System Leadership Team
Meeting No. 30
Chair: John Adler
Date: Thursday 19 September 2019
Time: 9.00am – 11.00am
Venue: 3rd Floor Conference Suite, Voluntary Action Leicester, 9 Newarke Street, Leicester LE1 5SN

Present:	
John Adler (JA)	Chief Executive, University Hospitals of Leicester NHS Trust
Caroline Trevithick (CT)	Interim Managing Director, West Leicestershire CCG
Professor Mayur Lakhani	Clinical Chair, West Leicestershire CCG
Professor Azhar Farooqi (AFa)	Clinical Chair, Leicester City CCG
Michelle Iliffe	Director of Finance and Deputy Accountable Officer, Leicester City CCG
Donna Briggs (DB)	Chief Financial Officer
Andrew Furlong (AFu)	Medical Director, University Hospitals of Leicester NHS Trust
Paul Traynor (PT)	Director of Finance, University Hospitals of Leicester NHS Trust
Evan Rees (ER)	Chair, BCT PPI Group, East Leicestershire and Rutland CCG
Stephen Bateman (SB)	Chief, Executive Officer, Derbyshire Health Care CIC
Ben Holdaway (BH)	Director of Operations, EMAS
Mark Andrews (MA)	Assistant Director Adult Services, Rutland County Council
Sue Elcock (SE)	Medical Director, Leicestershire Partnership Trust
Sharon Murphy (SM)	Deputy Director of Finance, Leicestershire Partnership Trust
In Attendance:	
Clare Mair (CM)	Board Support Officer, Leicester City CCG (Minutes)
Sarah Prema (SP)	Director of Strategy and Implementation, Leicester City CCG
Spencer Gay (SG)	Director of Finance, West Leicestershire CCG
Apologies:	
Andy Williams	LLR CCGs Accountable Officer Designate
Ursula Montgomery (UM)	Chair, East Leicestershire and Rutland CCG and GP
Frances Shattock (FS)	Director of Strategic Transformation/ Locality, NHS England and Improvement
Sue Lock (SL)	Interim LLR STP Lead, Managing Director, Leicester City CCG
Angela Hillery (AH)	Chief Executive, Leicestershire Partnership Trust
John Sinnott (JS)	Chief Executive, Leicestershire County Council
Dr Nick Pulman (NP)	West Leicestershire CCG
Steven Forbes (SF)	Strategic Director for Adult Social Care, Leicester City Council

SLT 19/99 Welcome and introductions	
JA welcomed everyone to the meeting.	
SLT 19/100 Apologies for Absence and Quorum	
Apologies were noted as above. The quorum was discussed in that ELR CCG were at present unable to field a clinical representative. DB advised this was being addressed.	

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SLT 19/101 Declarations of interest on Agenda Topics	
The papers had been reviewed by a CCG Governance Officer and no conflicts of interest had been identified.	
SLT 19/102 Notification of any other business	
The Chair was not notified of any other items of business.	
SLT 19/103 Minutes of meeting held on 22 August (Paper A)	
The minutes from the System Leadership Team held on 22 August 2019 were presented and agreed to be an accurate record of the meeting.	
SLT 19/104 Action notes of the meeting held on 22 August (Paper B)	
The action log was reviewed and the following noted; <u>21/01/08 – Partnership Group Terms of Reference</u> The Partnership Group are due to meet on Monday 23 September 2019. JA did not anticipate that Leicestershire County Council would participate for now due to the Council having issues about clarity on what an ICS is. Leicestershire County Council took a paper to their full council a week or so ago to reconfirm their commitment to collaborative working but raised a series of questions about ICS architecture and place. **CT to respond to JS advising a response to his paper would be prepared and would co-ordinate that with SP.** <u>19/92 - Urgent and Emergency Care</u> The AEDB met yesterday. A rigorous management approach and a demand management plan linking in with the financial recovery plan and LOS work are in place and all were being given the highest profile. CT advised WLCCG had been running a major incident approach to urgent care and holding daily review phone calls. A stock take would happen tomorrow. CT was taking part in an urgent care escalation call today with NHSEI. MP also advised that Dr Rizvi, GP was dedicating his clinical sessions to support CT on this. DB reported a Transforming Care Programme submission had been sent on Friday. More work was needed to close the gaps. **DB would bring the work plan to the October SLT meeting.**	**CT SP** **DB**
SLT 19/105 NHS Long Term Plan	
<u>LLR Five Year Financial Plan – presentation (Spencer Gay)</u> The system had been informed of five years' worth of allocations from 19/20 to 23/24. The modelling had been done as a system response across the organisations. Historic spend had been used as a baseline and inflation added for pay, non-pay and demographic need and local priorities, the LTP 'must dos' and the efficiencies LLR needed to make had been taken into account. There was a deficit in some of the years of the plan and that would need to be agreed with NHSEI. Funding was being asked through various sources; financial recovery fund, provider support fund, commissioner support fund. The system has accessed those funds historically to support the bottom line. Assumptions had been made but there was no guarantee of support. Growth had been assumed locally as 0.7+ on demographic, 1.3% on community and 2.7% on acute. Demographic growth had not been applied to mental health because there had been significant investment into the plan already (£10m for 2020/21). SG had checked against a number of investment areas and believed all were covered with the exception of two; Community CHC and PC investment standard was being checked as to how that	

would be measured but it was believed the investment had been met. Long Term Plans must demonstrate maintaining or returning to financial balance and not all organisations at present show a balance. SG believed NHSEI would question if the system was working quickly enough to achieve balance. 2019/20 had a £30m in year problem to address and SG was identifying the extent to which the solutions were recurrent/non recurrent.

