System Leadership Team
Meeting No. 25
Chair: Peter Miller
Date: Thursday 21 March 2019
Time: 9.00 – 10.30
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
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
Ben Holdaway (BH)	Director of Operations, EMAS
John Adler (JA)	Chief Executive, University Hospitals of Leicester NHS Trust
Avi Prasad (AP)	Assistant Clinical Chair, LC CCG
Nick Pulman (NP)	Clinical Vice-Chair, West Leicestershire CCG
Stephen Bateman (SB)	Derbyshire Health Care CIC
John Morley (JM)	Head of Adult Services & Principal Social Worker, Rutland County Council
John Sinnott (JS)	Chief Executive, Leicestershire County Council
In Attendance:	
Sarah Prema (SP)	Director of Strategy and Implementation, Leicester City CCG
Alison Moss	Board Support Officer, Leicester City CCG (Minutes)
Apologies:	
Andrew Furlong	Medical Director, University Hospitals of Leicester NHS Trust
Mark Andrews	Deputy Director for People, Rutland County Council
Steve Forbes	Strategic Director for Adult Social Care, Leicester City Council
Professor Azhar Farooqi	Clinical Chair, Leicester City CCG
Professor Mayur Lakhani	Chair, West Leicestershire CCG and Chair Clinical Leadership Group

SLT 19/22 Welcome and introductions

PM welcomed everyone to the meeting. Introductions were made.

SLT 19/23 Apologies for Absence and Quorum

PM noted that the meeting that the meeting was quorate but that NP needed to leave early, at which point the meeting would no longer be quorate.

SLT 19/24 Declarations of interest on Agenda Topics

No declarations of interest were noted.

SLT 19/25 Notification of any other business

PM advised that CT would be making a presentation on End Of Life Task Force.

SLT 19/26 Minutes of meeting held on 21 February 2019 (Paper A)

The minutes of the meeting on 21 February 2019 were approved as a true and accurate record.

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

SLT 19/27 Action notes of the meeting held on 21 February 2019 (Paper B)	
The action log was reviewed and it was noted all actions were not yet due.	
SLT 19/28 Update on Governance (Paper C)	
SP presented the report which updated the Team on arrangements for governance of the STP.	
The revised terms of reference for SLT had been approved and Derbyshire Health Care CIC had been invited to join.	
SP would be circulating the revised terms of reference of the Partnership Group with a covering paper to facilitate discussion within partner organisations. The next draft would be presented to the April SLT meeting for ratification. With regards to membership, JS thought that a standard approach should be adopted for the three Health and Well-being Boards and SP agreed to write to JS and Mark Andrews to confirm that each Health and Well-being Board would be invited.	**SP**
SP proposed to use the session in May to develop a Memorandum of Understanding (MoU) to inform the timelines and expectations of the organisations in developing an ICS. SP proposed that a governance pack be issued, including terms of reference, governance diagram (to be updated) and sub-groups' terms of reference (to be developed by SROs). Documents, including the MoU would be added in due course.	
RL reported that the national team was refreshing the ICS mandatory framework which was expected to be issued in April 2019. There would be a self-assessment and a MoU agreed between NHSE/I and each system to give clarity regarding the level of autonomy. RL was pressed on the timescale and she said, as it was near to completion, she anticipated it would be available in April although it could well be later.	
CT asked whether something should be added to the governance pack to explain the decision making process below SLT, for example, placed-based decision making forums. PM said that engagement with the public should be added to the diagram.	**SP**
UM asked how the development of Primary Care Networks (PCNs) would be reflected in the governance structure. SP noted the discussion at the previous meeting which concluded that Accountable Clinical Directors (ACDs) of PCNs should sit on the Partnership Board. It was thought there should be some level of representation on SLT but that not all of them would be needed nor could they be accommodated. It was thought that the clinical directors needed to work together to ensure they represented one another on different forums. It was further noted that confirmation of PCNs and ACDs was yet to take place.	
SL thought that consideration of how PCNs related to CCG Board GPs was also needed. KE noted that guidance on the role of clinical directors was expected the following week. PM noted that the governance arrangements would evolve over time.	
It was agreed to illustrate how Localities and PCNs fitted into the governance structure and describe the interface between the BCT structures and place-based groups such as the City's Joint Integrated Commissioning Board and the County Integration Executive.	**SP**
KE wondered if the governance pack would be ready for April as it was hoped to draw upon the work relating to commissioning capability which would not be happening until then. It was agreed to make a start and for the governance pack to list documents to be added at a later date. It was agreed to add 'governance' to the April agenda for SLT.	**SP**

