Board of Directors Meeting (PUBLIC)

04 September 2019, 13:30 to 15:30
Conference Room, Northgate Hospital, Morpeth, Northumberland, NE61 3BP

Agenda

1. Service User/Carer Experience

Presentation

2. Apologies

Verbal/Information

Chair

3. Declarations of Interest

Verbal/Information

Chair

4. Minutes of the previous meeting: Wednesday 7 August 2019

Decision

Chair

04. Board of Directors minutes 7 August 2019 IN PUBLIC FINAL KA.pdf (15 pages)

5. Action list and matters arising not included on the agenda

Discussion

Chair

05. BoD Meeting held in public Action List.pdf (1 pages)

6. Chair's Remarks

Verbal/Information

Chair

7. Chief Executive's Report

Information

Chief Executive

07.a CEO Report Aug 4th Sept.pdf (3 pages)

07.b. Appendix 1. Building healthier communities.pdf (74 pages)

07.c. Appendix 2. A Manifesto for new PM.pdf (16 pages)

Quality, Clinical and Patient Issues

8. Commissioning and Quality Assurance Report (Month 4)

Decision

Executive Director of Commissioning and Quality Assurance

08. BoD Monthly Commissioning Quality Assurance Report - Month 4.pdf (6 pages)

9. Annual Dean's Quality Meeting, Medical Report

Discussion

Executive Medical Director

09.a ADQM.pdf (2 pages)

09.b. NTW - Annual Quality Report 2019 (004).pdf (6 pages)

10. Research and Development Annual Report

Discussion

Executive Medical Director

10. RD Annual Report 201819 for Board Sept19.pdf (25 pages)

11. Independent Evaluation of the Global Digital Exemplar Programme

Information

Executive Director of Commissioning and Quality Assurance

Workforce

12. Workforce Directorate Quarterly update Report (Quarter 1)

Discussion

Acting Executive Director of Workforce and Organisational

12. Quarterly Workforce Report - August 19.pdf (7 pages)

Strategy and Partnerships

13. ICS Memorandum of Understanding

Discussion

Chief Executive

13.a NE and NC ICS MoU front sheet.pdf (1 pages)

13.b ICS MOU 16 Aug 2019.pdf (6 pages)

14. Cumbria

Discussion

Chief Executive

15. Draft Long Term Implementation Plan Submission

Deputy Chief Executive/ Exectuive Director of Finance

16. Emergency Preparedness Resilience and Response Annual Report

Executive Director of Nursing / Chief Operating Officer

16. EPRR - Board of Directors - Annual Report 2018 - 2019 Final.pdf (13 pages)

Regulatory

17. Trust Consitution

Deputy Director of Communications and Corporate Affairs

Minutes/Papers for Information

18. Committee updates

Verbal/Information

Non-Executive Directors

19. Council of Governors' Issues

Verbal/Information

Chair

20. Any other Business

Chair

21. Questions from the Public

Discussion

Chair

Date, time and place of next meeting:

22. Wednesday, 2 October 2019, 1:30 pm to 3:30 pm, Training Room 4, Hopewood Park.

Information

Chair

Northumberland, Tyne and Wear NHS Foundation Trust

Minutes of the meeting of the Board of Directors held in public
Held on 7th August 2019, 1.30pm – 3.30pm
In Training Room 4, Hopewood Park, Waterworks Road, Ryhope, Sunderland, SR2 0NB

Present:

Ken Jarrold, Chair
David Arthur, Non-Executive Director
Dr Leslie Boobis, Non-Executive Director
Alexis Cleveland, Non-Executive Director
Michael Robinson, Non-Executive Director
Peter Studd, Non-Executive Director
John Lawlor, Chief Executive
Rajesh Nadkarni, Executive Medical Director
Gary O'Hare, Executive Director of Nursing and Chief Operating Officer
Lisa Quinn, Executive Director of Commissioning and Quality Assurance

In attendance:

Debbie Henderson, Deputy Director of Communications and Corporate Affairs
Chris Cressey, Associate Director of Finance
Jennifer Cribbes, Corporate Affairs Manager
Michelle Evans, Deputy Director of Workforce and Organisational Development
Eilish Gilvarry, Deputy Medical Director *(item 8)*
Jan Grey, Associate Director of Safer Care *(items 11, 12, 13, 14 and 15)*
Claire Keys, Clinical Staff Governor *(item 1)*
Sunil Nodiyal, Consultant Psychiatrist *(item 8)*
Keith Reid, Consultant Psychiatrist *(item 10)*
Chris Rowlands, Equality and Diversity Lead *(item 9)*
Paul Sams, Project Co-ordinator Positive and Safe Care *(item 10)*
Ron Weddle, Deputy Director of Positive and Safe *(item 10)*
Ali Paxton, Commissioning and Quality Assurance Manager
Fiona Regan, Carer Governor
Bob Waddell, Staff Governor

1. Service User/Carer Experience

A special welcome was extended to Claire Keys, Staff Governor / CPN and Service User who was in attendance to share her personal experience. Ken Jarrold thanked Claire for sharing her story which was very powerful and valuable.

Lisa Quinn referred to Claire's positive experience of being supported by her manager and asked if she was part of the staff mental health network. Lisa explained that it would be good to share her story and her manager's approach to providing support with the rest of the organisation to share good practice.

In response to a question raised relating to improving her experience, Claire explained that it would be good to change the Trust's polices to allow staff to be treated by a service they do not work in.

Alexis Cleveland commented on the keeping in touch arrangements that had been in place during Claire's period of sickness absence and how it was focused on being a supportive arrangement to manage wellness.

Ken further thanked Claire for sharing her story with the Board.

2. **Apologies for absence:**

Ken Jarrold introduced the meeting and welcomed those in attendance. Apologies had been received from James Duncan, Deputy Chief Executive/Executive Director of Finance and Lynne Shaw, Acting Executive Director of Workforce and Organisational Development.

3. **Declarations of Interest**

There were no conflicts of interest declared for the meeting.

4. **Minutes of the meeting held 3rd July 2019**

The minutes of the meeting held on 3rd July 2019 were considered.

Approved:

- **The minutes of the meeting held 3rd July 2019 were agreed as an accurate record**

5. **Action list and matters arising not included on the agenda**

There were no actions to be updated and no matters arising from the minutes.

6. **Chair's remarks**

Ken Jarrold provided a verbal update and referred to a recent Schwartz Round he had attended. Ken explained that the Schwartz round was a very impressive process where staff share stories which are then reflected upon. Ken explained that the process highlighted the humanity and compassion of staff. The Board were encourage to attend a future Schwartz Round as part of their visit programme.

Resolved:

- **The Board noted the Chair's remarks**

Action:

- **Future dates of Schwartz Rounds to be circulated to Non-Executive Directors**

7. Chief Executive's report

John Lawlor spoke to the enclosed Chief Executive's report to provide the Board with Trust, Regional and National updates.

John referred to section 1 of the report on the Trust name and provided a rationale for the proposed name change to Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust. John explained that the proposed name met the criteria for NHS England's Identity Guidelines but more importantly, the change of name would reflect the Trust's wider footprint and the significant transfer of services and workforce from North Cumbria. John explained that work would be commencing to communicate the name with staff and key stakeholders from August.

John informed the Board that the Trust had entered into an Improvement Partnership with Lancashire Care NHS FT (LCFT). John explained that LCFT was in the process of acquiring services in South Cumbria and a framework was currently in development to enable us to work together.

John made reference to the Sunderland Recovery College and explained that the college has been very successful and has been developed using a different model.

John referred to the document 'Overshadowed - the mental health needs of children and young people with learning disabilities' and commented that there were good recommendations within the report.

Ken Jarrold referred to the reputation and success of NTW and highlighted the importance of NTW working with colleagues in Cumbria to provide better services across the whole region. Ken further noted that Gary O'Hare had been working in Cumbria and supporting Lancashire Care and commented that it was a privilege to be in a position to help and support others, while also learning from each other.

Resolved:

- **The Board received the Chief Executive's report**

Quality, Clinical and Patient Issues

8. Medical Revalidation submission

Eilish Gilvarry and Sunil Nodiyal provided the Board with an update on the Trust's current compliance with GMC medical revalidation. Eilish advised that it had been a very successful year and explained that the report had previously been presented to the Quality and Performance Committee.

Eilish noted that the Trust had 100% of appraisals completed during the year. It was explained that four doctors had been deferred for valid reasons such as being out of the country and no doctors had not engaged. It was further explained that AuditOne had completed an audit and have granted positive assurance.

Eilish explained further developments that had been made during the year including a review of policies, publication of a revalidation newsletter and development of work plans. Risks associated with the transfer of service from Cumbria were explained which included Doctors in Cumbria being on a different revalidation system.

Sunil Nodiyal provided further information in relation to: the number of trained appraisers; positive feedback on the appraisal process; the quality of appraisals received; and monthly SARD training for new starters and overseas doctors. Recognition was given to Eilish and the team in relation to GMC revalidation.

Rajesh further referred to the Fair to Refer report on GMC referrals for BAME doctors published by Dr Roger Kline and explained that he had been following the case which raises the importance of a fair approach to managing doctors in difficulty.

Peter Studd commented that he was pleased to see that the appraisals focused on development and highlighted the link between staff retention work and developing appraisers to become mentors.

In response to a question raised by Alexis Cleveland, Eilish explained that quality of appraisal would be measured through a survey that focused on quality metrics, understanding the quality of the reflection and individual discussions with each appraisee. Alexis suggested that information on the themes identified be included as an appendix of the report next year.

In response to a question raised by Les Boobis, Eilish explained that patient satisfaction, colleague feedback and audit quality improvement activity that has been reflected on, must be included in every appraisal. Les Boobis further questioned the use of using national metrics to measure the improvement of individual doctors over time. Rajesh explained that the Trust did not gather national data on individual performance.

John Lawlor and Rajesh Nadkarni thanked Eilish and her team for their work in relation to GMC revalidation.

Approved:

- **The Board approved the sign off of the statement of compliance for the higher level responsible officer for NTW and St Oswald's Hospice**

9. Equality and Diversity WRES update

Chris Rowlands spoke to the enclosed report to provide an update in relation to the Trust's position against the Workforce Race Equality Standard (WRES) and Equality Delivery System which are both requirements of the NHS standard contract.

Chris explained that EDS reporting had been mapped against EDS2 standards. However, EDS3 is due to be released in the autumn and the Trust will conduct a benchmarking exercise as soon as the tool is available.

Chris explained that WDES (Workforce, Disability Equality Standard) data had been collected for the first time. However, there was an issue with the data in relation to the non-disclosure of disability. Chris advised that there is a greater percentage of staff who have disclosed a disability or long term condition when completing the staff survey in comparison to the figure that has been disclosed directly to the Trust. Chris highlighted that this is likely to become part of a regional action to improve the collection and recording of protected characteristic information on to the ESR system. It was explained that the ESR system is currently being developed to support gathering more data.

Chris provided an update in relation to WRES work and informed the Board that local NHS Organisations held a joint recruitment event in April. The Trust received interest from the BAME community and work is ongoing to maintain links to those individuals interested in working in the Trust.

The results for WRES were similar to WDES and highlighted that work is required to engage with staff with protected characteristics, understand the position and create solutions. Lisa Quinn referred to the lack of data gathered in relation to disability and protected characteristics and requested that work be done within the appointment process to ensure the data is gathered from staff when they are appointed to a position in the Trust.

John expressed disappointment that 22.6% of staff had experienced bullying or harassment and emphasised that further work must be conducted to understand this further.

Resolved:

- **The Board received the Equality and Diversity WRES update**

10. Positive and Safe Annual Report

Ron Weddle, Keith Reid and Paul Sams were in attendance to speak to the Positive and Safe Care Annual Report. Keith Reid commenced by providing background information on the restraint reduction strategy and explained that the strategy focuses on various methods to reduce restraint such as education, training and service users and carer involvement. It was further explained that the Trust had seen a reduction in rapid tranquilisation, conflict, assaults on staff and aggression overall.

The Board were made aware of the patient dashboards that wards have access to which were designed in collaboration with patients. Paul Sams provided an update on the wards' action plans and process of reviewing them every three months. Paul explained that the reviews had developed to include service users and carers.

Paul provided further information on co-produced trauma informed care themes, safety huddles for staff and patients, Talk1st social media where good practice is shared and development of the colourful award.

Keith Reid provided further information including the approach of developing the future strategy with the involvement of service users, carers, sub-specialities as well

as nursing staff. Further work was explained including a CPD event on restraint reduction for medics, work on stalking and Seni's Law, training being extended to bank and agency staff, the better sleep project and engagement at all levels of the hierarchy in the Trust.

Ron Weddle commented that compassion should be used wherever possible as it has a positive impact on people, can change culture and support how staff approach difficult circumstances.

Keith made the Board aware that the use of restraint figure is likely to increase in 2019/20 as the Trust has recently started to care for some people who have previously been subjected to some distressing circumstances.

Finally Keith explained that work is currently being undertaken to understand if Talk1st should be applied to Cumbria or if they should continue with the system they are currently using.

Peter Studd commended the work undertaken by the Positive and Safe Team and questioned how far the improvements were as a direct result of the interventions and not just a result of different patients being in the services. Keith Reid explained that there is an evidence base used when introducing new interventions. It was further explained that interventions that had a good evidence base had been carefully adapted to meet the particular service.

Lisa commented that she was pleased that work was being conducted to include temporary staff, however questioned the slight increase in use of Mechanical Restraint Equipment. Keith confirmed that there was a review planned to understand why the use of Mechanical Restraint Equipment had increased.

Lisa further praised Paul for his work on social media and stated that there had been a number of people who have complimented the Talk1st social media forums. Debbie Henderson supported this stating that Governors had also shared praise.

Fiona Regan, Carer Governor asked why Body Worn Cameras had been introduced into Rose Lodge without any consultation process with families and carers. Ron Weddle explained that the Body Worn Camera pilot commenced on Beckfield and Alnmouth wards initially and was introduced into Rose Lodge in the second phase of the pilot following a request. It was explained that staff and service users had been informed of the introduction of Body Worn Cameras at that stage and information governance processes had been followed. Ron further explained that the initial feedback from service users had been incredibly positive and staff had also provided positive feedback. The evaluation was indicating that staff and service users felt safer as a result of the cameras.

Fiona further questioned why visitors to Rose Lodge had not been consulted. Ron explained that a process has been agreed with the Information Governance Team in which staff and service users had been engaged with. Gary O'Hare explained that the cameras had been introduced to improve safety, protect service users and staff.

Ken Jarrold summed up the conversation and reflected on the importance of ensuring that everyone is engaged with, including families and carers, when introducing significant new ways of working which impact on service users.

Gary O'Hare referred to a new project 'Sleep Well' and explained that he would also bring a report to the Board on the project in the future following the positive impact on reduction of restraint and helping people to sleep better.

Resolved:

- **The Board received the Positive and Safe Annual Report**

11. Annual Flu Plan

Jan Grey presented the Seasonal flu vaccination plan 2019/20 to the Board for approval. Jan advised that a total of 76.5% of front line staff received the influenza vaccine in 2018/19 and informed the Board that the CQUIN target for 2019/20 is to achieve 80% of all front line staff to be vaccinated. However, it was explained that this would be a greater number of staff than last year due to the transfer of staff from North Cumbria.

Jan confirmed that the Quadrivalent vaccine had been ordered for 2019/20 for both patients and staff and Trivalent had been order for individuals over the age of 65. However, Team Prevent had advised that there may be a delay in receiving the order. It was further explained that work was ongoing to train staff in Cumbria to administer the vaccines and deliver the same level of service across Cumbria and NTW. In response to a question raised by Peter Studd, Jan explained that 4200 vaccines are due to be delivered in September.

John Lawlor explained that a delay in receiving the flu vaccines was a concern as Australia had experienced a severe outbreak of flu which had begun earlier than usual.

Peter Studd asked the number of front line staff in Cumbria who had received the flu vaccine in 2018/19. Gary O'Hare explained that Cumbria also had a good uptake in 2018/19. However, the figures were not detailed enough to understand the number of Mental Health and Learning Disability staff who received the vaccine.

In response to a question raised by Les Boobis, Jan confirmed that the Trivalent had been ordered for individuals over the age of 65 and that staff could receive vaccines at their GP practice.

Approved:

- **The Board received and approved the Annual Flu Plan**

12. Safeguarding Annual Report

Jan Grey presented the Report. The Government had published new guidance in 2018 that set out how local areas should work to replace Local Safeguarding

Children Boards with new Safeguarding Children's Partnership arrangements that will come into effect by September 2019. Jan further explained that this results in six local authority areas of Northumberland, North Tyneside, Newcastle, Gateshead, South Tyneside and Sunderland; five CCGs of Northumbria, North Tyneside, Newcastle and Gateshead, South Tyneside, and Sunderland; and one Police region all coming together to form the Partnership. Jan further explained that work had been completed to develop how the partnership will work and the transition would be taking place over the next few months.

An update was provided in relation to Prevent training in which 96% of staff have now been trained. Furthermore this has resulted in a 40% increase in Prevent referrals as staff are identifying and reporting concerns. Jan explained that Northumbria Police had set up a CONTEST Strategic Board in which NTW is a member.

Jan noted that the police had increased the number of MARAC meetings from fortnightly to weekly due to the increase in domestic violence incidences that is happening both nationally and locally. She explained that there is a focus on how we can work differently and work in partnership to keep people safe.

Jan referred to the data in the report that shows an ongoing increase in safeguarding and public protection concerns received during 2018/19. It was explained that the SAPP team continue to triage all concerns received to ensure concerns are dealt with effectively.

The Board were advised that work had been undertaken to ensure Safeguarding and Public Protection arrangements for North Cumbria are in place from 1 October 2019.

Resolved:

- **The Board received the Safeguarding Annual Report**

13. Safer Care Annual Report

Jan Grey presented the report and advised that this was the first full year report in which the Safer Care Team have included their key achievements and ambitions. Jan explained that positive feedback had been received on a number of Safer Care activity including the learning and improvement sub-group, safer care bulletin, safer care website and serious case reviews.

Jan also informed the Board that the Safer Care Team had been working with neighbouring Trusts to look at the mortality review process and learn best practice.

It was further explained that the claims, complaints and incidents teams would be merging into one team to streamline process and provide a better service.

Jan made the Board aware that NTW had been the first NHS organisation as part of the Patient Safety Incident Management System pilot to submit data through a Local Risk Management System.

A significant amount of work is taking place in readiness for the transfer of services from North Cumbria to ensure that the Safer Care programme is ready on 1 October 2019. Ken Jarrold thanked Jan for presenting the report and commented that is was very powerful to have the six teams working together on delivering Safer Care.

Resolved:

- **The Board received the Safer Care Annual Report**

14. Safer Care Report (Quarter 1)

Jan Grey presented the report on safety related activity for the period April to June 2019 and referred to the new format of the report which had been made more concise, visual and focused on key metrics.

Jan brought the Board's attention to the increase in deaths during the quarter and explained that a theme had emerged that the increase in deaths was in part related to addictions.

It was explained that there had been a reduction in serious incident reviews, however in relation to homicides, Jan explained that there had been two in the quarter where an NTW service user had been charged as the alleged perpetrator and both were currently subject to a full serious incident review led by external investigation officers.

Jan highlighted that the Trust had an increase in safeguarding and public protection concerns reported during the period. As a result Jan advised that the SAPP Team were conducting a review to ensure the systems and processes were robust.

In relation to Infection Prevention and Control data, it was confirmed that there had been one patient with confirmed C. difficile during the period. It was explained the patient had been treated and a route cause analysis had been conducted. However, the cause of the infection was not identified.

Jan confirmed that there had been nine medical devices incidents which resulted in no harm caused.

Jan explained that the Trust had seen an increase in pressure ulcers which is recorded via the Safety Thermometer. It was further explained that a full review will be conduct on any category 3 or 4 pressure ulcer.

In relation to complaints, Jan explained that there had been a slight increase in the quarter. However, complaints are continuing to be triaged resulting in quicker responses being provided. It was further explained that the number of complex cases had increased which involved more than one organisation. Jan advised that the Trust had been audited on the complaints process and substantial assurance had been provided.

Alexis Cleveland highlighted that the report was considered in detail at the Quality and Performance Committee and questioned the information that is required to be

escalated to the Board of Directors. Debbie Henderson explained that following the Board Away Day session on Board reporting, work was ongoing to review this and the information will be published in the near future within the style guide.

Resolved:

- **The Board received the Safer Care Report (Quarter 1)**

15. Infection Prevention and Control Annual Report

Jan Grey presented the report which provided assurance on key issues relating to infection and prevention and control. She explained that there had been an outbreak of flu on two wards during 2018/19 where several patients and staff had been affected despite the vaccination uptake rates being high for both patients and staff. All patients and staff had made a recovery. However, work had been completed to learn lessons from the outbreak and areas of excellent practice had been identified and shared across the Trust. Jan explained that a number of audits had been completed to measure the effectiveness of care which had resulted in good assurance being provided.

The Board were made aware that a significant amount of time had been spent during 2018/19 to ensure that all medical devices in the Trust are logged and have ID numbers. This has allowed items to be replaced quickly when required.

Jan stated that the Trust had invested in high density pressure mattresses for beds which had made a difference to patients comfort and improved their sleep.

In response to a question raised by Les Boobis, Gary advised that he would look into the IPC training rates for Medical Staff.

Resolved:

- **The Board received the Infection Prevention and Control Annual Report**

Action:

- **Clarify IPC training compliance for Medical Staff**

16. Service User and Carer Experience Report Quarter 1

Lisa Quinn presented the report on the service user and carer experience feedback received for quarter 1 and referred to the comments in the appendices and explained that the Trust responds to all concerns raised.

In response to a question raised by Ken Jarrold, Lisa explained that the question asked to Service User and Carers had change. However, the question to staff had remained the same.

Resolved:

- **The Board received the Service User and Carer Experience Report**

17. Guardian of Safe Working Hours report Quarter 1

Rajesh Nadkarni presented the report on safe working hours of Junior Doctors for quarter 1 and highlighted that the Trust had been awarded £60k funding as a result of adopting the Fatigue and Facilities Charter to improve the working lives of Junior Doctors. It was explained that the Trust was currently working with Junior Doctors to understand the improvements that can be made.

In response to a question raised by Peter Studd relating to the increase in exceptions reported during the period, Rajesh advised that it had been as result of Junior Doctors working additional hours when services had been under pressure. Rajesh explained that each Junior Doctor who had worked additional hours had been granted time off in lieu.

Resolved:

- **The Board received the Guardian of Safe Working Hours Report**

18. Commissioning and Quality Assurance Report (Month 3)

Lisa Quinn presented the report for month 3 outlining progress against quality standards and advised that the report had been discussed in detail at the Quality and Performance Committee. Ken Jarrold commended the style of the report as an example to be used for other reports to the Board.

Lisa highlighted that the Mental Health Legislation Committee had been working on the outstanding actions associated with the two Mental Health Act reviewer visit reports.

Further detail was provided in relation to CPA metrics specifically in relation to 7-day follow up and Sunderland IAPT numbers entering treatment.

Lisa drew attention to the reduction in the number of people waiting more than 18 weeks to access services in non-specialised adult services and the decrease within children's community services in those waiting over 18 weeks in Newcastle/ Gateshead.

Chris highlighted that the current agency spend is slightly above the Trusts plan. However, it was explained that the current spend is in line with the NHSI agency ceiling.

Chris referred to the Resource and Business Assurance Committee meeting and explained that discussions had taken place relating to the risk associated with potential closure of some private care providers of learning disability services. Chris explained that there could be additional costs should we be required to increase staff to accommodate people into NTW services.

Resolved:

- **The Board received the Commissioning and Quality Assurance Report**

19. Safer Staffing Levels (Quarter 1) Including 6 monthly skill mix review

Gary O'Hare presented the report which included the ratio of qualified to unqualified staff, exceptions and the six monthly skill mix review of current staff. He highlighted the limitations of the safer staff data including the inability to account for short term staff moves between wards for a span of duty or where staff are providing high levels of observation. Therefore, narrative had been included to provide more information.

Gary brought the Board's attention to details on a current project on staff recruitment and retention. The Trust had supported staff to undertake their nursing training through the Open University and a number would be qualifying in the near future which will benefit the Trust.

Gary advised that he had received a letter from the Chief Nursing Officer regarding care per patient day which will be incorporated into future reports. Alexis Cleveland commended the structure of the report commenting that although there is less data, the increase in narrative was more useful.

In response to a question raised by Les Boobis, Gary explained that the Safer Staff Report was a statutory requirement and stated that he would like to develop a multi-disciplinary report over the next few months which would provide further information of other staff designations i.e. occupational therapists etc. It was agreed that a paper focusing on agency medical locums would be presented to a future Board meeting.

Resolved:

- **The Board received the Safer Staffing Levels report**

Action:

- **A report on agency medical locums to be presented to a future meeting**

20. Staff Friends and Family Report (Quarter1)

Lisa Quinn presented the results of the Staff Friends and Family test for quarter 1 and advised that there had been a 6% increase in responses during the quarter. It was explained that staff can provide narrative feedback and choose if they would like to share their feedback with the rest of the organisation or keep it private.

Lisa made the Board aware that the common themes arising from the responses relate to staffing levels, working environment and waiting times.

Lisa explained that the Trust has a key Quality Priority that focuses on access to services and advised that we are close to achieving the 18 week target is the large majority of services.

Resolved:

- **The Board received the Staff friends and family report**

Strategy and partnerships

21. NHS Long Term Plan Implementation Framework

John Lawlor provided a verbal update on the NHS Long Term Plan Implementation Framework and provided background information in relation to the process, technical guidance, Mental Health Long Term Plan, priorities and funding.

Lisa Quinn informed the Board that she had recently taken part in a webinar to discuss the Long Term Plan technical guidance and there had been a clear message from the national team on the importance of mental health.

Resolved:

- **The Board noted the NHS Long Term Plan verbal update**

22. Cumbria

John Lawlor provided a verbal update in relation to the proposed transfer of services from North Cumbria to NTW and explained that the transfer of services was on track for 1 October 2019 as the Board are satisfied that the conditions they have previously set out had been met.

John referred to a recent meeting of the Integrated Care Communities in Cumbria and advised that work currently being undertaken to integrate care and improve services was impressive.

John referred to section 1 of the Chief Executive's report and explained the rationale for changing the Trust's name to Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust on the 1st October to reflect the new geography and acknowledge that Cumbria is a part of the new Trust.

Resolved:

- **The Board noted the Cumbria update and the change of the Trust's name**

Regulatory

23. Board Assurance Framework (BAF) and Corporate Risk Register (CRR) (Quarter 1)

Lisa Quinn presented the BAF and CRR and explained that each of the Board Committees had reviewed their relevant risks. The Board was asked to approve the de-escalation of risk SA4.1 as the risk related to significant financial loss due to competition and choice. It was explained that there was now a focus on collaborative system working which has reduced the impact and scoring of the risk.

