System Leadership Team
Meeting No. 29
Chair: John Adler
Date: Thursday 22 August 2019
Time: 9.00 – 12.00
Venue: 4th Floor Conference Room, St Johns House, East Street, Leicester, LE1 6NB

Present:	
John Adler (JA)	Chief Executive, University Hospitals of Leicester NHS Trust
Caroline Trevithick (CT)	Interim Managing Director, West Leicestershire CCG
Ursula Montgomery (UM)	Chair, East Leicestershire and Rutland CCG and GP
Sue Lock (SL)	Interim LLR STP Lead, Managing Director, Leicester City CCG
Angela Hilary (AH)	Chief Executive, Leicestershire Partnership Trust
Professor Azhar Farooqi (AFa)	Clinical Chair, Leicester City CCG
Steven Forbes	Strategic Director for Adult Social Care, Leicester City Council
Andrew Furlong (AFu)	Medical Director, University Hospitals of Leicester NHS Trust
Dr Nick Pulman	West Leicestershire CCG
Evan Rees (ER)	Chair, BCT PPI Group, East Leicestershire and Rutland CCG
Tim Sacks (TS)	Chief Operating Officer, East Leicestershire and Rutland CCG
Stephen Bateman (SB)	Chief, Executive Officer, Derbyshire Health Care CIC
Ben Holdaway	Director of Operations, EMAS
Andy Williams	LLR CCGs Accountable Officer Designate
Mark Andrews	Assistant Director Adult Services, Rutland County Council
In Attendance:	
Clare Mair (CM)	Board Support Officer, Leicester City CCG (Minutes)
Sarah Prema (SP)	Director of Strategy and Implementation, Leicester City CCG
Richard Morris (RM)	Director of Corporate Affairs, Leicester City CCG
Sarah Warmington	Associate Director of Commissioning, ELR CCG (for item 91)
Yasmin Sidyot	Acting Director, Urgent Care, WL CCG (for item 92)
Fay Bayliss	Deputy Director of Nursing and Quality, Leicester City CCG (for item 93)
Bina Kotecha	Deputy Director of Learning and OD, University Hospitals of Leicester (for item 93)
Apologies:	
Donna Enoux (DE)	Chief Financial Officer
John Sinnott (JS)	Chief Executive, Leicestershire County Council
Frances Shattock (FS)	Director of Strategic Transformation/ Locality, NHS England and Improvement
Professor Mayur Lakhani	Clinical Chair, West Leicestershire CCG

SLT 19/85 Welcome and introductions	
JA welcomed everyone to the meeting.	
SLT 19/86 Apologies for Absence and Quorum	
Apologies were noted as above. The meeting was confirmed as quorate.	
SLT 19/87 Declarations of interest on Agenda Topics	

