Trust Board paper P

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

Trust Board Bulletin – 7 December 2017

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:-

- **Guardian of Safe Working quarterly update** – Lead contact point Ms L Tibbert, Director of Workforce and OD (0116 258 8903) – **paper 1**
- **System Leadership Team minutes (21 September and 19 October 2017)** – Lead contact point Mr J Adler, Chief Executive (0116 258 8940) – **papers 2 and 3**

It is intended that this paper will not be discussed at the formal Trust Board meeting on 7 December 2017, 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.

Junior Doctors Contract Guardian of Safe Working Report

Author: Jonathon Greiff, Guardian of Safe Working, Consultant Anaesthetist and Vidya Patel, Medical Human Resources Manager
Sponsor: Louise Tibbert, Director of Workforce and Development

Trust Board Bulletin 7 December 2017 **paper P1**

Executive Summary

The new 2016 junior doctors' contract has now been fully implemented at UHL in In line with the national timescales.

Context

This report has been produced in line with the requirements of the 2016 Junior Doctors Contract whereby the Guardian of Safe Working (GSW) will provide a quarterly report (June, September, December and March) on the management of Exception Reporting and rota gaps.

In the last 3 month period from September to November there have been 68 exceptions recorded, in total 277 exceptions have been recorded at UHL.

Questions

1. What is the current position on the implementation of the Junior Doctors Contract at UHL?
2. How many Exception Reports have been received at UHL in the last quarter and to date?
3. How many rota junior doctor gaps exist at the Trust?

Conclusion

1. The Trust has implemented the 2016 Junior Doctors Contract. All junior doctors (with the exception of two trainees) have moved to the new contract. These two doctors will transfer to the new contract in April 2018 in line with the national timescale.

2. An Exception Reporting procedure has been in operation from 7th December 2016. To date 277 exceptions reports have been recorded. Eleven are related to education issues and others relate to work patterns.

3. There are 114 vacancies on the junior medical staff rotas. The majority of these gaps are being managed by backfilling with locum doctors. Active recruitment is on-going to fill any remaining gaps.

Input Sought

We would like the Trust Board to note the progress being made and provide feedback if required.

1. The following **objectives** were considered when preparing this report:

Safe, high quality, patient centred healthcare	[**Yes** /No /Not applicable]
Effective, integrated emergency care	[**Yes** /No /Not applicable]
Consistently meeting national access standards	[**Yes** /No /Not applicable]
Integrated care in partnership with others	**[Yes** /No /Not applicable]
Enhanced delivery in research, innovation &ed'	[Yes /No /**Not applicable**]
A caring, professional, engaged workforce	[**Yes** /No /Not applicable]
Clinically sustainable services with excellent facilities	[Yes /No /**Not applicable**]
Financially sustainable NHS organisation	[**Yes** /No /Not applicable]
Enabled by excellent IM&T	[**Yes** /No /Not applicable]

2. This matter relates to the following **governance** initiatives:

   a. Organisational Risk Register [Yes /**No** /Not applicable]

   If NO, why not? Eg. Current Risk Rating is LOW

   b. Board Assurance Framework [Yes /**No** /Not applicable]

   If YES please give details of risk No., risk title and current / target risk ratings.

Principal Risk	Principal Risk Title	Current Rating	Target Rating
No.	There is a risk …		

3. Related **Patient and Public Involvement** actions taken, or to be taken: [NA]

4. Results of any **Equality Impact Assessment**, has been undertaken and shared with the Executive Workforce Board on 17th January 2017.

5. Scheduled date for the next paper on this topic: March 2018

6. Executive Summaries should not exceed **2 pages**. [My paper does comply]

7. Papers should not exceed **7 pages.** [My paper does comply]

1. Introduction

1.1 In line with the requirements of the new junior doctors contract the Guardian of Safe Working (GSW) will provide a quarterly report to the Trust Board (June, September December and March) with the following information:

- Management of Exception Reporting
- Work pattern penalties
- Data on rota gaps
- Details of unresolved serious issues which have been escalated by the Guardian

1.3 In addition the GSW shall provide a consolidated annual report on rota gaps in April 2018 and details of the plan to reduce these gaps.

1.5 These reports shall also be provided to the Local Negotiating Committee and the Trust Junior Doctors Forum.

1.6 The Board is responsible for ensuring the required reporting arrangements are in place. This includes annual reports to external bodies (including Health Education England East Midlands, Care Quality Commission, General Medical Council and General Dental Council).

1.7 All necessary reporting structures are in place.

2. Background

2.1 The new 2016 Junior Doctors Contract came into effect on 3rd August 2016. In line with the national timescales, transition to the new contract at UHL has been as follows:

- December 2016 - All Foundation Year 1 Doctors
- February to April 2017 - All F2, CT, ST3+ Doctors in Paediatric, Pathology and Surgery
- August 2017 - All Remaining Doctors with the exception of doctors in training whose contract of employment expiry was beyond August 2017.

2.2 There are two remaining junior doctors in training in Paediatric Surgery who will transfer to the new contract in April 2018 in line with the national timescale.

3. Management of Exception Reporting

3.1 In line with the Trust procedure for Exception Reporting, doctors that have transitioned to the new contract will raise Exception Reports on work pattern or educational problems using a web based package.