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

SLT 19/29 SLT Work Programme (Paper D)	
SL presented the report on SLT's work programme. The plan was for a mix of formal business-focused meetings interspersed with workshop-type development sessions. The paper proposed a list of standing items and specific issues to be addressed noting the ability to consider ad hoc items of business. SL noted that the risk register needed to be refreshed and the register, together with the performance framework information and system finance update, should be received by SLT, beginning in June, to set the system context for the test of the agenda items. Regarding the work streams updates, UM suggested that consideration of mental health and learning disabilities should be earlier in the year, possibly June 2019. JA suggested that the timing for Urgent Care would not work because of the date Accident and Emergency Delivery Board was to meet. He proposed that urgent care be considered later in the year. JS considered that the work programme should also reflect local authority plans, including education, social care, troubled families and finance reports. He agreed to liaise with Steve Forbes and Mark Andrews to propose additions to the work programme. SB asked whether the reports for the work streams would be highlight reports or deep dives. He said it would be useful to understand the programme management and how the enablers, such as IM&T fitted in. PM said it would be useful to have a performance dashboard and for SROs to produce a one-side highlight report. SL said there was a need to check whether the structures were right for monitoring and delivery. JA said it was difficult to strike the right balance with highlight reports given the breadth of work to oversee. He said that UHL made the distinction between exploratory discussions and navigational discussions. He acknowledged there was a sub-structure below SLT and it was the SROs' responsibility to drive the work programme. He added that there was need for SLT to identity the risks. KE thought that progress towards ICS was a risk and asked whether it would be reviewed. PM believed that the self-assessment tool from NHSE would be useful to assess the risk and that it progress should be reviewed quarterly.	 **SP** **JS** **SP**
SLT 19/30 Identification of System Risks	
SP asked SLT to identify key system risks. PM added that most risks would arise naturally having been escalated from the work streams but there were overarching risks to be considered. CT noted that the clinical risk register would be reviewed by CLG. The following strategic risks were identified: - Financial sustainability - Performance - Engagement and public awareness - Workforce availability - ICS development (pace of development) - IM&T (risks from the work stream) - Infrastructure changes to CCGs and leadership turnover - PMO structure - PCN development - System OD/culture - Governance structures.	

SLT 19/31 Contracting Update	
SL reported on the contracting arrangements for 2019/20 noting there was an escalation meeting with the regulators scheduled for later that day regarding the system position. With respect to the contract between CCGs and UHL there had been changes made at a national level to the financial structures and the way money flowed around the system. The expectation had been for a block contract but agreement could not be reached regarding the sharing of risk. The arrangement would be Payment By Results for elective care and a blended tariff for non-elective care which would be a new approach. There had been no national recommendation regarding the triggers or the marginal cost rates to be applied. There had been a process of mediation to reach agreement. The detail and the wording were being reviewed and it was expected that the contract could be signed soon. KE reported that the contract with LPT was to be signed today. Yesterday the agreement was £1M adrift but she thought it had since been resolved. There would be non-recurrent investment for CAMHS. Discussions to confirm that the MHIS had been met were taking place. It was noted that the outcome of contract negotiations meant there was a £11M funding gap for CCGs and hence the escalation meeting that afternoon. SL said she was optimistic that there would be efficiency savings through closer working and collaboration across the system. JS reported on the financial position for Leicestershire County Council (LCC) noting that it was reasonable for the next two financial years but following that it would depend in the outcome of the Fairer Funding Review. He said the problem would be with those authorities currently benefiting seeking transitional arrangements delaying the redistribution which would benefit LCC. He said that several councils were on the brink. For LCC, the biggest financial challenge was children's social care and for other authorities it tended to be adult social care. He added that despite an increase in demand for adult social care LCC had coped because of the increased partnership working and efficiencies. JM said that Rutland County Council was a in a similar position to LCC. JS commented that the financial position for the City Council would become clearer after the mayoral election in May. JS updated the meeting on LCC's capital programme which was £430M over a four year period. He said the Council faced considerable strain on resources from housing growth and the need to provide the infrastructure, such as roads and services such as education. He said negotiations for S.106 monies were often fraught and there was uncertainty how much money would be received from new developments. He referred to the growth planned around Melton and that no provision had been made for health care. KE reflected the discussion at the Health and Well-being Boards citing a lack of involvement in the strategic plan. She proposed that the issue be referred to the Primary Care Strategy and Estates Groups. It was noted that NHSE was responsible for primary care estates. KE noted that Tim Sacks, ELRCCG, had talked to all the district councils but primary health care needs had not been reflected in the plan. KE agreed to talk to Tim Sacks.	**KE**
SLT 19/32 Frailty End of Life Programme Report (Paper E)	
JA presented the Frailty End of Life Programme Report noting that the programme should have ended at Christmas but had been extended until the end of March 2019. Good progress had been made on a wide range of 'wicked' issues. Not everything had been completed and elements would be picked up by other work streams, for example, by Integrated Care Board and Community Services Redesign. JA commended the methodology used (referred to nationally as 'focus lab') as it created a more informal	