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The papers had been reviewed by a CCG Governance Officer and it was identified that any potential interests were downstream and there was no need for exclusions from business today.	
SLT 19/88 Notification of any other business	
The Chair was not notified of any other items of business.	
SLT 19/89 Minutes of meeting held on 20 June 2019 and 18 July 2019 (Paper A)	
The June SLT minutes had not been previously approved as the July meeting had not been quorate. Therefore minutes from 20 June and 18 July SLT meetings were presented. Both were agreed to be an accurate record.	
SLT 19/90 Action notes of the meeting held on 18 July 2019 (Paper B)	
The action log was reviewed and the following noted; <u>21/01/08 – Partnership Group Terms of Reference</u> SP advised the first informal meeting had taken place in July 2019 at which the draft terms of reference were presented to the group and very minor amendments made. The group felt the terms of reference reflected their role of support and oversight to SLT. Cheryl Davenport had advised SP the County LA had some outstanding issues with the terms of reference and SP was hopeful those would have been worked through by the first Partnership Group meeting in September 2019. JA advised in the meantime the first meeting was being arranged. **Once finalised the final terms of reference would be brought to SLT for information** as opposed to approval due to the hierarchy of reporting.	**SP**
<u>19/29 - SLT work programme</u> **SP to add Social Care Activities and Troubled Families to the SLT work programme.**	**SP**
<u>19/33 – Dorset ICS</u> SL had reported at an earlier meeting that Dorset ICS had some interesting views on leadership and talent management across the system but had not received a response to her request for some further information on their plans. Since then, local work had commenced. It was agreed to close the action.	
<u>19/76 - Integrated Community Teams</u> The Clinical Leadership Group (CLG) had taken on actions around joint working across UHL and primary care clinicians and OD support to PCNs and neighbourhoods. AFu advised a workshop scheduled for August 2019 had been deferred to October 2019 to ensure more take up. It was agreed to close the action.	
<u>19/81 - Maturity Matrix</u> The matrix had been circulated to SLT members. SP and MW would now meet to update the maturity assessment. JA felt this showed signs of LLR having moved forward and was now in the developing zone.	
SLT 19/91 Workstream Update – Learning Disabilities and Autism (Paper C1) and Mental Health (Paper C2)	
Sarah Warmington, Associate Director of Commissioning, East Leicestershire and Rutland CCG attended for this item and along with Steven Forbes, presented on two work streams; Learning Disabilities and Autism and Mental Health highlighting the scope and priorities, key achievements, priorities for the next 12 months and the risks. SW advised since issuing the slides she had spoken with NHSEI and had made some changes. <u>Learning Disability/Autism</u> The transforming care partnership had been operating for around 3 years and SW felt only in the last	

18 months since SF had taken on the executive lead had there been some traction and delivery. It was still a challenged service area.

During 2016-2019 achievements included extending the LD outreach team to be available seven days a week and providing a wrap-around approach as a means of trying to prevent admission and facilitating discharge out of IP beds. Deep dives into inpatients showed common themes and learning and the next step would be to apply that to the next cohort at an earlier point to avoid escalating to an IP admission. Peer review support has been provided by the Local Government Association and the work stream met with the STP executive lead who over a period of two days interviewed around 60 people and attended the Executive Board. The overall direction was praised and no specific areas were identified to deliver big wins. A multi-agency partnership has looked at why children who were admitted had not received more support to avoid admission, given they were known to services but there had been little proactivity to triangulate knowledge across. Transformation funding has been secured for three years to develop and an autism hub which will be launched as a website to signpost for families.

A residential facility had been explored with the remit of admitting LD/Autism patients for a few days to settle them and provide team support prior to a return home. This encountered DOLs issues and instead a room within a residential unit may be a permissible option.

CYP are supporting some young people and their families with multiple visits in a day. An application had been made to NHSEI for some additional support. The CAMHS workforce was now fully extended (part time staff had increased their hours) and a recruitment plan was needed.

In terms of discharge planning and removing barriers, clinical teams will be expected to review all inpatients and not just those in the Agnes Unit. A dynamic risk register will look at potential risk of admission and training on that was being rolled out. Case reviews had been undertaken for individuals with autism who had been admitted to the Bradgate/Agnes Units and that had been shared with the Director of Nursing at LPT. Every individual known to LPT will have a medication review as part of their six monthly review. Primary Care colleagues will receive an alert to review psychometric drugs and they will have in-reach to LPT for advice and guidance. Specific community forensic support will be developed for those returning to LLR with a forensic history.

Key priorities involve;

- Achieving the IP trajectory for LLR CCGs and Specialised Commissioning and CYP patients. LLR CCGs have to reduce their IP numbers to 15 by end of March 2020.
- An LLR review of community LD services is being commissioned for all those that have an interface with health and social care for which ELR will receive the funding and undertake a procurement process.
- Alternatives to IP provision are being explored; crisis accommodation and an accommodation strategy for LLR. Part of the transformation fund is being used to employ a nurse in the crisis team.
- SEND agenda and the service transition for 18/25 year olds.
- Gaining further clarity on workforce needs and understanding the needs of future cohorts and the wider workforce requirement to support those in the wider community as patients with more complex needs reside in the community.