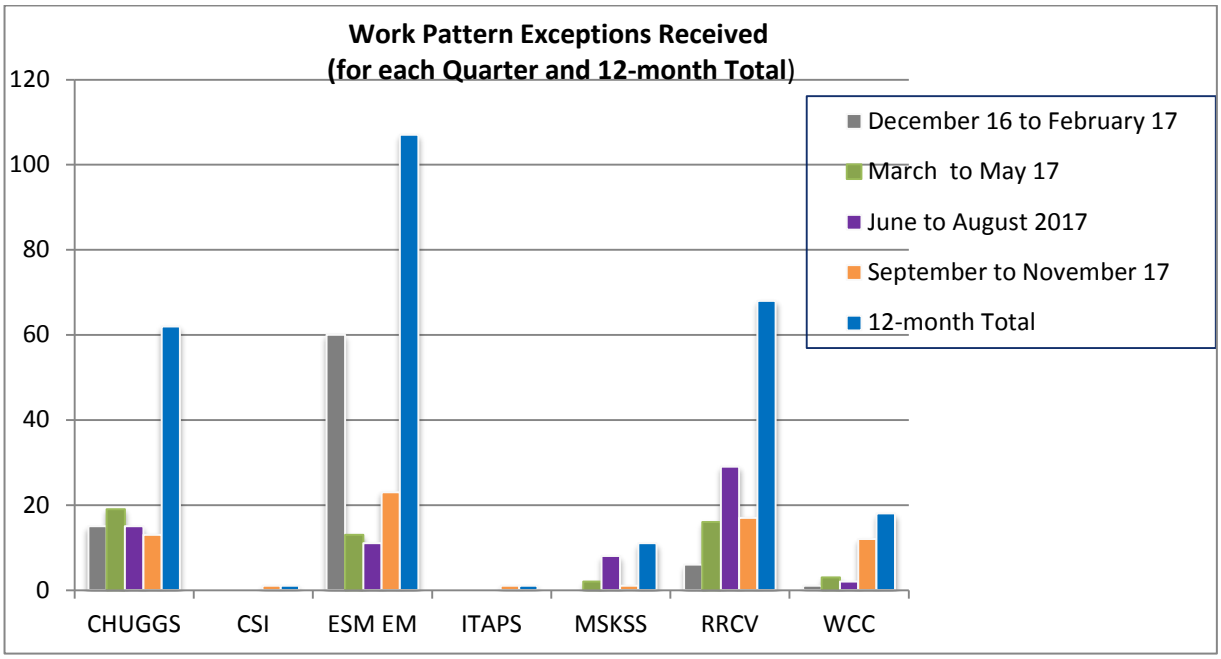
3.2 Number of Exceptions Reported

3.2.1 At the time of writing this report on 21th November 2017, a total of 277 Exception Reports have been received of which 68 were received in the last quarter (September to November

2017). There are 11 breaches that relate to educational opportunities and the remainder relate to work pattern or support issues.

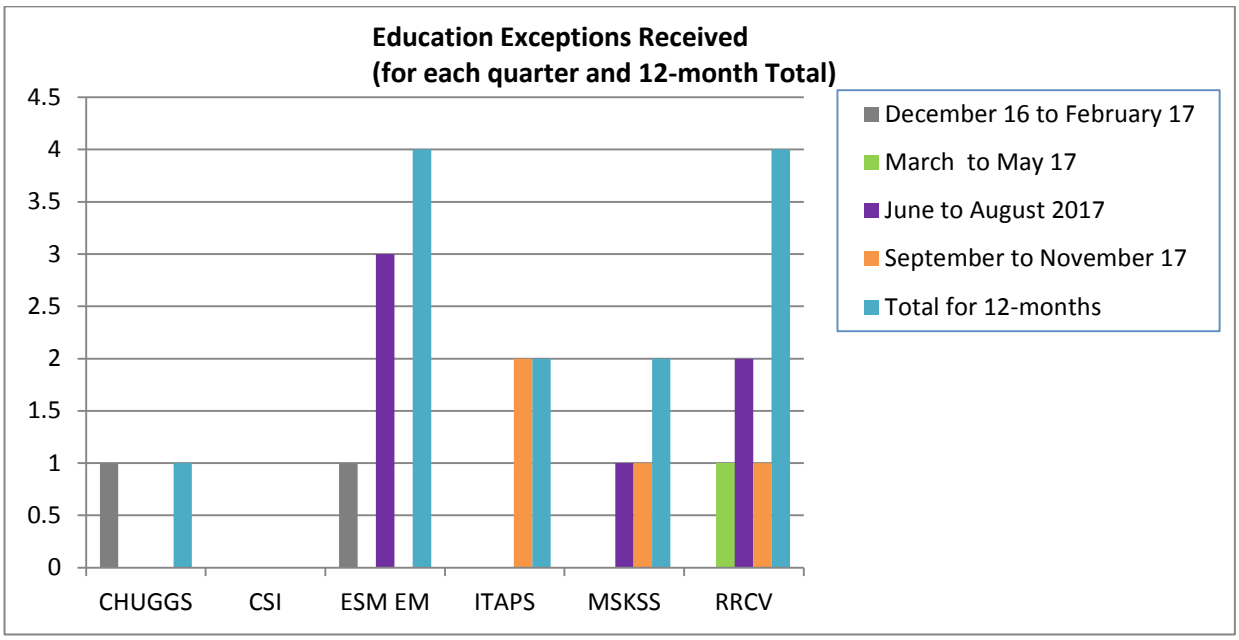
3.2.2 The graphs below provide an overview of work pattern and education exceptions received by CMG for each quarter and in the 12 month period:

Graph 1 - Work pattern/support exceptions



3.2.3 As indicated in graph 1 the highest number of exceptions have been raised in ESM EM, followed by RRCV this is representative of the high number of junior doctor establishment in these CMGs

Graph 2 Education exceptions by CMG for each quarter and in the 12 month period



3.2.4 The Exception reporting data is shared with the CMGs via email and at CMG Workforce Meeting.

3.2.5 All Exception reports are reviewed at Trust level to identify any patterns and/or cause for concern and focused reports are provided to the relevant Heads of Service leads to undertake a further review and to take appropriate action in a timely way.