Lisa referred to discussions held at the Mental Health Legislation Committee regarding the MM Ruling relating to conditional discharges and Community Treatment Orders impact on deprivation of liberty and noted that discussions were ongoing to consider the risk rating.

The Board were briefed on a discussion held at the Resource and Business Assurance Committee meeting relating to the risk associated with disinvestment in private care providers of disability services and the potential impact on the Trust.

In response to a question raised by Les Boobis, Lisa advised that she would liaise with James Duncan in relation to the capital funding for the CEDAR project and capture the potential risk.

Les Boobis raised concern in respect of a risk relating to CPFT medical staff vacancies. Lisa advised the risk relating to the transfer of services was captured as a Board level risk.

Resolved:

- **The Board received the Board Assurance Framework and Corporate Risk Register**

24. Quarterly Report to NHS I and Submission

Lisa Quinn presented the information submitted to external regulators for the period.

Resolved:

- **The Board received the quarterly reports to NHS Improvement and associated submissions**

25. CQC Must Do Action Plans

Lisa Quinn referred to the report on progress made against the CQC Must Do Action Plans. Lisa explained that the action plans had been reviewed at the Quality and Performance Committee held the previous week. Lisa explained that the actions were progressing well and work was ongoing to understand the impact. Alexis Cleveland informed the Board that some actions had been completed since the report had been written.

Lisa explained that following the transfer of North Cumbria services on 1 October 2019, NTW will inherit a number of Must Do Action Plans from North Cumbria which will be reviewed and overseen by Quality and Performance Committee.

Resolved:

- **The Board received the CQC Must Do Action Plan update**

Minutes/papers for information:

26. Committee updates

There was nothing to update from Committees.

27. Council of Governor issues

Ken Jarrold provided a verbal update on the work conducted by the Governors' Nominations Committee in relation to the Non-Executive Director appointment process. Ken explained that the Nominations Committee will be presenting a recommendation to the full Council of Governors at their meeting held on 10 September 2019.

Ken explained that Fiona Grant, Lead Governor, Margaret Adams, Deputy Lead Governor, Debbie Henderson and himself had delivered a presentation at the CPFT Council of Governors meeting to share proposed governance arrangements following the potential transfer of services on the 1 October 2019. It was explained that the meeting had been very successful.

28. Any Other business

Ken Jarrold advised the Board that Alexis Cleveland, Chair of the Quality and Performance Committee had shared the Trust's governance structure with him and copies were available for Board members. It was agreed that the governance structure would be loaded onto the Board Development section on AdminControl.

There was no other business to discuss.

29. Questions from the public

There were no questions from members of the public.

Date and time of next meeting: Wednesday, 4 September 2019, 11:30am to 12:30pm, Conference Room, Northgate Hospital, Morpeth, Northumberland, NE61 3BP

Northumberland, Tyne and Wear NHS Foundation Trust

Board of Directors Meeting

Action Sheet as at 4 September 2019

Item No.	Subject	Action	By Whom	By When	Update/Comments
Actions outstanding					
07.08.19 (15)	IPC Annual Report 18/19	Clarify IPC training compliance for Medical Staff	Gary O'Hare	September 2019	Verbal update to be provided at the September meeting
07.08.19 (19)	Safer Staffing Levels (Q1) incl 6 monthly skill mix review	A revised paper to include an MDT approach to safer staffing including agency medical locums to be presented to a future Board meeting	Gary O'Hare/Rajesh Nadkarni	November 2019	On track for submission to November meeting
24.10.18 (19)	Board Assurance	The Board to receive an assurance map for agenda items that require formal approval.	Debbie Henderson	October 2019	To be included in the Board Report style guide currently under development
22.05.19 (10)	Committee Terms of Reference	ToR's for Corporate Decisions Team and Charitable Funds Committee to be submitted to the October meeting	Lisa Quinn/Debbie Henderson	October 2019	On track for submission to October meeting
Completed Actions					
07.08.19 (6)	Chair's remarks	Future dates of Schwartz Rounds to be circulated to Non-Executive Directors	Jennifer Cribbes	August 2019	Complete

Northumberland, Tyne and Wear NHS Foundation Trust

Board of Directors Meeting

Meeting Date:	4 September 2019

Title and Author of Paper:	Chief Executive's Report John Lawlor, Chief Executive

Paper for Debate, Decision or Information: Information

Key Points to Note:

Trust updates

1. Trust Name
2. NHS Staff Survey
3. Climate Change

Regional updates

4. NE & N. Cumbria Integrated Care System (ICS) Memorandum of Understanding

National updates

5. Building healthier communities: the role of the NHS as an anchor institution
6. A Manifesto for the new Prime Minister

Outcome required: For information

Chief Executive's Report

4 September 2019

Trust updates

1. **Trust Name**
   As we will soon be providing services to the population of Cumbria, as well Northumberland, Tyne and Wear we have decided to change our name to reflect the geographical area to which we provide services.

   To give parity and equity to all areas we serve, and in line with NHS identity guidelines, our name will be alphabetical, therefore the decision which has been made is that on 1 October we will become Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust.

   We are currently undertaking a process of engagement with staff, stakeholders and the public in North Cumbria and I am sure the Board will join us in welcoming our new colleagues on the 1st October.

2. **NHS Staff Survey**
   The survey will launch in mid-September and we will continue to encourage staff to take part and to give as much feedback as possible.

   Last year's response was 66.5%, with 39 questions seeing an improvement in scores, 21 a deterioration and 21 remaining the same. Based on these outcomes a Trust wise action plan had been developed to focus on violence and aggression, bullying and harassment, improving satisfaction with the quality of care that staff are able to deliver, quality of appraisals, health and wellbeing and addressing ethnicity and disability issues. In addition, each locality and department has looked at the specific issues raised and have developed local actions.

3. **Climate Change**
   The organisation has recently been having conversations and presentations about the health impacts of climate change to ensure that we and our partners are doing all that we can to raise awareness of sustainability and to prevent future harm by limiting our environmental impact.

   A new Corporate Decisions Team sub group, chaired by James Duncan, has recently been convened to consider these important issues and to develop an involvement & engagement strategy as we know that our staff, service users and carers have lots of ideas about sustainable practices. A fuller update will be reported to the Trust Board later this year.

Regional updates

4. **NE & N. Cumbria Integrated Care System (ICS) Memorandum of Understanding**
   A Memorandum of Understanding has been developed through consultation with the organisations involved, to create a framework in which all the NHS organisations across the region will work together. This will include CCGs, NHS Foundation Trusts and national regulators, most particularly NHSI/NHSE, HEE and PHE. This will be considered at the Board meeting to seek agreement to the MoU being adopted across the ICS.

National updates

5. **Building healthier communities: the role of the NHS as an anchor institution**
   Attached as ***Appendix 1*** *or click* ***here*** to access the report which was recently published by The Health Foundation, an independent charity committed to bringing about better health and care for people in UK. The report outlines the opportunities for the NHS to maximise its contribution to the health and wellbeing of local populations. This includes widening access to quality work, purchasing and partnering locally and social benefit, and reducing its environmental impact.

   The report argues that more can be done to support and challenge the NHS to embrace its role as an anchor institution and in doing so, advance the welfare of local people.

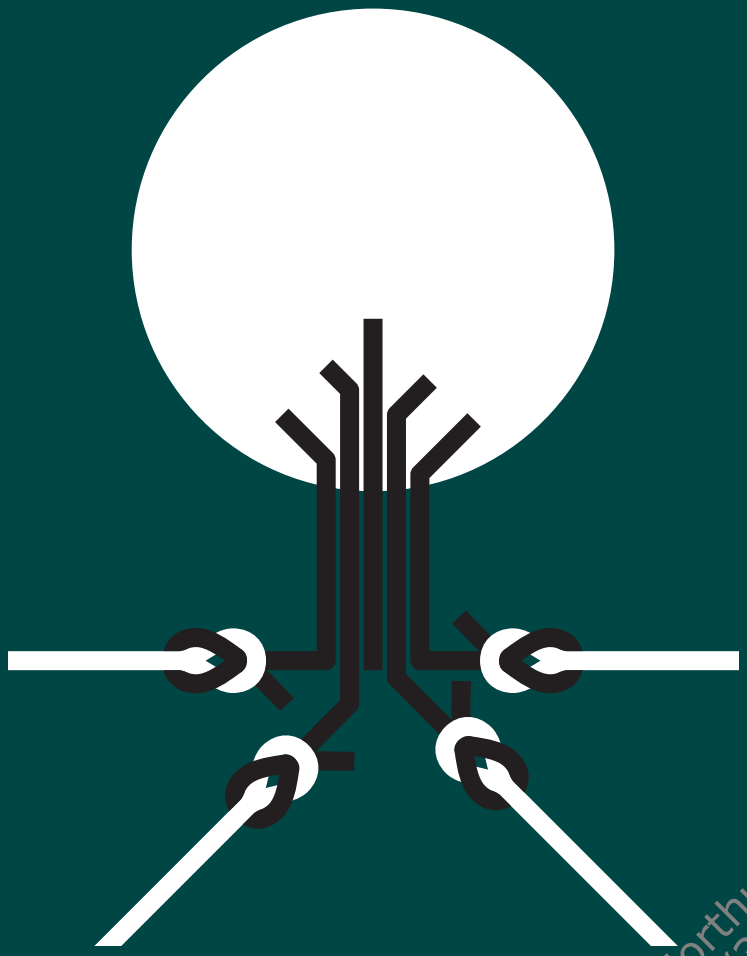
6. **A Manifesto for the New Prime Minister**
   The NHS Confederation and its networks have jointly compiled this briefing for the new Prime Minister, the Rt Hon. Boris Johnson MP. This briefing sets out seven key challenges for the NHS in 2019 and beyond including, funding, social care and the NHS in a post-Brexit world. I have attached as ***Appendix 2*** or click **here** to access the report.

Research

August 2019

Building healthier communities: the role of the NHS as an anchor institution

Sarah Reed, Anya Göpfert, Suzanne Wood, Dominique Allwood and Will Warburton



The Health Foundation

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This work draws on research by CLES and The Democracy Collaborative, funded by the Health Foundation, and we would like to thank Neil McInroy, Frances Jones, Tom Lloyd Goodwin, Ted Howard and Katie Parker for their collaboration throughout.

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Contents

Executive summary

What this report is about and why it matters

Widening health inequalities and growing pressures on health care services have prompted a fundamental conversation about the role of the NHS in prevention and its broader influence in local communities. The British economy is one where wages and living standards are stagnating and 22% of the population live in poverty.[1] People from the most socially deprived areas of England die nearly a decade earlier and spend 18 fewer years in good health than people born in the least deprived areas.[2] And while health care services on their own are insufficient to overcome these inequalities, the NHS could make a far greater contribution to this goal: it is the largest employer in the country, spends billions on goods and services each year and controls significant land and physical assets – all of which make it a powerful 'anchor institution'.

Anchor institutions are large, public sector organisations that are called such because they are unlikely to relocate and have a significant stake in a geographical area – they are effectively 'anchored' in their surrounding community. They have sizeable assets that can be used to support local community wealth building and development, through procurement and spending power, workforce and training, and buildings and land.

Anchors have a mission to advance the welfare of the populations they serve. They tend to receive (or are significant stewards of) public resources, and often have a responsibility to meet certain standards on impact or value. These characteristics mean that the NHS, like other anchors, is well placed to have a powerful voice in where and how resources are spent locally. The NHS can also lead by example, and help spread and champion the principle of anchor institutions in local economies.

The idea of anchor institutions is not new. In the UK, however, other public sectors (such as local government and universities) have arguably been more conscious of their role as anchors.[3,4] There are signs that this is changing; there is growing enthusiasm across the NHS for how health care organisations make up a key part of the social and economic fabric of communities, and can do more to channel their strategic influence to improve population health.

This report explores how NHS organisations act as anchor institutions. It gives examples of what anchor practices look like in a health care context, and how anchor institutions can maximise their influence on the wider determinants of health, as follows.

- Chapters 1 and 2 introduce the **concept of anchor institutions** and set out the case for change.
- Chapter 3 discusses **employment**, and how the NHS can widen access to quality work for communities furthest from the labour market, and be a better employer and place to build a career for more local residents.

- Chapter 4 looks at how **procurement and commissioning** can derive greater social value by shifting more NHS spend locally and towards organisations that provide greater community benefit.
- Chapter 5 considers how the NHS can make better use of its **capital and estate** by supporting the development of community assets like affordable housing and creating community spaces for local groups and businesses.
- Chapter 6 looks at how the NHS can promote **environmental sustainability** in its own operations and in the broader community.
- Chapter 7 discusses how the NHS can accelerate progress and impact at scale by working more effectively as a **partner across a place**, both within its own structures and with other anchor institutions in the local economy.

The central argument of this report

The size, scale and reach of the NHS means that it has a significant influence on the health and wellbeing of local populations. But how it chooses to function and leverage its resources will determine the extent of that impact. More can be done to support and challenge the NHS to embrace its role as an anchor institution and maximise the social and economic value it brings to local communities.

There are a range of promising anchor activities taking place across the NHS that provide an important foundation from which to advance progress. Though NHS organisations are all in very different stages of their role as anchors, where anchor practices are happening, they tend to be discrete, narrow in scope and not intentionally applied or integrated into central and local systems or organisational strategies. Nor are anchor approaches being evaluated in any systematic way to know where to prioritise efforts and what actions are likely to have the greatest impact on population outcomes.

There are opportunities at each level of the system to help the NHS more consciously adopt an anchor mission and to understand the impact of different approaches so that they become a central part of how NHS organisations function.

Considerations for practice and policy and taking it forward

Supporting NHS organisations to embrace their anchor mission is key to harnessing the NHS's powerful influence on community health and wellbeing. While NHS organisations face many immediate pressures that can make it difficult to adopt anchor strategies, the examples in this report show how parts of the NHS are taking a pragmatic approach and aligning anchor practices with other strategic objectives. While most change will be delivered at the organisational level, there is a key role for local system, regional and national leaders to help scale approaches, cultivate an anchor mission and support an environment where these practices become an embedded part of how the NHS operates.

This report draws on examples of promising practice and identifies key opportunities to help NHS organisations meet their potential as anchor institutions, regardless of the area of anchor activity being pursued (summarised in Table 1 below). We also surface some of the key tensions that may have to be worked through to balance priorities and direct efforts along an anchor mission, and present some examples of where practices have overcome them. These are summarised in Table 3 and discussed in more detail throughout the report. The report proposes key actions for national and regional policymakers, local system leaders, and NHS providers and networks to help the NHS advance its role as an anchor institution.

Table 1: Steps towards realising the NHS's potential as an anchor institution

1.	Build a baseline understanding of current practice to know where to prioritise action and establish informed goals.
2.	Develop metrics and evaluate the impact of interventions.
3.	Establish clear and visible leadership to embed anchor practices within organisational and system strategies.
4.	Enable staff to act on a collective vision for enhancing community health and wellbeing.
5.	Support the sharing and spread of ideas through networks.
6.	Engage proactively with communities to ensure that anchor strategies meet the needs of local people and to maximise impact on narrowing inequalities.

Figure 1: What makes the NHS an anchor institution?

NHS organisations are rooted in their communities. Through its size and scale, the NHS can positively contribute to local areas in many ways beyond providing health care. The NHS can make a difference to local people by:

Purchasing more locally and for social benefit
In England alone, the NHS spends £27bn every year on goods and services.

Using buildings and spaces to support communities
The NHS occupies 8,253 sites across England on 6,500 hectares of land.

Working more closely with local partners
The NHS can learn from others, spread good ideas and model civic responsibility.

Reducing its environmental impact
The NHS is responsible for 40% of the public sector's carbon footprint.

Widening access to quality work
The NHS is the UK's biggest employer, with 1.6 million staff.

As an anchor institution, the NHS influences the health and wellbeing of communities simply by being there. But by choosing to invest in and work with others locally and responsibly, the NHS can have an even greater impact on the wider factors that make us healthy.

References available at www.health.org.uk/anchor-institutions

Chapter 1: Introduction

It is increasingly accepted that good health is shaped by the conditions in which people live, learn, work and age, with access to clinical care playing an important but more minor role.[5,6,7,8,9,10,11,12] In addition to its core purpose of delivering health care services, the NHS has the potential to influence these conditions: it is the largest employer in the UK, spends billions on goods and services each year and controls significant land and physical assets – all of which give it enormous economic clout in local communities. Through its scale, size and relationship with local populations, the NHS represents a powerful 'anchor institution' that can positively influence the social, economic and environmental factors that help create good health in the first place.

The idea of anchor institutions is not new. Until now, though, it has mainly been local government and universities that have more consciously recognised their role as anchors.[3,4] There are signs that this is changing. The *NHS Long Term Plan* promised to explore the potential of the NHS as an anchor institution and identify examples of NHS initiatives that have benefited their surrounding communities.[13] But how the health service chooses to operate and leverage its resources will determine the extent of that impact. Questions remain as to how the NHS can best be supported and challenged to think differently about the social and economic value it brings to local populations.

This report explores how NHS organisations act as anchor institutions in five areas:

- employment
- procurement and commissioning for social value
- use of capital and estates
- environmental sustainability
- as a partner across a place.

It showcases where NHS organisations are already implementing anchor practices, and discusses opportunities for how practice and policy can evolve to maximise the NHS's contribution to local communities.

What are anchor institutions?

The term anchor institution gets used in different ways, but for the purposes of this report we are referring to large, public sector organisations that are unlikely to relocate and have a significant stake in a geographical area. Anchors have sizeable assets that can be used to support local community wealth building and development, through procurement and spending power, workforce and training, and assets such as buildings and land. Anchors have a mission to advance the welfare of the populations they serve. They tend to receive (or are significant stewards of) public resources, and often have a responsibility to meet certain standards on impact or value. These characteristics mean that the NHS, like other anchors, is well placed to have a powerful voice in where and how resources are spent. The NHS can also lead by example and help spread and champion the principles of anchor institutions in local economies.

Our approach

This report draws on a number of workstreams, including the following.

1. Research commissioned by the Health Foundation and produced by the Centre for Local Economic Strategies (CLES) and The Democracy Collaborative (TDC), which included a review of evidence on the role and impact of anchor institutions, as well as three case studies: University Hospitals Birmingham NHS Foundation Trust, Leeds Teaching Hospitals NHS Trust and East Lancashire Hospitals NHS Trust.
2. Interviews about existing practice from a range of perspectives, including the acute sector, community and mental health trusts, primary care, clinical commissioning groups (CCGs), research, policy and local government. Interviewees included leads for transformation, sustainability, purchasing, public health, partnerships, estates and workforce.
3. Workshops with an expert advisory group to identify the greatest opportunities for progress. Participants included representatives from acute trusts, local government, national bodies, academia, primary care, commissioners and the voluntary sector.

For each of the five areas (employment, procurement, capital and estates, environmental sustainability and partnerships), we explain why it matters, provide examples of what anchor practices look like in the NHS and briefly explore the policy context. We conclude with a summary of implications for practice and policy moving forward.

Chapter 2: Setting out the case for change – the role of the NHS in a local place

There is increasing concern about inequalities in different parts of the UK where the conditions for living life in good health are poor and deteriorating. Across England, wages, living standards and productivity are stagnating and more than one in five people (22%) now live in poverty.[1] Poverty represents a profound economic and social loss to the UK: the British economy spends an estimated £78bn pounds dealing with the effects of poverty.[14] People living in poverty are more likely to have poor health, and this is reflected in persistent inequalities in health outcomes.[15]

People born in the most deprived 10% of local areas in England are expected to die nearly a decade earlier and have 18 fewer years in good health.[16] While these inequalities are primarily driven by broader factors that sit outside the health system, there are several reasons why the NHS should and can play a stronger role in supporting their reduction.

The protection of health care spending relative to other parts of the public sector since 2011 creates a moral case for maximising the value and reach of NHS funding to improve population health and wellbeing. Health care accounted for 30% of public service spending in 2016/17 compared to 26% in 2009/10 and 23% in 1999/2000,[17] and budget reductions to local government have put both public health and social care services under severe pressure.

There is also an instrumental argument: even if the root causes of poor health and health inequalities are primarily driven by factors outside the control of the health sector, it is the NHS that deals with many of the consequences. It faces increased demand from preventable behavioural and socioeconomic causes,[18] and it is therefore logical to extract the most value from the NHS in its wider role within local communities.

Thinking of the NHS in this wider role goes with the grain of policy both in England and across the UK. The 2014 *NHS Five Year Forward View* demanded a 'radical upgrade in prevention',[19] with the 2019 *NHS Long Term Plan* expanding on this to set out a strategy to strengthen the NHS's contribution to tackling health inequalities and improving population health.[20] The government's Green Paper on prevention set out proposals to make progress on their ambition to extend healthy life expectancy in the UK by five years by 2035[21,22] (though the proposals have been criticised for not going far enough to narrow the inequalities between the richest and poorest needed to achieve this aim).[23] Wales and Scotland have already adopted cross-government approaches to improving health and wellbeing, placing duties on public bodies to take action to tackle the socioeconomic conditions that widen inequalities.[24,25]

Since 2016, health policy in England has also encouraged the NHS to plan and deliver services in collaboration with other bodies locally. Sustainability and transformation partnerships (STPs) and the emerging integrated care systems (ICSs) bring the NHS and local government together to design and deliver services to meet local population needs from a common pool of resources.[26] Though still very much under development, the promise of these partnerships is that the NHS may have more scope to establish and work towards common goals with sectors like housing, education and employment. In Scotland and Wales, health and social care are further integrated and NHS bodies have greater flexibility to work together to develop new approaches to improve population health.

Supporting inclusive economies

There is a growing synergy between the place-based lens of the NHS and broader policy that emphasises localism in shaping the socioeconomic environments in which we live.

The idea of inclusive economies – enabling all communities to benefit and contribute to economic success – has garnered significant attention nationally and internationally over the past decade. This is partly due to a recognition that economic growth has often failed to 'trickle down' and alleviate poverty or increase living standards across all communities as expected.[27] In England, growth has been concentrated in London and the South, with other parts of the country falling significantly behind.[28]

Inequalities and deprivation threaten long-term economic stability as many people become trapped in low-productivity work or are excluded from the benefits of growth altogether.[29,30] Local leaders have therefore increasingly turned to anchor institutions to create the conditions needed to support a healthy population, and help tackle inequalities while boosting economic growth.[31] Devolution and the subsequent creation of local enterprise partnerships* (LEPs) and local industrial strategies have been promoted as ways of giving more power to local communities. Though an emergent area of policy, these agendas are seen as an opportunity to bring economic players together across a place to drive productivity and distribute growth more fairly across the country – although whether these policies will lead to a narrowing of inequalities remains to be seen.[32,33] There is an inherent risk that increased localism could even widen socioeconomic divides if already advantaged places are better positioned to leverage local resources and capacities for the benefit of residents.[30] This makes it ever more important to consider the distinct role that health sector organisations play as anchors in local communities, given that the NHS exists everywhere and carries with it significant assets that can be channelled for public good.

The NHS is a key part of the social and economic fabric in all communities, and as an anchor is well placed to work with other sectors to support place-based approaches that promote prosperity and create the foundation for healthy communities. There is growing recognition that health systems have an important and positive impact on economies, and can improve health and wellbeing (directly and indirectly) through the size and nature

* Announced in 2010, LEPs are private-sector-led partnerships between local businesses and local public sector bodies. Their aim is to help set local economic priorities and undertake activities to drive local economic development and job creation. LEP boards are led by a chairperson from local businesses, with board members drawn from local industry, educational institutions and the public sector.

of their role.[34,35] However, the complexities of the NHS have often meant that health care organisations have acted as institutional siloes, often looking upwards to regulatory bodies more than outwards to their community for direction and to drive change. But given the economic challenges the UK is facing and the recent focus on localism, there is now a key opportunity for the NHS to work with other local leaders to develop a common agenda and support economic strategies that improve the socioeconomic conditions of local communities. This goal is important not only for building more inclusive economies, but for the NHS itself; by more consciously leveraging its resources and actions, the health sector can have even greater strategic influence across a place and be part of broader conversations that improve the context in which it works.

Learning from anchor practices

In the chapters that follow, we set out examples of anchor practices in a health care context to show how the NHS can leverage its assets to maximise its influence. These examples come from the grey literature and interviews, highlighting existing anchor practices in the NHS and what it might take to broaden their impact.

There are many ways of considering how the NHS functions as an anchor institution. We restrict our focus to examples related to five key areas: employment, procurement and commissioning, capital and estates, environmental sustainability and working in partnership across a place. Many of the examples involve provider trusts, because of their relatively large size. This should not be taken to imply that other parts of the NHS cannot function as anchor institutions, or have less scope or responsibility to intervene in the social determinants of health. Indeed, the formulation of primary care networks (PCNs) in England may create new opportunities to work at scale and implement anchor strategies in primary care. While most actions will take place at the level of the organisation, the report discusses how local system and regional/national NHS leaders can help create an environment in which NHS organisations more fully embrace their anchor mission and maximise their contribution to local economies. We focus primarily on England, given its different context and recent opportunities, and given that the other countries of the UK are making more progress in some areas.

Based on our findings, we conclude by suggesting actions at each level of the health and care system, including by national and regional policymakers, by local system leaders (that is, STPs and ICSs) and by local NHS providers or networks.

