System Leadership Group

Held on Thursday 11th September 2014
2pm-4pm
In the CCG Board Room, 5th floor, South Plaza

Minutes

Present:	Anthony Farnsworth (AF) Chair	Director, Area Team, Bristol, North Somerset, Somerset and South Gloucestershire
	Mary Backhouse (MB)	Chief Clinical Officer, North Somerset Clinical Commissioning Group (CCG)
	Penny Brown (PB)	Chief Executive, North Somerset Community Partnership
	Jane Gibbs (JG)	Chief Officer, South Gloucestershire CCG
	Jonathan Hayes (JH)	Chair, South Gloucestershire CCG
	Martin Jones (MJ)	Chair, Bristol CCG
	Sasha Karakusevic (SK)	Chief Operating Officer, North Bristol Trust
	Andy Kinnear (AK)	Director of Informatics and Business Intelligence, South West Commissioning Support (SWCS)
	Alison Moon (AM)	Transformation and Quality Director, Bristol CCG
	Michele Narey (MN)	Bristol Community Health
	Linda Prosser (LP)	Director of Commissioning, Area Team, Bristol, North Somerset, Somerset and South Gloucestershire
	Neil Riley (NR)	Head of Commissioning Intelligence and Insight, SWCS
	Janet Rowse (JR)	Chief Executive, Sirona
	Richard Smale (RS)	Deputy Director of Transformation, SWCS
	David Tappin (DT)	Director of Strategy and Service Transformation, SWCS
	Claire Thompson (CT)	Programme Director, SWCS
	Iain Tulley (IT)	Chief Executive, Avon and Wiltshire Mental Health Partnership NHS Trust (AWP)
	Nick Wood (NW)	Chief Executive, Weston Area Healthcare Trust
	Robert Woolley (RW)	Chief Executive, University Hospitals Bristol NHS Foundation Trust
In attendance:	Jo Wilson (notes) (JW)	SWCS
Apologies:	Julia Clarke	Chief Executive, Bristol Community Health (BCH)
	Jill Shepherd	Chief Officer, Bristol CCG
	Andrea Young	Chief Executive, North Bristol Trust

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1. Welcome and Introductions Those present were welcomed and apologies were noted as above.	
2. Context for the meeting AF made the following introductory remark: "Many of us will be aware of the history of Bristol Health Services Plan and the Healthy Futures Programme arrangements and the discovery over the recent past that the Healthy Futures Programme wasn't generating, despite the obvious need, the decisiveness needed, nor generating a clear forward view of the system as a whole. Many will recollect the Acute Services Review that PWC undertook on behalf of the two large hospital trusts approximately 18 months ago. It is important to note that the review did leave some unanswered questions particularly regarding the extent of the demographic and financial challenge and that the review and subsequent actions and plans have not been attended to. It is an important point to make, to acknowledge that we have had some marked successes with performance improvement in some areas but that we are carrying collectively between us some quite serious unsustainable problems in terms of achievements of expected constitution standards. Having been in the Area Team for 2 years now there is some history of reticence in holding one another to account for particular achievements or pieces of work. Having reflected on that and thinking about it before this meeting, we have suffered at time either from an overcomplicated or over extensive work programme or some lack of rigour in programme and project management together and how those arrangements have landed back here in terms of how the Chief Executives receive progress and talk about it. This hasn't helped the Chief Executives in the ability to sustain a particular topic and sustain that over time through the detail. This has been a weakness we have all collectively suffered, noting my own contribution to this as well. We do not want to go around the cycle of reviewing Healthy Futures: there has been some good effort, and some frustrations and as MJ commented some time ago, there was an element that was almost circular. There has been a small very consistent group of issues which are on the agenda today where there has been a consensus that collective actions across BNSSG are needed. The items are on the agenda today through quite a lot of discussion and thinking with a number of colleagues attending this meeting. Today's meeting is to debate and establish the vehicle for carrying this	