3.3 Resolution

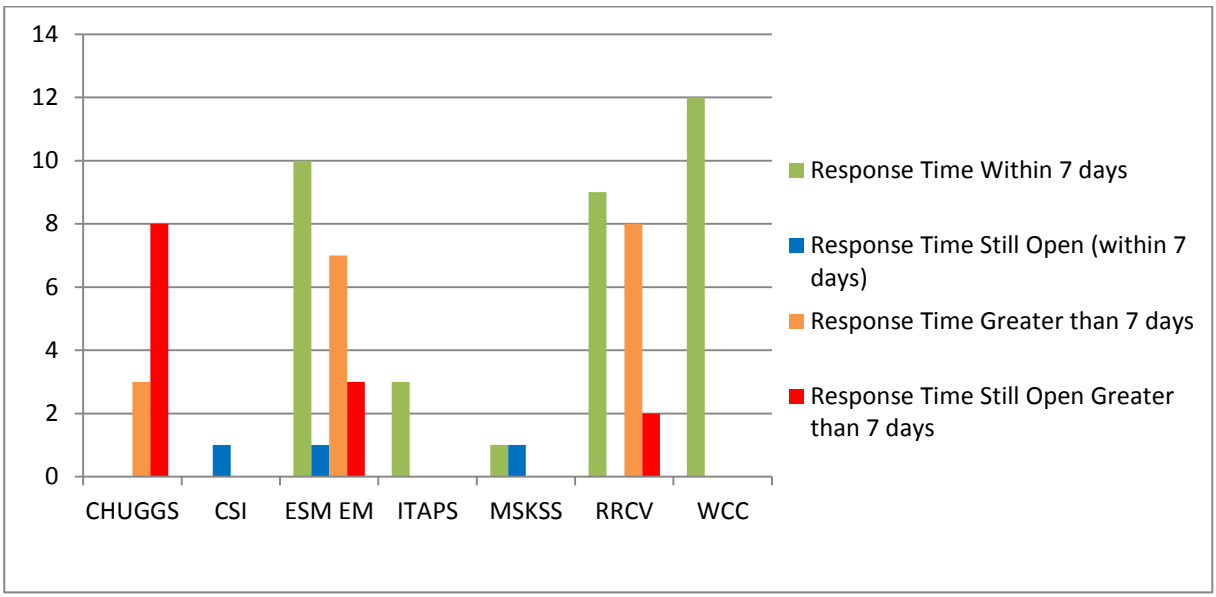
3.3.1 For the majority of the exceptions time of in lieu is allocated. In the last quarter out of the 69 exceptions received, time of in lieu has been allocated for 47 exceptions.

3.3.2 Following feedback from junior doctors, time of in lieu is now being allocated in agreement with the junior doctor, so that the doctor has the opportunity to advice when they would value TOIL time being allocated.

3.3.3 A penalty has been applied to one exception where the doctor was unable to achieve the required 8 hours of rest when working a non-resident on-call duty.

3.4 Response Time

3.4.1 Junior Doctors are required to raise exceptions with 14 days (7days if payment is being requested) of the issue occurring. The Trust has 7 days to provide a response. The response time for exceptions in the last quarter is detailed in the graph below:



3.4.2 At present CMGs are managing exception reports appropriately, however it is important to improve on outstanding response time so that the majority of the exceptions are closed within 7 days.

4. Work Schedule Changes

4.1 There have no work schedule changes in the last quarter.

5. Junior Medical Staff Vacancies

5.1 Both trainee and trust grade vacancies are provided as they work on joint rotas, therefore any vacancies at this level will have an impact on trainee doctors. The number of junior medical staff vacancies from August to December 2017 is provided in table below:

CMG	Establish-ment	FY1	FY2	CT1/2	TG F2/ CT1/2	ST3+	TG ST3+	Total	Percentage Vacancy
CHUGGS	133	0	0	1	3	4.9	0	8.9	7%
CSI	68	0	0	0	0	6	0	6	9%
ESM EM	172	2	1	3	4	6	9	25	15%
ITAPS	84	0	0	0	0	0	0	0	0%
MSKSS	127	0	0	0	6	0	11	17	13%
RRCV	153	4	1	6	6	6	6	29	19%
WCC	172	1	1	10	2	8.7	5	27.7	16%
Total	**909**	**7**	**3**	**20**	**21**	**31.6**	**31**	**113.6**	**12%**

5.2 During this period there are a total of 114 vacancies which equates to 12% of the total junior medical staff establishment.

5.3 The Trust has an active rolling recruitment programme for FY2/Core level trust grade posts offering 12 month posts in various specialities and therefore the vacancy data is subject to significant change on weekly basis.

5.4 Where active recruitment is not successful there is a requirement for internal and external locum backfill which is managed by the CMGs with an oversight from the premium spend group.

6. Additional Work

6.1 A review of the rest requirements for non-resident on-call rotas is currently being undertaken by meeting with trainees and consultants and where appropriate undertaking audit work. If any issues are highlighted action will be taken to improve the ability for doctors to take adequate rest.

6.2 The Medical HR Manager is attending service level consultant meetings to ensure consultants are fully aware of the new hours and rest requirements of the new contract and to ensure that they are fully engaged with the exception reporting process.

7. Conclusion

7.1 The implementation of the 2016 Junior Doctors Contract has gone well.

7.2 The next Guardian of Safe Working report will be provided in March 2018.

7.3 All exceptions have been handled appropriately and numbers are considered to be relatively low so far, with one financial penalty imposed.

8. Recommendations

8.1 Board members are requested to note the information provided in this report.

8.2 Board members are requested to provide feedback on the paper as considered appropriate.

System Leadership Team

Chair: Mayur Lakhani

Date: 21 September 2017

Time: 9.00 -11.15

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

Present:	
Mayur Lakhani (ML)	Chair, West Leicestershire CCG, GP, Silbey Co-Chair Clinical Leadership Group
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
Satheesh Kumar (SK)	Medical Director, Leicestershire Partnership Trust, Co-Chair Clinical Leadership Group
Sue Lock (SL)	Managing Director, Leicester City CCG
Peter Miller (PM)	Chief Executive, Leicestershire Partnership Trust
Will Legge (WL)	Director of Strategy and Information, East Midlands Ambulance Service NHS 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
Caroline Trevithick (CT)	Chief Nurse and Quality Lead, West Leicestershire CCG
Mark Wightman (MW)	Director of Communications, Integration and Engagement, University Hospitals of Leicester NHS Trust
Apologies	
Toby Sanders (TS)	LLR STP Lead, Managing Director, West Leicestershire CCG
John Adler (JA)	Chief Executive, University Hospitals of Leicester NHS Trust
Helen Briggs (HB)	Chief Executive, Rutland County Council
Andrew Furlong (AF)	Medical Director, University Hospitals of Leicester NHS Trust
Richard Henderson (RH)	Deputy Chief Executive, Rutland County Council
Andy Keeling (AK)	Chief Operating Officer, Leicester City Council
In Attendance	

Shelpa Chauhan	Office Manager, BCT
Janice Richardson	Admin and Project Support, BCT

1. Apologies and introduction

Apologies received from Toby Sanders, John Adler, Andrew Furlong, Richard Henderson, Andy Keeling, Helen Briggs

2. Conflicts of interest handling

ML explained that the governance lead of the NHS organisations had reviewed the agenda and papers for potential conflicts of interest. This indicated the following items of note for this part of the agenda;

Item 7 - Community services model update. Declaration of interest from representatives of LPT as the paper relates to services their organisation deliver; declarations of interest from UHL and CCG GP representatives due to implications for their own papers.

