Trust Board paper O

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

Trust Board Bulletin – 4 January 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 (16 November 2017)** – 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 4 January 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: 16 November 2017

Time: 10.30 – 12.00

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
Mayur Lakhani (ML)	Chair, West Leicestershire CCG, GP, Sileby Co-Chair Clinical Leadership Group
Will Legge (WL)	Director of Strategy and Information, East Midlands Ambulance Service NHS Trust
Sue Lock (SL)	Managing Director, Leicester City CCG
Peter Miller (PM)	Chief Executive, Leicestershire Partnership Trust
Tim O' Neill (TON)	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	
Satheesh Kumar	Medical Director, Leicestershire Partnership Trust, Co-Chair Clinical Leadership Group
Helen Briggs	Chief Executive, Rutland County Council
In Attendance	
Stuart Baird (SB)	BCT Communications and Engagement
Shelpa Chauhan (SC)	Office Manager, BCT
Shelly Heap	Board Support, BCT(Minutes)

1. Apologies and introduction	
Apologies received from Satheesh Kumar, Helen Briggs	
2. Conflicts of interest handling	
Nothing noted.	
3. Minutes of last meeting, 19th October 2017	
The minutes of the meeting on 19th October 2017 were accepted as a true and accurate record.	
4. Review of Action log	
171019/1 - Cardio Respiratory service design - Paper G on the agenda is a follow up on this item and has been circulated with the papers. 171019/3 – AF is not able to continue as STP clinical lead in future as the role requires a significant level of time commitment. It was agreed that the role requires clinical leadership and someone who will challenge views. AF and other members will provide support to the role holder. A meeting will be held with TS, AF, RP and ML and any other interested members of SLT to discuss the structure of the role and a proposal will be discussed at the December SLT meeting. AF will stay in role until a replacement is in post. TS noted that all other actions were either ongoing or to be discussed in the agenda.	TS,AF
5. BCT draft outcomes framework	
Sarah Cooke (SC) from Midlands and Lancashire CSU Business Intelligence (BI) for Leicester, Leicestershire and Rutland (LLR) attended the meeting to present the LLR STP draft outcomes model and framework set out in Paper C. TS explained that this is the first draft of the framework and will allow the Partnership to monitor quality improvements. TS requested feedback and reactions on the approach and format in order to develop the framework further over the next month. SC outlined the purpose of the framework which has been based on the New Zealand Canterbury model and developed from an LLR perspective with input from representatives of Clinical Commissioning Groups (CCG), Public Health and Commissioning Support Unit (CSU). SC explained the framework and key performance indicators (KPIs) and contributory indicators which have been sourced from a variety of locations, including the current STP dashboard which should help to contribute towards achieving STP strategies. SC requested agreement in principal to the framework at the meeting today with further development of the KPIs by Performance Managers in BI. It was noted that wider stakeholder engagement is currently underway. The partners provided feedback as follows: WL expressed support for the framework and suggested that care and crisis and clinical triage for emergency urgent care matrixes would support the framework and offered to work with SC on this. SL advised that A&E delivery board indicators could be included and asked that they ensure that the key indicators chosen are aligned and measureable to meet the outcomes. AF liked the approach but suggested that more work is needed to agree the four overarching KPIs and that patient experience should also be included.	

PM agreed that the approach is good, and suggested the inclusion of measures for children's health and dementia also be included and to link with the LA's on this.
JS supported the view that children's health be included.

AFa was supportive of the format and approach, believing that it is important to capture what patients want, such as assurances regarding waiting times and consultation, therefore it was suggested that more appropriate KPIs, with specific measures, be included such as health and equalities. In addition it was agreed that it is most important that KPIs on the workforce are included as this is key to delivery.

ER agreed to the framework, and requested the draft document to go to the PPI group for their input and comments in relation to the patient view.

ML highly recommended that the framework should be adopted and suggested only minor changes were necessary to incorporate work steam strategies into the goals. ML also suggested the use of why, what and how in the wording to ensure the framework was clear. It was suggested that a quarterly patient questionnaire be devised to capture patient feedback relating to their experience about their joined up care should be included as well as a staff satisfaction indicator (staff engagement index) such as used in America and the Mayo Institute who track physicians satisfaction and which are directly linked to outcomes. Otherwise choose indictors that are currently available.

RP was very pleased with the framework overall and suggested KPIs to consider GP extended access and opening times and working together practices. It was noted that the IAPT recovery rate KPI is good.

TS asked for SB's expertise to assist with the wording of the text so that the document is clear and concise.

TS confirmed the next steps:

- Input from the CLG (Clinical Leadership Group) at their next meeting on 14th December 2018.
- SLT members to request input from individuals within their organisations who have expertise.
- Input from PPI group at their December meeting.
- SC to share with work stream leads at the SRO Interdependencies meeting next week.
- SB to take to Communications Group meeting on the 17th November.

The group were asked to get feedback to SC and SP as soon as possible in order for the draft to be updated.