yet productive way of working. The methodology was already being used for the Community Service Redesign. He thought the mandate provided by SLT meant participants were motivated to make changes without focusing on their own organisational constraints.	
SL referred to the statement on page 4 that 'all providers have access to EPR core to enable view of S1 care plan' and noted that it was not the case for EMAS and NHS111. PM said IM&T Group was progressing the matter with EMAS. The question was raised about how the information was used. NP thought it should mention the Enhanced Summary Record. JA agreed to seek clarity regarding access to Systm1 in UHL.	**JA**
NP left at this point and the meeting was no longer quorate.	
SL referred to page 6 and the outcomes listed. She asked what lessons could be learnt about the methodology of estimating future impacts, noting the reduction in emergency activity was modest and well below anticipated levels. JA said that the success was in capping the activity when peer trusts had seen an average 17% growth. CT said that one of the lessons could be in building in QI methodology at the outset to enable success to be demonstrated.	
CT proposed that a formal handover of remaining actions be made to the SRO's who should be asked to confirm the actions had been included in their work plan.	
RL said the issue was how to sustain the progress made and assurance for the future outcomes. JA said the approach the Task Force took was to mainstream the work. He thought it would be useful to do a stock take and it was agreed for a further report to be made in October. This will be added to the forward planner.	**JA** **AM**
ER made reference to the statement on page 3 of the report; 'Related Patient and Public Involvement actions taken, or to be taken: [Not Applicable].' He said that there had been engagement and the report should have referenced the impact it had made.	
SLT thanked Rachna Vyas for the work and commended the approach taken for similar initiatives, such as End of Life Care. SP suggested the approach would be useful for the Interdependencies Group to understand and use.	
JA asked what the QI methodology was for the system adding that UHL was developing a uniform methodology. PM suggested that reference could be made to the commitment to learning within the STP.	
SLT 19/33 Update from STP Meetings	
SL reported on the last event she attended on 6 April. She noted there had been a review of constitutional targets and a nationally produced interim report issued. Four areas were trialling the changes with a view to making changes next year. The revised targets would be more clinically appropriate especially for emergency care.	
SL noted that reference had been made to the transfer of estate from NHS Property Services to trusts although no detail was available. PM said LPT would welcome more flexibility as at present it was not possible to transfer NHS property if it was still in use.	
SL reported that there had been a presentation from Dorset ICS on developing leadership across the system and talent management. SL undertook to get more information.	**SL**
SLT 19/34 LLR BCT IM&T Workstream Leadership Briefing	

The LLR BCT IM&T Work stream Leadership Briefing was received for information.	
SLT 19/35 Any other business	
LLR End of Life Care Taskforce CT gave a presentation on the work underway by the End of Life Care (EoLC) Task Force. She said that it was building on the work undertaken on Frailty with Rachna Vyas providing support. CT said the focus had been lost and the Learning Lessons to Improve Care presented some difficult challenges. The EoLC Working Group did not have the profile that was needed. There was data available on the place of death and the proportion dying in their own homes and dying in hospital. CT said it was important for patients to die in the place of their choice. There had been progress made by the End of Life Working Group in the testing of Integrated Palliative Care service but there was a need to focus on generalist EoLC offer in the community. Professor Mayur Lakhani was leading the Task Force and the objective was to 'to design a high quality, patient-led system of care for patients at the end of their life'. A representative from PPI was heavily involved and the Task Force was being support by Carole Ribbin. CT presented a slide which identified the governance arrangements noting the Task Force reported into SLT acknowledging the links to Integrated Care Board and Community Services Redesign. CT outlined the Quality Improvement ethos and the priority areas: 1) Identification 2) Proactive management 3) Crisis management 4) Improving culture and behaviours. CT said the intention was to work to the 'daffodil standards' (developed by Marie Curie) which had already been implemented at UHL and needed to be aligned in respect of community care. CT said the intention was to implement the RESPECT tool to enable clinicians to discuss 'ceilings of care' and broadening out the discussion beyond DNR. She added that EMAS had been keen on the initiative to ensure consistency across the region. JA welcomed the Task Force and asked how long it would be in place. CT thought 12 months and SLT considered that it needed to be a shorter period following which the remaining actions could be allocated to SROs as appropriate (replicating the approach for the Frailty Programme). SP asked whether the scope would address issues around CHC. CT confirmed. AP said that many city patients did wish to die in hospital due to cultural differences and this needed to be accommodated. He added that the primary and secondary care differed in the implementation of DNR. GPs, he stressed, were more likely to involve the family in the discussion as well as the patients. CT said that Dr Than was involved in the work and AP agreed to provide a case study demonstrating the value of discussion with the family.	**AP**
UM asked whether a link had been made to the work being undertaken by Leicester University regarding DNRs. She agreed to provide CT with a contact.	**UM**
SB thought there had been 'push back' from EMAS regarding RESPECT and concerns around the flow of information between primary and secondary care which created clinical risks. CT said that	

IM&T had been helpful in supporting the implementation of an electronic record but the national approach promoted paper records. SLT expressed their concern at this paper-based approach.	
Agenda for Confidential Meeting of SLT	
The minutes of the confidential meeting were reviewed. There were no amendments proposed. As the meeting was not quorate the minutes were not ratified. There were no actions on the action log and not confidential items for any other business.	
Date, time and venue of next meeting	
9am-12pm Thursday 18 April 2019, 4th Floor Conference Room, St John's House	