Trust Board paper Q

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

Trust Board Bulletin – 1 March 2018

The following reports are attached to this Bulletin as an item for noting, and are circulated to UHL Trust Board members and recipients of public Trust Board papers accordingly:-

- **System Leadership Team minutes (18 January 2018)** – Lead contact point Mr J Adler, Chief Executive (0116 258 8940) – **paper 1**

It is intended that this paper will not be discussed at the formal Trust Board meeting on 1 March 2018, unless members wish to raise specific points on the reports.

This approach was agreed by the Trust Board on 10 June 2004 (point 7 of paper Q). Any queries should be directed to the specified lead contact point in the first instance. In the event of any further outstanding issues, these may be raised at the Trust Board meeting with the prior agreement of the Chairman.

System Leadership Team

Chair: Toby Sanders

Date: 18 January 2018

Time: 9.00 – 10.00

Venue: 8th Floor Conference Room, St Johns House, East Street, Leicester, LE1 6NB

Present:	
Toby Sanders (TS)	Chair, LLR STP Lead, Managing Director, West Leicestershire CCG
John Adler (JA)	Chief Executive, University Hospitals of Leicester NHS Trust
Nicola Bridge (NB)	Finance Director and Deputy Programme Director
Karen English (KE)	Managing Director, East Leicestershire and Rutland CCG
Azhar Farooqi (AFa)	Clinical Chair, Leicester City CCG
Steven Forbes (SF)	Strategic Director for Adult Social Care, Leicester City Council
Andrew Furlong (AF)	Medical Director, University Hospitals of Leicester NHS Trust
Satheesh Kumar (SK)	Medical Director, Leicestershire Partnership Trust, Co-Chair Clinical Leadership Group
Mayur Lakhani (ML)	Chair, West Leicestershire CCG, GP, Sileby Co-Chair Clinical Leadership Group
Roz Lindridge (RL)	Locality Director Central Midlands, NHS England
Sue Lock (SL)	Managing Director, Leicester City CCG
Peter Miller (PM)	Chief Executive, Leicestershire Partnership Trust
Richard Morris (RM)	Director of Corporate Affairs, LCCG SRO Communications and Engagement
Tim O' Neill (TO'N)	Deputy Chief Executive, Rutland County Council
Richard Palin (RP)	Chair, East Leicestershire and Rutland CCG
Sarah Prema (SP)	Director of Strategy and Implementation, Leicester City CCG
Evan Rees (ER)	Chair, BCT PPI Group
John Sinnott (JS)	Chief Executive, Leicestershire County Council
Apologies	
Will Legge (WL)	Director of Strategy and Information, East Midlands Ambulance Service, NHS Trust

In Attendance	
Shelpa Chauhan (SC)	Office Manager, BCT
Shelly Heap	Board Support, BCT(Minutes)

1. Apologies and introduction	
Apologies received from Will Legge, EMAS Welcome to a new member of SLT, Roz Lindridge, Locality Director Central Midlands, NHS England.	
2. Conflicts of interest handling	
Corporate Affairs requested to note that item 6 regarding clinical leadership arrangements may result in funded roles which those present may have an interest in.	
3. Minutes of last meeting	
The minutes of the meeting on 21 December 2018 were accepted as a true and accurate record.	
4. Review of Action log	
TS noted that an individual update against each ongoing action has been recorded in the log. 171221/1 BCT draft outcomes framework. The new outcomes draft will be routinely discussed in a performance item on the agenda with effect from 1 April 2018. 171221/3 PPI workstream engagement. A stakeholder group event is scheduled on 31st January 2018. It was agreed that TS will attend, in addition to including a wider group of representatives from partnership organisations including UHL. RM will ensure invitations go out to the appropriate people. The remaining actions will be discussed in the agenda.	RM
5. Winter update	
JA presented a winter update to members. Paper C contains a letter from National Health Service England Improvement dated 2nd January 2018 which outlines further recommendations as part of the Winter Pressures Protocol as well as some comparative benchmarking information. Some of the key headlines to note are as follows: Acute trust was required to cancel non-urgent elective activity to free up capacity; in UHL this was only done when absolutely necessary where no alternative was available, and only when it would not impact on patients' conditions. There will be a financial impact in relation to these recommendations which CCG colleagues will be aware of. If elective activity doesn't go ahead it can potentially lead to 100% loss of funding. In a system sense this should be recorded as a neutral loss, however, it is likely to result in UHL going off financial plan. JA highlighted that in the budget approximately £350m was allocated for winter pressures of which this system received approximately £4.2m. Around half of this funding was directly allocated to providers to help deal with existing costs however; the financial forecast also had to be adjusted in line, therefore this will affect spending power. The deficit was planned to be in the region of £26.7m and has now been adjusted to £24.7m. The other half of the funding has been allocated to new schemes. However, there is a risk associated with accepting the funding as it is based on achieving 90% Emergency Department (ED) 4 hour target in quarter 4, otherwise there could be claw back on funding although it is unknown how much this would	