Agreement of the plan needed to go alongside agreement of contractual arrangements with all parties.

2019/20 identified a £9m planned deficit and for 2020/21 a £82m planned deficit. The full amount of external support would be requested for 2020/21. SG advised the system was receiving £40m of central funding support in 2019/20 so the £9m was artificial. The plan had been set to achieve financial balance by 2023/24.

JA noted most of the system deficit sat with UHL. SG responded there was quite a lot of investment in UHL that was not funded by usual contractual mechanisms and so the contractual arrangements and pattern of spend needed to change. The current construct meant that UHL internal savings were a benefit to them but any system-wide transformation or demand management was currently modelled to take income out of the provider. The reward and benefit of collective work needed to be considered. PT recognised £82m as the deficit for 2020/21 but the split across organisations was still for debate. He agreed more work was needed to understand the transformation projects and who would share the benefit. SG said the aim was to get every organisation to an even position regardless of the split.

JA queried the status of the numbers and SG said they would be submitted with the draft LTP. JA warned the numbers would need to be heavily caveated because as they stood support would not be given from the UHL board.

DB asked if there were any unidentified savings and SG said there were none for 2020/21 and he believed all options had been explored. DB felt the regulators would push back as there were six months until 2020/21 and they would say more could be done to bring down the deficit. SG said this set framework for people to go away and work up the plans in detail for example, £10m had been put aside for the MH investment standard but there was a work-up to be done on how it would be spent within the identified areas.

SG reported a 4% growth average with the exclusion of targeted funding which the system would bid for. SG believed the LLR share would be £30m and if successful would be used to deliver some of the system priorities earlier. SG reported over the next five years there would be enough funding to make the investments and meet pay and non-pay growth. Activity growth was not an option and therefore redesign of services to be more effective or demand management would be required.

Some additional funding for LPT had been funded from the baseline £44m, a fair share allocation nationally for STP of £31.5m and targeted funding for some areas of priority in LPT which was being held centrally and would be bid for. £50m of investment was anticipated for 2020/21.

Narrative and evidence to support the plan will be key to receiving approval from the regulator. SG wanted to be honest about the scale of deficit so that achieving balance would be deliverable. Benchmarking did not show LLR as an outlier. LLR had found it difficult to deliver transformational work in previous years but the five year view was helpful in setting out the ambitions early. It would take time for new ways of working and contracting to work through the system.

CT acknowledged that UHL didn't want to hold the risk for deficit but the CCGs didn't want to be in a position of holding an excess. It would be important to get NHSEI to understand that the current split needed to be remodelled. SG would talk to the regional team before submitting the numbers.

PT noted PSF was not in the modelling and getting back to balance by 2023/24 without PSF would not be easy. He expected push back on a worsening position for 2020/21. JA said UHL would have little choice but to increase its prices to reduce its deficit if the current split and the current contracting remained unchanged. Therefore the way in which LLR traded would need to change otherwise the futile efforts of UHL increasing prices and the CCGs challenging that would continue. SG assured the narrative in the body of the plan would state that LLR was looking to change and there would be a different contractual approach to sharing the risk. SG understood it would be difficult for UHL to sign up to the plan with the deficit sitting with them. MA made the point that UHL were being put in a position of risk to invest in other parts of the system that had not always been able to deliver the transformational change. MA didn't feel these discussions represented an emerging ICS and the whole system owning the risks and was not surprised that UHL felt uncomfortable. DB didn't feel the CCGs would be comfortable either with this either as the deficit moved to the CCGs; 100% of the deficit sat with in UHL in 2019/20 and 75% in 2020/21 with the other 25% shifting to the CCGs. DB was clear the ICS needed to own the total deficit. PT said the transformation work and creating a model with shared benefits would represent and deliver genuine partnership. SG asked if the boards would be less nervous if they were clear that a different contractual form was being moved into.

ML noted that both financial and clinical strategies would be needed to meet the requirements of the five year plan including the reshaping of primary and community care and contracting opportunities. Professor Farooqi commented that the numbers felt abstracts and clinicians would want to see some real examples of what the finances would mean for transformation of services.

JA felt UHL board would support the plan if the deficit risk was evenly balanced across the organisations and there was agreement for a new contractual form that facilitated the delivery of the objectives. As a trust in deficit UHL were nationally required to take out 1.6% in the absence of a CIP.