Item 8 - Integrated Locality Teams. Declarations of interest from LPT, Local Authority and CCGs as parties to the Integrated Locality Teams

JS expressed concern, both about the approach to considering potential conflicts of interest and the lack of involvement from the local authorities in considering this.

ML sought to explain that the conflicts of interest review process was an informal one designed to identify any potential issues so that these can be notified in advance to the Chair to enable them to consider how to manage these.

JS and RP suggested that this aspect of SLT working would benefit from being clarified and more explicit to avoid confusion over language used between parts of the system.

3. Minutes of last meeting, 17th August 2017

Minutes of the last meeting were approved.

4. Review of Action log

170817/02 NB advised work is in progress which includes looking at contract models. Needs to be done jointly with Contracting.

5. Mission and goals

LS presented Paper C, asking the partners to agree and approve the mission, vision, goals and principles with any amendments for inclusion in the revised STP draft.
LS stated that a draft of the Missions and Goals had gone into the Joint Integrated Commissioning Board (JICB) and PPI Group.

LS explained that the PPI group had fedback on the level of ambition and raised concerns on the engagement.

From the following discussion the partners expressed support for the paper. There minor points regarding language. PM queried whether it was appropriate to commit to ACS language given earlier discussions.

The paper was accepted by the partners pending the following amendments:

- Show all five goals in columns
- Amend the wording Accountable Care System to accountable health and social care system
- Replace the word citizens with people
- Amend the workforce core principle. We will support joy at work to promote high morale and staff wellbeing to remove the word joy as it may be perceived as trite.

In terms of language, LS noted that using the words and phrases that came out of the feedback from frontline staff and public engagement is likely to resonate more with people. She confirmed that the Mission and Goals has been shared with Social Care Leads.

6. Urgent and Emergency care up, including winter plan

SL and John Adler attended a meeting in London with 18th Sept along with representatives from other Trusts experiencing A&E performance issues.

SL relayed the key topics from the meeting:

- Concern about this winter, looking at the year on year growth at A&E activity. Over the last 15yrs emergency admissions have increased but the length of stay has been going down. In 2015/16 this changed as there was continued growth but no reduction in length of stay has also increased. Head of CQC, David Biel spoke about making unannounced visits to ED over the winter months' LLR's winter plan has been developed by the Accident & Emergency Delivery Board (AEDB). Any poor performing Trust's/hospital's winter plan will not be deemed acceptable. A local winter team is to be established consisting of medical ED lead/CCG UEC lead/Trust Operational lead reporting to SL and JA who in turn report to Dale Bywater, NHSE Regional lead
- Australasian flu pandemic and the possibility of it coming to the UK this Winter.
- GP extended access roll out, making it as easy as possible for patients to access
- 111clinical triage; increasing the level of clinical triage of calls through 111.LLR is recognised as performing well in the area of clinical triage
- Urgent Treatment centres. This is a national drive to re-designate treatment centres to urgent treatment centres if they met set criteria.
- Delayed transfer of care (DTOC) and the pressures experienced by LAs
- GP streaming at the front door of ED
- Ambulance response times including ED handovers and changes in ED layout that have led to improved handover times.
- Flu vaccination – how can it be increased

Pauline Phillips, National Lead for ED Transformation spoke about ED departments that had delivered and improved performance. She emphasised the idea that ED performance should be owned by the whole system, clinically owned by the whole hospital. LLR are meant to be achieving 90% by the end of September, at the moment we are just under 85%,

.

SL recommended looking at comms and engagement with patients and revising the Winter plan.

MW explained the connection between ED and the Acute wards. UHL achieved 95.2% on the first Sunday and on several other occasions, however maintaining consistency has proved challenging in the face of the daily variability. At the national meeting this was described as the Monday spike. This has been seen in all health economies which can result in a 30% increase of ED attendances and subsequent admissions. For UHL this translates as average ED attendances on Monday going from low 600's to high 700's. The challenge then becomes processing those admissions ready for the coming weekend.

UHL have implemented the following successfully:

- Increased consultant and registrar presence in the evenings and out of hours.
- Reconsidered perception of the four hour target has been introduced by interim Operating Officer Tim Lynch, which has increased in flow.
- Process red to green.
- Putting geriatricians and acute physicians at the front door, using a comprehensive frailty scoring to enable them to prevent frail patients penetrating majors, turning them around or taking them straight through to AFU. This has seen 30-40% of

these patients being turned around.

The Winter plan has gone to NHSE for comment and will be signed off at AEDB; however it can be provided to SLT for noting. SL/JA

It was agreed that the Winter Plan will be discussed at the City Health & Well-Being board in October. JS noted that the County Health & Well-being Board meet in November and would be able to discuss the plan there.

7. Community services model update

Paul Gibara (PG) joined the meeting to present paper D on the community hospital inpatient bed model, supported by his colleagues Sam Murthan-Hill and Chris Lyons.

With regards to the exam question, PG stressed that evidence is fundamental, however the decision needs to be made on what question is being answered. PG saw this as quantifying the number of beds and what are they used for. He noted that there are audits taking place in various work streams including an ICS review.

In establishing the baseline, PG stated there is an STP model however it is not fully realised:

- organisational relationships are muddled
- Clarity is required to define the financial framework.
- People still struggle to find existing facilities.
- There are tensions between local solutions and LLR wide solutions.
- Co-ordination is needed for the data that has already been acquired.

PG concluded that there is no evidence to support the three options available: a reduction in bed numbers, maintaining the existing numbers or increasing the number of beds given the level of scrutiny that such evidence would be subjected to. He explained it would not be robust enough and is therefore problematic particularly as NHSE requires the evidence to be obtained via a pathway specific process which has not been apparent or cannot be verified.

PG's personal view was to bring people together to review the bed numbers, although there maybe locality level issues, ensuring the right individuals were present to work on developing the right answer.

PG referred to the audit on patient settings which showed 31% patients in UHL were in the wrong setting of care and in Community the figure was 51%. Patients' outcomes are inevitably affected if patients are in the wrong place from the outset. PG said these are sub-acute patients who required additional medical input but they could be in a different setting. MW stressed that the issue is not about asking for more beds, it is about asking whether the existing bed base is being used appropriately. The partners need to agree on one answer that goes into the STP

PM stated that a model that increased the community beds capacity would not be deliverable from a workforce capacity. Moving the 31% quicker would lead to a different model, therefore in his opinion the ICS model and ICS review are critical to this work,.