amount to. All other recommendations outlined in the letter have been completed. JA explained the operational difficulties due to extremely high activity with 111 and the ambulance service and noted the burden that Glenfield Hospital has been under due to the dominance of respiratory conditions, particularly since the new year. Patients were also cared for at the Royal Infirmary due to the volume of cases. The situation was compounded as there were very few patients who could be discharged especially over the Christmas period as they were not physically fit enough to go home. It was noted that the pressure continues. Also of significant concern was the impact on cancer surgery due to a sequence of pressures including a lack of Intensive Treatment Unit (ITU) capacity and general surgical beds which resulted in multiple cancellations. This was recently raised in the winter crisis debate in parliament and there has also been media coverage. There has been maximum escalation around this to work on control measures particularly as this has a major detrimental effect on cancer patients. JA assured the members that all cancelled appointments have been rescheduled mostly in January with a few going over into February 2018. Overall, performance has been satisfactory throughout this period, however, the National and Regional 4 hour benchmarking taken from the latest data from NHSE which was published in December 2017 (available on NHSE website) places the LLR at 22 out of circa 40 systems. TS raised a query regarding LLR Delayed Transfers of Care (DTOC) performance as it appears the position has deteriorated. JS clarified that this item was specifically discussed yesterday and is in hand with a report to be provided next week on the county position. It seems that there are some issues with the availability of packages of care and the workforce to deliver them. ML requested clarification regarding the process for deciding which cancer patient's surgery is cancelled. JA & AF responded that clinicians and surgeons have daily discussions about individual patient's prognosis, including any clinical risks and determining factors in order to come to a joint decision. JA pointed out that the cancellations are unusual and due to the exceptional capacity pressures over winter. ML told the members about an important new research paper which was just published. The research was one of the largest studies to be carried out on circa 800,000 people attending A&E. Findings show that there is little correlation between GP access and A&E attendance. However, predictors include - long term conditions, poverty, poor education and isolation and suggest that urgent care strategies should reframe their priorities towards these areas. The paper will be circulated to SLT. There was a discussion about the deployment of staff and teams between the General and Royal Hospitals and the number of approaches that have been taken to ensure that consultants, nurses and junior staff are deployed most effectively. The members acknowledged that it has become increasingly difficult to make improvements safely within the resources available, however, it was agreed to focus on some specific issues immediately including the avoidance of cancer cancellations and the DTOC position. JA noted some positives including the new A&E department and a reduction in trolley waiting times. CQC have just undertaken a 'well led' inspection which included a visit to ED and there was a particular commendation for the controlled environment, safety and privacy. The result of this was 'good' and is a much improved result since the previous inspection. KE asked what the impact of referral to treatment (RTT) would be on funding and whether the target had been relaxed. JA stated that the Cancer Delivery Group is currently considering this	BCT Office

issue which is likely to have a serious impact on funding. RL confirmed that the target has not been relaxed and explained that there are ongoing discussions relating to the impact and parameters including how this will relate to performance. RL will circulate the NHSE planning guidance as soon as it is available. JA and Tamsin Hooton will be reframing the UHL recovery plan to ensure that the A&E Board are working to one effective plan. An update will be presented at February SLT meeting.	JA/TH
6. Clinical Leadership arrangements	
ML, SK and AF presented Paper D on behalf of the Clinical Leadership Group (CLG) regarding arrangements for clinical support to the STP. ML offered an overview of the rationale behind the proposed change. Given that the CLG is unable to provide dedicated clinical support along with the limitations of the current arrangements, discussion was invited from SLT. Additionally, although there is a national expectation for STPs to focus on their clinical leadership arrangements, no specific model guidelines are recommended, consequently it requires local determination on the best model for LLR going forward. ML provided an example of a successful model that has been adopted by a STP in London which comprises of general practice, primary medical care, secondary medical care, allied health professional (AHP) and nursing. It was thought to be beneficial that these positions are taken up alongside the substantive post as long as backfill is provided to allow sufficient time to commit to the requirements of the position. ML outlined the proposal to appoint three or four dedicated clinical leaders at STP level, comprising of primary and secondary medical care, AHP and nursing. It was recommended that CLG would be reshaped to become a clinical cabinet consisting of dedicated senior staff. In addition a clinical cabinet office with senior staff to support and manage the clinical networks would be required. NB and ML will have further discussions about the number and level of posts required. SK explained whole system clinical leadership, as outlined in the presentation, and noted that the STP plan is a good one which requires robust clinical leadership in order to achieve the required outcomes. It was accepted that these alterations will require a significant change of the clinical leadership function as well as including a remit for a full review of the function. Additionally, it was agreed to look at how to integrate the power of people leading at the edge to ensure two way influencing and innovation. AF supported the proposal and highlighted that the clinical leadership roles will require around two full days per week, which is not possible in the current arrangements. TS prompted the views of the members outlined as follows: • Strong support was unanimous for the appointment of four clinical leadership roles (including medical posts from both primary and secondary care) • PMO support and admin capacity requirements to be developed further – SK/NB • Social care and public health inclusion integral to achieve balance – ER/TS/SK • Define leadership roles and governance arrangements - consider delegated authority from SLT – AFa/AF/NB • Consider links to commissioners and general practice – RP • Clinical cabinet to provide scrutiny and proactively support workstreams to develop clinical solutions for their plans – SP/SK • Ensure a focus on leaders from the edge – AF/SK • Forum for reviewing latest research, system working and innovation - to shape direction, pace and challenge – AF/SK/AFa • A change of CLG to a Clinical Cabinet was widely supported	