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work and, if successful, then by mutual agreement this vehicle may be able to carry other pieces of work. In preparation for this meeting a number of you have said that it would be better to establish the "core" of strategic issues that definitely require collective effort and to work on these and establish confidence in our ability to carry them forward. I feel that a group of this sort is at the summit of contributing to these streams of work and effort and I sense those working for us are looking for a sign confirming our collective will. There is a symbolic component to that and also a component of substance which comes of the requirement this will draw us to contribute and to expect others to contribute to particular pieces of work. The example which we set and the expectations we convey are important. AF suggested that at the end of the meeting in AOB he would test whether the group can agree today and draft a short explanatory narrative about this arrangement and what it's for and to do that so that it can be shared with the different Board and Governing Bodies of the organisations attending this meeting. This would help to create a wider understanding of our joint approach regarding and create a commitment in each corporate body around the actions the organisation will undertake. This will be designed to be a binding agenda. I very much welcome the discussions about the role of the Directors of Finance (DoFs) Group (DoF) and how the DoFs Group will come together to support the work of the System Leadership Group. This was a piece of deliberate design. The CEOs need to make sure the DoFs do share some of the accountability for progress. Many of the brakes and accelerators lie in the DoFs' hands. There are linked areas of work in Demand and Capacity and the fundamental centre piece around the alignment of organisational plans. Both pieces of work are designed to be overseen by the DOFs. In the Terms of Reference (ToR) for the DoFs Group there is a suggestion which RW made around the importance of the development of business case methodology so that the proposals for agreement have been through the rational challenge and assessment of the DoFs. I am highlighting this so that it is open and understood at this meeting so that some of these pitfalls are not stumbled in to. I feel there is tremendous positive potential for this group. Bristol has great clinical and managerial potential and is England's wealthiest provincial city. The new willingness of people to work together and the joint frustration of not capitalising on those strengths can help address how we underperform for the health of our population. We can use this vehicle to overcome these obstacles and move forward in a positive direction".	

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Comments on AF's opening remarks: JG: We are a health group and we will deal with our colleagues in a different way. We are going to have to think about that as we form our agenda. Local Authorities (LA's) seem to be quite happy with the idea of us feeding back to them and doing work through Health and Wellbeing Boards. This is different by its nature to what we have previously tried to do. AF: A number of us have been testing this with LA colleagues and they have not resisted but do not want to be excluded from the right discussions. **2.1 Alignment of 5 year plans** DT gave a verbal presentation on the alignment of plans. A set of slides named "The Challenge To Live Within Our Means" was presented to the group summarising the outcomes of a desktop review of the CCG and provider plans. The slides were designed in order to enable a discussion amongst those present today about how to proceed with the alignment of plans. The slides highlighted the cumulative QIPP challenges set out for the CCGs of over £100 million and acute providers cumulative cost improvements of around £200 million savings in 5 years. The figures did not include all providers or NHSE. The desktop review covered the plans for CCGs, UHB, NBT and Weston and illustrated common ground in terms of the strategic direction described. The narrative was consistent, with a focus on a shift away from acute hospital care. There were however some significant inconsistencies amongst the activity and financial assumptions. Some of the variance is explained by specific factors such as the Better Care Fund assumptions not being reflected in provider plans; and the CCG plans not containing the assumptions made by providers with regards to some service transfers. Overall CCG planning assumptions show a high degree of consistency between the different commissioners. The recognised areas of difference do not explain the scale of the overall difference within the sets of plans. DT confirmed that the intention of the presentation was not to get into a detailed debate about the differences and assumptions between provider and commissioner plans, but to test whether there was commitment to align plans and agree actions to take work forward. If there is going to be sustainable change then clearly there are some significant changes are required to the way in which services are delivered, but also in how they are commissioned and contracted and risks shared. CCGs had indicated their desire to understand provider plans and explore shared opportunities. . DT noted that it was proposed that the DoFs group would take leadership of this piece of work. It was proposed that they would	

