Trust Board paper T

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

Trust Board Bulletin – 7 September 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 report** – Lead contact point Ms L Tibbert, Director of Workforce and OD (0116 258 8903) – **paper 1**, and
- **System Leadership Team minutes (20 July 2017)** – Lead contact point Mr J Adler, Chief Executive (0116 258 8940) – **paper 2.**

It is intended that this paper will not be discussed at the formal Trust Board meeting on 7 September 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
Sponsor: Louise Tibbert, Director of Workforce and Development
Trust Board: 7th September 2017

Executive Summary

The Trust is implementing the 2016 Junior Doctors Contract in line with the national requirements and timescales set out by NHS Employers.

Transition to the contract commenced on 7th December 2016 and is coming to the final stages of implementation as majority of the doctors have transferred onto the new contract. The majority (790 to date) of the junior doctors in training have now transferred on to the new contract.

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. The format of the report is in line with national requirements.

To date 194 exceptions have been recorded.

Questions

1. What is the current position on the implementation of the Junior Doctors Contract at UHL?
2. Does the Trust have a procedure for managing Exception Reports in place and how many Exception Reports have been received at the Trust from 7th December 2016 to date.
3. How many rota junior doctor vacancies exist at the Trust?

Conclusion

1. The Trust is making good progress towards implementation of the 2016 Junior Doctors Contract. A total of 790 doctors have now transferred on to the new contract.

2. An Exception Reporting procedure has been agreed by the Task and Finish Group and has been in operation from 7th December 2016. To date 194 exceptions reports have been recorded. Six are related to education issues and others relate to work patterns.

3. There are a total of 70 junior doctor vacancies for August 2017 equates to 6.8% of the total junior medical staff establishment.

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: December 2017

6. Executive Summaries should not exceed **1page**. [My paper does comply]

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

1. Introduction

1.1 Transition to the contract commenced on 7th December 2016 and is progressing well at UHL. The majority of the junior doctors in training have now transferred on to the new contract.

1.2 In line with the requirements of the contract the Guardian of Safe Working (GSW) will provide a quarterly report (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 These reports shall also be provided to the Local Negotiating Committee and the Trust Junior Doctors Forum.

1.4 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).

2. Exception Reporting

2.1 Exception Reporting replaces monitoring as the mechanism for ensuring safe working patterns. In line with the Trust procedure for Exception Reporting, approved by the Task and Finish Group and in operation, doctors that have transitioned to the new contract will raise Exception Reports using a web based package.

2.2 At the time of writing this report on 23rd August 2017, 194 Exception Reports have been received of which six are related to educational opportunities and the remainder relate to work pattern issues. A summary of the Exception Reports received by CMG is provided in the table below:

	Number of Exceptions Received		
CMG	**Work Pattern Exceptions**	**Education Exceptions**	**Total**
CHUGGS	44	1	**45**
CSI	0	0	**0**
ESM	84	3	**87**
ITAPS	0	0	**0**
MSK/SS	8	1	**9**
RRCV	46	1	**47**
W&C	6	0	**6**
Totals	**188**	**6**	**194**

2.3 The reports received to date have been recorded by 48 doctors. A summary of the outcomes of the Exception Report is provided in the table below:

Outcome	Number of Exceptions
Time off in lieu	85
Overtime payment	7
Closed with no further action	13
Request for more info (awaiting further response from junior doctor)	25
Pending outcome	64
Total	**194**

2.6 As majority of the junior doctors in training are now working on the new contract from August 2017, it will be possible to comparatively analyse trends for future reports. During August there have been 27 exceptions recorded.

3. Junior Medical Staff Vacancies

3.1 The current number of junior medical staff vacancies as at August 2017 is provided in table below. 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.