Chapter 3: The NHS as an employer

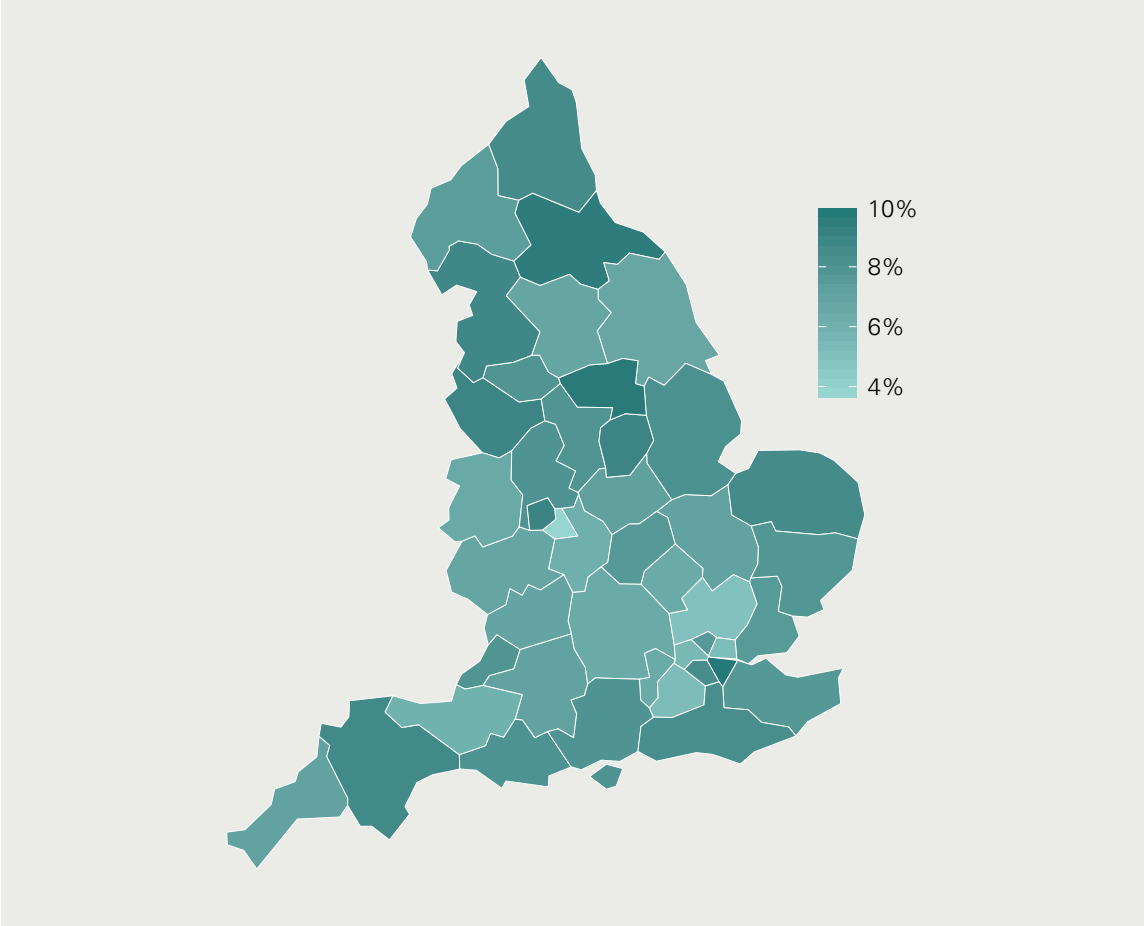
Why this matters

The NHS employs more than 1.6 million people in the UK[36] and, with more than 350 career options, is a critical source of economic opportunity for local people. Figure 2 shows the percentage of jobs the health sector contributes locally by level of STP. The figure demonstrates how the NHS, which accounts for most of these jobs, is a major driver of employment in each regional economy, though some areas (the North and parts of London) are more reliant on the NHS for employment relative to other sectors.

There is a strong link between work and health; for work to have a positive impact on health, it must be 'good work' – providing stable employment, paying a living wage, and offering fair working conditions, work-life balance and career progression.[37] By helping more residents – particularly those furthest from the labour market – into quality work, the health system can improve the welfare of its local communities and begin to narrow inequalities. Building a workforce that is more representative of the local area can also better respond to patients' needs. Furthermore, employing local people can contribute to reducing the carbon impact of the health sector by reducing the number of staff reliant on transportation to get to work.

Anchor workforce strategies involve thinking not only about how the NHS can grow local workforce supply and widen access to employment for local communities, but also how it can be a better employer and place to build a career for more people. It acts as an anchor not only in the number of jobs it creates, but in how it can support the health and wellbeing of its staff through good employment conditions and the working environment – a timely undertaking, given the enormous workforce pressures confronting the NHS.

Figure 2: Health employment as a percentage of total employment by STP level



Office for National Statistics, Business Register and Employment Survey (2017)

Notes: data are for all people employed in hospital activities, medical and dental practice activities and other human health activities (eg, medical nursing homes, rehabilitation centres, psychiatric hospitals, etc.). Data will include people working in the private sector as well as part-time.

What do anchor workforce strategies look like in practice?

Widening workforce participation

1. Targeting positions for local people
2. Understanding local demographics and opportunities
3. Creating pre-employment programmes, work placements and volunteer work experience

Building the future workforce

1. Engaging young people and supporting career development
2. Increasing the number and types of apprenticeships

Being a good employer

1. Supporting health and wellbeing of staff
2. Supporting fair pay and conditions of employment
3. Supporting professional development and career progression

Policy context

Workforce shortages are the biggest threat facing the health and care system, with significant implications for the quality of care. Hospitals and mental health and community providers in England alone are reporting vacancies of more than 100,000 full-time equivalent (FTE) staff.[58] Based on current trends, the NHS will continue to fall substantially short of the workforce it needs unless there are significant actions to increase staff supply.[38]

There are multiple strategies that the NHS, as an anchor institution, can adopt to address workforce shortages, including better attention to career progression and training for NHS employees, with numerous efforts targeting support roles, including health care assistants. This includes the Health Education England *Talent for Care Strategic Framework*,[39] which aims to create more opportunities for people to start and build a career in the NHS. Alongside this, the *Widening Workforce Participation Strategy*[40] established a programme to expand access to education, employment and development opportunities for under represented communities. The *Interim NHS People Plan* also explicitly recognises the NHS's responsibility, as an anchor, to support employment opportunities for local communities by creating new job pathways and making the NHS a more inclusive work environment and better employer for more people.[41] The government's *Industrial Strategy* also creates further scope for the NHS to work with local partners to improve local skills development.

Apprenticeships are another mechanism for widening access to employment. A new apprenticeship levy came into effect in 2017, and as the largest employer in the UK, the NHS has led the public sector in its use. In health and social care, around 420,000 people have started apprenticeships since 2011.[42] The levy covers the costs of training, but not the apprentices' wages. Smaller employers, like GP practices, can also access the levy to pay 90% of their apprenticeship training costs. There are plans to create 100,000 more apprenticeships in England by 2020, including nursing and health care assistants, and in IT, estates and facilities, domestic and housekeeping services, and business administration.[42,43]

Workforce shortages are compounded by poor experiences for some groups of staff. The 2018 *NHS Workforce Race Equality Standard* survey found that 15% of black and minority ethnic (BME) staff reported experiencing discrimination in the past 12 months, and that 28% did not believe that their organisation provided equal opportunities for career progression (this compares to 7% and 13% of white staff, respectively).[44] These inequalities need urgent attention. The *Interim NHS People Plan* promises to deliver a more compassionate and inclusive culture that promotes equality of opportunity for all staff.[41]

Learning from practice

Widening workforce participation

1. Targeting positions for local people

NHS organisations have worked with community partners to target certain positions for local residents, who might otherwise face barriers to work. Partners include local councils and other community organisations that often have deeper reach and insight into local populations, which helps identify potential candidates and promote work opportunities.

For example, Barts Health NHS Trust has a proportion of roles available to locally unemployed applicants. In the same way that some roles are ring-fenced for internal hires, the trust prioritises local hires for a certain number of entry-level positions and works with local authorities to identify and match potential candidates (see case study on page 19).

To monitor progress, some organisations are using targets to increase the percentage of local hires – a practice adopted by some hospitals in the United States. In 2015, Johns Hopkins Health System and Johns Hopkins University launched HopkinsLocal, which stipulated that 40% of new hires for entry-level positions should come from Baltimore neighbourhoods with high poverty and unemployment. Hopkins met this target within the first year and by 2018, 47% of targeted positions (381 new hires) were filled by residents from these areas.[45] The hospital worked with local organisations to identify unemployed and underemployed individuals for specific jobs, and provided tailored training, skills development and assistance with the application process. Residents who apply through the programme are guaranteed a first look by recruiting managers.

These recruitment methods need to reach as wide a pool of applicants as possible. This means writing job descriptions accessibly, advertising NHS roles in a broad range of outlets and using selection techniques that support inclusivity and diversity. NHS Employers and Health Education England (HEE) have created a range of tools, resources and guidance to support NHS organisations to engage local communities throughout the recruitment process, offering a helpful starting point when developing or expanding anchor strategies.[46]

2. Understanding local demographics and opportunities

Where possible, NHS organisations should aim to employ a staff mix that is drawn from, and broadly representative of, the local population it serves. This requires baseline data to know where employees come from to ensure that areas with the highest levels of deprivation are represented in the workforce, and that people from these areas have equal opportunity to advance their careers.

The Leeds Teaching Hospitals NHS Trust has been thinking critically about how to build career opportunities for local people from deprived or excluded communities, and is working with Leeds City Council through a new programme called Priority Neighbourhoods. This initiative uses local data to develop 'neighbourhood profiles' to help target local investments and create more opportunities in areas that fall within the 1% of the most deprived areas nationally.

‘Some little things have been easy to do. For example, some of the most disadvantaged neighbourhoods in Leeds are on our doorstep, like Lincoln Green, which has a high percentage of people who’ve recently emigrated to the UK. Feedback from those working in the priority neighbourhood highlighted that many people felt helpless as to how to get on a career pathway. In-work poverty was and is a key challenge. Working with the council we have run a series of recruitment events locally to promote routes into careers, alongside an employability programme and language courses. This has seen us make around 30 hires from within the neighbourhood and surrounding area. We’re currently planning our next cohort.’

Director of Policy and Partnerships
Leeds Teaching Hospitals NHS Trust

3. Creating pre-employment programmes, work placements and volunteer work experience

A growing number of NHS organisations (supported by strategies such as *Widening Participation* and *Talent for Care*) are developing employability programmes that provide training and support to help local people acquire the skills needed to work in health and care, often linked to direct work experience, training or volunteer roles.[*,47]

One example is the University Hospitals Birmingham NHS Foundation Trust, which has worked with local partners like The Prince’s Trust to establish a Learning Hub (set up in 2008). This is a purpose-built centre fully staffed to offer pre-employment advice, training, guidance and direct links to jobs in the NHS to unemployed local people and those furthest from the labour market. In a 12-week programme, participants complete 3-week volunteer work placements in roles across the NHS and receive mentoring from trust employees.[48] To ensure that the recruitment opportunities are widely accessible, the organisation has agreed to accept references from social workers instead of traditional employment references, for refugee populations. The Learning Hub has so far supported nearly 2,500 local people into employment within the trust and partner organisations since it opened.[49]

East Lancashire Hospitals NHS Trust has launched a programme that offers more residents a chance to gain a qualification and volunteer work experience within the trust. Partnering with the Department for Work and Pensions and Blackburn College, the trust provides pre-employment training for the long-term unemployed, homeless people, people with learning disabilities and people struggling with drugs and alcohol.[50] Participants complete a 3-week course at Blackburn College on employability skills in adult and child care, then

* Volunteering takes many forms and can give a range of benefits to the recipient, the organisation and the individual who is giving time. For the purposes of this report, we focus specifically on the benefits of volunteer opportunities in terms of providing work experience opportunities and supporting skills development and routes into employment for different populations.

do a 2-week volunteer work placement within the trust in roles including catering, laundry services or business administration. Twenty-five people completed the training as part of the first cohort in 2018, four of whom have secured permanent employment within the trust.

Survey data from HEE show that in 2015/16, there were nearly 800 employability programmes of this nature across the NHS, with 1,219 participants, many of which targeted local people or underrepresented populations.[47] The roles targeted have tended to be lower-banded operational and administrative roles that are critical to the running of the NHS. However, there may be further scope to expand opportunities and connect more local people to clinical roles in nursing and allied health professions that have clear progression routes and where more staff are needed.

It will be important to evaluate these programmes robustly. At the sites where we conducted interviews, there has been limited attention to measuring effectiveness of pre-employment support and other efforts to widen workforce participation. Indeed, a HEE survey found that fewer than half (48%) of NHS organisations with an employability programme had evaluated it.[43] Yet the limited evidence available suggests these programmes can work: an evaluation commissioned by HEE of programmes offered in three trusts (Manchester University NHS Foundation Trust, South Tees Hospitals NHS Foundation Trust and North Bristol NHS Trust) found that of 732 people participating in a programme at one of the sites, 52% went on to work at the trust as an apprentice or in a permanent job.[43,51]

So far, pre-employment programmes have been created in large hospital trusts with limited offers in general practice or commissioning.[47] This suggests that more support is needed to encourage other NHS organisations to follow suit. This could be an important part of STP/ICS planning – to develop a wider health employment programme that links local people to opportunities across the sector. The introduction of PCNs may also create more scope to pool resources and develop pre-employment programmes or work placements for general practice across a locality.

There are examples of health and care organisations working together to develop opportunities across a local system. As part of the North West London Health and Care Partnership, the NHS is working with local councils and unions to develop a formal skills partnership to help more local people from disadvantaged backgrounds access good-quality work. Since forming the partnership, the NHS in west and north west London has become the largest provider of supported employment opportunities for young people with special education and development needs. By working more closely with the council, NHS organisations have made new relationships with other large employers locally (such as Heathrow Airport) and are developing further joint programmes to benefit local people.[52] The *Interim NHS People Plan* promises a shift to devolving more responsibility to STPs/ICSs for workforce planning,[41] creating further opportunities to develop collaborative approaches for improving the economic prospects of more people.

Building the future workforce

1. Engaging young people and supporting career development

Helping young people to gain the skills and qualifications they need to pursue careers of their choice is key to supporting a healthy transition into adulthood.[53] In the UK, over 10% of young people aged 16–24 are not in education, employment or training (NEET),[54] which can have serious long-term effects on their economic prospects and employability. As an anchor in local communities, the NHS can work with local partners to help break down barriers to future employment for young people.

A growing number of NHS organisations are collaborating with local schools and community organisations to expose more young people to careers in the NHS, raise the profile of different types of NHS jobs and help support skills development locally. This has also been a part of HEE's *Widening Participation* strategy, which has introduced a framework to support the NHS to partner with schools to create new training opportunities and mentoring for students.[40]

Through our research, we have identified several examples of trusts implementing initiatives to support young people to understand potential NHS career options and to gain the experience and skills needed to work within the sector and broader local economy. Many of these examples focus on young people from disadvantaged communities.

For example, Birmingham has one of the highest rates of youth unemployment in the country, and the local trust has developed programmes that target young people at risk of homelessness and unemployment. In addition to its programmes with The Prince's Trust through its Learning Hub (see page 15),[55] the University Hospitals Birmingham NHS Foundation Trust is also working with Birmingham City Council to deliver Youth Promise Plus – a city-wide initiative providing training, support and work opportunities to at least 16,000 young people (aged 15–29) classed as NEET. Together with Birmingham and Solihull NHS trusts, the local hospitals have committed to supporting 850 participants through this programme.[49]

The Leeds Teaching Hospitals NHS Trust is also promoting careers to young people in the local area. It has appointed a cohort of staff to act as health career ambassadors to promote NHS opportunities in local schools. It has also established a work experience programme that enables young people to directly observe the trust's work in both clinical and non-clinical areas. After finding that the initial uptake of work experience placements came from younger people in more affluent areas, the trust has started to target schools in more deprived postcodes to redress the balance.

2. Increasing the number and types of apprenticeships

NHS apprenticeships can offer paid employment, protected learning time and clear career progression from support worker through to a degree or postgraduate-level qualification.[56] They can be used to support new trainees as well as internal staff looking to advance in their careers.

Some NHS organisations have used the funds they contribute to the apprenticeship levy to scale their approach. The Leeds Teaching Hospitals NHS Trust is one of a few organisations piloting a nurse apprenticeship programme, to give more people from different backgrounds an opportunity to access NHS careers. The pathway involves a 6-week traineeship with a guaranteed interview on completion for a Level 1 apprentice clinical support role. Building on the initial success, the trust has expanded the programme to include roles in administration, facilities, medical engineering and other clinical support areas. In 2018, apprentices accounted for 3% of the trust's workforce; since 2015, it has increased its apprenticeships by 51% each year.[57]

Stakeholders we interviewed welcomed the concept of a compulsory employer funded and led training programme like the apprenticeship levy, but felt that some changes are needed for it to provide greater local benefit. For example, it would be better in some cases if unused funds could be retained within the sector or within localities, rather than redistributed elsewhere. There is also a lack of data on where people move on to after completing their apprenticeship, which hampers understanding of how the programme supports career prospects, and for whom.

Some felt that the levy should have explicit aims to boost social mobility, so that the funds could support economic prospects for people from disadvantaged backgrounds or who have not benefited from apprenticeships so far. This could mean prioritising a certain number of placements for local people living in more deprived areas and who are underrepresented in the NHS clinical workforce. The *Interim NHS People Plan* committed to explore how the apprenticeship levy could evolve to support more inclusive pathways into NHS careers,[41] which may provide an impetus to implement some of these changes. In either case, given the challenges NHS organisations already face in using the levy,[58] any changes must be balanced and not overly burdensome to administer.

Case study 1: Barts Health NHS Trust

Based in east London, Barts Health NHS Trust is the largest NHS trust in England, with an annual total workforce spend of £869m and around 16,500 staff. It has high vacancy and staff turnover rates, exceeding 10% and 13% respectively. The trust's response to this provides a good example of how an NHS organisation can combine a range of programmes and initiatives in one of the key anchor areas to focus on improving local health, wellbeing and social mobility, while also addressing workforce pressures.

Targeting positions to help local unemployed people

To employ more local people, particularly from disadvantaged backgrounds, the trust ring-fences a proportion of entry-level roles for local applicants. These vacancies are shared with local authorities who help identify and match potential candidates based on their skills, interests and other requirements. The most common positions targeted are clinical and corporate roles that do not require advanced degrees, ensuring that they are accessible to residents who may not have high educational attainment.

The public health team advocating for this change needed buy-in from recruitment managers, who worried that prioritising local applicants would limit choice of candidates. The team argued that even if fewer applicants were shortlisted for each role, this process was more efficient as candidates were pre-screened and pre-matched by the local authority according to their skills and interests.

Supporting career opportunities for younger people in the area

The trust has also been working with schools and community partners on programmes designed to generate qualified and prepared local applicants from socially disadvantaged communities.

Project Search East London, run in partnership with local schools and employment services, aims to increase career opportunities within the trust for young people with learning difficulties and/or disabilities. Adapted from an initiative at Cincinnati Children's Hospital in the United States, it provides employability skills training and job placements for young people at Barts. In the five years since it launched, 54% of participants (46 interns) have moved into paid employment in roles including ward clerk and ward host, and in catering and portering.[59] The project has a designated job coach who works with managers to provide inductions, define work placement duties and support interns with any specific learning or workplace issues.[59] Project Search is also being adapted by some other NHS organisations across the UK.

Barts Health NHS Trust has also recently launched a Health Horizons programme, a multi-pronged strategy to help more young people locally build their careers in the NHS. Run by the trust in partnership with Barts Charity and supported by the JP Morgan Chase Foundation, the programme works with schools across local boroughs to increase awareness of NHS careers and promote the NHS as a local employer. The trust has appointed sector career champions and mentors working with secondary schools and local councils to offer career advice, run career awareness events and recruit for volunteer work experience placements.

For students aged 16–18, the programme works with Jobcentre Plus and local authorities to identify career opportunities in target boroughs and deliver coaching and interview training. The programme is building local supply in roles where recruitment has been especially challenging, including allied health professions, nursing and nursing associates, health care assistants and health care navigators. As of summer 2019, it is yet to be fully implemented, but aims to recruit 400 students to work experience placements or apprenticeships and support 100 participants through pre-recruitment programmes (with a target of 50% ultimately going on to employment in health or social care).

Being a good employer

1. Supporting health and wellbeing of staff

The NHS has an opportunity to improve the health and wellbeing of local people in the way it treats and supports its own large body of staff. Supporting a happy and healthy NHS workforce can also have a knock-on impact on the health and wellbeing of the wider community, given the number of connections NHS staff have through their families and social networks.[60] The latest NHS staff survey results reveal that the NHS could do much more to promote a healthier working environment. While there have been improvements in some areas, less than a third of staff reported that their trust takes positive action on health and wellbeing.[61]

Many NHS employers have prioritised improving staff health and wellbeing, offering workplace wellness schemes to reduce stress and promote healthy lifestyles. Though important, these strategies need to be carefully designed to be accessible to all and to not inadvertently widen inequalities within the workforce. Studies have shown that employees who participate in workplace wellness programmes often have higher incomes and are in better health than those who do not.[62]

This was a case in point at the Royal Free London NHS Foundation Trust, where an internal review of its workplace programmes revealed that, of the 1,700 participants, only 10% were from bands 1 and 2 – despite these staff having some of the highest rates of referrals to occupational health and missing the most work days due to musculoskeletal issues. These staff also reported feeling extremely stressed at work and often ignored or unvalued. The trust therefore co-designed a workplace wellness programme with staff in the facilities team (including porters, domestic and security staff), which led to a range of activities including cooking classes, family and social events, a financial advice workshop and group walks. An independent (unpublished) evaluation indicates that the programme brought benefits, including more staff reporting that they felt valued, physically active and less stressed at work. The evaluation also suggests a reduction in sickness absences of 1.6 days for porters and domestic care staff compared to a control arm of other band 2 staff during the 12 months of the project. The trust now needs to find a way to sustain the programme beyond its initial national grant funding.

2. Supporting fair pay and conditions of employment

An important determinant of staff wellbeing is the terms and conditions of their employment, including receiving a fair wage and having a good work–life balance. Low pay can lead to financial hardship, trapping people in in-work poverty,* with important implications for health and wellbeing. Being an anchor means ensuring that the NHS provides secure employment and fair compensation so that all its staff can live with financial security, not least because in some areas the NHS is the largest employer.

* 'In-work poverty' refers to individuals living in households where income is below the poverty threshold despite one member of the household working either full-time or part-time. The poverty threshold is defined as under 60% of the average household income (before housing costs).

The Health Foundation's *Closing the Gap* report with The King's Fund and Nuffield Trust shed light on the current challenges in staff pay and how they impact on different employee groups.[58] The 2018 pay deal marked an important change in how NHS staff are paid, lifting the 1% cap and resulting in almost all staff receiving real-term pay increases. Staff in lower bands received the biggest increases, and from 2019/20, every worker employed directly through the NHS is now paid at least the real living wage.[63]

Lifting the pay cap is a crucial step for many NHS staff experiencing hardship. For example, the Royal College of Nursing (RCN) reported that the number of nurses and health care assistants receiving a grant from the RCN Foundation to alleviate severe financial hardship had doubled between 2010 and 2016.[64] And a Unison survey of 12,000 NHS employees in lower-paid roles showed that 21% had to take on another paid job to make ends meet.[65] As the *Closing the Gap* report makes clear, it is critical that pay for NHS staff keeps up with the cost of living beyond 2021/22 (when the pay deal expires) if the NHS is to support the financial security of all who work for it.

The NHS also needs to remunerate staff fairly, addressing the persistent ethnic and gender pay gaps, if NHS organisations are going to maximise their potential as anchor institutions and provide a model for other employers.[58] The NHS also has an opportunity to go further and influence the wellbeing of many more workers by extending living wage and fair working condition standards to all its contracted employees.

3. Supporting professional development and career progression

Supporting staff to meet their full potential and advance in their roles is a key feature of any good human resources (HR) policy, but is particularly important for anchor institutions. Given the size, scale and varied nature of its workforce, the NHS has a key opportunity to ensure that no one gets trapped at the low end of the labour market. It can do much to help staff progress into higher-wage positions – for example, by mapping out clear potential career pathways for all roles and offering continuing professional development and training for staff at all levels, not just those in the highest-paid bands.

While the NHS has focused at both the national and local level to improve staff development, there is significant scope to ensure that these opportunities are accessed equally across staff groups. For example, people from BME backgrounds are underrepresented in leadership positions, with the 2018 *NHS Workforce Race Equality Standard* report revealing that over half of trusts (52%) have no BME representation in the 'very senior manager' pay band.[66] The percentage of chairs and non-executives of NHS trusts from a BME background has nearly halved, from a peak of 15% in 2010 to 8% today.[67] As with pay, it is important that the NHS seeks to understand what is driving inequality and develop strategies to redress this.

Equality of opportunity is also important in the context of broader technological advances that will change the nature of health care work. The *Topol Review* noted that clinical staff will need new training and development to acquire the skills that digital transformation requires.[68] These changes offer an opportunity to improve the quality and efficiency of health care, but the workforce implications must be closely considered. For example, where new technology brings automation of care or tasks, the risks to lower-banded support roles

(an important entry point to NHS careers for many people) should be monitored. As an anchor institution supporting inclusive employment, the NHS must use technology to upskill and advance all roles, not just those in the highest-paid positions. The Care City case study below provides an example of an inclusive professional development strategy that has used digital enhancement to improve the career prospects for more junior members of staff.

Case study 2: Care City

First established by North East London Foundation Trust and the London Borough of Barking and Dagenham, Care City is a centre for healthy ageing and social regeneration that works across northeast London. The area has 10% unemployment and the lowest life expectancy in London. Care City brings investment and opportunity to help regenerate the boroughs. One way it does this is by testing new ways of using digital technology to improve the skills of people working in support roles, such as health care assistants. Funded through the Test Beds programme run by NHS England and the Office for Life Sciences,[69] the programme involves three components:

- Building the skills and confidence of domiciliary carers to use new technology that helps spot deterioration among patients with long-term conditions early, and supports better medication management.
- Training health care assistants working in primary care to support patients who have been prescribed a digital application by a GP to make use of the technology and help prevent deterioration of long-term conditions.
- Teaching skills to administrators in acute care to provide support for people with heart failure and administer digital programmes that support education and exercise between appointments.

Care City leadership saw an opportunity with this programme to develop people in support roles – who often have the least access to technology – to improve the way they deliver care.[70] An evaluation is underway; the team hopes that the digital training will not only improve care delivery and the patient experience but also support future career prospects and professional advancement for more junior members of the health and social care workforce.

Summary and implications for practice and policy

Growing a local workforce and making the NHS a better place to build a career are areas where the NHS has the largest scope to maximise its role as an anchor. These goals also align with the policies and programmes the NHS is pursuing to address recruitment and retention challenges.

At the national level, delivering the *NHS Interim People Plan* can support NHS organisations to widen workforce participation and create more diverse and accessible pathways into NHS careers. This includes ensuring adequate funding and resources for training and development so that all staff can progress in their roles, and that opportunities are inclusive and help break down the barriers to advancement that exist for many staff groups. Where policy levers (such as the apprenticeship levy) already exist, they should be reviewed and, if necessary, reformed to ensure that they create opportunities for communities who could benefit the most.

At the local system level, STPs and ICSs should enable NHS organisations to advance anchor strategies as part of local workforce plans, and develop joint approaches with local partners that improve employment prospects for local people. The NHS's regional teams can also help share learning and evidence between systems.

There is also scope for individual organisations to do more to widen participation, increase the numbers of local people they employ and ensure good work for current and prospective employees. NHS providers could make inclusion, diversity and local hiring explicit organisational goals, and work with partners to deliver more volunteering, work experience, apprenticeships, skills training and coaching to build a pipeline of future employees and prepare more people for work in the NHS. This requires both local demographic data and baseline data about existing staff to identify the greatest areas of need and to target interventions. Once staff are in post, every opportunity should be taken to support staff health and wellbeing and create equal opportunities for career development and progression.

If approached correctly, anchor strategies can respond to workforce pressures at the same time as improving health and addressing inequalities within local communities. These strategies need to be accompanied by clear targets and metrics to help assess progress and the wider impact of these strategies over time.