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review the plans of all commissioners and providers represented at the System Leadership Group to assess what the differences are and why and put a plan of action to build alignment to the System Leadership Group for agreement. **Comments / Questions:** NW: Questioned whether, given the scale of the challenges, a more radical approach is required, which develops a single plan to effect significant change across all organisations, which overrides the individual interests of particular organisations.. AF: Recognised what NW had said was a valid challenge. However, in the context of what he had said in the introduction to the meeting, he reiterated the importance of making progress on the core agenda which had been identified as the immediate areas of shared interest. SK: Noted the need to think about alternative perspectives to the DoFs when progressing with this work. PB: Noted her concern that the review had not included community providers. DT: The desk top review that has taken place so far has focused on acute provider plans, but he was clear that this would need to be extended to cover all providers. MJ: Noted that a community based model will rely on social care and their financial requirements have to be taken in to account at some stage. JR: Noted the need to effect change at the right level. A lot can be delivered by health and social care working effectively together at the local level. RW: Noted that he was keen to check the difference in assumptions that had been presented and to understand it better. He expressed his interest in making this approach work. He noted that, as Chief Executive of a Foundation Trust he is obliged to ensure his organisation is sustainable And this creates potential tensions with a focus on the sustainability of the system. In this context he emphasised the importance of ensuring that changes happen in a managed way. RW noted that he felt that is missing in the DoFs' Terms of Reference. We have to do both; sustain the organisations we have got and plan and manage changes in a reasonable way. AF: Recognised that there are issues facing providers and commissioners as we look ahead. At this time there is not a reconciled set of plans. We need to find out what the differences are and decide which ones can be addressed. JG: Noted that DT's presentation was encouraging us to understand each other's plans and where that alignment is. To understand each other's intent. There is a real benefit in	

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understanding each other's business. AF: Explained that the items on the agenda were the 4 key items that are enabling pieces of work that need to be done at a wide scale to support the change.RW: Said that we should do the work proposed and that all the about the different underlying assumptions UHB have gone back to Monitor to say they won't deliver 4% for CIPs as they do not believe this is achievable. . At the same time UHB loses money on Medicine and can see the benefits to UHB as well as to other organisations of changing the way these services are delivered. Understanding where we all are and what we think is achievable, is essential. IT: In the light of RW's comments, noted the importance of looking at the whole system as opposed to part of the system and considering whether there are shared opportunities. He suggested this should be a focus for the work on alignment of plans also. AF: Agreed with these comments. Following this discussion, the Group **agreed** to proceed with the work on alignment of plans through the DoFs Group as proposed. AF noted that he would come back to the point raised by SK about how to ensure different perspectives inform this work,	
3. Role of the Group **3.1 Terms of Reference** The suggested ToR and membership were discussed. **Comments / Amendments/ Suggestions:** AF: Noted that he was starting from the point of identifying 4 specific areas of work where collective effort is needed. In time the agenda may be extended to include more clinical topics (e.g. such as 'improving the management of heart disease'). He noted that, before that, we need to deliver the key enabling pieces together. He also noted that we should not draw work to this group which belongs locally. JG: Noted that Healthy Futures worked well in terms of describing enabling activities, but these are not well described in the diagram in the terms of reference. Following discussion, it was agreed that deputies could attend the meeting. Authority to make key decisions at these meetings to be discussed between CE and deputy prior to attending. LP noted that her title needed to be changed to Director of Commissioning.	**CEs**

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With these changes, the terms of reference were **agreed**. **Action:** RS to amend terms of reference to reflect these comments. **3.2 Principles – Working Together Concordat** A discussion took place to agree the principles of working together, underpinning how we behave. JH: Queried if the approach was being 'clinically led' as indicated in the Concordat. AM: Asked AF how he saw the clinical leaders' voice being heard at System Leadership Group. AF: Felt there was a lot of clinical leadership and engagement in the work taking place outwith the Group, on local work to redesign services. The initial focus of the Group was on enabling activities. MB: Said that what is going on the ground is generally clinically led. The redesign we are doing with local authorities at a local level is clinically led. MJ: Suggested reference could be made in the diagram in the terms of reference to what happens locally with clinical leadership and engagement. The Concordat was **agreed** by the Group.	**RS**
4. Role of the Directors of Finance **4.1 Terms of Reference** A discussion took place focussing on the role of the DoFs' Group in supporting the system leadership work. RW: Proposed that the terms of reference should include identifying the impact of change for individual organisations? With this change, the terms of reference were **agreed**. **Action:** RS to update Concordat **4.2 Chair of the Group** AF: Proposed that IT take on the Chairmanship of the new DoFs Group This proposal was warmly endorsed by the Group.	**RS**

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5. Strategic Resilience Group

5.1 Terms of Reference

CT gave an update on the Strategic Resilience Group (SRG). This group was created as a result of national guidance which was released in the summer of 2014. The group covers unplanned care and elective care issues as they relate to the whole system. Local forums already exist for the management of local unplanned care issues. The benefit of having the SRG reporting to the System Leadership Group was noted.