	Junior Medical (trainees and Trust Grade) Vacancies - August 2017								
CMG	Establish-ment	FY1	FY2	CT1/2	TG CT1/2	ST3+	TG ST3+	Total	Percentage Vacancy
ITAPS	84	0	0	0	0	0	0	0	**0%**
CHUGGS	133	0	0	1	2	2	1	6	**4.5%**
ESM	287	1	1	2	1	2	6	13	**4.5%**
MSK/SS	127	0	0	0	1	0	3	4	**3.2%**
RRCV	153	4	1	3	1	5	6	20	**13.1%**
W&C	172	1	0	9	2	11	0	23	**13.4%**
Other	70	0	0	0	0	4	0	4	**5.7%**
Total	1026	6	2	15	7	24	16	70	**6.8%**

3.2 A total of 70 vacancies for August 2017 equates to 6.8% of the total junior medical staff establishment, and also lower than the 109 vacancies last month.

3.3 Active recruitment and vacancy management is in place in all CMG's, which seeks to minimise impact of gaps on a proactive basis. This will include review of recruitment activity and timelines and alternative roles etc. The most significant areas of risk are RRCV and Women's and Children's. In total there are 12 vacancies in Neonates and Neonatal Central Transport. Some of these vacancies are backfill by Advanced Nurse Practitioners, however the high number of vacancies created out of hours gaps on

the rotas. A meeting (involving junior doctors, consultants and Medical HR) was held to review the options available and agreement was reached to increase the out of hours cover on a voluntary basis by giving junior doctors time off in the day.

3.4 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.

3.5 Where active recruitment is not successful there is a requirement for internal and external locum backfill which is managed by the CMGs. All agency usage is overseen by the Premium Spend Group in line with premium pay trajectories in place.

4. Conclusion

4.1 The implementation of the 2016 Junior Doctors Contract is progressing well, overseen by the Task and Finish Group.

4.2 The next Guardian of Safe Working report will be provided in December 2017.

4.3 Exceptions are being handled appropriately and numbers are considered to be relatively low so far, with no financial penalties imposed.

5. Recommendations

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

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

.

System Leadership Team

Chair: Toby Sanders

Date: 20th July 2017

Time: 11.15 -12.00

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
Nicola Bridge (NB)	Finance Director and Deputy Programme Director, BCT
Karen English (KE)	Managing Director, East Leicestershire and Rutland CCG
Steven Forbes (SF)	Strategic Director for Adult Social Care, Leicester City Council
Andrew Furlong (AF)	Medical Director, University Hospitals of Leicester NHS Trust
Michelle Iliffe (MI)	Chief Financial Officer, Leicester City CCG
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
Will Legge (WL)	Director of Strategy and Information, East Midlands Ambulance Service NHS Trust
Peter Miller (PM)	Chief Executive, Leicester Partnership Trust
Tim O'Neill (TO'N)	Deputy Chief Executive, Rutland County Council
Richard Palin (RP)	Chair, East Leicestershire and Rutland CCG
Avi Prasad (AP)	GP, Co-Chair, Leicester City CCG
Sarah Prema (SP)	Director of Strategy & Implementation, Leicester City CCG
Evan Rees (ER)	Chair, BCT PPI Group
John Sinnott (JS)	Chief Executive, Leicestershire County Council

Apologies	
Helen Briggs	Chief Executive, Rutland County Council
Azhar Farooqi (Afa)	Clinical Chair, Leicester City Clinical Commissioning Group
Richard Henderson (RH)	Deputy Chief Executive, Rutland County Council
Sue Lock (SL)	Managing Director, Leicester City CCG

In Attendance	
Shelpa Chauhan	Office Manager, BCT
Martha Milhavy (MM)	Communications and Engagement Manager, BCT
Janice Richardson	BCT Admin and Support, minutes