The partners agreed that it would be better to select an answer that can be defended and will stand up to testing rather than strive for a perfect answer. SL asked whether it would be feasible to provide a figure for the plans with a plus or minus tolerance.

PG proposed that co-ordination was done through the STP programme. MW proposed a mapping exercise to identify who needs to be in the room working on the answer to the exam question.
Workshop to be arranged to undertake mapping exercise to understand the bed requirements for the future model PG

8. Integrated Locality Teams

Angela Bright (AB), Chief Operating Officer for WLCCG presented Paper E. S asking the partners to note any areas for consideration for CCB. The report is in response to the CCGs looking at increased collaborative working and how it can be taken forward. It also reflected the ACS paper by PM/TS/SP which spoke of the need for collaborative working at three levels: system, vertical clinical networks and horizontal place-based teams.

AB explained that the model was agreed last year, building 11 locality leadership teams to drive integration forward, reinforced by the local response to the GP 5YForward view. It was agreed that implementation around Integrated locality teams would be driven by each individual CCG for their area. Integrated locality teams are one of several programmes overseen by LLR Integrated Teams Programme Board.

Initially the leadership teams were asked to do a readiness assessment which was then repeated in July. The teams felt that they had moved forward positively in terms of:

- engagement
- leadership development
- developing a sense of trust as a leadership team

However they did not think that this had translated into tangible actions that frontline staff could recognise as resulting from the ILT. AB has also conducted 30 one hour structured interviews with team members over a two week period. All interviewees supported place based integrated working and recognised that more was needed to make it a reality.

AB acknowledged the discrepancy between where each CCG area is largely a consequence of the CCGs starting the programme at different points as well as the relative priority it is given within the geographical footprint. These differences are not seen as an issue, it was felt more important that they were recognised and learning taken from them. Each CCG area know what the model is and need to clear on how it is translated at a local level in each area.

To engage frontline clinicians, AB felt that it was important that they:

- See that there is a leadership team in their area and know who they are
- Know who the staff are working in their area
- See/recognise that work is being done on patient pathways, making them more efficient and reducing handoffs between teams.

The partners were supportive of the paper. ML noted that there was a lot of excitement and engagement from GPs involved in the programme that saw the potential for significant change. AB noted that people recognised what the next steps are.

Locality leadership teams need to be allowed the time to adjust to cultural change and engage. The teams responded positively to OD work done with Lisa Sharples and now say they are ready to put this into tangible action.

In terms of the wider focus, AB noted that many interviewees recognised that the programme is looking beyond the initial cohort of patients and are asked question how do you bring in Community and Mental Health teams, which is seen as the next natural step as many of the patients they are dealing with are multi-morbid and frail and many have mental health problems.

The issue of conflict of interest was raised, how close can federations come to commissioning decisions? AB explained that in some areas there is not sufficient clarity around federations and federated working. There is a need to query whether the provider or commissioner is driving the development of placed based integrated teams. WLCCG are developing a provider management forum, the providers leading the work with the CCG in a facilitating capacity which may help to reduce conflict of interest.

9. Date, time and venue of next meeting

9am-12pm Thursday, 19th October, 8th Floor Conference Room, St John's House	

System Leadership Team

Chair: Toby Sanders

Date: 19th October 2017

Time: 9.00 -10.50

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

Present:	
Toby Sanders (TS)	LLR STP Lead, Managing Director, West Leicestershire CCG
John Adler (JA)	Chief Executive, University Hospitals of Leicester NHS Trust
Karen English (KE)	Managing Director, East Leicestershire and Rutland CCG
Azhar Farooqi (Afa)	Clinical Chair, Leicester City Clinical Commissioning Group
Steven Forbes (SF)	Strategic Director for Adult Social Care, Leicester City Council
Spencer Gay (SG)	Chief Financial Officer, West Leicestershire CCG
Mark Gregory (MG)	Leicester, Leicestershire & Rutland General Manager, East Midlands Ambulance Service NHS Trust
Satheesh Kumar (SK)	Medical Director, Leicestershire Partnership NHS Trust, Co-Chair, Clinical Leadership Group
Mayur Lakhani (ML)	Chair, West Leicestershire Clinical Commissioning Group, GP, Sileby Co-Chair, Clinical Leadership Group
Sue Lock (SL)	Managing Director, Leicester City CCG
Peter Miller (PM)	Chief Executive, Leicestershire Partnership NHS Trust
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 & Implementation, Leicester City Clinical Commissioning Group
Evan Rees (ER)	Chair, BCT PPI Group
John Sinnott (JS)	Chief Executive, Leicestershire County Council

Apologies	
Helen Briggs (HB)	Chief Executive, Rutland County Council
Niki Bridge (NB)	Finance Director and Deputy Programme Director, BCT
Andrew Furlong (AF)	Medical Director, University Hospitals of Leicester NHS Trust
Richard Henderson (RH)	Deputy Chief Executive, East Midlands Ambulance Service NHS Trust

In Attendance	
Stuart Baird	Communications and Engagement, BCT
Charles Walker	Communications and Engagement, BCT
Shelpa Chauhan	Office Manager, BCT

Janice Richardson	Project and Admin support, BCT(Minutes)

1. Apologies and introduction

Apologies received from Andrew Furlong.

TS noted that the partners will be aware changes are being made to strengthen the Communications and Engagement support, in terms of external stakeholders management for the STP. A number of changes have been made within the programme, including the SRO for Communications and Engagement strand being taken up by Richard Morris in place of Mark Wightman, to ensure this role was held and managed within the CCG network. TS expressed thanks to Mark Wightman for his valued support over the last few years.

TS explained in the interim Stuart Baird and Charles Walker will assist Richard Morris, and are in attendance at this SLT meeting to then be able to prepare a newsletter for external stakeholders and the public summarising the current position of the programme, to address matters around consultation, and give an update on the financial position.

2. Conflicts of interest handling

The Conflicts of Interest Screening Panel had reviewed the agenda and papers for potential conflicts of interest. This indicated that there were no specific comments in relation to conflicts of interest other than regular conflicts to be declared / noted for this part of the agenda.