CT noted that the SRG had evolved from a response in relation to the Frenchay closure and the need to address the associated cross community issues. Had SRG existed at that time it would have provided a natural forum for these discussions.

The Group has picked up the baton for Operational Resilience Planning that needs to be done at a pan CCG and provider level e.g. checking alignment of investments at each individual system level. It is also supporting the BNSSG wide escalation policy through its work on demand and capacity modelling.

The terms of reference had been approved by organisations and were shared with the System Leadership Group for information. CT queried that everyone felt comfortable with these arrangements.

JG: Noted that it reinforces that clinicians need to be the driving force. Forums like the Urgent Care Boards are places where key local decisions get made but the SRG is a good way of sense checking that we are at the right place.

CT: In response to a question from RW, advised that the process of identifying clinical leads is in hand. In response to a question from NW, noted that we need to be careful that Urgent Care Networks and Planned Care Networks are invigorated and not replaced by the SRG.

LP: Suggested that what is different about this group is that it recognises the interdependencies of the Planned Care and Urgent Care systems and that's the critical space it operates in.

SK: Felt that the current Urgent Care working groups are the right groups for securing resilience and was not sure this has been built in to the terms of reference.

The Group noted the report.

Action: CT to talk to SK to refresh the terms of reference.

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5.2 Update report CT spoke briefly to the update report provided.	**CT**
6. Programme updates and highlight reports **6.1 Demand and Capacity Modelling** CT introduced a presentation on 'Modelling Demand and Capacity'. She noted that the CSU is developing technical modelling that aims to meet the needs of commissioners and providers. One of the purposes is to inform 2 and 5 year planning, commissioning and contracting processes. The development is to be supported/coordinated through a technical sub-group which has been established with commissioner and provider representation. Representation from system partners is being sought. Overall future governance for system-wide Demand and Capacity modelling will be through the BNSSG Directors of Finance group. It was highlighted that this was a complex area and there was a need to have the right tools to do the job. Future challenges and opportunities include new software requirements for presenting information; the need to develop links to Public Health Needs Assessments and Health Impact Assessments and the need to build and sustain a core group of people to create the information, translate it to intelligence and articulate it for use. There was also a call to specify requirements for modelling in response to organisational and system dynamics and to ensure the work is focused. The need to work smarter was also noted, with the opportunity of getting external validation of the approach from university partners and the Academic Health Science Network noted. **6.2 Connecting Care Programme** AK presented a paper on Connecting Care Business Case / Finance Update which included three options. AK noted the current position in terms of revenue and capital funding commitments and noted the associated risks.	

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It was noted by AK that there are some opportunities to mitigate the financial risks, through dialogue with the supplier and through scaling the programme of work to be undertaken. MJ: Noted that he could not see how we can support effective change across organisations without Connecting Care. He was in favour of proceeding with Option1 (approval to proceed with Stage 2 of the Connecting Care Programme). RW: Said he was supportive of Option1, on the basis we mitigate the risks where we can. AK: Noted that there are 6 projects each year in a programme so if necessary we could scale back the rate of development in line with our financial envelope. MJ: Queried the AHSN offer of money. RW: Noted this was still under discussion. NW: Noted that if Weston was being asked to sign up for 2 years this might change their position. JG: Supported proceeding with Option1,with a scaling back of the revenue implications if necessary. AF: Noted the encouraging nature of the discussions and the commitment to joint working. It was **agreed** to proceed with Option 1, on the basis that AK and the Connecting Care Programme Board would seek to mitigate capital and revenue risk.	
7. Any other business AF asked group if there was support for writing a piece of text explaining the purpose of the Group to organisational boards. This was agreed. **Action: AF/RS to generate a draft for approval.**	**AF/RS**
8. Dates of future meetings The next meeting will be held on Thursday 20th November from 2-4pm in the CCG Board Room, 5th floor, South Plaza. Actions for scheduling meetings in 2015 will now be taken forwards based on the outcome of today's meeting.	**RS**
9. Close	