SC will coordinate the comments and views with the involvement of CLG, Public and Patient Involvement Group (PPI) and Communications and Engagement work stream and bring back an updated version to the December SLT meeting to coincide with the refreshed Sustainable Transformation Partnership plan (STP). — SC

6. ACS local/national update and potential next steps

TS presented the Accountable Care System (ACS) journey in LLR outlined in the attached discussion paper D and requested SLT to feedback on systems working arrangements and next steps.

TS confirmed that there is a clear national NHS direction of travel for all STPs to move towards adopting the ACS as a model of working over the next few years. This will create a structure and approach with a shared purpose, common goals and principles for collaborative working to improve the integration of care using a single regulatory framework to deliver the service transformation required. This is on the agenda for discussion at the Joint Board event on 28th November 2017.

It was agreed that the local approach of the LLR STP will focus on the critical competencies and component strands and prioritise how to move forward with these and to agree the timetable. WL commented that ASC is a good provider centric model for an integrated way of working, however, it was noted that moving from the current traditional system towards a whole systems approach will be challenging. The group discussed working towards the principles of the ACS in relation to service development, operating models, contracting and consultation whilst continuing to focus on the evolution of the partnership, developing collaborative joint working arrangements and improving the patient experience. JA considered that SLT should focus on delivery responsibilities such as primary care and contracting and consider whether the CCGs can realise financial saving by reviewing the management operating costs to assess potential back office savings. SP advised that it is important that the pathway network is consolidated as it gets closer to the delivery phase. ML agreed that the partnership should continue to evolve and transform and commit to joint working and it was acknowledged that the principals of the ACS are good. It was acknowledged that strong clinical leadership is required so that clinicians own, shape and drive forward the development of operational pathways and models. AF supported the view about the clinician led perspective. RP referred to the plan of action that the three CCGs agreed in September 2017 and noted the hard work and change, describing integrated working that has already taken place over the past year and expressed that he is broadly supportive of the ASC paper, as well as looking for potential budget savings by reviewing the Programme Management Office costs. SL agreed with the other members regarding budget savings but queried what level of support there is likely to be with the current financial challenges being faced and suggested that this should be explored further. It was noted that a city specific set of actions would prove helpful going forward. TS asked that NHS Chief Officers share the paper with their executive teams and to let him have feedback regarding any critical foundation blocks omissions or inclusions by next week so that it can be discussed further at Joint Boards on 28 November 2017. The paper will also be shared with the NHS Executive Board for their consideration and feedback.	NHS CO's
7. New local NHS contracting model	
Paul Traynor (PT), Chief Financial Officer UHL, Spencer Gay (SG), Chief Finance Officer WL CCG and Sarah Shuttlewood (SS), Associate Director, Contracts, LC CCG joined the meeting to present an overview on the new contracting model proposal set out in Paper E. SG attended the previous SLT meeting in October where he presented a broad outline of the model. Since then significant development has taken place with input from Chief Finance Officers and contracting staff and the plan being outlined today is an ambitious, bold and simple proposition. SS outlined the background work that has been undertaken and explained that there has been an extensive review of the vanguards across this area. Several models have been reviewed, and developments in Essex and Hull have been explored. Work has been undertaken on the underlining principals to change to an Aligned Incentive model for the contracting framework. There has been good progress and engagement with CFOs and contracting staff who collectively support this way forward.	

The LLR contracting approach was discussed including the following points: • Fixed budget with risk/gain share arrangements. • Cost based budgets (expenditure only). • Risk Share Fund at system level to stop financial risk being moved from one organisation to another. • A single financial saving programme (not CIPs and QIPPs). SG proposed the use of the virtual model for 2018/19; however it was highlighted that there should be a commitment to continuing with this approach going forward into 2019/20 and beyond. SS told the group that further financial modelling will be needed to agree a fair and transparent way to manage the budgets across all the organisations in order to achieve targets. It was noted that using this system will make it easier to recognise the scale of the financial challenge and will help to clarify where savings are needed. The group provided feedback on the proposal as follows: JA stated that system control is an essential building block. UHL are in agreement with the proposal, however there is further work needed to develop the model and regulators must be on board for this to be successful. PT advised the group that the Chief Finance Officers are fully supportive and committed to the use of this model, nonetheless they acknowledged that it will involve a complete change to current working practices. ML supported the model and agreed that further work should be carried out, however, queried how patient funding would be managed. There was a group discussion regarding internal capacity to carry out further work on the development of the model in order to achieve the tight timeline. SG suggested arranging a workshop with key people to explore this further, and it was agreed that permission would be needed to realign resources. PM, SL, ML and the remaining SLT members were very supportive of moving forward and agreed that it will require significant trust and openness. KE also supported the approach but was unable to commit any resource over the next three weeks although will participate in the workshop. The group committed to work constructively together over the next few weeks to develop a transformative proposal outlining the benefits and risks and to include wider involvement. TS will discuss this with NHSE as it involves fundamental changes to operations and resources and to seek a mandate from them to continue working on the proposal. The proposal will be tabled at the beginning of the December SLT meeting agenda so that SG and SS can attend to present it.	SG/SS
8. Date, time and venue of next meeting	
9am-12pm Thursday, 21st December 2017, 8th Floor Conference Room, St John's House	