SP advised the draft would be submitted on 27 September 2019 and between then and 8 October 2019, NHSEI regional team, programme team and finance team would review. The LLR feedback meeting was diarised for 9 October 2019. Between 9 October 2019 and 15 November LLR would go through a reiterative process with the region and the plan revised in light of the feedback. The plan would be taken through trust boards at the end of October/early November 2019. The contractual principles would need to be in there. SP and SG would work on the narrative to reflect what had been discussed today. **SG SP**

SLT agreed that a new approach to contracting, particularly the UHL contract was required and committed to work on this for inclusion in the LPT papers to boards in November 2019.

<u>LLR Five Year Plan</u>

The narrative had been revised since presented to SLT in August 2019. The narrative describes how the LLR system will meet the LTP commitments through structural and services changes, ICS development and achieving financial balance. The plan builds on existing BCT work, the community services redesign and LTP transformation programmes. SP had been balancing the strategic and operational requirements of NHSEI. The region had increasingly been issuing KLOEs about what needed to be in the plan resulting in a lot of detail therefore SP was trying to deliver a balance of answering the questions at a reasonable level but still ensuring the plan was strategic. There was more work to do on workforce. Region was providing some support which LPT and UHL workforce leads would link into. More work was also needed on the health inequalities chapter. The plan narrative would come to boards at the end of October/early November 2019. The draft plan narrative has been to CCB, the planning and operational group and CLG. SP invited comments bearing in mind there was one week before submission.

CT was pleased NHSEI were helping with the workforce area and it was agreed the two workforce

leads would be asked to attend SLT to provide an overview on risks. A chief officer lead needed to be identified. It was agreed to discuss that with SL. SP would send out a final copy of what was submitted. MP had talked to the 25 PCN leads about how they would want to interface with the system. MP and AFa proposed 2 PCN ACDs from each current CCG footprint to join the SLT membership. AFu wanted assurance they would be empowered by the other 19 PCN ACDs and AFa affirmed they would be speaking on the others' behalf. SP was mindful of their time commitment as they needed to get involved in the care alliance discussions which she felt was of more benefit. AF suggested starting with 6 PCN ACDs to begin with and then revisit the number in due course. MA felt 6 was a lot and one per place was more sensible. MA felt a discussion about how to properly integrate at a local level was needed and bringing the LAs into the alliance discussion to better integrate resources across LAs and health. JA agreed PCN attendance on that scale was a lot but could be tried as a starting point. It was agreed to include them on the SLT at present and see what other groups opened up to them, such as the CLG and care alliance. JA asked if there was anything else to feedback on PCNs such as work stream interface. AFa advised the PCNs has established an LLR forum and the next meeting would look at representation on work streams alongside looking governing body GPs alignment to work streams. The CCGs would put together a development programme for PCNs and £800k a year was available across LLR for their development needs. MP noted the level of recruitment for ANPs, pharmacists, social prescribers, physios etc. and with a limited pool of these skills it was important to think about how these roles could be recruited to so as not to destabilise other providers in the system. MP asked if there was capacity and capability in the system to provide HR support to PCNs for job descriptions and recruitment. A number of different streams of work were happening that needed bringing together; Helen Mather was working on a training passport, UHL Chief Pharmacist had raised the issue of staff movement, Tim Sacks was leading on PC workforce. **SP would speak to Tim Sacks to ensure UHL pharmacy, EMAS and LPT were invited to the next session. SP would talk to Tim Sacks about mapping out all the meetings and to see if PCNs wanted to be involved.** **SP requested that CEOs and AOs read the forward she had written on their behalf. SP would add EMAS and DHU into the forward if they wanted that.**	**SP** **All**
SLT 19/106 Financial Recovery Plan	
FRP was submitted at the end of July and was due for resubmission on Friday 20 September. The figures were still based on month 4 and no major changes were expected. The overarching message is that system is primacy. Individual organisations have got control totals and are receiving their PSF. The financial recovery plan had been split into several areas; demand management, cost control, managing capacity, budgetary review and flexibilities. CCB went through the 'no go' FRP areas last week; cancer, clinically urgent, 52ww, 26 week rebook, anything that would be detrimental to ED performance, MHIS. The month 4 FRP position reported a £28.9m problem across the system. Elective and non-elective care are areas of focus. £5m for elective had been built in but heavily caveated that work needed to be done and £8.8m for the urgent care target. There is currently a £11.7m gap and NHSEI will want to know what else is being looked at. There is potentially £750k of overseas visitors income opportunities based on national benchmarking. The system submitted a balanced plan but that position had deteriorated. An escalation meeting was taking place next week. UHL and LPT internal pressures were recognised. A move to sharing the	

financial risks and benefits and contracting differently would indicate to NHSEI the change of intent. PT said despite the efforts over the next few months the elective and non-elective gains would be small and the sooner the system moved into proper transformation the better.	
Date, time and venue of next meeting	
9am-12pm Thursday 17 October 2019, 4th Floor Conference Room, St John's House. CT would chair SLT from October to December.	