was:
   - CAMHS project – green
   - UHL expansion of Level 3 ICU – green
   - Hinckley & Bosworth – amber, as work was being undertaken with regards to timeframes
   - Estates efficiencies – no great progression but was stimulating discussion/debate at forum

ER flagged the importance of stakeholder engagement as currently there was much public interest in NHS estates and what was being done with them.

SB highlighted the required move of DHU from Fosse House in 18 months' time and the desire to avoid having to take up a private estate when they could be a co-located service with social care, mental health, community (clinical navigation hub). DB confirmed that this issue was on the estates forum's radar.

ML also highlighted that for primary care co-location would be a key principle going forward.

It was **RESOLVED** to:

- **RECEIVE** the update report on LLR Joint Estates Forum – November meeting.

SLT 19/142 Proposal to Change the LLR System Governance (Paper E)

AW gave feedback on his discussions with elected members, council partners and HWB Chairs within the 3 LLR councils (Leicester City, Leicestershire County and Rutland County) with the consistent message coming back that SLT didn't work for the Councils, the HWB agendas needed to change and there was lack of clarity about the role and value of ICS.

AW explained that he had spoken with colleagues about this situation and what had been decided as the way forward to enable good partnership working with local government meant talking more directly with the democratic elected executive about the things that mattered to them in Place and working with

them differently at a system level to build on processes.

AW thought the NHS agenda needed to have two components:

1. Coherency
2. The need to go to Place (when discussing Place) i.e. local government and HWB.

AW explained from the NHS point of view things were moving forward with:

- The 3 LRR CCGs coming to the realisation that whilst it was important to still have a very clear identify around Place, there was a role to play at System.
- The key NHS family members were on board with working as a single system. UHL, LPT and CCG AOs had spent focused time thinking on what that single system would look like and how to create an NHS Executive within LLR which would enable all the organisations (UHL, LPT, EMAS, DHU, CCGs) to work as one NHS family.

AW highlighted the two aims were:
1. To bring together the NHS into a coherent service strategy i.e. one NHS working for LLR
2. To go to government on terms that made sense to them.

Proposal
AW proposed that Systems Leadership Team and Partnership Board be stood down with immediate effect and that an NHS Executive be implemented to ensure a way of working to a standard that partners had been asking to be delivered for some time.

AW noted that he would be revisiting City Council and County Council in New Year and Rutland County Council in early February with a view to having a joint conversation with the three councils in February to allow for positively putting into place a new approach to partnership working.

ER thought the proposal made sense and offered his support. He asked for consideration to be given in next steps as to how both the public and Healthwatch fitted into the process.

AW noted that Healthwatch would fit in at several different levels within the process.

SF highlighted that the HWB had Healthwatch representation and also provided a public facing element.

BH supported the proposal but enquired as to representation needed at HWB.

AW explained that the feedback from elected members and council partners was that the NHS needed to be represented by a small group who would leave the meeting and deliver on what had been agreed. AW therefore thought the NHS Executive would consider and decide who needed to attend the HWB as a team representing the NHS family.

SF pointed out that if the Council needed to speak to individual organisations they would be called to attend the Scrutiny Commission.

FS thought the proposal sounded pragmatic but thought that non-executives needed to be included in meetings with executive officers and chairs. AW noted that there would be development of all boards in new year with discussion of any issues and how to affect governance through this collaborative approach. AW agreed it was important that non-executives be included in this journey.

FS also questioned involvement of NHSE / I and AW agreed to speak with her further outside of meeting.

SB supported the proposal and thought there would be less duplication and drain on resources. He did think that there needed to be commitment to what was currently in place in terms of Public Health and Prevention as that was absolutely the right thing to do.

MW noted he had discussed this proposal with John Adler and Andrew Furlong and they all endorsed it being taken forward. MW put forward two comments:

1. HWB had potential to be really powerful but needed input from all parties to improve content and strengthen. SF agreed that there was a need to jointly review the HWB across LLR and set out a plan that made sense to the NHS.
2. Membership element of the NHS Executive needed to include clinical representation at provider level.

ML gave support to the proposal agreeing that change was needed. ML questioned:

1. What needed to be done to be able to initiate more discussion and engage the wider audience?
2. The role of clinicians - could be problematic if not linked to NHS Executive

AW proposed the Joint CCG Board meeting in January would be well-placed for discussion on how accountability would be discharged and how to revert back to a managerially led, clinically moderated NHS.

AW also proposed that the boards of all NHS organisations be brought together for discussion.

AW summarised this item as the proposal being supported by the SLT membership. AW noted that there were actions needed to implement it and a lot of thought would be give on how to enact it. AW concluded that this was the last meeting of SLT in the current guise and noted that information would be issued about the successor going forward.

It was **RESOLVED** to:

- **SUPPORT** the proposal to stand down SLT meetings with immediate effect.

SLT 19/143 AOB

It was noted that no Any Other Business was brought to today's meeting

Date, time and venue of next meeting

It was noted that as SLT was being stood down with immediate effect there was no future date, time or venue for next meeting.