Practical resources to support implementation

Economic and Social Impacts and Benefits of Health Systems (World Health Organization Regional Office for Europe)

NHS Workforce Health and Wellbeing Framework (NHS Employers)

Recruiting from your community (NHS Employers)

The Talent for Care. A National Strategic Framework to Develop the Healthcare Support Workforce (Health Education England)

Think Future – tools, resources and learning (NHS Employers)

What Comes Next? National Strategic Framework for Engagement with Schools and Communities to Build a Diverse Healthcare Workforce (Health Education England)

Widening Participation. It Matters! Our Strategy and Initial Action Plan (Health Education England)

Chapter 4: The NHS as a purchaser and commissioner for social value

Why this matters

The NHS has significant purchasing power, spending £27bn each year on goods and services in England alone.[71] Decisions about what the NHS decides to buy, and how, have ramifications on local population health and wellbeing. Procuring and commissioning* more goods and services from local small and medium-sized enterprises (SMEs) and voluntary and community sector organisations can have an important economic impact, as resources spent locally have a multiplier effect and are reinvested in the local community at a faster rate than resources spent with national corporations.[72,73] There is limited conclusive evidence on the size of local multipliers and the extent to which local procurement stimulates local economic growth.† This will depend in large part on the nature of local economies, but some studies have shown an effect ranging between 1.7 and 2.1 (for example, investing £1 in a local economy generates between £1.70 and £2.10 worth of growth).[74,75,76,77]

An analysis of procurement data of 10 anchor organisations in Leeds (four local authorities, two colleges, a university, a hospital, a CCG and a housing association) found that they collectively spend £1.4bn a year on goods and services, nearly half of which (£665m) left the local economy.[78] The analysis concluded that by shifting 5%–10% of their spend locally, these anchors could generate between £168m and £196m a year of additional economic activity in the local economy when multipliers are factored in.[74] By spending more resources within the community, anchor organisations may help local businesses to grow, employ more people and pay higher wages, thereby stimulating local economic development.

* Procurement and commissioning are both used in reference to social value and mean slightly different things. In this paper, we use the following definitions:

- **Commissioning** is the process that public sector organisations go through to assess and determine what services are needed for a local area and choose what and how to allocate resources to provide services that meet those needs. Commissioning is a cyclical process involving many steps to meet strategic objectives, including identifying need, scoping the market for potential providers, drawing in expertise, establishing service specifications, deciding how to resource the service, selecting a suitable supplier, and evaluating and monitoring performance against service specifications. Commissioned services can be funded in many ways, including providing the service in-house, grant funding or procurement from external providers.
- **Procurement** refers to the method of purchasing goods and services by public sector organisations from other external or third-party organisations, resulting in a contract.
  Source: www.gmcvo.org.uk/system/files/issues%2019.pdf

† Local multipliers are used to estimate the knock-on effects (for example, new employment opportunities or increased incomes locally) of stimulus spending on local economic growth. A multiplier greater than 1 corresponds to a positive growth stimulus (returning more than £1 for each pound invested locally), whereas a multiplier less than 1 indicates a net loss from spending.

The NHS could also derive greater social benefit from the money it spends by introducing principles of social value into its contracts and procurement processes. There is no standard definition of 'social value', but it broadly refers to the wider societal benefits that can be gained from purchasing decisions (over and above those to the contracting organisation) – for example, by specifying that jobs are created locally with living wages and fair working conditions. By choosing to work with suppliers that advance social, environmental and economic outcomes in their local populations, the NHS can secure even greater value from its investments and support broader community health and wellbeing. By changing its procurement and commissioning processes, the NHS can also lead by example and influence other organisations in its supply chain, thereby having a wider community impact.

What do anchor procurement strategies look like in practice?

Shifting more spend locally

1. Building local capacity and supporting local supply chains

Embedding social value into purchasing decisions

1. Prioritising and monitoring social value
2. Building organisational capability and capacity for social value

Policy context

Applying anchor strategies to NHS procurement is not without challenge, as this is an area where NHS organisations have less local flexibility, particularly in England. This is especially true following the introduction of the Future Operating Model (FOM), which aims to improve efficiency and effectiveness of NHS purchasing by introducing greater standardisation and price transparency.

It is expected that once the FOM is fully implemented, 80% of the NHS's spend in England on everyday hospital goods, consumables and capital equipment will be purchased through centralised procedures.[79] The FOM was developed in response to recommendations in Lord Carter's review into operational productivity in English hospitals, which determined that the NHS could do more to leverage its collective buying power to reduce unwarranted variation in prices and procurement approaches and help release savings.[80] The FOM covers 11 'category towers' or areas of spend, including medical consumables, capital equipment and common goods, but there are still areas where the NHS has more flexibility to procure locally, including catering and hotel services.

Even with these changes, procurement and commissioning can still be used to improve health outcomes for local communities. In England and Wales, the 2012 Social Value Act requires public sector commissioners to consider how the services they buy support wider

social, environmental and economic wellbeing when they procure services above OJEU (Official Journal of the European Union) thresholds.[81,82] Scotland has a similar policy, where the government requires contracting authorities to consider how procurement can help reduce inequalities and shift more spend towards SMEs in contracts of £4m or above.[83] In Wales, the government also requires public sector organisations to apply a community benefits policy to all procurement, regardless of the value of the contract (though outcomes need only be reported on contracts worth over £2m).[84] The UK government also committed to spending £1 in every £3 with SMEs by 2020,[85] and there are separate requirements in England that food and catering services procured by central government or the NHS must meet specified social and environmental aims.[86]

The legislation should, in theory, promote anchor practices, but there are significant differences in how NHS organisations have applied its principles.[87] In England, a 2017 analysis of CCG Freedom of Information Act requests revealed that only 13% of clinical commissioners actively considered social value as part of decision making, and 43% had no policy in place.[88]

Although this variation suggests room for improvement, some NHS organisations are already using social value and purchasing decisions to benefit the local community.

Learning from practice

Shifting more spend locally

1. Building local capacity and supporting local supply chains

An important first step in shifting more spend locally is to understand current purchasing practices. NHS organisations can conduct internal audits of procurement spend to identify the percentage of purchasing that stays within the local region, and then work out how to reallocate more of the purchasing budget towards local organisations. The Centre for Local Economic Strategies (CLES) benchmarked spend at two NHS provider trusts by examining procurement data on goods and services from their top 300 suppliers for 2017/18 (see Table 2).

Table 2: Procurement spend of East Lancashire Hospitals NHS Trust and Leeds Teaching Hospitals NHS Trust, 2017/18

	Procurement spend	Percentage spend in local authority	Percentage spend in wider region	Percentage 'leakage' outside wider region*
Leeds Teaching Hospitals NHS Trust	£482m	28% (Leeds City)	31% (West Yorkshire including Leeds)	69%
East Lancashire Hospitals NHS Trust	£117m	19% (Burnley and Blackburn-with-Darwin)	23% (Lancashire)	77%

This shows that significant spend at each trust is 'leaking' out of the local economy, and there is potential to work with local suppliers and get more value from procurement. How local economic boundaries are defined will vary by area, but benchmark analysis can help organisations set reasonable targets for retaining more spend within communities.

Once an organisation understands its purchasing practices, it needs to find ways to prioritise local suppliers. Stakeholders reported pushback from staff who fear that requiring suppliers to be local is anti-competitive and violates existing regulations. While regulatory frameworks do prevent NHS organisations from requiring suppliers to be only local or use only local labour, procurement experts we spoke to said that it can be specified that potential suppliers must help advance local community development. More can be done to provide training and clarity to purchasing teams on what is legally possible and how to enforce social value.

Some efforts by anchors to procure more goods and services locally have been criticised as protectionist or inefficient.[89,90] It is important to fully evaluate and understand the impact of these strategies; anchor strategies should aim to boost the competitiveness of local suppliers, not shield them from competition. Any effort to shift more spend locally must be in line with existing regulations that require services to be competitively procured. Audit functions can be bolstered to help ensure these potential risks are mitigated and that local suppliers compete credibly on costs and quality.

Shifting more spend locally will also depend on the capacity and capability of the local supplier market, and may not be possible in all areas of spend. Anchor organisations have a role in supporting local supply chains and ensuring that local businesses, social enterprises and SMEs can compete for and secure NHS contracts. Existing tools and guidance make clear that building local capacity starts in the pre-procurement phase, identifying which resources and services can be secured by organisations working in and with people from

* To provide context to these figures, CLES has created an average of the spend of the 26 analyses it has carried out covering procurement in a range of anchor organisations (including local authorities and higher education institutions). It finds that on average, anchors spent 36% of total spend inside the local authority boundary and 63% within a wider regional area.

the community.[91,92] This may involve conducting audits and outreach with the local economy to identify opportunities and build new relationships, particularly with SMEs and voluntary sector organisations. Local NHS charities are often well placed to know voluntary sector organisations or SMEs in the area with whom to engage.

Interviewees noted how this engagement can help build awareness and encourage smaller organisations to bid for and win contracts. Engagement also helped contracting organisations understand the barriers that local organisations face in working with the NHS. Experts we spoke to thought that STP and ICS leadership could be helpful in coordinating this engagement across a larger area, but that individual organisations still need to conduct their own engagement and outreach, particularly in the lead-up to large projects and contracts being advertised. Procurement leads described how it can be difficult to reach smaller organisations that may not always have the capacity or staff to engage in outreach. This is why NHS organisations should also consider taking other measures alongside engagement, like ensuring prompt payment terms or unbundling contracts into smaller parts so that SMEs are more able to compete, and are not required to deliver all aspects of a service to be successful. Interviewees warned, however, that enacting these strategies can be administratively time-consuming, and not all NHS teams have capacity and expertise to do this.

Some anchor organisations have also developed toolkits and guidance for suppliers to help organisations understand the required criteria and improve the quality of applications. For example, the Greater Manchester Combined Authority developed a toolkit for suppliers that lists clear examples of what provider organisations can offer as part of their bids against core social value criteria, alongside a list of resources to help organisations implement these practices.[93] And in Wales, the Co-operative Centre (a community development agency that supports social enterprises and co-operatives) has developed modules and guidance for suppliers demonstrating ways they can contribute to broader social value, as well as tools and techniques for reporting against criteria.[94]

More can be done at the national and regional level to help NHS organisations spend more locally. For example, in England, stakeholders noted how the FOM towers (see page 25) could incorporate at least one regional provider (where possible) in categories to give NHS organisations an opportunity to retain resources within the health economy where appropriate.

Case study 3: North Bristol local food procurement

North Bristol NHS Trust changed its approach to procurement of catering services to purchase more food locally. In 2018, 54% of its food spend went towards local produce. It has been awarded Food for Life certification by the Soil Association, recognising excellence in catering that provides environmentally sustainable and ethical food.

To make this change, the catering team conducted a large audit to identify what produce was available locally and the financial implications of switching suppliers. They removed certain menu options (lamb) that could not be sourced within a 50-mile radius. This increased costs slightly: for example, beef cost 1p more per meal when sourcing from a local and organic provider. The director of facilities, who was supportive of the change from the start, looked for savings from elsewhere to offset the increase. Existing regulations helped gain senior backing for the approach, as trusts are already required by the Department of Health and Social Care to have a food and drink strategy that supports procuring more food from local, sustainable sources.[95 96]

Embedding social value into purchasing decisions

1. Prioritising and monitoring social value

There are promising examples of NHS organisations that have embedded social value into procurement processes, either by introducing explicit weightings or designing core contract specifications so that suppliers must meet specific conditions – for example, creating local jobs and training opportunities, paying a living wage and adopting environmentally sustainable practices.

To aid this process, some NHS organisations have established frameworks and action plans with specified outcomes and definitions for social value to assess bids and help measure performance against social objectives. Doing so often requires sophisticated cross-department working to write contract specifications and agree common aims and procedures. Stakeholders we interviewed noted that senior leaders play an important role in developing a clear vision and strategy for social value to underpin these efforts and ensure they are consistently applied.

STPs/ICSs also have an important role in strengthening the application of social value across a health economy. At present, very few STP plans (13%) refer explicitly to social value,[88] though some do include related objectives around narrowing inequalities, improving access to housing and reducing poverty. STP and ICS leads could work with partners across a place to agree shared objectives and define common metrics for social value, which in turn could help reduce local variation in how the concept of social value is adopted in a local health economy and could help mainstream it in practice.

Even where frameworks exist, the NHS could take a broader approach to have an even greater impact on community health and wellbeing. For example, when NHS organisations consider social value it tends to be primarily as part of competitive tender processes, which are limited to large contracts. Applying these principles more systematically across areas where the NHS has greater flexibility (such as hotel and catering services), even though they may be of lower value, can help maximise spend for community benefit. Stakeholders noted that the overall weighting NHS organisations give to social value when scoring

contracts tends to be low (between 5% and 10%), with most value placed on cost and quality. This is lower than local government, where social value weightings can be as high as 30%.

Applying more weighting to social value increases the likelihood of selecting suppliers who provide greater community benefit, but even so, there are trade-offs. For example, requiring that all suppliers pay their staff a living wage can make a service more expensive to deliver:

> 'Often we have no flexibility to increase the cost of running a service, so requiring suppliers to pay a living wage means we can't deliver the whole service to the same level. This is made harder by the fact that we face pressure to achieve cost savings on contracts year on year… This is why we've started with a weighting of 10%, with the goal of increasing it slowly over time. This felt more manageable to our purchasing team.'

Head of partnership
Clinical commissioning group

There are still limited accountability mechanisms for enforcing the use of social value, which interviewees believed may contribute to inconsistencies in how it is applied. To be compliant with the Social Value Act, public sector commissioners are only required 'to consider' social value in purchasing decisions, yet they are rarely scrutinised to show what 'consideration' means. Even with the incorporation of social value into the NHS Standard Contract in England,[97] CCGs and trusts reported not being required to provide evidence for how they meet the requirements.

Strengthening the legislation so that public bodies are required to formally incorporate social value into purchasing decisions could help mainstream it in practice. In 2018, the government announced plans to do just that – making social value an explicit requirement of central government contracts.[98] Legislative proposals intended to ease the implementation of the *NHS Long Term Plan* also aim to introduce a 'best value test'. Although more detail is needed on how the test will operate, this has the potential to support system leaders to incorporate wider considerations of public and social value when commissioning services.[99] But legislative changes notwithstanding, there is more that can be done to build greater accountability for social value across the sector. Interviewees said that NHS England and NHS Improvement could help introduce stronger incentives for social value, either by encouraging use of weightings or helping to define minimum key performance indicators (KPIs) through existing levers, including CCG assurance frameworks and STP/ICS guidance. They could also set minimum social value standards for the NHS nationally, establish common metrics and showcase promising practices that can be adapted locally. The Scottish government, for instance, has issued guidance

for contracting authorities on how to define community benefit requirements as part of procurement, with suggestions for how public sector organisations can develop metrics to monitor performance against national and local outcomes.[100]

However, even where national standards and resources exist to support more progressive procurement, they have not always become embedded in practice. For example, the Government Buying Standards for Food and Catering Services (GBSF) requires all central government departments and the NHS in England to meet basic minimum standards for sustainability and socioeconomic value, and to use a balanced score-card when evaluating bids to ensure that more complex criteria, like how companies source from SMEs, are factored into procurement. A 2017 government review found that while significant progress had been made to adopt GBSF standards, almost half of NHS trusts were not fully compliant.[101] According to stakeholders we interviewed, the scorecard has been difficult to mandate centrally, given that these services are procured so differently across organisations and often involve sub-contractors that can be harder to monitor.

Many NHS organisations also lack the means to ensure that their suppliers follow through on social value commitments. Establishing monitoring frameworks so that NHS organisations can systematically collect evidence and track progress against social value indicators could help build accountability and increase the benefit of anchor procurement strategies.[102] However, stakeholders noted that contract management can be time-consuming, and should be proportionate to the size of the contract to avoid being overly burdensome.

Case study 4: Wales community benefits measurement tool

Wales provides an example of how to monitor and build accountability for social value at national and local levels. The government requires public sector organisations to report on the broader community benefit of contracts over £1m (though organisations are encouraged to consider social value as part of all procurement decisions, irrespective of value).

To aid this, the Welsh government has established a community benefits measurement tool to help organisations capture the full range of outcomes, including worksheets and guidance for purchasing managers to report on a number of defined measures. These include whether procurement budgets have: supported businesses based in Wales and SMEs; helped local unemployed people to find work; diverted waste from landfills; and created new apprenticeships and training opportunities. Organisations report to the government, which can then track the broader social value and multiplier effect of public spend.[103]

While designed primarily as a reporting tool, this resource has also provided a consistent way for organisations to measure outcomes. It is used locally by organisations as part of their ongoing contract management process to ensure that suppliers meet agreed standards for social value.

Case study 5: Social value in Salford

Salford provides one of the more advanced examples of what a collective approach to social value and progressive procurement can look like. In 2016, organisations across the public, private, voluntary and community sectors formed the Salford Social Value Alliance, which supports all partner organisations to deliver services and contracts with social value in mind. In 2017, it launched a campaign to make a 10% improvement across 11 social and environmental outcomes by 2021. This included increasing the number of residents from vulnerable groups accessing jobs and training; supporting more people to cycle when commuting; and directing more spend towards local organisations.

The alliance includes local NHS organisations, which took part in early engagement activities to help establish shared principles for how to embed social value priorities in health and care commissioning and procurement. Salford CCG has since developed an action plan for social value,[104] which acknowledges its role as an anchor and builds on the metrics set in the 10% campaign. It is also expected that this strategy will help underpin developments through the ICS and joint working with the local council as part of integrated commissioning arrangements.[104]

The alliance has also created toolkits and resources to help partner organisations embed community benefit into commissioning and procurement decisions, and to measure impact.[105] The city council has taken the lead in producing annual reports on social impact. In 2018, 59% of local government's direct procurement spend was with Salford-based suppliers, nearly half of their wage bill goes towards residents and 18 council suppliers are accredited Living Wage Foundation employers (up threefold on the previous year).[106]

2. Building organisational capability and capacity for social value

It is essential that any effort by system leaders to embed social value comes with capability building for those in charge of procurement. Interviews revealed how purchasing managers – even those who understand the importance and concept of social value – often have limited capacity and capability to incorporate principles in their daily work:

‘The expertise of our patient meals contract manager, for example, is to make sure that our patients are satisfied with the quality of their meal, and that they get what they need to support their recovery. It’s not usually in their skill set to write contracts to drive social value and provide evidence for how they are increasing local employment and reducing gender pay gaps across employees… Even when they understand why the principles of social value are a priority, it is not something they have been trained to do.’

Sustainability lead
Acute trust

Purchasing teams must also be given the time and space to build skills and knowledge on social value and explicit permission to integrate these outcomes into contracting decisions. System and organisational leaders can help signal more clearly that social value is a priority, and take steps to ensure that local teams see it as part of their role.[107] They also have a role in facilitating sharing of learning evidence and good practice. Numerous tools and resources exist to help support staff training on social value and progressive purchasing practices. For example, the NHS Sustainable Development Unit (SDU) has developed a range of resources, including a learning module, case studies and social value calculator, to help NHS organisations apply the Social Value Act.[108] Social Enterprise UK has developed a *Social Value Guide* to help procurement managers and commissioners apply social value in practice.[109] Some of our interviewees from CCGs also mentioned developing training packages on social value for use by procurement teams across their health economy. (Further resources to support staff capability and knowledge on social value are available in the box on page 35.)

The experience of NHS trusts also shows the value of having a designated sustainability or social value lead who can oversee local purchasing initiatives and link up efforts across departments. Interviewees said that the person in this role can also train purchasing managers across the organisation and ensure that strategies are applied systematically (also freeing up capacity among purchasing managers, who are often pressured to meet other efficiency targets).

‘It can be helpful to have someone who sees supporting social value across the organisation as their primary role and has the knowledge to think of the same problem through different lenses. Workforce teams don’t always work with procurement teams, or with estates – it can be really helpful to have someone who can link efforts and help bring these functions together as part of one strategy.’

Sustainability lead
Acute trust

Stakeholders also emphasised the value of designating a board member to lead on social value and sustainability to help join up efforts as part of a more centralised organisational approach.

Summary and implications for practice and policy

Directing more of the NHS’s spend towards community benefit is not without challenge, given that many purchasing decisions are made centrally. However, there are still areas of procurement (particularly within services) where purchasing can be a lever to stimulate local economic development and support broader socioeconomic aims. There is legislation in each country of the UK to support this, but more must be done nationally to help clarify definitions, metrics and opportunities to fully embed social value principles. This means defining minimum standards nationally and putting in place accountability for delivering social value across the system.

While implementation will look different based on local and organisational contexts, there are opportunities nationally to develop templates, standard contract language and measurement tools that can be adapted by local systems to avoid unnecessary duplication of efforts.

Underlying all these efforts will be a need to build greater organisational capability. For NHS organisations, this means giving purchasing managers the time, training and resources they need to develop new expertise and progressive procurement approaches. Local system and organisational leaders should signal promoting social value as a priority and ensure that teams are given the permission to adopt new approaches. NHS organisations should also be encouraged to learn from other local partners (such as councils) with experience in implementing progressive procurement policies. Driving change will require baseline data on current practices so that each organisation can set informed and realistic targets for directing more spend towards community benefit. It also requires organisations to understand their local markets and address barriers that local suppliers face when trying to work with the NHS. And, as with all anchor practices, progressive procurement approaches will have greater impact if included as an explicit organisational aim, with someone leading on coordination and monitoring across the organisation.

Practical resources to support implementation

Creating Social Value – module (Sustainable Development Unit)

Economic and Social Impacts and Benefits of Health Systems (World Health Organization Regional Office for Europe)

Social Value Calculator (Sustainable Development Unit)

Social Value Toolkit. Guidance for Suppliers (Greater Manchester Combined Authority)

Social Values Forums Toolkit (Wales Co-operative Centre)

The Public Services (Social Value) Act 2012. An Introductory Guide for Commissioners and Policy Makers (Department for Digital Culture, Media and Sport)

The Social Value Guide. Implementing the Social Services (Public Value) Act (Social Enterprise UK)

Using the Social Value Act to Reduce Health Inequalities in England Through Action on the Social Determinants of Health (Public Health England and UCL Institute of Health Equity)

Chapter 5: The NHS as a land and capital asset holder

Why this matters

NHS organisations often have significant physical assets that can be leveraged for community benefit. Though data are limited on the exact size of the NHS's entire estate portfolio, it includes 8,253 trust and primary care sites across 6,500 hectares of land in England alone.[110]

Anchor strategies involve thinking about how the NHS can manage and develop its land and estates to support broader social, economic and environmental aims – for example, by working with partners to support more high-quality, affordable housing and widening access to community spaces. This is especially important for lower-income groups, which tend to have poorer-quality housing and less access to green and community spaces.[111]

Housing is an important driver of health; physical and mental health is affected by quality of housing, where it is located and how connected it is with the wider community.[112] Estimates from 2011 suggest that poor quality housing costs the NHS around £2.5bn per year.[113] Affordable housing close to workplaces can benefit staff, while helping to improve retention and offering environmental benefits.

Communities are also more resilient when people are connected through social networks,[114] and opening NHS buildings and land for community use or supporting the development of green spaces can provide vital opportunities for social interaction.[115] The NHS also influences the local economy through who it lets operate and conduct business in its facilities (such as stores and food outlets). By providing more opportunities for SMEs and working with organisations that promote social good, the NHS can further support community wealth development.

What do anchor capital strategies look like in practice?

Expanding community access to NHS property

1. Enabling local groups and businesses to use NHS estates

Converting and selling estate for community benefit

1. Supporting access to affordable housing or housing for key workers using NHS estate
2. Working in partnership across a place to maximise the wider value of NHS estates
3. Developing accessible community green spaces

Policy context

In many parts of the country, NHS estates are in poor condition, lacking sufficient buildings and infrastructure to meet clinical demands.[117] The capital budget for investments in buildings and maintenance has declined in real terms between 2010/11 and 2017/18, leading to chronic maintenance backlogs and many NHS sites needing significant upgrades.[117] The government did recently announce a £1.8bn short-term capital funding increase for the NHS in England, but this level of investment falls well short of what is required to bring NHS infrastructure to modern standards.[113,116] These immediate pressures can make it difficult for the NHS to consider the wider value of its estate for local communities.

This context has put pressure on the NHS to raise capital through sales of land and assets, which have more than doubled since 2010/11.[117] In 2017 the government published the Naylor Review to help develop a new strategy for NHS estates, which reinforced the need for the NHS to dispose of surplus land to free up more funding for capital.[118] Financial pressures have meant that NHS organisations are sometimes incentivised to sell land and assets to the highest bidder as an opportunity to plug funding gaps.[119]

At the same time, there is now greater emphasis on how unused or surplus NHS land can be used to widen access to affordable housing. The Naylor Review recommended that any NHS land that is sold should be developed into housing for NHS staff as a priority, and that 30,000 homes could be built on land belonging to acute estates.[118] This would support broader government aims to accelerate the development of new housing across the UK and help achieve the Department of Health and Social Care's aims of releasing NHS land to build 26,000 more homes by 2020.[120] According to 2019 figures, NHS trusts have nearly 890 hectares of surplus land that could be sold or converted.[121] Lack of affordable housing has compounded the recruitment and retention challenges currently facing the NHS,[122] providing further impetus to use surplus estate to develop housing for staff, particularly clinicians.

However, ownership and control of NHS estates is complex, with important implications for how property can be sold and repurposed for community benefit. NHS trusts own most of the land they occupy, though this is not the case with general practices, which typically lease land from NHS Property Services (which owns and manages over 10% of all NHS estate), community health partnerships or owners outside of the NHS.[118] This means that the opportunities to implement anchor strategies will look different across the sector, as accountability sits with different NHS organisations.

Moreover, since the 1990s, NHS organisations have used private finance initiatives (PFIs) to fund building development.[123] PFIs allow the NHS to use private finance to fund capital projects, and usually mean that NHS organisations only obtain full ownership of the asset once payments have been completed (typically 30 years). This places further constraints on the ability of some NHS organisations to use their estate for broader community benefit.

Given the context, it is not surprising that we see fewer examples of NHS organisations adopting anchor practices on the use of land and estates compared with areas like employment. However, there are opportunities to think differently about how the NHS leverages its assets for social benefit.

Learning from practice

Expanding community access to NHS property

1. Enabling local groups and businesses to use NHS estates

The NHS often has facilities that are not used at certain times (such as weekends), which means it can offer the space to community groups at little or no cost. This could make a big difference to small local charities and organisations that otherwise would have no access to space, and help enhance social networks locally.

For example, University Hospitals Birmingham NHS Foundation Trust regularly gives community groups free use of its buildings and facilities, allowing charities to host their annual conferences there. It is also looking into hosting free film screenings for the community in unused lecture theatres. Some trusts are also allowing local schools to use their space in the evenings and at weekends for arts programming.

Another way the NHS can support staff and the wider community is by offering childcare facilities on site, increasing the provision of childcare available in the local community. Sussex Community NHS Foundation Trust, for example, offers nursery places on three sites for NHS and emergency services staff, also reserving some places for local families.