The panel noted that there were a number of verbal updates and recommended moving away from verbal updates to assist the screening panel identify any potential conflicts of interest.

3. Minutes of last meeting, 21st September 2017

Minutes of the meeting were accepted pending the following changes:

Karen English's role to be amended.

Item 2 –Conflicts of interest
JS said that the minutes did not adequately reflect the point he was making about the conflict of interest handling at the September meeting and that it was still not clear enough what the purpose of this section of the agenda was or how it was being managed.

TS noted that he had not been present at the last meeting but explained that given the status of the SLT as a formal joint committee of the three CCGs, it was important in terms of good governance for any potential conflicts of interest, particularly between NHS commissioner and provider organisations, to be identified and noted. This function is currently being performed informally by the corporate affairs leads of the NHS organisations, along the lines of the 'CoI screening panel' used in some partner organisations. The main purpose is to identify potential competition/procurement/commercial interests which could be perceived as inappropriately influencing the work of SLT. The intention was not to restrict or limit discussion or debate, or to imply that the views of parts of the system were not valid or legitimate.

JS noted this response and suggested that it would be helpful to keep the operation of this aspect of the meeting under review through subsequent meetings.

4. Review of Action log

170817/1 - Review the contracting and finance elements and options at Septembers SLT meeting – Next steps discussed within agenda item 5.

170817/3 - To present the detailed plan to September SLT meeting prior to

NHS E end of September deadline – TS noted that this will be discussed at Collaborative Commissioning Board. 170817/4 - An additional meeting to be held involving UHL and Leicester City CCG to present a proposal to SLT to progress further changes to the CDU model - SP confirmed that the MDs approved the risk share and investment at meeting on 27 September is progressing. It was decided for a report to be provided to SLT in November following a further meeting scheduled for 23 October to discuss the implementation of the in-year plan, workforce provision and contract variation to enact the risk share. 170817/6 - Toby Sanders to email to the group proposals to progress with filling the immediate gaps in the PMO – To be discussed within agenda item 5. 170817/7 - Accountable Officers/SRO's to review the STP work stream capacity analysis summary and STP capacity analysis by Individual work streams -to be discussed within agenda item 5. 170921/1 - Winter plan to be provided to SLT to note. – Completed. SL noted that an issue that was highlighted at the A& E Delivery Board in terms of an update with TASL around patient transport, and a discussion was held as to whether a contingency plan needed to be considered. JA has been in contact with Caroline Trevithick confirming senior level activity to improve management of the contract whilst recognising that a formal contingency plan may be required. It was proposed that this is reported into the A& E Delivery Board and would be coordinated through Caroline Trevithick.	Louise Young
5. STP leads updates	
ACS next steps for NHS organisations TS confirmed that a joint NHS board's session has been arranged on Tuesday 28 November held at the Leicester Racecourse. Discussions will include financial arrangements, mechanisms for next year and the progress on the final draft STP. TS noted that NHSE is likely to be interested in active local arrangements, particularly CCG arrangements and how they relate to the STP work which may lead to further guidance, support or clarity from NHSE. In preparation of the NHS joint Boards on the 28th November: - NHS organisations to share useful information that could be fed into proposals for an Accountable Care System (ACS), the next steps ahead of the joint NHS Board meeting. - ASC next steps document feedback from the Boards to be taken on board an incorporated into an updated discussion paper for November SLT meeting. *Local authority discussions re: STP/ACS* TS said that following from the letter received from the three Health and Wellbeing Board Chairs a joint discussion on how NHS organisations and Local Authorities work together on the STP and ACS has been provisionally arranged for 31st October. JS noted that NHS/Local Authority relationship was broadening beyond the STP into Delayed Transfer of Care (DTOC) and TS suggested that this topic should be included in the discussion. *Feedback from national events on 26th September* PM attended the STP leads event, ML and Caroline Trevithick attended the STP Clinical Leads event.	NHS organisations TS

PM provided an overview of the STP Leads event. The key speakers included Jim Mackey, Simon Stevens, David Pearson and Bruce Keogh, they focused on current delivery and not necessarily the five year plan. Topics that were discussed included the following:

- Winter plan
- flu vaccination
- DTOC
- Demand management
- Flow, GP streaming
- Extended access
- Ambulances

PM said that the key message was that 'nothing was more important than the now'.

Mental Health, Cancer and Primary Care were identified as three key priorities to maintain services this winter.

Jim Mackey discussed finance, workforce challenges from an operational perspective, and breakout sessions were held around how the STP can support 2017 winter plans and emphasised that STP is a partnership not a plan.

To support with the delivery, CQC system wide reviews will be completed, highlighting that the reviews are not inspections and ought to be viewed as means of providing recommendations for improvements.

David Pearson focussed on the Accountable Care Systems (ACS).

It was announced that new capital will be allocated after the November Autumn Statement, and it will not be limited to higher scoring STPs. The most important criteria are transformation, demand management, returns on investment and financial sustainability, a clear STP estates narrative will be essential.

In the clinical engagement session, Bruce Keogh asked the delegates to consider whether they are playing for 'club or county' namely if they were representing the whole system wide STP or their own individual organisation.

ML reported that this was the first meeting for the STP Clinical Leads and was well attended. The STP clinical leads were asked to consider what the best clinical model to provide clinical support to the STPs.

Simon Stevens had focussed their discussion on the winter planning and the national challenges and how nationally we might be supporting with these issues.

The event was told that tensions between Local Authorities and NHS partners are being picked up nationally, appearing to be a generic issue about culture and decision making.

NHSE see a greater role for clinical leads in the STP and see the STPs led by clinical leads in the future. TS noted, in the CCG checkpoint meeting with NHSE there had been discussions about STPs appointing Medical Directors into their structures to provide medical oversight around quality and safety regulations. Discussions are to be held to review Andrew Furlong capacity as the role of the STP Clinical lead and to consider clinical network support.

JA, Andrew Furlong, ML and SK

SK noted that as there won't be a national directional support, a clinical network may need to be considered by the Clinical Leadership Group (CLG), TS replied that this will link in with the direction of travel in identifying ASC roles.