The trajectory will identify and track each individual. Expected performance by trajectory by March 2020, based on current services and approach are; CCG IP +1, Spec Comm IP -3, CYP IP +1 and LLR IP on track. NHSEI challenged that was not good enough. LLR also had to absorb those stepping down from Specialised Commissioning and it was important to see the patient story and flow through the system tiers.

Risks and Issues;

- Now moved from regional to national scrutiny.
- 7 MOJ patients are included in the overall 15 IP count. They are not fit for discharge and because of their offence are not able to be stepped down from IP care.
- A small number of children with high social care needs have experienced delayed transfers of care due to difficulty in finding suitable residential placements.
- The non-recurrent nature of transformation money is helpful for short term fixes but longer term solutions are required.
- The system has a limited number of experts by experience and independent clinicians for the CETR process. Financial penalties will be levied if CETR is not achieved.
- Responsible commissioner disputes between CCGs take time to resolve and can be costly if taken to legal arbitration. The 'who pays' guidance and legal stance does not match.
- No LD nurse trainees were taken into the 2019/20 due to lack of interest. There is a depleting LD nurse workforce.
- The lack of a local rehabilitation offer in LLR reduces connections with families and friends.

SF commented the escalation decision had been disheartening given the efforts over the last 18 months to overhaul processes. The sessions with Ray James and NHSEI colleagues had not identified one specific thing to make a big difference. This is a complex small group of people with individual lives and needs. SF felt the support network for clinical services was a main issue and would be needed, even if a capital solution could be found to the residential issues. A rehabilitation solution has been constrained by the PFI costs for a redesign of the Agnes Unit.

NP asked if anything was being done to help GPs understand the wrap around services for LD. He felt most GPs had little insight into the services. SW advised there was a primary care liaison nurse for LPT for each CCG. NP asked for better information on PRISM in terms of a whole pathway and assessment/information process and what to do/who to approach when things went wrong. NP offered his support to develop PRISM information.

UM noted there was nothing reported on the role of PCNs and suggested mapping the LD population to PCNs as there may be some clusters within which some clinical models could be trialled. GPs also needed to be aware of STOMP-START.

ER asked to understand what the CQC concerns were to which SW advised it related to LPT and the current action plan in place but occasionally CQC concerns were raised about other providers with whom patients were placed. AH offered to provide a future update to SLT on the CQC part of the action plan and gave assurance this was being fully worked on.

AW asked to understand the level of risk; were the identified risks fully mitigated or were the risks unstable and was there a need for decisive action to be taken and to do things differently in order to meet the target. SW acknowledged there were some things that needed more pace such as crisis accommodation, forensic support, the correct support for individuals with complex and challenging needs to enable discharge. Thematic reviews and consistency of clinical reviews would assist that to be driven forward. SF said getting to grips with the CYP cohort was key because the numbers had grown significantly and children needed to be identified much earlier. A solution for the MOJ cohort was also a pressing requirement.

AW said he would not want people to be forced to make bad decisions in order to achieve the target and doing the right thing for patients was key, however a system solution was also needed and he felt people were working hard but the target would not be achieved unless something different was done