As an anchor, the NHS can also support community development by leasing its retail space to local community businesses, thereby encouraging patients, staff and visitors to spend local. Some hospitals host farmers' markets on trust estates that are open to the broader community. Cambridgeshire Community Services NHS Trust, after consulting with the community advisory group, is opting to work with a locally owned cafe rather than a large national chain while rebuilding a community hospital.

Some NHS organisations have reported that PFI contracts can restrict their ability to allow local businesses to sell on-site due to exclusivity clauses (although some NHS organisations have been able to negotiate access for local businesses on PFI-owned sites). For example, Southmead Hospital in North Bristol worked with PFI contractors to negotiate a weekly local farmers' market on-site for patients and visitors using locally sourced produce. The trust had to demonstrate how the farmers' market would not be in direct competition to existing shops within the hospital. To help make the produce more affordable for residents, the farmers' market agreed to reduce profit margins to help expand access to healthy food within the trust and community. In exchange, the trust provides volunteers to help run the stall.

Converting and selling estate for community benefit

1. Supporting access to affordable housing or housing for key workers using NHS estate

Given the links between housing and health, there is a case for NHS organisations to ensure that their decisions around land use support the needs of their staff, the local community and, over time, contribute to reducing health problems from poor housing. Our interviews with stakeholders revealed that where such efforts are taking place, they are often motivated by more immediate issues of improving recruitment and retention, rather than part of an anchor mission to tackle inequalities:

> 'We are absolutely struggling to recruit nurses because no nurses can afford to live and work in some areas, so it is in our interest to somehow build affordable housing, so you can subsidise nursing staff to live in the community, which means they're not going to be struggling to recruit those staff.'
>
> **Deputy director of strategy**
> NHS England

There are opportunities to align the NHS's strategic priorities around workforce with broader social objectives, and some NHS organisations are explicitly prioritising social value as part of decisions to sell land. For example, when NHS Property Services sold the former St George's hospital site in Hornchurch for £40m (the largest reinvestment in the NHS through sale of surplus land), 15% was allocated for social housing and 1.6 hectares of land retained to host a new community health centre.[124]

When selling surplus land, or redeveloping its own land, the NHS could more actively consider social value and the impact on the wider community – though doing so is not always straightforward. Stakeholders we interviewed expressed concern that most NHS land sold by trusts does not include affordable housing provision. A New Economics Foundation analysis of NHS surplus land sales in 2017/18 found that of the sites with planned homes, two-thirds will be unaffordable for nurses on an average salary.[125] Even when there are provisions for affordable housing embedded in the sale agreement, it is not always achieved. For example, in West Yorkshire, a large housing developer committed at the point of sale to building 30% affordable housing on the site of Pontefract General Infirmary – a figure later reduced to 6% after declaring 'financial unviability'.[126] Strong accountability mechanisms are necessary to ensure that the full social value of NHS estates can be realised after sales are completed. NHS organisations will not always have full control over decisions on the use of their surplus estate for affordable housing, as local authorities often have the primary role. This makes developing partnerships ever more important in delivering these aims.

Converting NHS land and facilities for community use can also require significant upfront investment that many NHS organisations cannot afford in the current financial climate. Stakeholders emphasised the overriding pressures in the NHS from system leaders and trust boards to sell any surplus land on the open market to the highest bidder, even if gains are short-term:

> 'We've engaged with housing associations, we've engaged with primary care associations, all are very keen for us to promote and take forward plans to develop affordable housing. We find ourselves slightly thwarted by the centre… They are completely focused on today's agenda as opposed to a more broad, long-term view.'
>
> **Deputy director of planning**
> Acute trust

Housing associations, local councils and other community organisations often miss out on development opportunities as they have fewer resources than private developers to make competitive bids. However, interviewees said there is scope for the NHS to pursue alternatives to open market sale and enter into joint ventures with housing associations or councils, who may be able to help attract upfront investment for the development of housing and community spaces. This could help ensure that more of the NHS's land benefits the community; for example, the NHS could sell land to or enter a leasing arrangement with housing associations, who then develop the land themselves and give the NHS a share of the rental income.[127] However, the need to offset current deficits may severely limit these options. Interviews and learning from the grey literature suggest that, where this is possible, partnerships tend to be more successful if the housing association and the NHS have long-standing relationships and the housing association can make a clear financial case which directly benefits the individual NHS provider.[128]

2. Working in partnership across a place to maximise the wider value of NHS estates

Beyond the sale of surplus assets, NHS organisations in some areas are working proactively with other anchors to help improve the local built environment to support community health and wellbeing.

At the national level, NHS England's Healthy New Towns programme is bringing together NHS providers, commissioners, local government and other partners to test how new housing developments can advance population health through 10 demonstrator sites.[129] The *NHS Long Term Plan* committed to publishing guidance based on learning from the programme to help other local areas work together to develop healthier built environments. There will also be a new quality standard to incentivise future developments that support prevention.[20]

Cambridgeshire Community Services NHS Trust is negotiating with the Ministry of Defence and the local council, which own adjacent land, to manage the whole site as one plot on which to rebuild a smaller hospital and develop affordable housing. While the circumstances in Cambridgeshire are specific, with strong historical relationships, they highlight the potential for the NHS to partner across a place and to think differently around land use when opportunities arise. STPs and ICSs may provide further scope for the NHS to build these relationships and work more collaboratively to improve local planning and the built environment for health.

If NHS organisations are to make the most of opportunities to use their estate for public good, then meaningful public engagement during the planning process is essential. This has been an important lesson from Healthy New Towns, which highlighted the importance of developing a shared vision with local people on how space can be used, and actively involving communities and residents in decision making on new developments.[130] Partnerships and local stewardship can unlock this, particularly with marginalised and underrepresented communities, as local councils and housing authorities may have different relationships with the community and can be instrumental in forging new links.

3. Developing accessible community green space

Given the positive associations between quality green space and health and wellbeing outcomes, some NHS organisations are exploring how they can create more accessible community parks. These green spaces provide a habitat for wildlife and space for physical activity, and contribute to improved health and wellbeing, particularly for people who otherwise would not have access.

Some NHS sites have existing green space that they have opened to the local community, and others are working to develop green space on unused land. For example, Bromley-by-Bow Centre – a GP practice and community charity based in a socially deprived area in east London – owns 3 acres of land that it has converted into green space, with a children's play area, an allotment and garden. And at a primary care centre near Sunderland, staff worked with NHS Property Services and a local charity, Groundwork, to convert derelict space into a community garden and allotment. The space is now used to run a gardening course as part of a community mental health recovery programme.

Summary and implications for practice and policy

Taking a broader view of the socioeconomic value of NHS capital and estate can be difficult. The demands placed on NHS capital and lack of capital funding puts pressure on the system to immediately dispose of surplus land, typically to the highest bidder. While these pressures will continue, there are examples of good anchor practices where NHS organisations are supporting the development of affordable housing and other community assets and doing more to open their doors to community organisations. However, there is more that can be done.

Nationally, NHS policymakers can support local action by providing clear guidance and clarity to NHS organisations on how to embed provisions for social value into sales and monitor their implementation, and signal this as a priority.

At the local system level, NHS organisations can work with other public sector partners to develop joint strategies that optimise the use of public estate for broader social objectives, such as affordable housing and green spaces. This can also help with immediate organisational pressures around staff recruitment or retention.

For individual organisations, knowing how best to leverage land and estates for social value starts with a detailed understanding of existing estate portfolios to see what can be opened for community use or converted from surplus land. NHS organisations should build relationships with housing associations and local councils to pursue alternatives to open market sale. They should also engage in discussions with local residents to explore community needs for space, and how NHS land and estates can be used to meet those needs.

Practical resources to support implementation

Housing Associations and the NHS: New Thinking, New Partnerships (The Smith Institute)

Putting Health into Place. Introducing NHS England's Healthy New Towns programme (TCPA, The King's Fund, The Young Foundation, Public Health England, NHS England)

Supporting the Healthy New Towns programme (The King's Fund)

Chapter 6: The NHS as a leader for environmental sustainability

Why this matters

NHS organisations have a significant impact on the environment and are some of the largest contributors to climate change and air pollution. The NHS alone is responsible for 40% of public sector emissions in England.[131]

Delivering high-quality health and care places numerous demands on natural resources and the environment, such as:

- use of energy, water and consumables, including plastics
- waste production and waste management
- travel, which requires fossil fuels and contributes to air pollution.

In 2017, the health and social care system used 27.1 million tonnes of CO_2e and 2.23 billion m^3 of water. This includes 589,000 tonnes of waste and 9.5 billion travel miles generated by NHS providers.[132] Indeed, health and care-related travel constitutes around 5% of all road travel in England.[132] Given its large carbon footprint, any action the NHS takes to support responsible consumption and reduce waste can have a significant impact on the environment. This is important not only to reduce the carbon impact, but to support more sustainable utilisation of finite resources overall.

The climate crisis has serious direct and indirect consequences for health.[133] Toxic air pollution is associated with acute and chronic health conditions that cost health and social care £157m in 2017.[134] Exposure to air pollution is estimated to cause the equivalent of 40,000 premature deaths in the UK each year, and more than 2,000 GP practices and 200 hospitals are in areas affected by toxic air.[135,136] Climate change and air pollution also disproportionately affect disadvantaged and vulnerable populations.[137,138] These communities are more exposed to climate hazards, more vulnerable to the harms they cause and have relatively fewer resources to cope or recover from their effects, thereby further entrenching inequalities.[139,140,141] And while improving environmental sustainability will have benefits beyond local populations, it is one of the main ways the NHS has influence as an anchor institution, and can improve the wider determinants of health and support community development. It has the power and responsibility to influence action on a broader scale to reduce its contribution to climate change and protect resources for the health of future generations.

What do anchor environmental sustainability strategies look like in practice?

Adopting sustainable practices within the NHS

1. Developing leadership and staff buy-in for environmental sustainability

Influencing sustainable practices in the community

1. Helping shape community environments and behaviours and influencing local suppliers

Policy context

Public sector organisations are legally required to deliver environmental sustainability as outlined in the Climate Change Act 2008, which commits the UK to reducing its carbon emissions by 80% by 2050.[142] The legislation has since been amended to introduce a target to bring all greenhouse gas emissions to net zero by 2050.[143] NHS leaders have enacted several changes to help deliver on these aims. NHS England and Public Health England jointly fund the SDU, which helps NHS organisations with expert advice and guidance on how to support environmental and social sustainability. NHS organisations in England are also required by the NHS Standard Contract to produce an annual Sustainable Development Management Plan that sets out how they will reduce carbon emissions.[144] And as previously discussed, Wales, Scotland and England each have legislation in place to promote the social value of public purchasing, including considerations for broader environmental sustainability.

The *NHS Long Term Plan* re-emphasised the importance of reducing greenhouse gas emissions and air pollution associated with delivering health care, and acknowledged the need for collective action from all NHS organisations to reach these targets.[20] The NHS has made progress over the past decade by reducing its carbon output by 18.5%,[132] though as one of the world's biggest organisations with one of the largest carbon footprints in the UK public sector, these improvements could go much further if the NHS embraced and developed its role as an anchor institution.

Learning from practice

Adopting sustainable practices within the NHS

1. Developing leadership and staff buy-in for environmental sustainability

Reducing the health and care system's carbon footprint involves taking action in several areas, including improving energy efficiency, supporting more sustainable travel for patients and staff, and reducing waste and water consumption.

As with all complex improvements, changing organisational behaviour to support environmental sustainability needs leadership and commitment from senior leaders.[102,145] Interviewees told us that responsibility for implementation has often been left to sustainability officers without more senior or board-level support. This has often meant that interventions lack coordination and visibility, and could have a greater impact if they were part of an organisation-wide strategy.

Stakeholders who have managed to get senior leaders on board emphasised the importance of creating a vision that appeals to corporate strategic aims. Clearly linking environmental sustainability to goals around improving health has been helpful for some:

> ‘I just kept banging my drum (about) the whole 40,000 excess deaths a year in the UK due to air quality. So, that stat always hits home.’
>
> **Sustainability lead**
> Acute trust

There is also a lack of accountability on sustainable development within the system. Despite a strong legal context for action, there are no sanctions or incentives beyond national targets for action on sustainable development, which are insufficient on their own to motivate and drive change. One promising development is that the SDU is developing a dashboard to help organisations understand their baseline, assess their readiness and set individual targets in line with their own goals. This data will amalgamate to STP and ICS level to support greater system accountability and regional planning.[146]

Adopting more sustainable operational practices also relies on staff engagement at all levels, requiring a shift in culture, attitudes and knowledge.[147] Research suggests that staff resistance often comes from feelings of having insufficient knowledge or skills to implement change and not knowing the impact of interventions.[147,107] Giving teams the tools and resources they need to feel empowered to implement solutions and measure impact is key to supporting the NHS to support environmental sustainability for local communities.

During interviews, senior leaders commented that NHS organisations have often been able to make the greatest progress on reducing local air pollution, partly because this is an area with clearly defined metrics that can more easily demonstrate impact.

There are numerous tools and resources to support teams to reduce pollution. These include the Clean Air Hospital Framework, which offers best practice and guidance on how hospitals can improve outdoor and indoor air quality in key areas like procurement, travel, construction and energy generation.[148] The SDU’s Health Outcomes of Travel Tool supports NHS organisations in measuring the impact of travel and transport, helping to quantify the impact of pollution from different sources and how to reduce them.[149] The SDU is also developing frameworks to support progress in other areas where the NHS can have an impact, including recycling schemes, biodiversity, responsible chemical disposal, responsible construction and conservation.[146]

A number of interviewees felt that action on sustainability has become easier as more staff are aware of the climate crisis and its impact. Organisational champions and communication campaigns have helped build a sense of shared motivation, responsibility and ownership over solutions. The NHS has an important role to play in educating staff about what they can do, both at work and outside of work.

'When I started here, it was just me and nobody really taking sustainability on… Slowly, got more people on board … After a couple of minutes, you can tell them what it's about and a lot of people, the light bulb just clicks that it's just good business; like being efficient and using all your resources whether it be staff, the patients we're dealing with or the environmental impacts of your actions … The tide turned quite a few years ago.'

Sustainability lead
Acute trust

Examples of action by NHS organisations include promoting use of public transport or walking and cycling to work, monitoring waste generation and recycling rates, and installing more energy efficient heat and power sources. But NHS organisations and local systems could do more to coordinate their efforts. There is also an opportunity for regional and national policymakers and the SDU to share good practice and innovations – something NHS England and NHS Improvement have committed to as part of the *NHS Long Term Plan*.

Case study 6: University Hospitals of North Midlands NHS Trust and Beat the Cold

University Hospitals of North Midlands NHS Trust has launched an initiative to establish more sustainable and affordable energy sources and reinvest savings in the community.[150] Recognising the links between hospital readmissions during winter and poor heating and living conditions, it worked with residents and the local council to crowdfund for 1,100 solar panels, installed on NHS hospital buildings. By switching to renewable energy, the trust saved nearly £300,000 that was invested into a local charity, Beat the Cold, which tackles cold-related sickness and fuel poverty.[150] This initiative has helped strengthen relationships between the trust and residents. Early evaluation suggests the project has helped achieve savings by reducing the rate of readmissions, particularly among elderly people and other vulnerable groups. Having the support of the chair of the board was essential:

'It was so important that we had the support of the hospital chairman. On the day we were putting the solar panels up a member of the board tried to stop us… The hospital chairman had to overrule him.'

Business development manager
Beat the Cold

Influencing sustainable practices in the community

1. Helping shape community environments and behaviours and influencing local suppliers

As an anchor, the NHS can use its voice to push for broader developments that support the environmental health of local communities. For example, some NHS organisations have advocated for more public transport routes and cycling lanes to NHS hospitals, which benefits individuals' health as well as the environment. This has knock-on benefits for local public transportation, which research has shown can help improve social inclusion and stimulate economic regeneration in deprived areas.[151]

For example, Epsom and St Helier University Hospitals NHS Trust has been working with local councils to improve public transport links to the hospital for staff and the local community. After receiving repeated complaints about the difficulty of getting to the hospital via public transport, the sustainability officer at the trust negotiated with local councils to pilot a new 'on-demand' bus service for residents in Surrey, with a designated bus stop on the hospital site. The staff shuttle bus has become a public bus service, and the trust has negotiated with Transport for London to further extend bus services to the hospital.

Purchasing and commissioning can also be harnessed to influence sustainability practices in the community. The supply chain is one of the biggest components of the health and social care system's carbon footprint, accounting for 57% of its carbon emissions in

2017,* with the largest hotspots being medical instruments and equipment, followed by pharmaceuticals.[128,152] As discussed in the procurement section, the NHS can reduce some of this by working with local suppliers to reduce its carbon output.

For example, as part of its Care without Carbon strategy, Sussex Community NHS Foundation Trust is working with suppliers to reduce carbon emissions, which make up 60%–70% of the trust's overall carbon footprint. The sustainability team has embedded sustainability criteria and metrics into the tendering process by setting targets for suppliers to reduce their vehicle emissions over the lifetime of the contract.

Improving environmental sustainability in the wider community requires strong partnership working, and much can be achieved by anchors working together – something we explore in the next chapter.

Summary and implications for practice and policy

As one of the largest public sector resource users and polluters, the NHS must take action to reduce its environmental impact. Beyond changing its own organisational practices, the NHS can drive progress within local communities by using its influence at all levels of the system to advocate for broader changes that promote sustainability and improve the wellbeing of communities, particularly for disadvantaged populations who face the highest levels of environmental risk.

For national bodies, this means moving beyond simply setting national targets on narrowly defined areas such as air pollution to supporting the development of metrics, tools and resources across all domains of environmental sustainability and supporting capability at the front line.

At the local system level, organisations can work together to develop shared goals and strategies to improve environmental sustainability and track their impact. The NHS is also well placed to work with other anchors to influence supplier behaviour and make local transport or infrastructure more environmentally sustainable.

NHS organisations need strong leadership to give visibility to strategies, align efforts with other organisational priorities and maximise the influence of the NHS on environmental sustainability within their local area. Understanding which of their practices and activities have an adverse environmental impact is an important first step; securing engagement and buy-in from staff is also essential to finding solutions. Organisations should educate their staff and offer skills, resources and tools so they can take action.

* This includes carbon emissions associated with the extraction, processing, assembly, packaging, transport, storage and handling of products and materials that are directly and indirectly consumed by service providers.

Practical resources to support implementation

Care Without Carbon – our strategy (Sussex Community NHS Foundation Trust)

Clean Air Hospital Framework (Global Action Plan)

Health Outcomes of Travel Tool (Sustainable Development Unit)

Chapter 7: The NHS as a partner across a place

Why this matters

Across each dimension of anchor activity, the NHS can accelerate progress by working with others across a place – both within the NHS and with anchors from other sectors – to scale impact and develop shared approaches. The combined assets of anchor institutions (in terms of local jobs, spending and land) can be significant; working collaboratively can give anchors more reach into the community than they would have individually, and allows sharing of best practice. And by working together locally, anchors can use their collective influence to encourage other organisations in their local economies to adopt similar practices.

Establishing anchor partnerships and collaboratives can be key to developing greater intentionality and shared purpose around an anchor mission. There are, however, some contextual and wider issues around place-based anchor collaboration that must be carefully considered.

What do anchor partnerships look like in practice?

Partnering with other anchor institutions across a place

1. Developing anchor collaboratives and networks to support shared approaches locally

Partnering with other NHS anchors

1. Developing networks to support shared learning and spread good practice

Policy context

The growing focus on place-based approaches to improve health and economic outcomes, both within and across local areas, has changed the dynamics of how anchor institutions may function and work together across a place.

In some areas, devolution has brought sectors together to think collectively about how to channel assets to improve the wellbeing of local populations. For example, the Greater Manchester devolution deal, which gave the combined authority control over £6bn spend on health and social care in the 10 boroughs, has supported anchors to develop a joint strategy for improving population health and economic prosperity across the city region.[153] But even when health and social care have been incorporated into plans, the NHS has not always actively contributed to broader economic strategy development and discussions.[154]

Likewise, the delivery of the government's *Industrial Strategy* relies on place-based approaches and calls on combined authorities and LEPs to come together to develop ways to spur growth across local communities.[155] The extent to which NHS organisations have engaged with LEPs has been mostly limited: very few LEPs have NHS representation on their boards, though there are some exceptions – like in Dorset, where the chief system integration officer for the local CCG is a member.[156,157] Stakeholders have noted that there is an opportunity for the NHS to take a more active role in supporting the delivery of these place-based strategies, given the significant economic assets they bring, and their powers to improve skills development, innovation, employment and infrastructure to support productivity.* Moreover, working in partnership on these strategies can open up opportunities to access new funding streams.

'We are very much trying to take an approach looking at how the local NHS organisations begin to play their part in shifting conversation. I don't think what we've ever done particularly well in the NHS is to say, "What is the role of our organisation in contributing to the economic success of that area?" I don't think we've made that connection powerfully enough, yet.'

Strategy lead
Combined authority

Within health and care, we have identified a number of opportunities for STPs and ICSs to develop anchor approaches around common aims. These are relatively new forums for partnership working and it is too early to tell whether they will realise their promise of supporting more collaboration around prevention. None of the 2016 STP plans referred explicitly to an anchor mission, and few described initiatives to work on anchor-like strategies to intervene in the wider determinants of health. However, as ICSs are a key part of the delivery mechanism for the *NHS Long Term Plan*, they may create the incentive for NHS organisations to develop their anchor role and collaborate with local partners for the benefit of local communities.

The emphasis on place, both within the NHS and in broader government policy, creates fertile ground for NHS organisations to think differently about their role in a place. If harnessed effectively, it could provide the conditions needed to support greater collaboration to develop communities and take collective action to tackle inequalities and improve the socioeconomic environments needed for good health.

* The NHS Confederation's *Health in all local industrial strategies?* briefing offers examples of how health intersects with local industrial strategies and ways the NHS can engage with LEPs to shape their development around mutual aims. Source: www.nhsconfed.org/-/media/Confederation/Files/Publications/Documents/Health-in-all-local-industrial-strategies.pdf

Learning from practice

Partnering with other anchor institutions across a place

1. Developing anchor collaboratives and networks to support shared approaches locally

Anchor institutions in several UK cities have started to work more closely to combine their influence and scale impact in local communities. This has often taken a range of forms including collaboratives, networks and economic coalitions, with shared objectives around a common anchor mission.

For example, in Sheffield the NHS has joined with local universities, housing associations, colleges, the city council, chamber of commerce and voluntary sector organisations to drive a collective commitment to building a more inclusive local economy. Led by the city council, the Sheffield City Partnership has developed a framework with a vision, commitments and shared objectives for implementing a city-wide approach to: education, skills and work; environmental sustainability and inequality; procurement; and homelessness and violent crime.[158] The framework provides focus for working together around an anchor mission. It is also being underpinned by extensive engagement with local people to help identify what an inclusive economy would mean for them, and help define common standards and indicators to help track progress and ensure that resources are invested in the areas that could bring the greatest community benefit.

While the potential benefits of greater collaboration between anchors are clear, a range of structural and contextual factors conspire to make partnering around an anchor mission difficult. For one, each anchor has different accountability and governance mechanisms that affect their ability to develop and implement anchor strategies. Across each category of anchor activity, organisations will be accountable to different stakeholders, require different administrative processes and have different financial constraints, affecting their ability to work together across a place.[159]

Having a clearly defined geographical area can help focus efforts,[160] but the geographical footprint and population that each anchor works to, even when in the same locality, can vary.

> ‘We are all trying to get the best spend of our local pound, really, but there are challenges with that. We have different footprints – at the trust we are part of the ICS footprint, which is a different footprint from the city region. So, we have this constant footprint debate, which plays out when you’re trying to articulate the governance framework, the accountability, the permissions, and who has the authority to make decisions.’
>
> **Deputy chief executive**
> Acute provider trust

This is why stakeholders have emphasised that when developing collaborative approaches, it can be helpful to be flexible, by establishing common objectives and minimum standards for advancing anchor goals but allowing each organisation to determine the most appropriate path to implementation.

Without pre-existing relationships, collaboration at any level is even harder,[161] and so a first step for anchor institutions is to find the time and space to foster working relationships. The exact method will vary, but it is often less about setting up new forums or mechanisms for collaboration and more about identifying those places where different anchor institutions already come together and using those as building blocks to build alignment around an anchor mission. In the current context, this may include health and wellbeing boards, local partnership boards, LEPs, or STP and ICS boards. Regardless of the forum, stakeholders emphasised the need to have the space and time to co-develop a shared vision to drive successful collaboration.

> 'There are a lot of potential benefits to STPs and ICSs for developing anchor partnerships and approaches, but I don't think we've realised them yet… But we probably just haven't had enough space and time to think all that through well.'
>
> **Non-executive director**
> Acute trust

Building these relationships undoubtedly takes significant time, and it can be difficult to establish trust, respect and mutual understanding in the short term. Evaluations of the Greater Manchester devolution deal found that Manchester's strong sense of place and 30-year history of partners working together was pivotal to delivering the plan and linking up policies to improve population health and wellbeing.[162]

Given the different structures and focus of anchor organisations, it can also be difficult to know the best level at which to engage within each organisation around place-based strategies. Interviewees from outside the NHS said it is not immediately clear who holds responsibility or the most relevant expertise. Having a designated anchor or sustainability lead within NHS organisations can help, as it makes it obvious who to start conversations with, in cases where the NHS has not always taken part (for example, as part of LEPs).

Relationships have also been helped by working with third-party organisations who can act as a convener and facilitator and provide much-needed additional capacity to support partnership working. For example, the Joseph Rowntree Foundation has worked with Leeds[163] (see case study 7) and CLES with places like Birmingham and Preston to bring different anchors together to provide forums for discussion and develop a common approach.[164]

Local government has also frequently been an important driver of cross-sector collaboration, as in Sheffield, where councils have linked anchor partnerships to broader strategies around supporting more inclusive community development. NHS stakeholders

we interviewed noted that when working in partnership, it is essential to recognise the value and expertise that other sectors bring, and be willing to work as equal partners alongside other sectors:

> 'You know, (NHS organisations) should be partners, and we are partners with our local community. We shouldn't be putting ourselves up on a pedestal, and then there's a risk of that sometimes … we have a lot to contribute to the local growth agenda and the sustainability agenda, but we should do that in partnership.'
>
> **Deputy chief executive**
> Acute trust

Collaborative anchor approaches have been developed in procurement, where NHS organisations are working with other anchors to maximise the social value of public spend. Adopting joint progressive procurement strategies can help retain more money locally while also sending a collective market signal that social objectives are a priority, which can influence supplier behaviour.[78] For example, in Birmingham, partners across the STP have agreed to apply a 10% social value weighting in their contracts and use procurement to meet shared social aims, including increasing the number of apprenticeships, recruiting more people from vulnerable populations and lowering carbon emissions.[165]

By working collaboratively, anchor organisations can help build a common language for social value and reduce variation in how the concept is understood and applied in practice across a health economy. Interviews with stakeholders revealed that commissioners and providers often use a mix of approaches that contribute to a lack of clarity in how to interpret social value while also unnecessarily duplicating efforts. For instance, in one local area, a trust had to respond to two local authorities with different requirements for social value to deliver the same sexual health service:

> 'The service specification looked exactly the same, but we had to report different types of evidence to show how we would meet standards for social value. This required a degree of expertise in how to respond to contracts, that thankfully we had, but not all providers do. It also created inefficiencies without changing anything fundamental about our approach to social value or increasing the community benefit we would bring in the way we delivered the service.'
>
> **Head of sustainability**
> Acute trust

STP and ICS leadership can help establish common standards while reducing duplication by coming up with contracting templates that can be adapted by anchors across the partnership.