PMO arrangements

TS said that the PMO team are in the process of TUPE transfer from LPT to WLCCG to ensure consistency and alignment with TS's role as STP Lead. Recruitment for PMO Programme Director and other capacity roles within the team is currently on hold and the PMO structure will be reviewed once there is a clearer position across the three CCGs on their joint working arrangements, and how this fit in with STP work. TS confirmed that areas where there is an immediate requirement in particular with Communications and Engagement. JA suggested that a timeline would be useful for the PMO discussions and questioned if there will be any proposals ready for the joint NHS boards session. TS advised that ongoing conversations are being held with the CCG's around collaborative working that will involve Paul Watson from NHSE before being progressed further and this meeting is likely to be by the end of November. *PPI engagement* ER reported that the BCT PPI group have been increasingly concerned about engagement since moving from BCT into STP framework and the re-organisation of the work streams. ER raised the following points: • Requirement of public facing information about progress of the STP; • Requirement of engagement within many of the work streams; • Need to discuss with PPI on the overarching topics such as ACS; • STP work stream capacity analysis shows Communications and Engagement as green which is viewed it from one perspective as the PPI group would query this rating; • ER had decided that it was currently not appropriate to share the SLT confidential papers to the PPI group following the recent information released on social media since this was initially agreed in principle by TS and ER ER felt that assurances of producing a public newsletter will be beneficial. ER will be working with BCT Communications and Engagement to provide an evaluation report at November SLT meeting following meetings with SRO's regarding PPI engagement in clinical work streams. TS attended the last PPI group meeting and the feedback received was that whilst some members said that their work stream engagement was good, other PPI members said that engagement within their own work stream was variable. TS proposed that ER follow up with the Chief Officers by email after his meetings with the SROs. JA pointed out that there had been previous discussions about engagement that included holding regular engagement meetings. TS advised that early December would be an appropriate time to hold a quarterly engagement forum for stakeholders, and will be scheduled.	ER and BCT Communications and Engagement
6. Clinical Leadership Group (CLG) feedback from maternity clinical model review	
TS mentioned that following from the consultation timelines one of the key processes that needed to be completed in sequence is CLG reviewing the maternity clinical model. This peer review took place a couple of weeks ago. ML said the process of having an internal review of the plans worked well and CLG had met with the team that were leading the maternity plans alongside an external peer support from Rebecca McConville from the East Midlands Clinical Senate There are approximately ten thousand births annually in LLR and the idea is to concentrate those births at a proposed women's hospital, having various options within the single site. Women would essentially have the choice of consultant-led, standalone midwifery unit with shared care, with options for the location of this service, and finally	

home delivery.

CLG had explored the several key lines of enquiry:

- Single site approach
- Workforce; national standards require giving women continuity of care. A three point plan was presented.
- Sustainability of estates
- Electronic patient records

ML also pointed out the dependency on the STP plan, as this is part of the move from three to two sites.

JA questioned if there were any collective views on locating the stand alone midwifery led unit on the Leicester General Hospital site. ML confirmed that it was one of the key lines of enquiry. RP felt that it was important to help the public understand that the risk for a stand-alone unit delivery is the same as a home birth. A stand-alone unit requires a certain number of births to be sustainable. AFa asked for more clarity on this matter for consultation, noting there is proposed 12 month pilot within the existing estate at the Leicester General Hospital site to establish whether this a viable option. SL pointed out that there had been a lot of patient and public engagement to get to this point and further engagement plans will be arranged leading up to consultation

ML added that there was a strong clinical case for a single site in terms of infant mortality in Leicester City, with national evidence for continuity and workforce, which continues to respect women's' needs and wants in relation to pregnancy in terms of choice.

SP confirmed that she received an amendment from UHL on the maternity section based on the clinical review, and has updated the narrative in the STP draft plan.

ML reported that CLG were content that the plans for maternity were good, incorporating quality and choice and confirmed that the proposed model is consistent with the current national guidance.

RP noted that Rebecca McConville was very supportive of the model and provided some suggestions on the presentation and did not propose any significant modifications to the content of plan.

TS expressed thanks to CLG for their support in reviewing the maternity clinical model review.

7. Delayed transfers of care position update

TS said that the delay transfers of care (DTOC) has been included at SLT to understand the positions from the Local Authorities and the CCG's and to receive assurance that plans are in place to address the current matters regarding DTOC.

TO'N noted Rutland's performance as good from a local perspective, confirming that the members have signed up to the proposed target while acknowledging the challenge in terms of timescales. The underlying concerns of elected members is that nationally the NHS is trying to performance manage local authorities. Equally there is frustration that LAs performing well are being penalised by NHS regulators.

TO'N highlighted the following key matters;

- As a system there is a good understanding of working together to meet targets, which is not helped by this nationally driven process;
- There is an urgent need to bring together the experts together to work through how to record and report on DTOC. Currently it is very difficult to explain this narrative to the elected members;
- Need to spend time with data experts and owners of the targets to clarify the system messaging about the DTOC performance. Underlying issue of Health

and Social Care DTOC, Rutland do not make that distinction locally but are aware that there other authorities do distinguish and there needs to be a consistent system wide approach and narrative developed. SF pointed out that Rutland's performance was in fact exceptional, and described Leicester City's social care performance as good. The system appears to be penalising this significant effort, and elected members are struggling to understand why Leicester City is one of 16 authorities nationally who are being penalised for what feels like exceptional performance in this area. There are concerns at continued pressure to hold them accountable for something that Leicester City and other Local Authorities do not immediately or directly influence for themselves. Similarly, City also feel that NHSE are trying to performance manage the Authority. A fundamental concern that there is a risk to the local system/base level social services if CCGs are directed by NHSE not to transfer funds via the BCF. It undermines local work that is being done, driving a wedge between the two parts of the system. Cheryl Davenport (CD) explained that Leicestershire are in a similar position, they have a good understanding of the breakdown of the current performance in terms of the rate that needs to be achieved. They understand how the 3.5% national rate translates into the local rate and how their trajectory is expressed. The issue has been escalated with their cabinet and they have changed their corporate risk register so it now shows as red RAG status. A potential outcome of the risk escalation is a CQC review; using the CQC methodology Leicestershire are conducting a self-assessment. In LPT the adult social care team have been updating and corporate management team on all the positive work going on. LPT are working on a data driven solution to give clarity on DTOC performance, as currently there is no way of forecasting when they will reach the target, which is a risk issue for the whole system. JS expressed shared frustration at the situation, empathising with CCG colleagues' position. Push back from MPs is already being seen nationally. JS also pointed out the risk should be seen in context of how the local NHS and Local Authorities currently work together. He was unable to see how the partners can continue to deliver current performance if financial problems arose for the Local Authorities. TS summarised risks in terms of operational performance, system performance and financial risks. From an NHS perspective views continue to be expressed locally, regionally and nationally through different channels and groups. The possibility of future escalation around delivery was highlighted, leading TS to reflect on the following; • What is our plan and what are we doing about the residual areas where we have issues. How are the issues raised at both A&E Delivery Board or BCF groups linked up? • Data reporting and understanding both locally and nationally needs to be addressed. • The distinction between health and social care DTOCs, and how is that going to be captured. CD confirmed that the LLR action plan sits with the Discharge Working Group, who report into the A&E Delivery Board. Direction needs to be given in particular for the LPT DTOC forecast. Work is currently underway following direction from Tamsin Hooton. Consideration is needed on how to report partner performance in a consistent manner. JA confirmed that A&E Delivery Board review an operational update monthly. PM pointed out that further work on data is required for consistency in LPT, the data in Mental Health is better than for Community services. TS proposed the Delayed Transfers of Care position update to be included in November's SLT, to consider current plans, data and reporting and the direction of travel	All partners