in addition. JA was hearing the CYP and MOJ were critical areas and asked if SW and SF had suggestions on these areas. SF said the most pressing issues were children being identified early on the pathway and a build solution for MOJ supported by a clinical community service. That would not be delivered by March 2020. **JA requested the work stream identify what was needed to fix the issue and provide a plan and proposals to the next SLT. To be picked up as a matter arising. SF to lead on that.** SB asked if there was 24/7 cover for LD services given the OOH service could be signposting patients at any period of time and whether patients were flagged appropriately to ensure the receiving service could identify their needs. SW said the service comprised different components at different times but there was 24/7 cover. UM said 89% of LLR practices were on Systmone and ED clinicians were able to access that so coding was in place (as practices identified and coded their patients through an annual LD health check offer) to identify LD/Autism patients being conveyed or presenting to ED and to make reasonable adjustments to their care. CT felt a solution for MOJ patients was too long and therefore in the meanwhile the focus could be on bringing forward a community model for the rest of the IP cohort and then to look at MOJ for the longer term. JA summarised there was a lot of good work but a number of challenging issues had been identified and SLT would hear about the work stream proposition at the next meeting. <u>Mental Health</u> The work stream had experience some attendance issues but had been relaunched and redesigned with some key pieces of work identified and new terms of reference. Dr Graham Johnson is now the clinical lead and Angela Hillery will chair as the STP lead. Underneath the work stream are a number of work programmes. In terms of risk, LLR is the second worst STP for LOS and number of individuals going through a bed. The national average was eleven patients through an IP bed and LPT were last audited as having an average usage of seven patients per bed. The result is long LOS and high OOA placements. The number of OOA placements went up to 39 last week which is poor for patients and family from a quality and contact point but also financially costly to the system. NHSEI placed LLR in escalation based on April 2019 data. A recovery plan has been developed to achieve no inappropriate OOA placements by 2021. The predictions for bed days are; October 1050, Sept 750, Oct 496 and Nov 256. It will also be important to understand the flow and if patients are discharged and stay out or are readmitted and what preventers are needed to avoid readmission. Funding has been received and a recruitment plan is now required. The crisis service will be needed to gate keep and prevent admissions. SW believed patients with MH needs who required housing were not classified as highly as some family units without health needs. Changes in pathways will require senior clinicians to work together and SW raised concerns about the working relationship between some LPT clinicians. AF asked for assurance that was being addressed. AH did not feel SLT was the forum for a level of detail on this issue. AH noted the unprecedented levels of activity and gave assurance that LPT were working on additional capacity for MH and focussing on flow. SP asked what was needed in terms of support from the wider community, such as housing and how partners would be brought into these discussions. JA asked if it was correct that MH status did not have a bearing on housing priority. SF said that would be defined in the housing policies of each LA and the weighting given to medical impact. He advised that supported housing for adult social care needs would be a priority 1.	**SF**