Case study 7: Leeds City Region anchor framework

In Leeds, anchor organisations from across the city have formed an anchors collaborative and agreed common goals for supporting inclusive development. Working with the Joseph Rowntree Foundation, the collaborative developed a tool for partners to self-assess how they perform on five anchor dimensions (employment, procurement, capital, service delivery and corporate responsibility), visualise where they want to be and identify what actions they can take to get there. The framework has also helped anchors establish common goals and have a broader impact by sending a powerful collective signal to the local economy that narrowing inequalities and supporting inclusive economic development are priorities. To support this effort, Leeds City Council has also created a data dashboard so that areas with the greatest needs and inequalities can be targeted.[166]

Though the framework establishes clear goals and specific actions for all partners, flexibility in how the tool is adapted and applied within each organisation is key.

Case study 8: Birmingham anchor network

A new network has formed in Birmingham to explore how six anchors can work together, including Queen Elizabeth Hospital, Birmingham City Council, the police, University of Birmingham, local colleges and the local housing association.[167] This network builds on work these organisations have done with the Centre for Local Economic Strategies (CLES) funded by the Barrow Cadbury Trust to map their collective assets and understand their baseline contribution to the Birmingham and West Midlands economy.[167] With combined annual budgets of £6bn and more than 50,000 employees, the network will support anchors to develop individual strategies and advocate for an anchor approach on workforce, procurement and management of land and assets.[168] One collective priority is around construction, as a significant proportion of money leaks from the local economy from new building projects, and the upcoming Commonwealth 2022 games in Birmingham present an opportunity to shift practice. The network is also developing ways to measure the impact of different approaches to better understand how anchor practices can benefit communities.

Partnering with other NHS anchors

1. Developing networks to support shared learning and spread good practice

In addition to coming together across a place, there is an opportunity for NHS organisations to work together to develop their collective identity as anchor institutions to tackle common issues. Peer networks can be a powerful tool in generating knowledge and supporting a culture of learning.[169] However, there is currently no formal network of health care anchors in the UK. The NHS Confederation and the SDU have been convening NHS organisations to facilitate shared learning, provide expertise and develop skills

around local economic development and environmental and social sustainability,[170] but our interviewees felt there could be more collaborative networks and communities of practice to help make an anchor mission an institutional priority across the NHS.

In the United States, The Democracy Collaborative (TDC, which supports a network of more than 40 health care systems) could serve as a model for the NHS. These health systems together employ 1.5 million people and purchase over $50bn worth of goods and services annually. The network allows health care organisations to share knowledge, work through common challenges, identify areas for joint working and co-develop tools that can be adapted by each organisation to accelerate progress.[171] A key aim is to help members drive culture change within their respective organisations and adopt more intentional and conscious anchor strategies within their health system's overarching strategy. Since its inception, members have implemented changes in their local areas, including investing in affordable housing, committing to living wages for all staff and creating new career pathways for non-clinical entry-level roles.

In the UK, there are also examples of anchor collaboration within other sectors. For instance, 37 vice-chancellors recently signed a Civic Universities Statement Agreement pledging to prioritise the social, economic, environmental and cultural life of their local communities. This includes specific commitments to collaborate with each other and other anchor institutions to support their aims.[172] There are also dedicated programmes and networks in local government,[3] housing,[173] and the arts and culture sectors.[174]

Summary and implications for practice and policy

NHS organisations can work with each other, and with other anchor organisations across a place, to share learning and establish common goals so that the anchor mission more directly informs how the NHS functions within a place. As many of the examples have demonstrated, where individual institutions have come together to collaborate on a shared vision and work together to hold each other to account, the benefits can be significant.

There is a real opportunity to capitalise on STPs and ICSs to help the NHS forge new partnerships across a place and develop shared approaches and anchor strategies as part of broader system plans. Anchor strategies may also provide a gateway for the NHS to take part in other place-based strategic discussions, including with LEP, to help align approaches with broader economic proposals that improve the health and wellbeing of communities. National leaders should work with partners to create space for NHS organisations to come together to share and spread ideas through action learning and to work through challenges unique to the NHS context.

Practical resources to support implementation

A Partnership Framework for an Inclusive and Sustainable Economy (Sheffield City Partnership)

Anchor Collaboratives: Building Bridges with Place-Based Partnerships and Anchor Institutions (The Democracy Collaborative)

Community Wealth Building Through Anchor Institutions (Centre for Local Economic Strategies)

Health In All Local Industrial Strategies? (NHS Confederation)

Healthcare Anchor Network (The Democracy Collaborative)

Leeds City Region Anchor Institution Progression Framework (Leeds City Council)

Local Growth Academy (NHS Confederation)

Learning from other sectors

Civic University Agreements – List of Signatories (Civic University Commission)

Great Places Commission Interim Report (National Housing Federation)

Inquiry into the Civic Role of Arts Organisations. Phase 2. What Happens Next? (Calouste Gulbenkian Foundation)

Leading Places programme (Local Government Association)

Local Access (Big Society Capital and Access)

Conclusion: actions and opportunities for change

Consciously adopting an anchor mission

In this report we have explored a range of opportunities for the NHS to harness its considerable influence to have an even greater impact on the health and wellbeing of communities. There are many anchor activities already taking place across the sector that provide an important foundation on which the NHS can build. NHS organisations are all at different stages in embracing their role as anchors, but where strategies are being adopted, they tend to be discrete and narrow in scope, rather than joined up and embedded as part of central, local system or organisational strategies. Anchor approaches are often being applied in one area only (for example, workforce). While NHS organisations will have to start somewhere, the greatest impact will come from pursuing changes in each domain of anchor influence and with other anchors and partners across a place. It is also the case that anchor practices are not yet being evaluated systematically to understand what actions have the strongest impact on population outcomes. More needs to be done to help NHS organisations cultivate an anchor mission and know where to prioritise efforts, both within their organisations and in their local communities.

This report has also identified cross-cutting opportunities – regardless of the area of anchor activity being pursued – to make anchor practices more embedded in the NHS, and these are summarised below. While most actions will be delivered at the level of NHS organisations and networks, national, regional and local system leaders have a strong role in signalling the anchor mission as a priority and supporting an environment where these changes can happen. These opportunities are set out in Table 4.

Adopting new ways of working for an anchor mission requires time, resources and upfront investment that can be hard for NHS organisations to come by. The report has highlighted tensions the NHS may have to work through to balance priorities and direct its anchor efforts (described in Table 3). These tensions play out at different levels of the system and are not always inevitable, but when they do arise can often be mitigated or managed with careful implementation and planning. For instance, the NHS can boost international recruitment to address shortages in certain jobs and geographies while also taking steps to increase local workforce supply over the long term. The examples given throughout the report show how the NHS can shift practice by taking a pragmatic approach and aligning anchor practices with other system goals.

Table 3: Potential tensions between anchor practices and the current policy/ practice context

Anchor practices	Tensions to balance
A desire to develop the local labour market and create pipelines into NHS jobs and careers.	The need to fill vacancies quickly to address severe workforce shortages requires a focus on external labour sources, including international recruitment.
An aspiration to increase social value by taking a wider range of factors into account when making decisions on purchasing and procurement.	A push to reduce costs and increase efficiency, given the wider economic climate and financial pressures on the health service.
A desire to increase capability in the local supply chain, leading to more local purchasing and procurement.	A need to avoid potentially anti-competitive behaviour.
A focus on developing strong and resilient local places in specific geographical areas.	The risk of widening inequalities (as those places with the largest or best-resourced anchors will benefit most and may draw resources away from neighbouring areas).
A desire to allow flexibility for NHS anchors to adapt activity to meet local context and local needs.	A national drive for greater standardisation of activities to reduce variation.

What can the NHS do now to develop its role as an anchor?

1. Build a baseline understanding of current practice to know where to prioritise action and establish informed goals.

Data are key to helping organisations understand their baseline levels of activity and assess their readiness to change. Baseline audits can generate information on purchasing behaviour, use of estates, employment practices and environmental impact. This can then inform goal-setting and targets for shifting behaviours based on current levels of practice.

Baseline data can also help signal where there may be more immediate opportunities and where change will have to happen over the longer term. NHS organisations may find it easier to start in domains such as employment, where there is clear data on vacancies and local unemployment to show where to target efforts, and where anchor actions align with broader organisational strategies. Within procurement, NHS organisations can use data to establish achievable targets of how much spend can be shifted locally, identifying which contracts are up for renewal that may lend themselves to working with local suppliers. People with improvement skills are well placed to support the development of aims and measures to inform goals, and the ability to facilitate change.

2. Develop metrics and evaluate the impact of interventions

Data are also vital for measuring the impact of interventions and building the business case for future investment. National leaders can help establish metrics in each area of anchor activity for local NHS organisations and STP/ICS leads to use to assess progress, and fund evaluations of the wider impact and return on investment. This could build on existing work such as the framework developed in Leeds (see page 55) that defines metrics across different anchor dimensions to help organisations measure progress around shared goals. Within procurement, some local system leaders have already defined metrics to help guide purchasing decisions and build an understanding of the broader social impact of public spend (see Chapter 4). STPs and ICSs can help track progress across a place by creating dashboards that pool data from partner organisations and help guide future strategy. Evaluation requires significant resources and time, so it is important that teams are funded and supported with the skills and capacity necessary to use data effectively to inform decision making.

3. Establish clear and visible leadership to embed anchor practices within organisational and system strategies

Leadership is needed at each level of the system to make anchor practices visible and an integrated part of organisational and system strategies. Unless leaders see an anchor mission as a core part of the NHS's role and responsibility to local communities, little will be achieved. At the organisational level, gaining board support will be an essential early step to ensure that efforts are adequately resourced and prioritised over the long term. Nominating a board-level lead for anchor strategy can help cement that support, while raising the profile of anchor practices across the organisation and connecting them up. Beyond board support, having a designated manager – for example, an anchor or sustainability lead – to oversee and coordinate anchor practices across an organisation can be a key driver in getting efforts off the ground and integrating anchor strategies into operating models.

Linking anchor practices to existing organisational priorities and goals can be useful in gaining senior buy-in. For example, showcasing how anchor practices that build local workforce supply or provide more affordable housing for staff can address staff recruitment and retention challenges at the same time as helping to reduce inequalities, can gain traction for these ideas. And when there are tensions between short-term performance pressures and longer-term improvements to population health, having board-level support can give staff the permission and air-cover needed to prioritise practices in support of an anchor mission.

At the local system level, STP and ICS leads have an opportunity to work with system partners to create a shared view around an anchor mission and embed strategies as part of delivery plans. This requires building consensus around common aims and identifying which anchor strategies are best done in partnership to achieve more ambitious and long-term goals. Local system leaders have a role in articulating a clear vision for inclusive development while permitting flexibility for organisations, to account for different contexts.

While most anchor practices will be delivered at the organisational and local system levels, national leaders can be instrumental in helping to shape the collective vision of how the NHS acts as an anchor and setting expectations about its broader role in the local community. The explicit references to anchor institutions in the *NHS Long Term Plan* and *Interim NHS People Plan* are positive developments that help signal the anchor mission as a priority. There may be more opportunities to incorporate an anchor approach into other national frameworks and guidance – for example, through the CCG improvement and assessment framework, or STP/ICS guidance. These frameworks should be backed by proactive support to ensure that teams have the resources and capability needed to support effective implementation. There is also a role for national leaders to help clarify definitions and provide guidance and templates to ensure consistency in anchor practices and how they can be integrated into NHS practice.

4. Enable staff to act on a collective vision for enhancing community health and wellbeing

Change will not happen unless staff are engaged in the anchor mission and have the time, skills and capability needed to embed anchor practices within daily roles. The anchor mission may offer an opportunity to tap into employees' intrinsic motivation, by connecting operational functions like HR, procurement and facilities management to the aims for front-line delivery – that is, improving the health and wellbeing of local communities. One way to do this is to co-produce and design potential solutions directly with staff so that they feel ownership over the challenges and feel part of the collective vision for supporting wider community health and wellbeing.

It is also the case that anchor practices may be new territory for staff, who may need support to incorporate considerations for population health and social value effectively into their daily roles. We have cited numerous resources and tools throughout this report to help staff put these ideas into practice. NHS organisations should use these tools as a starting point, and national and system leaders should ensure that local teams have the skills and capabilities needed to carry out these practice changes and develop methods that support a consistent approach.

Where there are gaps in skills and expertise, working in partnership can also help the NHS build greater capacity. Working with partners can bring different perspectives and skills from outside health care that are invaluable and give NHS organisations greater reach into local communities. Many of the examples of anchor activity we have highlighted involve NHS organisations collaborating with local community, public sector or commercial partners on a specific initiative. Whether this is working with housing associations to ensure that NHS land is developed for affordable housing, or engaging local government around improving public transport for staff and patients, effective partnerships is often a core component of success.

5. Support the sharing and spread of ideas through networks

Sharing knowledge and ideas can help the NHS more intentionally adopt and apply anchor strategies in practice. Networks could add value and support the NHS to maximise its anchor role at different levels: locally, by convening anchors across a place to support

community cohesion, align practices around a shared vision and maximise combined impact; and nationally, to facilitate peer learning and help health care organisations carry out anchor activities more effectively and efficiently.

STPs/ICSs can play a key role in convening and establishing these relationships across anchors in a locality. The introduction of PCNs may also create an opportunity to align operational practices and strategy in general practice around an anchor mission, and feed into broader goals of improving population health at the STP/ICS level. Regional and national leaders are well situated to encourage and support NHS organisations from different localities to convene and share learning and expertise across NHS peers. Whether national or local, networks may benefit from working with an independent third-party facilitator to build consensus and sustain engagement over the long term.

6. Engage proactively with communities to ensure that anchor strategies meet the needs of local people and to maximise impact on narrowing inequalities

Maximising the NHS's contribution to community health and wellbeing requires a deep understanding of local priorities and needs. This means engaging with residents in new ways to explore their needs and developing a shared vision and strategy for how the NHS can be a better partner for and leader in change. For example, being a better and more inclusive employer requires an understanding of the needs of residents who face the greatest barriers to employment. It means getting residents' views on how NHS estate and land can add most value, and creating access to community spaces for those who need them most. This type of engagement requires connecting with people who are seldom heard and poorly served – something that many NHS organisations may not currently be equipped to do, which makes partnership working and local collaboration essential. Local organisations should prioritise this engagement as part of the design and delivery of different interventions, and local system leaders may also be well placed to coordinate engagement strategies across a place.

Table 4: Opportunities for action by different stakeholders

Opportunity	Action	For action by
Build a baseline understanding of current practice to know where to prioritise action and establish informed goals	Conduct internal audits to set targets and goals for shifting practice.	NHS provider organisations and networks*
Develop metrics and evaluate practices to understand the impact of different interventions	Continuously monitor and collect data to track impact of anchor strategies, ensuring teams have the resources and capacity needed to make effective use of data and make evaluation a priority.	NHS provider organisations and networks
	Establish dashboards that pool data and track progress across a place.	Local system leaders†
	Help define metrics for tracking and measuring impact at the local system and organisational levels.	National/regional policy makers‡
Establish clear and visible leadership to embed anchor practices within organisational and system strategies	Designate a board-level lead for anchor strategy and operational lead to help coordinate and align efforts across an organisation.	NHS provider organisations and networks
	Embed anchor strategies as part of local system plans to help deliver broader aims on population health and prevention.	Local system leaders
	Establish clarity around common definitions to build system understanding of what anchor practices look like, and how they support broader social value and community benefit.	National policy makers
	Send clear signals through national policy, guidance and frameworks that the anchor mission is a priority for the NHS.	National policy makers

* Trusts, GP practices, PCNs, etc.

† STP/ICS leads, CCGs, etc.

‡ NHS England and NHS Improvement, for example.

Enable staff to act on a collective vision for enhancing community health and wellbeing	Co-design solutions directly with teams, appealing to intrinsic motivation among staff.	NHS provider organisations and networks
	Use existing tools, resources and guidance to build capability, awareness and knowledge around anchor practices.	NHS provider organisations and networks
	Work in partnership with other organisations that may have greater community reach or skills and expertise to support implementation of anchor practices.	NHS provider organisations and networks Local system leaders
	Deliver support programmes that equip teams with the resources, skills and expertise needed to operationalise anchor practices and strategies.	National policy makers Local system leaders
Support the sharing and spread of ideas through networks	Establish place-based networks that convene anchors across a locality to develop a shared vision and objectives for improving community health and wellbeing.	Local system leaders
	Encourage and support NHS organisations to convene through networks to learn and share practice for applying anchor strategies in the NHS context.	National policy makers
Engage proactively with communities to ensure that anchor strategies meet local needs and to maximise impact on narrowing inequalities	Work in partnership to engage with communities, particularly seldom heard groups, to ensure that all residents have a voice in shaping anchor approaches and strategies.	Local NHS providers and networks Local system leaders

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The Health Foundation is an independent charity committed to bringing about better health and health care for people in the UK.

Our aim is a healthier population, supported by high quality health care that can be equitably accessed. We learn what works to make people's lives healthier and improve the health care system. From giving grants to those working at the front line to carrying out research and policy analysis, we shine a light on how to make successful change happen.

We make links between the knowledge we gain from working with those delivering health and health care and our research and analysis. Our aspiration is to create a virtuous circle, using what we know works on the ground to inform effective policymaking and vice versa.

We believe good health and health care are key to a flourishing society. Through sharing what we learn, collaborating with others and building people's skills and knowledge, we aim to make a difference and contribute to a healthier population.

The Health Foundation
8 Salisbury Square, London EC4Y 8AP
T +44 (0)20 7257 8000
E info@health.org.uk
@HealthFdn
www.health.org.uk

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NHS CONFEDERATION

A MANIFESTO FOR THE NEW PRIME MINISTER

A view of the NHS in 2019 and a prescription of priorities for health and social care

JULY 2019

The NHS Confederation

The NHS Confederation is the membership body that brings together and speaks on behalf of all organisations that plan, commission and provide NHS services in England, Wales and Northern Ireland. We support our members by:

- being an influential system leader
- representing them with politicians, national bodies, the unions and in Europe
- providing a strong national voice on their behalf
- supporting them to continually improve care for patients and the public.

About this briefing

The NHS Confederation and its networks have jointly compiled this briefing for the new Prime Minister, the Rt Hon. Boris Johnson MP.

This briefing sets out seven key challenges for the NHS in 2019 and beyond including, funding, social care and the NHS in a post-Brexit world.

The NHS Confederation looks forward to working with the Prime Minister and Secretary of State for Health and Social Care to overcome the challenges and deliver better outcomes for patients in the months and years ahead, as set out in this prescription of priorities for health and social care.

Key points

Realising the aims of the NHS Long Term Plan

- The UK Government must ensure that sufficient funds are available to pay for aspects of the health and care service not covered by last year's £20.5 billion boost in NHS England funding in order to achieve the goals of the NHS Long Term Plan. These include capital spending, training and education budgets, public health and social care.
- Supporting the evolutionary approach to reform set out in the plan will help develop the necessary local relationships between the NHS, local government and voluntary and private sector providers.
- Prioritising legislative reforms that will improve mergers and acquisitions policy, simplify commissioning requirements (including procurement), and facilitate joint working will be welcome.

Harnessing the benefits of local leadership

- There is an opportunity for the new Prime Minister to act as a champion for local health and care systems, which promise to ensure health and care services are better rooted in communities and more tailored to the needs of local populations.
- Senior politicians can show leadership by supporting local health and care leaders to make meaningful decisions about how services should be organised, within the parameters of an effective regulatory framework.
- The government should avoid making any changes that will have the effect of further centralising decision making with the arm's length bodies, given the emphasis on local leadership in the Long Term Plan.

Supporting the NHS workforce

- Given the potential impact of the pension annual allowance taper on the availability of senior clinical staff, the government should either reform aspects of the tax system or the NHS pension scheme to rectify this problem.
- The 2019 spending review must set a realistic budget for Health Education England to restore investment in training clinicians, facilitate recruitment and retention programmes and mitigate the effects of the loss of the nursing bursary.
- Better value could be achieved by using some of the apprenticeship levy funding to support a wider range of training activities to help deliver successful apprenticeships.
- Integrated care systems should be further empowered to better influence their local labour market, with devolved powers over strategy and planning, supply and retention and deployment.

Achieving financial sustainability

- The UK Government should invest in NHS education, training and staff development beyond 2020/21 to help the NHS attract and retain new staff.
- The government should commit to greater capital investment to arrest the decline in NHS estates and facilities, and to enable NHS leaders to modernise services.
- Without improved public health funding, the progress of the prevention agenda within the Long Term Plan will be undermined, leading to more serious and costly health need in future.

Maintaining progress on mental health

- Previous pledges to increase mental health funding should be acted on, with funding reaching the front line.
- Leaders should capitalise on young people's interest in mental health by opening more avenues into mental health roles and expanding the number of mental health places available at medical and nursing schools.
- The new Prime Minister should support the publication of the forthcoming white paper in response to the independent review of the Mental Health Act and commit to bringing forth a new mental health bill.

Creating a sustainable social care system

- Eligibility for social care services should be widened and based on need instead of means to pay.
- Any new settlement should provide secure, long-term funding at a level that enables the social care system to operate effectively and deliver the outcomes that people want and need.
- There needs to be both short term funding increases to cover immediate gaps in provision and a long term financial settlement.

Mitigating the risks of Brexit

- Medical supply chains should be protected to ensure that the import and export of medications between the UK and the EU can continue after Brexit. At present, this represents 45 million 'patient packs' (items of medication) leaving the UK and 37 million entering the UK each month.
- Reciprocal healthcare should be honoured so that 190,000 UK pensioners living in the EU continue to receive healthcare in the member state in which they reside.
- Without workforce agreements in place, the NHS could be short of 51,000 nurses by the end of the Brexit transition period. And in social care (which has become increasingly reliant on EEA nationals), the sector will struggle even more.

Introduction

It is a time of unprecedented challenge and opportunity for health and care services. During a prolonged period of constrained funding and against a backdrop of escalating demand for services, the NHS has taken significant steps to improve its efficiency. Social care has faced even greater funding pressures, resulting in a reduction in the availability of care services across England and Wales.

Recognising that this was not a sustainable position from which to approach the next decade, NHS England in January published a new ten-year strategy for the NHS, the NHS Long Term Plan. This strategy builds on previous policy goals around boosting community provision, expanding ambulatory care and making services more joined up to improve the experience of patients in order to reduce reliance on hospital-based services. The plan includes a welcome focus on some clinical priorities where there is the potential to improve outcomes. These include mental health, children's health, cancer, cardiovascular disease, maternity and neonatal health, stroke, diabetes and respiratory care.

The mechanism for driving improvement set out in the Long Term Plan is to empower local systems encompassing health and care providers and commissioners to take the lead in developing solutions tailor made for the populations they serve. This emphasis on local leadership has been warmly received within the NHS, on the basis that only by genuinely empowering leaders to use their local knowledge will we be able to drive further significant improvements and efficiencies in the way we organise and provide services.

The Long Term Plan has been well received within the NHS, but there are some enduring challenges. Funding for social care, public health, workforce, training and capital remains unresolved, and will need to be addressed in a government spending review. NHS England has identified some legislative reforms which may be useful to accelerate delivering the Long Term Plan, but these will need to be adopted sensitively. Unless serious and systemic problems relating to social care provision, workforce and NHS capital spending are addressed, any have the potential to derail the Long Term Plan's success. Brexit is another issue of high significance to the NHS in terms of its potential impact on staffing, access to medicines and clinical trial availability.

Provided these challenges are addressed, there is an opportunity for the new Prime Minister to champion the work underway under the Long Term Plan, while leading a radical reshaping of the nature of social care provision in England.

Realising the aims of the NHS Long Term Plan

The NHS remains an iconic and highly valued element of the UK's public service offer. However, our population is ageing and more people are living for longer, often with multiple long-term conditions.

Over the last five years, the health service has performed well, maintaining services and delivering significant improvements in care in spite of huge increases in demand and little extra funding. The NHS has been treating more patients within most of the constitutional standard areas, but for many years it has been unable to meet key waiting time targets. The Powis Review, which published an interim report in March, is in the process of reviewing clinical standards to ensure they are appropriate for current clinical practice, but it's important that any future changes to NHS waiting times targets do not dilute patient access to care. Many NHS organisations throughout England have also been unable to balance their books.

An ultimate objective of the Long Term Plan is to enable NHS organisations to get back on track financially and to return to previous high levels of performance against clinical standards. That said, the plan is not solely about responding to challenges. It puts in place the foundation to adopt new technologies and to improve quality and safety for patients, for instance through adopting new models of provision such as primary care networks and same day emergency care.

The NHS Long Term Plan therefore arrives at a critical point for the NHS. The plan's more ambitious elements raise the prospect of a health service which embraces the digital era and radically changes the way care is provided. Many of the plan's recommendations involve ramping up progress in areas such as care coordination and increasing provision in the community in order to reduce reliance on services provided in hospitals. These changes are widely recognised as being important for effective, modern healthcare that can respond to rising demand over the next decade as well as improving public health and tackling health inequalities.

Following publication of the Long Term Plan, NHS England and NHS Improvement (the two national arm's length bodies with responsibility for how health and care services are delivered) announced a series of proposed legislative changes designed to remove some existing and perceived barriers to collaboration. The main purpose of these was to remedy aspects of the 2012 Health and Social Care Act that were introduced when the realities on the ground facing health and care services were very different.

The main vehicle to achieve this is local health systems, known as integrated care systems (ICSs), which will see local leaders driving forward service improvements and population health outcomes, based on an assessment of what is needed in their areas. Championing these measures offers an opportunity to lead a reform programme that capitalises on local health and care leaders' expertise in serving their populations.

As health and care leaders work to implement the Long Term Plan's goals, we recommend the following steps for a new government:

1. Ensure the NHS has the necessary resources to deliver the plan

The £20.5 billion funding boost for the NHS announced by former prime minister Theresa May represented a welcome and necessary injection of cash into a stretched system. But funding arrangements for several critical areas of health service spending remain unresolved, as they fall under the remit of the comprehensive spending review. The UK Government should ensure that the necessary resource is provided in the spending review to ensure sustainable approaches to social care, public health, workforce, training and capital spending. The significance of this extra funding is addressed in more detail in sections 4 and 6 of this document. There is a real risk that if the spending review does not address the challenges in these areas, the plan itself could fail.