TS requested views from the Local Authority members. SF suggested Principal Social Worker level role from social care for clinical input and TO'N advised including outcomes and deliverables along with further work on the focus and benefits. JS expressed the view that this should be part of a wider discussion about the STP governance. TS and JS met recently to discuss governance. Further meetings are scheduled next week with Leicester City and Rutland Council. The proposals for the BCT Partnership Delivery Model Governance will be presented at February SLT meeting. It was agreed for CLG to progress with the STP Clinical Model to include deliverables and outcomes and to consider the wider clinical cabinet membership. This will also be presented at the February SLT meeting.	TS CLG
7. Draft MOU for NHSE/STP support and alignment	
RL presented the draft Memorandum of Understanding (MOU) between NHSE and LLR STP as outlined in Paper E. The members were asked to provide comments on the draft document directly to RL and TS. RL described the context for NHSE membership of STP's which aims to provide practical support for service transformation within local partnerships to help them work together more effectively across health and care systems. The draft memo of understanding looks at the interface between NHSE and SLT partners. It outlines future connections with a proposed way forward for NHSE to proactively provide support bringing the respective resources together. SLT's involvement will shape the MOU to become particularly focussed on the needs of LLR STP. The intent of the MOU is to: • Enhance and contribute resources to support local operational plans including the 5 year forward view areas (mental health, urgent care, primary care and cancer) and other priority areas such as diabetes and maternity also to reflect local BCT priorities. • Align core working arrangements between SLT and NHSE STP Support & Development Team. Key support roles are outlined in the draft MOU however these roles work at various geographies therefore will not be available on a full time equivalent basis, but will link with the relevant STP roles to support with particular issues such as quality, enhanced performance reporting etc. • To provide continued support with the existing primary care co-commissioning model and to embed staff within the three CCGs. • Coordinate and bring together the clinical networks across the key priority areas to actively support the STP. In addition to national budget there are further financial resources available over the next two years. There will be £126,014 in 2017/18 for the LLR STP for clinical leadership to support the mental health and diabetes priorities, however, RL is open to discussion regarding how this funding can best be utilised at LLR. Funding for 2018/19 (subject to confirmation) will be £167,110 of which some will go towards urgent emergency care. Further support and funding has been released for primary care. An identified primary care transformation lead will provide support, additionally, there is funding for GP international recruitment although this funding can be used flexibly dependant on the specific needs of the LLR. Furthermore, assistance will come from local professional networks such as pharmacy, dental and optometry.	

Oversight arrangements will fit into existing SLT governance. Future CCG assurance will be consistent and aligned across the LLR. There is a meeting in February to discuss this further with NSH Improvement to progress towards a single oversight framework for the STP. The STP plan refresh, along with the policy changes and the reframing of the oversight groups, that SLG currently have underway, fit into the timeframe of April 2018 for joint approval of the plans. Leads have been identified for each priority as outlined in the paper. Initial questions and feedback from the partners included the following: • Direction of travel will help to streamline information sharing - JA • Building operational support and capability into the workstreams was welcomed • Governance arrangements and NHSE STP role functions to be clearly defined - All • Alignment of clinical networks is positive – PM • Central co-ordination of STP alignment, funding and assurance was well received - SK JS believed that this item should be an internal NHS conversation and assumes the STP plan will be signed off with public support. ER asked how Communications & Engagement (C&E) will be considered. RL responded that there are currently strong links between the STP and NHSE and that there is expertise within the team to assist with engagement, quality and/or resourcing dependant on what input would be most helpful for LLR and this will be explored further. TS noted that the LLR STP has struggled with capacity and resourcing in some parts of the system including how to deploy capacity most effectively. Moreover, it was highlighted that many changes are taking place which will impact on current STP arrangements. Therefore TS welcomed NHSE input and support with expertise, operational support and additional funding and was keen for SLT to shape and evolve this for the LLR STP. In addition it was thought that similar SLT membership from NHSI would be very helpful in terms of consistent messaging although it was noted that resource and financial support would not be expected. Draft MOU for LLR STP to be shared electronically with the Executive Team and comments to be provided to TS and RL by 26 January 2018.	All
8. Date, time and venue of next meeting	
9am-12pm Thursday, 18th February 2018, 8th Floor Conference Room, St John's House	