CT asked if past system successes, such as the work undertaken for DTOC had been looked at. SW advised she had spoken with Peter Davies yesterday about re-establishing the group. AFu suggested AH bring the OD issues for LPT workforce to the Clinical Leadership Group. ER noted the question in the presentation on where drug and substance abuse services should fit. SW said the work stream had asked that to be raised. Some individuals with substance misuse would also have mental health issues but not exclusively. UM said dual classification existed and the two were not easily separated and felt some specialist advice was needed on this. AH recognised the prevention element and that drugs and alcohol were a key predictor and risk for mental health. It was agreed this needed to remain in the work stream. **Next steps – SW to provide a bespoke report on an approach to improve flow and any other wider requests of the system if required) to the SLT meeting in November. SP to add to the work programme.**	SW SP
SLT 19/92 Urgent and Emergency Care (including Transformation Plan) (Paper D)	
Yasmin Sidyot, Acting Director of Urgent and Emergency Care, West Leicestershire CCG presented the LLR Transformation Plan for Urgent and Emergency Care. The key focus on the plan is to reduce activity and manage demand across LLR urgent and emergency care. Twelve key actions had been identified between now and over the winter to support financial recovery and sustain the system. The AEDB is taking the lead and membership has been strengthened. Clinical representation has been difficult due to the timing of the meeting being on a Wednesday and YS suggested a non-board clinical lead. **CT undertook to pick this up at the 17 September event.** The plan has been submitted in draft form to NHSEI and they were positive in their response and a letter of full assurance has now been received. JA thanked YS and colleagues for their work. The challenge was now in the delivery of the plan and given the pressure on system performance, the right level of senior accountability at AEDB was vital. **JA asked for some of the actions to be rephrased to be more precise and trackable.** JA noted the system had a significant capacity deficit, the solutions being to reduce LOS or avoid admission rather than increase beds. JA had been surprised by the significant impact on bed requirements by slightly reducing LOS. AFa noted the potential of a GP led facility at the LGH for short term observation bays and said City PCNs were keen to deliver this model. SP advised she had a meeting planned on LGH site possibilities. AFa also noted the potential incentive schemes for PCNs to reduce acuity but SP said that was for the 2021/22 year, however 2020/21 would have specifications on care homes, case finding for CVD and respiratory and anticipatory care. AFa felt there was potential for starting some local pilots. SP would keep JA appraised. TS advised the impact and investment fund for PCNs would start at £1 per patient rising to £5 per patient by 2024. Specifications would not be out until February 2020 which gave little time to understand the impact. UM advised ELR CCG had commissioned an independent review of their urgent care centres and was concerned that they did not meet the minor injury unit definition. A rise in the use of urgent care had been seen by the 18-25 year patient cohort and UM asked if university practices were being considered as pilot sites for e-consultation. YS advised discussions were taking place and ideally the focus would be in place in time for Fresher's week, as part of an existing process, and then finding other opportunities throughout the rest of the year. NP advised 10 pilot practices had launched across LLR last week. SL noted the city population was considerably younger but wider than a student population and she had spoken with Cheryl Davenport about a project to identify what motivates them	**CT**

to seek health care and advice. SL felt the view on care homes perhaps needed to change and whilst they were providers in their own right and needed to meet standards, they provided a significant portion of care and needed to be supported and PCNs now provided a good opportunity to have designated support and develop that relationship. AW commended YS and the team on a really good plan. He noted the papers generally received today were financially and activity modelled and required a real step change. However the NHS did not have a good track record on delivering significant change and he asked what would be enacted in the delivery of this plan for LLR to deliver something that no one else could. He felt the scale of the challenge ahead was on a par to major incident planning and as such would require weekly reporting, having oversight on care homes and bed availability and treating each admission as an SUI if a care plan with a DNR was in place but the patient had been admitted anyway. AW said the £5m-6m would only be delivered if the plan was given precedence above all other activities with both primary care and the acute signed up to it. JA was in agreement and made reference to the MAAD and MADE real time events. UHL enacted that process when at OPEL 4. Whilst avoiding admissions for some of the elderly care homes cohort was the right thing to do from a quality and capacity point, AFa said those patients would still need to access an alternative service. AW felt the approach would be to see what had happened each day, what needed to be done differently, better, resourced, such as a dedicated team, care homes in contact with 111. NP made the point that data collected evidence was not being used to link back to what had made a difference such as focussing on multi-morbidity and chronic conditions as a significant driver for capacity and cost. NP noted the excellent work of Dr Shepherd and Mark Pierce on ACGs but that had not been matched back to potential PCN schemes. There was general support for a level of intensity at a very senior level to ensure the plan delivered but a realism that it could not be achieved alongside the 'day job'. **The work stream was asked to develop what the support mechanism and reporting could look like.** SB asked that DHU understood the impact of any changes to ensure their workforce was able to respond. SB also asked if there were plans to communicate the level of concern to the public. AW said it was evidenced that the greatest way to change behaviour was to de-escalate public anxiety and acting as business as usual whilst working hard in the background. Simon Stevens had been clear that the 'choose well' campaign should cease. CT felt it was worth reflecting that the other groups set up to address system pressures had not made much difference and to understand that and ensure the next iteration was done differently. JA asked that the **AEDB be fully sighted on the review from the ELR CCG UCCs before taking any action. UM agreed.** **It was agreed that further urgent discussions would take place following the meeting to identify the mechanisms that would be put in place to ensure sufficient priority for this work.**	**CT /JA**
SLT 19/93 Person Centred Leadership Framework (Paper E)	
Fay Bayliss, Deputy Director of Nursing and Quality, Leicester City CCG and Bina Kotecha, Deputy Director of Learning and OD, University Hospitals of Leicester attended for this item to report on a proposed Person Centred Leadership Framework for adoption across the health and care system. This would support an outcomes focus, build on a platform of positive culture; support a systems mind-set approach and behaviours that support collaborative working. The Clinical Leadership Group was supporting the work. The Person Centred Leadership Framework (PCLF) follows a journey from drivers to outcomes and the importance of a shared purpose. The PCLF considers the drivers in the LTP and the interim people plan and takes account of what matters most to patients. This framework is delivered through being person centred and developing a shared culture of mind sets and behaviours.	