2. Support the health and care system to transform while ensuring sustainability of provision

One of the most successful elements of the Long Term Plan is that it takes an evolutionary, rather than a revolutionary, approach to reforming the health service. The NHS has undergone radical reform over the last decade. Our members have told us there is no appetite for a top-down reorganisation of the NHS.

The continuity underpinning many of the commitments in the plan, along with adequate funding, will be important factors in the ability of health and care leaders to stabilise the system and ensure its sustainability. Health and care leaders have identified the importance of giving new systems space and time so that strong and effective partnerships between the NHS, local government, third sector and private providers of health and social care services described in the plan can reach fruition. Supportive encouragement of the development of this, rather than further reform, will be important to ensure that the NHS has the best chance of achieving stability.

3. Facilitate greater local collaboration

The proposed legislative reforms facilitate greater local collaboration. Our members support removing merger and acquisition oversight of trusts by the Competition and Markets Authority (CMA), but also believe that changing procurement duties to remove section 75 requirements and introducing a 'best value test', will make a positive contribution to achieving more joined up local systems.

Commissioners and providers have said that making procurement less burdensome will be welcome, but it is important that commissioners retain the ability to secure the best possible services for patients, whether from an NHS, independent, voluntary sector or social enterprise in order to deliver value for money from the new funding.

We support in principle introducing integrated trusts in England, allowing the creation of joint committees, and simplifying commissioning arrangements including to allow joint commissioning for some functions. However, for each of these changes, we need to proceed at an appropriate pace and to be clear that the replacement approach would not introduce other difficulties. For example – when creating joint committees between commissioners and providers, it's important the unique role of clinical commissioners is not undermined.

Harnessing the benefits of local leadership

Achieving the changes set out in the Long Term Plan for the NHS in England requires a shift in emphasis from the historic 'top down' model of NHS management to an approach which is more locally led. NHS England and NHS Improvement are spearheading this transition.

The main vehicle in the Long Term Plan for achieving locally-led change is the integrated care system (ICS). This is a local partnership, encompassing NHS provider and commissioner organisations, local authorities and others, which takes collective responsibility for managing resources, delivering NHS standards and improving the health of local people through prevention and public health measures. The ICS approach is relatively new – at present, more than a third of England's population is covered by an ICS, but it is intended that there will be full coverage by 2021.

Steps that ICSs can take to address the fundamental challenges facing the NHS include making more services available closer to people's homes, making sure patients with multiple conditions experience more 'joined-up' care, and focusing effort on preventing people from getting ill in the first place, where possible. ICSs are significant because they provide a forum for joint strategic decision making that has not previously been available at a local level, and also because they emphasise the clinical voice in these strategic decisions.

The NHS Confederation supports the approach set out in the Long Term Plan for the NHS in England. There are three ways in which we would urge a new government to help drive forward this agenda:

1. Advocate for approaches that empower local leaders to make decisions about what is needed in the health systems they run

There is an opportunity for the new Prime Minister to act as a champion for these emerging systems, which promise to ensure health and care services are better rooted in communities and more tailored to the needs of local populations. Doing so would help to raise the profile of this work and to increase the momentum behind the changes.

2. Champion local leaders as they put in place the machinery to effect change

Perhaps the most well-received element of the Long Term Plan is its emphasis on allowing the knowledge and expertise that exists within health and care systems to service improvement through meaningful local partnership.

There is sometimes an understandable desire in Whitehall to see greater standardisation across the service, as well as a strong push from the Treasury to see measurable results from the additional investment. But this can be at the expense of solutions that are genuinely responsive to local circumstances. Senior politicians can help local leaders by supporting them to make meaningful decisions about how services should be organised, within the parameters of an effective regulatory framework.

3. Politicians can empower local health leaders

The UK Government should avoid making any changes that will have the effect of further centralising decision making with the arm's length bodies, given the emphasis on local leadership in the Long Term Plan.

Supporting the NHS workforce

With a significant shortage of more than 100,000 staff, including 40,000 nurse vacancies, the case for greater investment in education and training for both existing staff and new entrants is compelling. A recent survey of our members in England emphasised the magnitude of concern NHS leaders have that they will be able to meet increased demand for staff with 65 per cent saying they were not confident that they would be able to achieve this. In addition, recent decisions around pension reform led to senior clinical staff reducing their availability in order to avoid large tax penalties on pensions, compounding staffing issues.

We urge the UK Government to prioritise the following issues:

1. Pension reform

The annual allowance, which limits the amount of tax relief on pension saving, has been a growing problem for members of the NHS Pension Scheme in England and Northern Ireland. The annual allowance has reduced substantially over time; tapering of the standard annual allowance was introduced and employees are exhausting their carry-forward of unused annual allowance from prior years. This has resulted in some members of the scheme receiving large and unexpected tax bills. There are two potential solutions: reforming the tax system or reforming the NHS Pension Scheme. We would welcome urgent engagement on this issue with the Treasury.

2. Policy which supports recruitment to social care and health

There are widespread concerns about the ability of the NHS to plug the workforce gap. In line with the commitments given in NHS England's Interim People Plan, it is of vital importance that the 2019 Spending Review sets a realistic budget for Health Education England to restore investment for continuing professional development and consider other potential financial incentives to attract people into training following the end of the nursing bursary. Moreover, there must be a long term migration policy which enables recruitment of vital social care and health staff.

3. Apprenticeship Levy

Better value could be gained from this levy if employers in the NHS were able to use some of the levy funding to support a wider range of training activities to help deliver successful apprenticeships. We also recommend allowing the use of the levy to support backfill for apprenticeships that require significant supernumerary time as part of their training.

4. Locally- led workforce strategy

A one-size-fits-all approach to developing our workforce is no longer the best way for the NHS and social care. In line with other areas of responsibility, there needs to be greater influence and accountability for workforce at local level. This is central to the broader Integrated Care System agenda.

Achieving financial sustainability

For some time, the NHS provider sector has been operating with a deficit. In 2018, the NHS Confederation commissioned the report *Securing the future* to model the funding needs of the country's health and care system over the next 15 years. Subsequently, the government dedicated an extra £20.5 billion to the NHS in England by 2023, representing a 3.4 per cent real-terms increase in annual funding for NHS England and an annual increase of 3.9 per cent for social care.

We welcome this additional funding, but we fear it will not be enough to drive the improvements and innovation in health services that the public rightly expects. For health services to be truly improved, The Health Foundation and the Institute for Fiscal Studies calculated a 4 per cent real-terms increase in public spending on both the NHS and on the health sector at large would be required. The £20.5 billion does not address areas of need such as capital investment, public health, social care, workforce, education and training, which fall under the remit of the comprehensive spending review.

The Long Term Plan seeks to remedy this financial challenge in part through service level change, but the scale of the task is significant, and steps will need to be taken separately in order to improve the financial stability of the service. In particular, we support plans to move beyond the current control total approach to a system which takes better account of the realities facing different NHS organisations.

Our recommendations for the financial challenge:

1. Invest in education, training and staff development

With the NHS suffering from a shortage of more than 100,000 vacancies and with Health Education England having seen its budget cut by 24 per cent since 2013/14, the case for greater investment in education and training could not be more compelling.

2. Fund capital investment to modernise services and improve efficiency

Capital investment in buildings, equipment and IT has been cut in recent years due to rising pressures on daily running costs within the NHS. Capital per worker in trusts reduced by 17 per cent between 2010/11 and 2017/2018. In a recent survey of NHS Confederation members in England, 85 per cent said that a lack of NHS capital investment has inhibited the ability of local systems to deliver the goals of the NHS Long Term Plan. Unless the UK Government commits soon to greater capital investment, the health service's current maintenance backlog of more than £6 billion will grow and local NHS leaders will remain unable to modernise services and facilities.

3. Deliver resources for public health to realise the vision of prevention

The public health grant has been reduced in real terms by £850 million since 2014/15. This is equivalent to a reduction in the grant of 23 per cent in real spending per person over the past five years. In our recent survey of NHS Confederation members, 80 per cent stated that reductions in public health spending have restricted the ability of their local system to deliver NHS services either "somewhat" or "to a great extent". Without improved public health funding, the prevention agenda of the NHS Long Term Plan will be greatly undermined, leading to an accumulation of health problems which could be prevented now and will instead have to be addressed in the future at greater expense.

Maintaining progress in mental health

We welcome the increased policy focus on mental health services since 2010. This includes the introduction of the first ever national waiting times standards in mental health and legislating for parity of esteem. However, a large care deficit still exists, with fewer than four in ten people who need support accessing it.[1] We are also detaining more and more people every year under the outdated Mental Health Act and the racial disparities in detention rates are unacceptable.

The commitments in the Long Term Plan to increase the spend on mental health as a proportion of the entire NHS budget, and to increase the proportion of the mental health budget that is spent on children and young people is a step towards true parity. There exists an exciting opportunity to build on the many positive advancements in mental health awareness and provision in recent years. In order to achieve this, we propose that you consider three key areas of importance.

Priorities for mental health:

1. Workforce

Mental health sees some of the highest vacancies in the NHS, especially in mental health and learning disability nursing. We should capitalise on young people's interest in mental health by opening additional avenues into the sector, expanding the number of places in medical and nursing schools, reviewing the impact of tuition fees on mental health nursing and work through all levels of education to promote mental health careers. We also need to better support the mental health and wellbeing of the entire workforce and take action to encourage more staff to stay working in the health and care system.

2. Funding

Previous pledges made on mental health investment need to be followed through and the additional funding must reach the frontline. Capital funding, vital for implementing the Long Term Plan and the recommendations of the Independent Review of the Mental Health Act must be provided as part of the forthcoming Spending Review, and increased investment is needed in mental health research to identify the most effective interventions.

3. Mental Health Act reform

The new Prime Minister should support the publication of the forthcoming white paper in response to the Independent Review of the Mental Health Act and commit to bringing forth a new Mental Health Bill during this parliament.

1. The Mental Health Policy Group (2019), *Towards mental health equality: A manifesto for the next Prime Minister*

Creating a sustainable social care system

We warmly welcome the commitment made during the new Prime Minister's leadership campaign to solving the social care crisis via a cross-party approach. With 1.4 million older people unable to access the support they need, 58 per cent of people over 60 living with at least one long-term condition and an ageing population, the challenges facing social care are significant and will require strong and bold leadership.

Health and social care must be viewed as a singular, integrated system that has at its heart the wellbeing of the entire UK population. The NHS Confederation is leading a coalition of 15 health organisations calling for reform to secure the future of the social care sector. Without reform and investment in social care, we risk putting the ambitions of the NHS Long Term Plan at risk.

Our recommendations for social care are:

1. Widen eligibility

Eligibility should be based on need and must be widened to make sure that those with unmet or under-met need have access to appropriate care and support. Around 2.1 million people in the UK were estimated to have received some level of informal care in 2014, but the number of family and friends providing unpaid care in England increased from 4.9 million in 2001 to 5.4 million in 2011. Moreover, Age UK have identified that at least 1.4million people have unmet or under met need.

2. Secure a long-term settlement

Any new settlement should provide secure, long-term, funding at a level to enable the social care system to operate effectively and deliver the outcomes that people want and need. The settlement needs to address immediate needs from April 2020, as well as putting the social care sector on to a sustainable path for the longer term. That will require the right funding, workforce and a diverse and stable market of providers. This will need to be supported by good quality, trusted information and advice to help people navigate the care system effectively. The Spending Review presents an essential opportunity to invest in social care at the same scale as the gGovernment is now investing in the NHS.

3. Reform and integrate services

A recent report commissioned by the NHS Confederation, and undertaken by the Institute for Fiscal Studies and the Health Foundation, calculated that social care is facing high growth in demand pressures, which are projected to rise by around £18 billion by 2033–34. That means social care funding would need to increase by 3.9 per cent a year to meet the needs of an ageing population and an increasing number of younger adults living with disabilities. We recognise that any significant additional funds must be accompanied by reform and improved service delivery. Social care services and the NHS are working together to transform and integrate local care services, but they can only go so far when services are being placed under so much strain.

Mitigating the risks of Brexit

Patients must not suffer because of the Brexit process. We recognise the enormous effort that has gone into making these plans as robust as possible. But the truth is that much of this is outside of the control of the NHS and our members; that is why we continue to advocate a negotiated deal which will provide maximum protection for patients.

Around three quarters of our medicines and over half our clinical consumables come from, or via, the European Union and so it is vital that the supply chain continues to work.

We have worked closely with the Department of Health and Social Care, to make sure that we are in the strongest possible position once the UK leaves the EU. Under the Brexit Health Alliance, we have been working with industry to make recommendations to government on Brexit. And as part of the Cavendish Coalition, we have been addressing the implications of Brexit for the health and care workforce. While we will continue to work with the Department of Health and Social Care and others to prepare the sector for all scenarios, there should be no illusions about the severe implications of no deal for the NHS.

Brexit also has unique challenges for the NHS Confederation's members in Northern Ireland, including concerns around the land border with the Republic of Ireland. Specifically, measures will need to be put in place to minimise the impact of Brexit on staff who live in the Republic of Ireland and work in Northern Ireland, as well as supporting the continuation of cross border services that are already in place. The lack of devolution and the current incapacity to make political decisions remains of significant concern in Northern Ireland at such a complex time of change.

The key risks of no-deal Brexit:

Medical supply chains

45 million patient packs go to the EU from the UK every month, and 37 million patient packs go to the EU from the UK. In the short term, there could be delays in importing medicines due to new border arrangements, requiring stockpiling and good supply chain management to ensure there will be no shortages. The creation of a medicines authorisation regime separate from the rest of the EU could lead to further delays. The UK could be excluded from the European Rare Diseases Network. This raises particular concerns regarding orphan medicines (treatments that aren't commercially viable for the UK market alone) as to whether such medicines will even reach the UK market, which will have implications for the treatment of rare diseases.

Reciprocal healthcare and public health

190,000 UK pensioners living in the EU currently have the right to receive healthcare in the member state in which they reside. The ending of reciprocal healthcare agreements could disrupt patient care, effectively leaving UK nationals in the rest of the EU currently in receipt of medical cover through the S1 scheme without health care. The arrangements in place for the European Health Insurance Card could also come to an end. On public health there could therefore be an impact on NHS services if some people decided to return to the UK for treatment. If the UK no longer had a relationship with the European Centre for Disease Prevention and Control, both UK and European health protection will be weakened due to a reduction in information exchange.

Workforce

The Cavendish Coalition commissioned the National Institute of Economic and Social Research last year to undertake a major study of workforce implications through Brexit. The report found that the NHS could be short of 51,000 nurses, enough to staff 45 hospitals, by the end of the Brexit transition period. And in social care (which has become increasingly reliant on EEA nationals with a 68 per cent increase between 2011 to 2016), the sector is under considerable strain with a vacancy rate of 12.3 per cent and will have to navigate a transition period in which a critical portion of its workforce considers its future. In the event of no deal, new immigration rules could affect the ability of the NHS to recruit doctors and other medical staff from the rest of the EU, and there may be changes to current rules around the mutual recognition of medical qualifications.

For more information or to discuss any of these points, please contact Victoria Fowler, Public Affairs Manager: victoria.fowler@nhsconfed.org

NHS CONFEDERATION

If you require further copies of this publication or to have it in an alternative format, please contact enquiries@nhsconfed.org We consider requests on an individual basis.

NHS Confederation
Portland House, Bressenden Place, London SW1E 5BH
Tel 020 7799 6666
Email enquiries@nhsconfed.org
www.nhsconfed.org

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Northumberland, Tyne and Wear NHS Foundation Trust

Board of Directors

Meeting Date: 4th September 2019

Title and Author of Paper: Integrated Commissioning & Quality Assurance Report (Month 4 July 2019) – Anna Foster, Deputy Director of Commissioning & Quality Assurance

Executive Lead: Lisa Quinn, Executive Director of Commissioning & Quality Assurance

Paper for Debate, Decision or Information: Information & Discussion

Key Points to Note:

1. This report provides an update of Commissioning & Quality Assurance issues as at 31st July 2019.
2. The number of people waiting over 18 weeks to access services has decreased this month in non-specialised adult services from 38 to 36. There has been a significant decrease in Children & Young People waiting over 18 weeks in the Newcastle / Gateshead team, from 229 to 90 and an increase in Sunderland and South Tyneside from 485 to 547.
3. The Trustwide appraisal figure has decreased to 83.8% this month, which is below the Trust standard. Areas for improvement relate mainly to corporate functions.
4. There have been two Mental Health Act reviewer visit reports received since the last report relating to Woodhorn and Alnmouth wards. There were actions which had been resolved along with actions which remain unresolved from previous visits. On Woodhorn an action which remains unresolved related to patients being unable to access drinks without staff support. On Alnmouth the unresolved actions relate to patient's capacity to consent to treatment, keys to access bedroom and noise and the temperature of the ward.
5. The confirmed June 2019 sickness figure is 5.5%. The provisional July 2019 sickness figure is 5.90%. The 12 month rolling average sickness rate has remained the same at 5.72% in the month.
6. Out of area treatment bed days continue to increase, with 230 in July 2019.
7. The number of follow up contacts conducted within 7 days of discharge has decreased in the month and is reported at 92.7%. This is reported below standard. Nine patients were not seen in the required timescale trustwide.

Risks Highlighted: waiting times, sickness and out of area treatments

Does this affect any Board Assurance Framework/Corporate Risks: Yes

Equal Opportunities, Legal and Other Implications: none

Outcome Required / Recommendations: for information and discussion

Link to Policies and Strategies: NHS Improvement – Single Oversight Framework, 2019/20 NHS Standard Contract, 2019/20 Planning Guidance and standard contract, 2019/20 Accountability Framework

Executive Summary:

1 The Trust remains assigned to segment 1 by NHS Improvement as assessed against the Single Oversight Framework (SOF).

2 There have been two Mental Health Act reviewer visit reports received since the last report relating to Woodhorn and Alnmouth wards. There were actions which had been resolved along with actions which remain unresolved from previous visits. On Woodhorn an unresolved action related to patients being unable to access drinks without staff support. On Alnmouth the unresolved actions relate to patient's capacity to consent to treatment, keys to access bedrooms, noise and the temperature of the ward.

3 There have been three Commissioner Quality Assurance visits this month. To Ward 1, Walkergate Park, North Tyneside Community Treatment Team and Stephenson, Ferndene.

4 We did not meet all NHS England and local CCG's contract requirements for month 4. The areas of underperformance continue to relate to CPA metrics, seven day follow up and in Sunderland IAPT numbers entering treatment.

5 All of the CQUIN scheme requirements have been internally forecast to be achieved at Quarter 2 with the exception of improving data submitted to the Mental Health Services dataset (MHSDS) which has been rated as amber due to identified risks.

6 The number of people waiting over 18 weeks to access services has decreased this month in non-specialised adult services from 38 to 36. There has been a significant decrease in Children & Young People waiting over 18 weeks in the Newcastle / Gateshead team, from 229 to 90 and an increase in Sunderland and South Tyneside from 485 to 547.

7 Training rates have continued to see most courses above the required standard. There are two courses more than 5% below the required standard which are Clinical Risk Training (79.4% was 79.4%) and PMVA Basic Training (77.7% was 78.4% last month).

8 Reported appraisal rates, at 83.8% Trustwide, are below the 85% Trust standard.

9 The confirmed June 2019 sickness figure is 5.5%. This was provisionally reported as 5.46% in last month's report, highlighting an ongoing issue with delayed recording. The provisional July 2019 sickness figure is 5.90%. The 12 month rolling average sickness rate has remained at 5.72% in the month.

10 At Month 4 the Trust has a surplus of £0.1m which is £1.5m ahead of plan. The forecast surplus is £2.6m which includes £2.6m of Provider Sustainability Funding (PSF) which is in line with the control total. Agency spend is £2.7m which is £0.6m above Trust planned spend but in line with the trajectory of our NHSI allocated agency ceiling of £7.9m. The Trust's finance and use of resources score is currently 2 and the forecast year-end risk rating is 2.

Other issues to note:

- There are currently 21 notifications showing within the NHS Model Hospital site for the Trust.

- The Sunderland IAPT service moving to recovery rate was 53.5% for the month which is above the 50% standard.

- The numbers entering treatment for Sunderland IAPT service has not been achieved in month 4. 547 patients have entered treatment in the month against a target of 691.

- The number of follow up contacts conducted within 7 days of discharge has decreased in the month and is reported at 92.7% which is reported below standard. Nine patients were not seen within the required timescale trustwide.

- The number of follow up contacts conducted within 72 hours of discharge is reported at 81.5% for July 2019.

- There were 230 out of area bed days reported in July 2019 relating to thirteen patients. This is a significant increase in the month.

- The service user and carer FFT recommend score is at 87% this month which is just below the national average.

- There has been an increase in the number of clusters undertaken at review in July 2019 and is reported above standard at 85.3%.

- The latest published Data Quality Maturity Index Score relates to April 2019 and is reported at 86.9% which is a decrease from 91.8% in March 2019. Work continues to review this data internally.

Commissioning and Quality Assurance Summary Dashboard – July 2019

Regulatory

Single Oversight Framework

1	The Trust's assigned shadow segment under the Single Oversight Framework remains assigned as segment "1" (maximum autonomy).	Use of Resources Score:	3

CQC

Overall Rating	Number of "Must Dos"	
Outstanding	3	There have been two Mental Health Act reviewer visit reports received since the last report relating to Woodhorn and Alnmouth ward. There were actions which had been resolved along with actions which remain unresolved from previous visits. On Woodhorn the unresolved action related to patients being unable to access drinks without staff support. On Alnwood the unresolved actions related to patient's capacity to consent to treatment, keys to access bedrooms, noise and the temperature of the ward.

Contract

Contract Summary: Percentage of Quality Standards achieved in the month:

NHS England	Northumberland CCG	North Tyneside CCG	Newcastle / Gateshead CCG	South Tyneside CCG	Sunderland CCG	Durham, Darlington & Tees CCGs	Cumbria CCG
81%	90%	100%	70%	80%	86%	62%	62%

NHS England and most local CCG's did not achieve the contract requirements during month 4. The areas of underperformance continue to relate to CPA metrics, seven day follow up and in Sunderland IAPT numbers entering treatment
There have been three Commissioner quality visits during the month to Ward 1 Walkergate Park, North Tyneside Community Treatment Team and Stephenson at Ferndene.
The Specialised Mental Health data submission quality score has decreased to 88.1% at the last submission and work is ongoing to improve this further. Nationally most areas have seen a reduction in the data quality score.

CQUIN - Quarter 1 internal forecast assessment RAG rating:

Staff Flu Vaccinations	Alcohol and Tobacco Brief Advice	72 hour Follow Up Post Discharge	Improving Data Quality Reporting/ Interventions	Use of specific Anxiety Disorder measures within IAPT	Healthy Weight in Secure Services	CAMHS Tier 4 Staff Training Needs	Local Neuro-rehabilitation Inpatient Training	Mental Health for Deaf

All of the CQUIN scheme requirements have been internally forecast to be achieved at Quarter 2 with the exception of improving data submitted to the Mental Health Services dataset (MHSDS) which has been rated as amber due to identified risks.

Internal

Accountability Framework

North Locality Care Group Score: July 2019		Central Locality Care Group Score: July 2019		South Locality Care Group Score: July 2019	
4	The group is below standard in relation to CPP metrics	4	The group is below standard in relation to a number of internal requirements	4	The group is below standard in relation to a number of internal requirements

Quality Priorities: Quarter 1 internal forecast assessment RAG rating

Improving the inpatient experience	Improve Waiting times for referrals to multidisciplinary teams	Equality, Diversity and Inclusion	Evaluating the impact of staff sickness on Quality

Waiting Times

The number of people waiting more than 18 weeks to access services has decreased in the month for non-specialised adult services. The number of young people waiting to access children's community services has also decreased in month 4 significantly in Newcastle/Gateshead. There are continuing pressures on waiting times across the organisation, particularly within community services for children and young people. Each locality group have developed action plans which continue to be monitored via the Business Delivery Group and the Executive Management Team.

Workforce

Statutory & Essential Training:

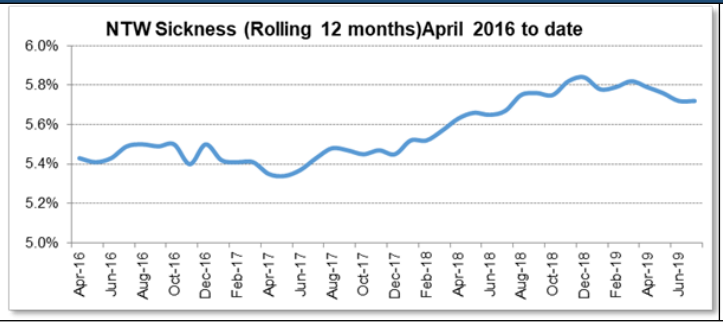
Number of courses Standard Achieved Trustwide:	Number of courses <5% below standard Trustwide:	Number of courses Standard not achieved (>5% below standard):
14	3	2

Information Governance (93.6%), MHA Combined training (84.6%) and Clinical supervision training (84.2%) are within 5% of the required standard. Clinical risk training (79.4%) and PMVA basic training (77.7%) remain at more than 5% below the standard.

Appraisals:

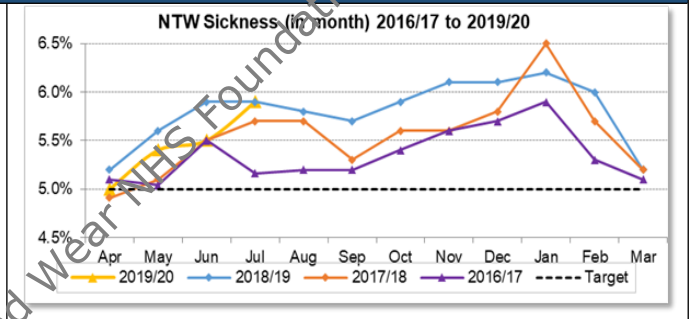
Appraisal rates have decreased to 83.8% in July 19 (was 84.9% last month).

Sickness Absence:



The provisional "in month" sickness absence rate is above the 5% target at 5.90% for July 2019

The rolling 12 month sickness average has remained at 5.72% in the month



Finance

At Month 4, the Trust has a surplus of £0.1m which is £1.5m ahead of plan. The Trust is ahead of plan due to income being higher than plan which is partly due to re-profiled contract income from Commissioners received in July to cover the payment in April to top of the scale Agenda for Change staff. The forecast surplus is £2.6m which includes £2.6m of Provider Sustainability Funding (PSF) which is in line with the control total.

Agency spend is £2.7m which is £0.6m above Trust planned spend and £0.1m above the trajectory of our NHSI allocated agency ceiling of £7.9m. Forecast agency spend is £7.3m. The Trust's finance and use of resources score is currently a 2 and the forecast year-end risk rating is also a 2. Due to an over-commitment on the NHS capital budget the Trust has agreed to try and reduce capital spend by £1.0m in 19/20.