1. Apologies and introduction	
Apologies received from Sue Lock, Azar Farooqi and Richard Henderson.	
2. Conflicts of interest handling	
Nothing noted at this time.	
3. Minutes of last meeting, 22nd June, 2017	
Minutes were approved as an accurate record.	
4. Review of action log	
TS stated that the amber actions are ongoing and are due back in subsequent meetings: **170215/15 CDU** JA provided an update confirming that there is overall commitment to continue with the service. It was acknowledged that there were challenges around releasing resources to enable progress. JA also noted that UHL have agreed try to and find a way of freeing up resources for the community based respiratory physicians. JA advised that he met with Ursula Montgomery to discuss pulling together a team to find a solution.	
5. National policy/messages update	
TS provided an update and said that the Regional Directors, Paul Watson and Dale Bywater have invited STP leads in response to feedback that STP leads would benefit from more direct contact with the regional directors. It is unclear whether this session will become a regularly scheduled event. TS, PM and JS will be attending from LLR and will feedback in the subsequent SLT meeting. TS advised that the agenda will be circulated and invited any questions and comments from the partners.	TS/All SLT members
TS confirmed that the NHSE CCG ratings and bandings have been decoupled which has resulted in some organisations changing categories. TS advised that the official announcement will be made tomorrow at 10.30am, the STP dashboard and CCG annual ratings will be available in the public domain. TS advised that the NHSE dashboard information to capture the overall progress of the STP health and care systems will be shared with SLT along with the national list of the areas that are receiving intensive support. The NHSE Dashboard to capture the overall progress of the STP health and care systems to be shared with SLT.	TS
6. Accountable care system development: Next steps following joint stocktake on 18th July	
SP provided a brief overview of the feedback from last session on ACS of the LLR Joint Boards Stocktake event on Tuesday 18th July. There was overall consensus on the ten building blocks identified being the correct components to work on. Leadership and relationships were the most important and the key to making it work. SP discussed the following feedback from the additional themes:	

• A strong emphasis on shared purpose – why are we doing this? This answer to this question would help to shape and guide the next steps taken. • A clear role for the patient voice in the development and whatever system is developed should be designed around patients and not organisational benefits. • Consolidating commissioning. • Revising the contractual forms, moving the business model from incentivised contracts to outcomes • Sharing back office functions including shared patient records. SP explained that governance had come up during early discussions with people noting that many existing governance structures were not strong enough or flexible enough in terms of the speed of decision making and could be viewed as a blocker. TS mentioned that Jeremy Hunt, Minister for Health, had said that the NHS should integrate within itself, which would be a significant step towards reducing fragmentation. TS stated that the ACS would need to focus on NHS working in partnership with local authorities. TS invited the partners' views on the themes identified by SP; governance, finance and contracting. CFO Spencer Gay and CCG Acute Contract Lead have already been asked to look at areas that have developed alternative methods on contracting. TS proposed a smaller financed focused discussion on contracting outside of the SLT forum. With regards to provider integration, KE suggested that the priority should be deciding on the model of care before getting into contracting. TS stated that both governance and contractual will need to support the model and suggested that members of SLT write a proposition on the model and what can be done to move forward. This led to the partners discussing the consolidation of the commissioning function to sit alongside as a fourth strand. ML suggested calling the third work stream new care models as these are the way to get full integration and set a target to have an agreed number of Multispecialty Community Providers (MCPs) by the end of the year. He suggested using the existing twelve localities to reflect the footprint of the ACS using them as the 'engine room' for integration with an ACS at a pre-cursory level while creating integrated care systems at local level. AF cautioned against creating ACS at local level as providing for twelve or more ACS may prove very difficult. Some standardisation may be needed for practicalities; however standardisation may flatten the offer. ML responded and said that the services may be locally tailored but generally there would be a common offer. This led onto a discussion about the optimum size for integration and the consolidation of commissioning function to sit alongside this as a fourth strand. TS said that it may be possible to do alternative processes at different levels, an operational interface would be more appropriate at a local level however moving up to the whole area would require provider network with an ACS type arrangement through a strategic commissioning function. JA urged the partners to move on with putting together a proposition and what the organisational models look like, giving priority to contractual and financial flow elements unlocking some of the blockers. It was agreed an initial meeting to be held to scope ACS options/proposals. ER requested genuine co-development with patients from the out-set. As starting with what patients can see and understand will mean the technical discussion can flow easier as opposed to trying to translate a technical discussion for patient understanding. SK suggested that the first discussion on the finance, should be together within the SLT and consideration should be given to what do we want to achieve financially. Agreement was made on holding a meeting in three weeks' time, prior to the next SLT meeting to allow other individuals from the various stakeholders (non-exec, chair, governance lead) to be involved in exploring the ACS approach	TS, PM, SP All SLT members
7. Date, time and venue of next meeting:	

9.00 – 12.00, Thursday 17th August 2017 8th Floor Conference Room, St Johns House, East Street, Leicester, LE1 6NB	