FB gave an example from her own practice; working at place level in the city to deliver pathways for patients at end of life out of hospital. The driver was the patient cohort stranded in acute beds and not achieving the quality premium. A self-managed team was set up to address this. The patients were mostly cognitively impaired and most had 1 to 1 nursing care and were at end of life and needed to get home to die. The enabler used was a tried and tested quality improvement methodology and the real delivery came from the distributed leadership model through a local authority case manager who led the PDSA meetings as they understood the patients and the knotty issues and were able to deliver better outcomes for the patient. Many died at home with good domiciliary or palliative care, where needed. The feedback from families was very positive saying they had felt listened to and cared for. Therefore the team had delivered 'more good days'. FB said this approach was not new and was currently happening in pockets but the PCLF would look to deliver this consistently across LLR. It was proposed to develop a knowledge hub at the centre and a web-group had been created for people to link in. A roadmap of key activities and timelines to achieve had been developed and FB wanted to test the framework against the end of life framework.

FB welcomed comments and asked if there was anything to add. CT welcomed this and said a system of support had been much needed for a long time. AW was also supportive but noted systems generally worked better if people already knew each other. AW asked whether the support needed was permission for people to get on and do it or whether it was more than that. CT responded that people needed to be freed up to be part of this and to have the experts wrapped around the teams to carry them through the process.

FB said she was working closely with BCT communications support and wanted to create a pin badge with the BCT and More Good Days logos/strapline. Leicester City Council was shortly holding a Festival of Good Practice and Ruth Lake was keen to promote the More Good Days message at the event. Support was given to producing the pin badges.

It was RESOLVED

- To support and adopt the framework.

SLT 19/94 Current System Financial Position and System Recovery Plan (Paper F)

Spencer Gay, Director of Finance, West Leicestershire CCG presented a slide set outlining the level of financial risk facing the LLR NHS system in 2019/20 in order to deliver financial targets in line with financial plans. He reported on the likely case of £28.9m of risk materialising which would require the development of a system financial plan to deliver requirements. SG advised he was more confident about the cost review than the elective and non-elective care challenges. There was no plan B and all elements needed to be delivered; demand management, cost control, budgets and flexibilities. The next steps included working through the detail of what could be achieved and the impact of that on organisations including monitoring and sign off of organisational plans, when ready.

JA reported that the UEC team had identified those areas of the urgent care transformation plan which should be focussed on to impact on the demand and financial pressures in tandem. The £5m non elective delivery would be challenging due to the blended tariff. SG was confident the controls were robust and would deliver but some solutions were non-recurrent in nature and would be a one-off benefit for 2019/20. SG advised there was about £10m identified/deliverable and £18m of risk. SL reported LLR was now at regional escalation and was reporting monthly on progress. The governance/escalation is going through the Chief Officers meeting which takes place fortnightly. LPT had flagged a risk on their ability to achieve their control totals. UM asked for the reference to Fielding Palmer Hospital to be removed as the specifics had not been agreed for CSR bed review and pathway 3.