for future health and social care shared performance.

8. BCT Work stream capacity

Martin Pope (MP) joined the meeting and presented Paper C which maps the managerial capacity to support work streams. MP explained that the original analysis has been revisited and verified.

General themes of where gaps were identified were around IM&T strategic support and organisational development, specifically around change management, additionally a number of work streams that have gaps around implementation leads and project management. MP advised that further analysis of IM&T would have been beneficial in terms of the underpinning work stream and the technology element of the clinical work streams. PM advised that he is working with Tim Sacks and Ian Wakeford on IM&T solutions to establish the right capacity to deliver the required solutions. The aim is to get all work streams to understand their IM&T needs, feed back into the IM&T work stream, and produce a revised version of the digital road map.

In terms of the Shared Services work stream there is resource in place to create a plan; additional support is required for delivery and implementation. JA noted that there are bilateral discussions takin place between UHL and LPT as well as between the CCGs, that at some point could be brought together, rather than trying to find an additional resource.

In terms of Planned Care, SL recognised and acknowledged that there is more that could be done in the work stream, though a different approach is needed and further consideration given to establish the full potential of what is achievable.

ML identified Clinical Leadership as an enabling work stream with a lot of ambition that he felt that it does not have enough support in the system. ML asking how it was represented in this analysis. MP advised that through the work on interdependencies there had been discussions on whether CLG focus could change to provide input into the individual work streams.

JS said that in terms of ambition he was unsure how the level of innovation and mechanisms for change, including new ways of working, can be tested. ML said that it was key that this was understood. TS replied that as the group were work streams sponsors; each member of the SLT needed to consider how confident they are that their plans are sufficiently innovative.

Primary Care and Estates were highlighted as under resourced. KE stated that there is no Estates resource; she is alone in reviewing paperwork. While KE has explored different opportunities, none have been forthcoming.

AFa observed that with limited resources it felt like silo working. MP advised that the interdependencies work will help to address this. There was also the suggestion of potential consolidation across the work streams and a possibility that some roles could work across a group of work streams. SL cited Cancer work stream as an area where silo working has seen increasing input from the East Midlands Cancer Alliance and funding coming down into local communities, reconfiguration of local networks is also being discussed and local resource is still needed for implementation.

TO'N suggested that partners should give consideration to data and understanding outcomes as LLR are moving towards a phase in the programme where discussions will be around delivery impact. MP advised that work is in progress on an outcomes framework.

TS presented opportunities that SLT could consider how to strengthen resources. TS is expecting written confirmation of NHSE's reconfiguration of staff in clinical network to support STPs. TS said that NHSE have identified a technical resource to redeploy to

support STP areas and Midlands & Lancashire CSU offer to potentially provide support. In terms of the BCT work stream capacity it was proposed: - To discuss at November's SLT meeting the IM&T, primary care, OD and Estates work streams that require further support. - Martin Pope to hold conversations with Karen English regarding the NHSE offer to deploy STP resources to support with the Estates and primary care areas.	Relevant Chief Officers work stream sponsors KE and MP
9. Business Intelligence strategy	
CD presented Paper D on Business Intelligence (BI) asking SLT to approve the development of an LLR business intelligence strategy as a priority and as an enabler. The paper provides LLR's current position in the use of Business Intelligence tools and analytics across LLR. CD said that there was good progress in our local area but there is not much awareness around all of the partners. The report provided a stock take on the type of tools currently used and looked at how data is brought across from multiple sources and use tools that can integrate across health and care. There is a huge reliance on good quality linked analysis, understanding LLR's current position and measuring the impact of the changes that are taking place. The work streams would look to have this in terms of integrated dashboards, integrated data and tools that can be used for this purpose even allowing for national IG rules. There are existing BI strategies for some organisations within LLR which could be used as a starting point. CD proposed that a system wide BI strategy would need to be ambitious to enable delivery. A useful operational exercise would be to do a stock take against the current overview of LLR's position on BI tools. PM drew attention to the fact that some of the BI tools across the system are coming up for re-procurement, which he has already discussed with CD and Mark Pierce. A system wide strategy would be useful in terms of procurement. PM asked the partners to consider what we collectively required across the system and understand a shared single version of the truth around BI. PM expressed support for an LLR Business Intelligence strategy from an IM&T perspective. Acknowledging challenges from an Information Governance (IG) perspective, SK asked for an IG specialist to be involved from the start in the development of the BI strategy. SL suggested including CD in a meeting with the National IG lead on undertaking IG concerns on research. TS put the recommendations to the partners supporting the strategy as a priority enabler and linking the strategy through the IM&T board in terms of the information element. TS proposed PM and CD to discuss resourcing, looking at how to get capacity through IM&T work stream in general. TS suggested that the recommendation on standard operating procedures (SOP) is seen as secondary piece of work. This would allow other pieces of work such as IG to be worked through first. Decisions around BI tools should be seen within the context of this piece of work which would entail time constraints given and a Draft Business Intelligence strategy to be brought back to January's SLT meeting.	PM and CD
10. Date, time and venue of next meeting	
9.00 – 12.00, Thursday 16th November 2017 8th Floor Conference Room, St Johns House, East Street, Leicester, LE1 6NB	