In terms of oversight the System Sustainability Group would meet each week and the Chief Officers meeting would review each fortnight. It was RESOLVED - to note the level of financial risk faced by NHS partners, the outline recovery plan actions and their expected impact and to oversee delivery of the plan.	
SLT 19/95 Draft Long Term Plan (Paper G)	
The plan was presented in three elements; first high-level draft led by Sarah Prema, Director of Strategy and Implementation, Leicester City CCG, a patient report on engagement of the Long Term Plan led by Richard Morris, Director of Operations and Corporate Affairs, Leicester City CCG and a financial framework for developing the Long Term Plan led by Spencer Gay, Director of Finance, West Leicestershire CCG. <u>Draft Plan</u> SP advised LLR had been required to write a system plan articulating the system transformation needed over the next 5 years to become an ICS, how it will meet the requirements of the LTP and maintain or regain financial sustainability over that period. The plan would be submitted to NHSEI on 27 September including the narrative, finances, workforce and some new metrics. NHSEI was due to send out an e-workforce tool to all providers for completion to set a baseline for staffing numbers. SP recognised there were some gaps and areas to be strengthened such as health inequalities and section 4 on outcomes. There was debate at region level between the programme leads and planning leads as the plan was intended to be strategic but the programme leads wanted an operational plan. SP had worked with the SROs on each area. SP requested any further feedback ahead of **bringing it back through SLT in September.** The LLR CCG's would consider the plan at their development session next week. SP would speak with UHL and LPT about their assurance processes. SP did not envisage seeking LA assurance before submitting to which SF was in agreement but felt members would want to have sight of it. NHSEI did not intend for the plan to be published until November and discussion took place as how best and when to share the plan with stakeholders. SP would check up the line what was permissible ahead of the publication date. In the meantime SP was happy for people to share the draft in confidential boards or at development sessions. **Comments to SP by 6 September on the initial draft.** <u>Patient and Public Involvement</u> RM advised it was not intended to undertake a significant amount of patient and public involvement on the plan as there had been a lot of activity recently as he felt the public appetite had been tested due to continual requests. Instead a compendium of PPI activities over the past two years had been produced and that that insight would feed into the LTP. The key elements of the plan would be engaged on at a future point but RM did not believe it would add value at this stage. It was noted that NHSEI instruction not to publish the plan until November was not helpful. RM advised NHSEI had commissioned Healthwatch nationally to engage on the LTP at a local level and for LLR that had garnered about 600 responses. <u>Financial Framework</u> SG reported a single financial model was being completed collaboratively by the LLR organisations taking account of historic spend, demographic growth and pay inflation. The numbers were not being shared at this point as they needed to be checked against the requirements of the LTP to ensure all investment requirement would be achieved. SG felt the 'do nothing' gap would be smaller than had been seen before despite the pressures due to the significant amount of allocation growth. SG expected the headline figures next year to be driven by more cost inflation due to the MH investment standard, A4C inflation, and a challenged system this year which would be carried through into 2020/21.	**SP**

It was RESOLVED
- to receive the draft LLR BCT System Five Year Plan.

SLT 19/96 BCT Outcomes Framework Quarterly Update (Paper H)

The BCT Outcomes Framework for Leicester, Leicestershire & Rutland (LLR) Sustainability & Transformation Plan (STP) was noted.

It was RESOLVED
- to note the latest performance measures in the BCT Outcomes Framework and the accompanying exception reports (appendix B) for those measures which are currently not achieving target.
- to endorse development of an outcomes framework for the emerging LLR Integrated Care System (ICS).

SLT/ 19/97 EMAS Clinical Operating Model (Paper I)

The item was deferred.

SLT/ 19/98 IM&T update (Paper J)

The update was noted.

SLT 19/99 Any other business

There were no other items of business.

Date, time and venue of next meeting

9am-12pm Thursday 19 September 2019, 4th Floor Conference Room, St John's House