Financial Performance Dashboard

NTW Income & Expenditure

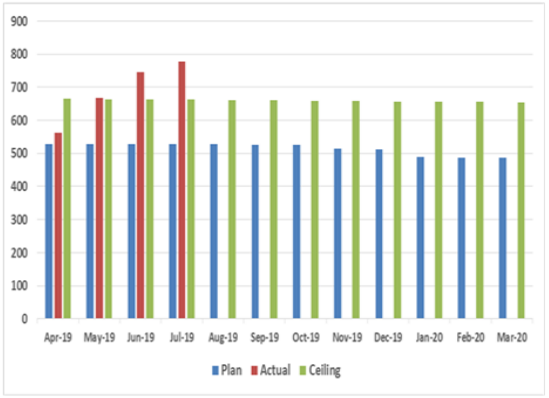
	YTD Plan £m	YTD Actual £m	YTD Variance £m
Income	110.6	110.5	0.1
Pay	(88.2)	(88.5)	0.3
Non Pay	(23.8)	(21.9)	(1.9)
Surplus/(Deficit)	**(1.4)**	**0.1**	**(1.5)**

Control Totals

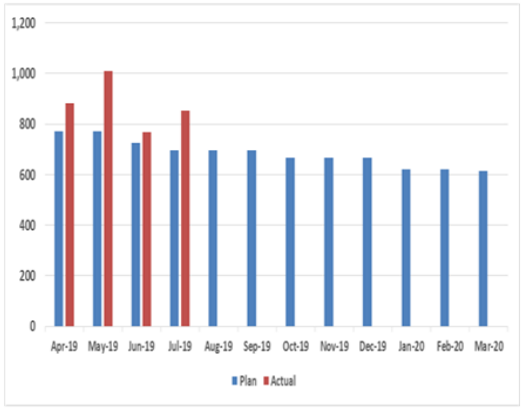
	YTD Plan £m	YTD Actual £m	YTD Variance £m
North	7.7	7.6	0.1
Central	6.1	6.8	(0.7)
South	9.7	10.0	(0.3)
Central Depts	(24.9)	(24.3)	(0.6)
Surplus/(Deficit)	**(1.4)**	**0.1**	**(1.5)**

Key Indicators	Current	Fore-cast
Risk Rating	2	2
Agency Spend	£2.7m	£7.3m
FDP Delivery	£2.7m	£10.4m
Cash	£29.0m	£18.4m
Capital Spend	£3.4m	£11.4m

Agency Spend



Bank Spend



Key Issues/Risks

- Surplus/Deficit - £0.1m surplus at Mth4 which is £1.5m ahead of plan. This is due to income being above plan partially as the result of income to cover AfC Top of Scale payments in April being received from commissioners ahead of plan.
- Control Total – The Trust is forecasting delivery of its £2.6m Control Total.
- Risk Rating – The Use of Resources rating is a 2 at Mth4 & the forecast year-end rating is also a 2.
- Pay costs are £0.3m above plan at Mth4. Bank and agency costs need to reduce to get back in line with plan. .
- Agency Spend – Agency ceiling is £7.9m and Trust planned spend is £7.3m in 19/20. Spend at Mth4 is £2.7m which is £0.6m above plan and £0.1m above the ceiling trajectory.
- Financial Delivery Plan – Savings of £2.7m have been achieved at Mth4 which is in line with plan.
- Cash – £29.0m at Mth4 which is £10.4m above plan.
- Capital Spend – £3.4m at Mth4 which is £0.3m below plan. The Trust has agreed to reduce its planned spend for the year by £1.0m.

Reporting to NHSI – Number of Agency shifts and number of shifts that breach the agency cap

	01/07/2019		08/07/2019		15/07/2019		22/07/2019		29/07/2019	
Medical	92	28	92	33	92	33	92	33	92	33
Qual Nursing	83	5	80	5	80	5	93	5	85	5
Unq Nursing	704		738		738		812		770	
A&C	59		74		50		113		75	
	938	**33**	**984**	**38**	**960**	**38**	**1,110**	**38**	**1,022**	**38**

In July the Trust reported an average of 37 price cap breaches (32 medical and 5 qualified nursing). In July 7 medics were paid over the price cap. 1 paid over £100 per hour.

Northumberland, Tyne and Wear NHS Foundation Trust

Board of Directors Meeting

Meeting Date: 4/09/19

Title and Author of Paper:
Health Education North East Annual Deanery Quality Report 2019

Executive Lead: Rajesh Nadkarni

Paper for Debate, Decision or Information: Information +/- debate

Key Points to Note:

HEE NENC was pleased to note that the Trust has continued to receive excellent feedback from both the medical trainees and from trainers, and which is reflected in the overall assessment.

HEE NENC raised concern in regard to the lack of formal communication to HEE regarding the transfer of mental health services from CPFT to NTW. This has since been rectified and there is a board paper next month outlining the governance and plans.

HEE NENC noted that training experience in inpatient services at SGP remains a concern and is being monitored.

Risks Highlighted to Board :

The relationship with HEE NENC is important. The overall visit and feedback was overwhelmingly positive. The concerns raised are important to address to maintain our good reputation, financial relevance, and continuing our advances in training, research and recruitment.

Does this affect any Board Assurance Framework/Corporate Risks?
Please state **Yes** or **No**
If Yes please outline

Equal Opportunities, Legal and Other Implications:
In relation to transfer of services there are important regulatory requirements in relation to approval of posts and contractual requirements in relation to employed doctors in training

Outcome Required: For information discussion or feedback

Link to Policies and Strategies:
Links to range of clinical and workforce policies and strategies including medical workforce strategy and supervision policies

Health Education England North East & North Cumbria

Annual Quality Report 2019

Northumberland, Tyne and Wear

NHS Foundation Trust

Final Report – July 2019

Table of Contents

1 Background to this Annual Report

The 2019 Health Education England North East & North Cumbria (HEE NENC) Annual report provides a 'year-end' summary of the education and training currently provided by the named Local Education Provider (LEP). It is intended to promote a board level overview of the training related strengths and weaknesses of the LEP, together with priority areas for action and associated HEE NENC offers of support. Detail supporting this report is contained in the Training Dashboards, each LEPs own Self-Assessment Report and the ongoing LEP Quality Improvement Plan. The HEE priorities identified for 2019-20 are to be reported on over the 2019/20 training cycle in order to inform the next Annual Dean's Quality Meeting (ADQM) in 2020.

HEE NENC's role in Quality Management and Assurance of the Clinical Learning Environment

HEE NENC is responsible for monitoring and providing onward assurance to HEE, the professional regulators and the wider NHS regarding the quality of the clinical learning environment for all training placements. The required standards are contained in the six themes of the HEE Quality Framework and the associated escalations of the HEE Intensive Support Framework and, for medical training programmes, in the GMC Standards for Training. HEE NENC works with and provides support to each LEP throughout the training cycle and provides significant amounts of funding to each organisation through the LDA to support training placements, trainers and educators.

HEE NENC gains assurance through the scheduled programme-led monitoring of training placements including Quality Reporting, Visits, and Meetings, and through triangulation of the data and information it shares with and receives from programmes managed at a regional or national level (e.g. Libraries, Pharmacy, Healthcare Science), other organisations including HEIs, other NHS Arm's Length Bodies and Regulators. Where concerns arise, HEE NENC uses its escalation processes to describe and monitor its concerns, the level at which it is having to work with an individual organisation, department, programme or the wider system to ensure the appropriate steps are taken to clarify, improve and resolve the concerns raised.

When there are concerns that a LEP is failing to meet the required HEE or regulator standards, (either as a whole organisation, in individual training departments, or when there is system-wide concern raised about an organisation), HEE NE works directly with the wider NHS via Quality Surveillance Groups, Improvement Boards and Risk Summits to collectively discuss the issues of concern, confirm plans for improvement with the LEP and to agree measures of success with a realistic timeframe for these to be achieved.

HEE NENC is always keen to provide support in order to improve training in all locations. Should programme-level actions fail to resolve issues then the relevant HEE NE Deputy Postgraduate Deans/Directors (Foundation, Specialty, GP, Dental, Quality and Revalidation) together with the Postgraduate Dean, are available for consultation, advice and further actions as deemed necessary; all will work with the LEP at Director and Board Level to help resolve issues and concerns.

The statutory responsibilities of the Postgraduate Dean

Please note that the Postgraduate Dean is the Responsible Officer (RO) for ALL doctors in training in approved training placements. The Postgraduate Dean has statutory accountability to the General Medical Council for both assuring quality of training placements for ongoing approval, and for the revalidation of individual doctors in training. Should revalidation or fitness to practice concerns arise concerning any doctor in training then, as the doctor's RO, the Postgraduate Dean MUST be informed and be involved in the decision-making processes. For ALL doctors in training (other than Foundation Programme trainees) the Lead Employer Trust must also be informed in its role as the doctor's employer.

2 Executive Summary

HEE NENC Annual Assurance Statement on overall quality of training & education provision

HEE NENC is pleased to note that the Trust has continues to receive excellent feedback from both the trainees placed with you and from the trainers you employ and whom HEE support through funding distributed via the LDA. We would like to thank you on behalf of the Lead Employer Trust for ensuring that all monthly payments to the LET to cover the Trust component of the salaries of Doctors in Training were made on time throughout the whole financial year.

Whilst acknowledging the challenges of reorganising services, we have significant concerns with regard to the governance of the impending transfer of mental health services from CPFT to Northumberland Tyne & Wear NHS Foundation Trust and the lack of formal communication of the proposed changes to HEE.

Actions are ongoing to address the concerns raised, especially with regard to the notification of changes in specific posts and placements during service transfer which are needed to meet both the regulatory requirements for continued approval of training placements, the code of practice for the contractual employment of doctors in training, and the ongoing funding of training placements from HEE via the LDA.

A summary of overall HEE escalation levels for the Trust is provided in the grid below and more detail for specific domains and training placements is contained in the HEE NE Quality Reporting Documents including the Training Dashboards, the Trust's Self-Assessment Report (SAR) and the Quality Improvement Plan (QIP).

HEE NE and NC Summary View of Northumberland, Tyne and Wear NHS FT							
HEE NE Funding provided to Trust in 2018/19: £ 6,020,935							
Current HEE Intensive Support Framework Escalation Levels							
LEP Overall	**Overall ISF Level**	**Domain 1** Learning Environment & Culture	**Domain 2** Educational Governance & Leadership	**Domain 3** Supporting & Empowering Learners	**Domain 4** Supporting & Empowering Educators	**Domain 5** Delivering Curricula & Assessments	**Domain 6** Developing a Sustainable Workforce
Level of HEE management	**0* Director level**	**0 Director level**	**1 Dean Level**	**0 Director level**	**0* Director level**	**0 Director level**	**0 Director level**

Summary of training provision by exception

Areas of sustained high-level training provision

Sustained high level performance in training provision is noted in the following areas:

- Overall Trainee NTS feedback
- Overall Trainer NTS feedback

Escalated/Continuing training concerns requiring action in 2019-20 Training Cycle

Concern regarding the performance of training provision has been noted in the following areas:

- St Georges – General Psychiatry
- Notification of service changes

Emerging or recurrent training concerns requiring further triangulation/action in 2019-20

During the 2018-19 training cycle, areas of potential concern have been identified which require further triangulation following which formal escalation may result if these concerns are confirmed:

- Ferndene - CAMHS
- Monkwearmouth - General
- Hopewood - General & GP
- Tranwell Unit - Old Age

Emerging workforce concerns identified as potentially impacting on training placements/programmes

The following programmes and placements have been identified as being affected by issues within the Trust's own workforce for service (i.e. NOT numbers of trainees/placements) and thereby at risk of being unable to deliver the relevant curricula if not addressed.

- None

Specific actions required from Trust in 2019-20 Quality Reporting Cycle

1. To report in 2019-20 SAR on the HEE NE overarching priorities for training provision outlined in this Annual Report

2. To provide updates on all areas noted above in 2019-20 Self-Assessment Report and Quality Improvement Plan and to work with HEE NE Programmes, Directors, and Dean as necessary to resolve any escalated or emerging issues of concern.

3. To keep HEE NE informed of any potential changes in Trust configuration in order to minimize impact on training placements and to prevent potential withdrawal of training approval.

3 HEE NE overarching priorities for all LEPs to report on in 2019-20 Training Cycle

As well as being responsible for the monitoring and onward quality assurance of the clinical learning environment in all LEP placements, HEE NE promotes system-wide sharing of best practice and has identified priority areas for the 2019-20 training cycle. LEPs will be asked to specifically report on these areas in their 2019-20 SAR and can anticipate the items to be included in the agenda of their 2020 Annual Dean's Quality Meeting.

In addition to routine quality reporting, the 2019-20 SAR will therefore request specific information from all LEPs in the following priority areas across the six domains of the HEE Quality Framework:

Domain 1 – Learning Environment & Culture

- Assessing the impact of clinical workload on ability to deliver both clinical service and training and how impact varies and is managed across different learning environments

Domain 2 – Educational Governance & Leadership

- Continued monitoring of LEP use of financial resources provided by HEE NE to support training.
- Governance of service changes as the Cumbria & North East Integrated Care System develops and in particular the planning and notification of proposed changes to training placements to fulfil statutory and contractual requirements.

Domain 3 – Supporting & Empowering Learners

- How exception reporting is managed within each organisation and how educational exception reports are managed where a training session has been lost rather than additional hours worked.
- Provision of resources to all trainees and learners including rest areas, library facilities IT system access and how financial resources provided for this purpose have been used

Domain 4 – Supporting & Empowering Educators

- Reporting on how resources allocated within the LDA are used to provide specific time, remuneration, and development opportunities to all trainers and educators

Domain 5 – Delivering Curricula & Assessments

- As new clinical roles and workforce models develop including a planned increase in clinical placement numbers, we wish to explore how training opportunities are prioritised to meet the curricular needs of all trainees and learners

Domain 6 – Developing a Sustainable Workforce

- How will your organisation meet the needs of the NHS People plan with a focus in 2019-20 on The Nursing Challenge (chapter 3) and delivering a 21st Century Workforce (chapter 4)

4 GMC 2018 Quality Review of HEE NENC

Education and training has been praised by the General Medical Council (GMC) in its 2018-19 Regional review of medical education and training in the North East. The regulator's report recognised education and training within the region to be a 'valued part of organisational culture' and that strong relationships and an organised approach are helping to improve the experience of doctors in training. The findings for how each site visited is complying with the GMC's standards and requirements can be found in the individual site reports. Specific requirements and recommendations for organisations in scope and that require attention have been listed within section 2 of this report.

The GMC identified common themes for the region to address as "potential areas to develop". All providers should now consider the following, to identify improvements and to share best practice:

1. Identification of doctors in training and their grade / level from both a patient and team perspective (recognising competence of individual trainee levels, especially by nursing staff).
2. Terminology including the use of outdated terminology such as "SHO".
3. Educational feedback to doctors in training on completion of clinical sessions including night shifts to maximise learning (as oppose to handover only).
4. Handover processes.
5. Induction – both consistent approaches to catch up induction as well as induction to other roles such as acute OOH, to ensure clarity around roles and responsibilities.
6. Support for trainers including time for training.
7. Awareness of the existence of the formal process for raising concerns (patient safety and undermining).

5 2019-20 Quality Cycle – Reporting Timeline and Significant Events

To facilitate planning of quality reporting and meetings in 2019-20, the table below summarises key dates and events from July 2019 onwards. Please note that the HEE NE Quality Team can always be contacted via Quality.NE@hee.nhs.uk

HEE NE analysis of 2019 GMC NTS Trainee & Trainer Surveys	July 2019
HEE NE to send LEPs 2019-20 Reporting Documents & Guidance	End July 2019
HEE NE Quality Team offer of support meetings to LEPs	Aug-Oct 2019
LEPs to return to HEE NE completed Unit Level Reports	End Sept 2019
LEPs to return to HEE NE completed SAR/QIP/Dashboards	End October 2019
HEE NE to arrange dates with LEPs for 2020 ADQMs	End October 2019
Anticipated dates for 2020 GMC NTS for Trainees and Trainers	March-May 2020

HEE NE Annual Dean's Quality Meetings with LEPs	April-May 2020
HEE NE 2020 Annual Reports to be sent to LEPs	End July 2020

On behalf of HEE North East & North Cumbria July 2019

Professor Namita Kumar
HEE NE Postgraduate Dean

Mr Pete Blakeman
Deputy Postgraduate Dean & Quality Director

NORTHUMBERLAND TYNE AND WEAR NHS FOUNDATION TRUST

BOARD

Meeting Date: 4th September 2019

Title and Author of Paper: R&D Annual Report 2018/19
Simon Douglas, Joint Director of Research Innovation and Clinical Effectiveness

Executive Lead: Dr Rajesh Nadkarni

Paper for Debate, Decision or Information:
Information

Key Points to Note:

The R&D Annual Report is presented for information. Since the R&D strategy was approved in 2012 there has been significant progress and some clear evidence of the impacts of the strategy.

The implementation of the research strategy has seen increases in research activity through increases in numbers of research projects, numbers of service user participants, numbers of staff involved and grant income received. Further achievements have been NTW being ranked in the top 5 most research active mental health and learning disability trusts in England in terms of number of research studies since 2015 (18/19 5th) and top 10 in number of participants recruited (18/19 3rd). We can also point to a significant number of high profile national and international publications based on research in the Trust; significantly strengthened research collaborations across the region and further progress in successful funding applications.

The key points to highlight from this report are:

1) Research activity and funding increases

   Research activity within NTW remains on an upward trend with a significant increase in the number of NTW participants recruited to large scale national research in 18/19 taking NTW up to 3rd in the national league table of mental health Trusts. Research funding income has also increased significantly to over £3m for 18/19.

2) Assurance on NTW research

   As part of an internal review of NTW's approach to governance of research we redesigned the process for audit and monitoring of research happening in NTW. The new standard is that we audit 10% of hosted studies and 100% of sponsored studies annually. This means we have reliable assurance that the research which is happening in NTW is being run in accordance with best practice standards (in addition to the ethics and Health Research Authority assessments and approvals which are done nationally). The results of the audits are reported with no significant deviations, and we have a range of actions in place to address the minor issues which were highlighted.

3) NTW confirmed as host for the North East and North Cumbria ARC

   NTW have been confirmed as the host organisation for the NIHR North East and North Cumbria Applied Research Collaboration (ARC). This is a 5 year, £9m grant which is aimed at developing regional collaborations in research across health, social care, public health and academia which addresses the major health and care challenges

facing the region. The ARC is organised into themes, several of which have direct relevance to NTW: Multimorbidity, Ageing and Family, Supporting Children and Families, Prevention, early intervention and behaviour change and Integrating physical, mental health and social care.

Risks Highlighted to Committee :
N

Does this affect any Board Assurance Framework/Corporate Risks?:
Please state No
If Yes please outline

Equal Opportunities, Legal and Other Implications:
None

Outcome Required: for information

Link to Policies and Strategies:
NTW Research and Development Strategy (2016 – 2021)

Northumberland, Tyne and Wear NHS Foundation Trust

Research and Development Annual Report 2018/19

Caring | Discovering | Growing | **Together**

Contents

Glossary and Abbreviations

NIHR	National Institute for Health Research	The research arm of the Department of Health
	NIHR Portfolio	A register of large scale research projects which meet certain standards of size and quality, usually funded by NIHR
CTIMP	Clinical Trial of an Investigational Medicinal Product	A trial involving administration of a drug or medicine
ARC	Applied Research Collaboration	A national NIHR Programme for applied research involving Health Trusts, Social Care, Public Health, Universities and third sector organisations
MRC	Medical Research Council	Funding Provider
RfPB	Research for Patient Benefit	NIHR funding stream
PGfAR	Programme Grant for Applied Research	NIHR funding stream
EME	Efficacy and Mechanism Evaluation	NIHR funding stream
HTA	Health Technology Assessment	NIHR funding stream
NIHR CRN	NIHR Clinical Research Networks	The research delivery arm of NIHR, represented in the North East by CRN North East and North Cumbria (CRN NENC)
PID CR	Performance in Initiating and Delivering Clinical Research	A measure of performance of NHS Trusts in approving clinical research to run in the NHS, reported by DH
RCF	Research Capability Funding	Strategic funding given by NIHR to NHS Trusts based on previous year's NIHR grant income
LCRN	Local Clinical Research Network	Local (North East and North Cumbria) regional branch of the Clinical Research Network (CRN)
DenDRoN	Dementias and neurodegenerative diseases	Specialty Group of the LCRN

1 1 Page Summary

Key achievements in R&D for 2018/19:

- Up to 3rd in the NIHR league table for mental health trust recruitment of participants
- Successful regional bid for an NIHR ARC hosted by NTW (£9m over 5 years)
- NTW became a sponsor of CTIMPs for the first time
- Introduction of a robust NTW Quality Management System for research
- Lead and host for two key NIHR Health Technology Assessment awards totalling £3m
- Increased number of NTW participants into NIHR portfolio research to 3174 (from 1746)
- NTW ranked fourth in its division for research approval timescales and ninth nationally, which makes us one of the top performing trusts for setting up research projects in the country.
- 121 publications authored or co-authored by NTW staff and related academics
- Annual Audit Schedule now in place – 26 studies audited with no major findings
- Increases in numbers in all of NTW's research registers (mental health, dementias and neurology)
- Impact in developing the careers of NMAHPs including successful Fellowships, Internships and training and development
- International recognition and Huntington's Disease Clinical Trial Site Certification

We look forward to another successful year in 2019/20.

Simon Douglas, Joint Director of Research Innovation and Clinical Effectiveness, July 2019

2 NTW Research Strategy

The NTW Research strategy was approved by the Trust Board in 2012 as a plan for the first three years of a ten year programme. Work to refresh the strategy to provide a plan for the next five years in line with the Trust strategy was completed in 2015/16, leading to a refreshed plan for implementation in 2016/17.

The original three strategy objectives were retained but the initiatives and actions required were significantly updated and in doing so we reflected on the successes and challenges to date. These successes have seen NTW become one of the leading research active mental health and learning disability Trusts, generating and participating in increased large-scale research (NIHR Portfolio) activity, embedding research and evaluation into the Trust's service provision and developing the capability and capacity of the workforce.

Some of the challenges associated with the strategy remain: maintaining the value and importance of research to all stakeholders in a time of financial difficulties for the NHS; systematically involving service users and carers in the full range of our research activity; widening participation in research to a full range of health disciplines, including nurses and Allied Health Professionals (AHPs); and promoting the opportunity to take part in research for all of our service users.

A range of initiatives were continued from the original strategy document but in addition there were several new ideas which were to be developed as new streams of work for the strategy implementation plan. Notably we promoted an approach to engage with all local Universities within our footprint with the aim of harnessing academic expertise which would fit with the diverse service provision of NTW as a Trust and a focus on developing the careers in research or nurses and allied health professions. This was broadened out in 2017/18 with initiatives to engage farther afield to ensure we were able to learn from other research collaborative such as SLAM/Institute of Psychiatry and the Biomedical research Centre in Nottingham.

3 Impact of NTW research in 2017/18 – collecting suggestions

Research has been widely recognised as being an important factor in providing high quality care for healthcare organisations. Not only does organisational involvement in research improve clinical outcomes and service user satisfaction but it is also suggested in the evidence that organisations are able to attract higher quality employees, organisational culture benefits so that employees are more interested in basing care and treatment decisions on the best available evidence and on measurable improvements in outcomes. While these are benefits of NTW involvement in research there should also be a demonstrable benefit for our service users. In some areas this is clear but for others it can take several years for benefits to filter through to front line services, this is something we should aim to address in future developments of the R&D strategy.

A wide range of examples of impact of the NTW research Strategy on care and treatment for our service users were presented at the Annual Research Conference in May 2018. We have further highlighted some examples of impact in 2018/19 below:

Outstanding International Recognition in the field of Lewy-Body Dementia

Newcastle's reputation as a leader in the field in research into DLB (dementia with Lewy bodies) was again highlighted by the NIHR with data analysis published by Expertscape (a site which objectively ranks people and institutions by their expertise) which showed Newcastle University as the leading institution worldwide with 7 of the top 15 academics either currently at Newcastle or having had part of their career here. This ensures that people with this diagnosis within NTW and other local NHS Trusts can hope to receive world-leading opportunities to take part in research. The world's leading academic in DLB was Professor John O'Brien who was recently at Newcastle and NTW and will be presenting his latest findings at the NTW R&D conference in October 2019!

The final draft of International Classification of Diseases (ICD-11) criteria, for implementation by January 2022, includes recently developed in Newcastle DLB criteria and enshrines the construct of separating dementia with Lewy bodies (DLB) from Parkinson's disease dementia (PDD). This will mean up to 4 million people globally with LBD, will be diagnosed in the same framework with scope to access research studies, and health and care reimbursement.

Individual successes

Dr Stuart Watson, Consultant Psychiatrist at NTW and Clinical Senior Lecturer at Newcastle University is now Handling Editor for the British Journal of Psychiatry and Associate Lead for Investigator Initiated Trials (IITs) with the Local Clinical research Network NENC. In addition his own research study Cap-Mem has recruited over 1700 participants in the last 12 months.

Professor Ian McKeith received the 2018 European Grand Prix for Alzheimer Research. The award came with €90K to support a project with Dr Dan Erskine (early career researcher and previous BRC PhD student) which will investigate the role of astrocytes in LBD pathogenesis.

Dr Charlotte Allan was successful in obtaining BRC funding as an early career clinical academic which allowed her to secure a prestigious Health Foundation Innovating for Improvement award (≈£90K) focused on developing creative, arts-based interventions for patients with dementia and enhancing support staff well-being.

Research in and with Pharmacy at NTW

- 19 posters presented at local and national conferences with two oral presentations given at national conferences.
- Working with AHSN on STOMP (Stopping over-medication of people with a Learning Disability) which resulted in 5 publications and numerous other publications from various members of the Pharmacy team.
- At the end of 18/19 we had a bid accepted by AHSN to produce guidelines and support for the reduction in use of hypnotics.

Award Nomination

NTW has been nominated as a partner in a shortlisting for the Nursing Times award for best service improvement project, along with the lead Karen Giles at Sunderland University, for a project to evaluate for pop up clinics for improving access for people with a learning disability.

NTW has been consistently ranked in the top 5 of mental health trusts for research activity since the NIHR league tables were first published. For 2018/19 we have been ranked 3rd of mental health trusts for recruitment of participants, so in that year 3174 NTW service users were recruited to large scale NIHR portfolio research.

4.1 Number of portfolio research studies

Research activity is an important measure of progress in R&D. One of the measures is the *number* of large scale portfolio research projects which have recruited participants from NTW. Figure 1 below shows the number of studies recruiting from NTW and illustrates a gradual increase year on year, with a slight fluctuation in 2018/19. The graph below shows a slight drop in the amount of research studies this year, however recruitment to the studies has actually increased. NTW is fifth in the NIHR-published league table of most research active mental health trusts and we hope to hold or improve upon this position in the coming year.

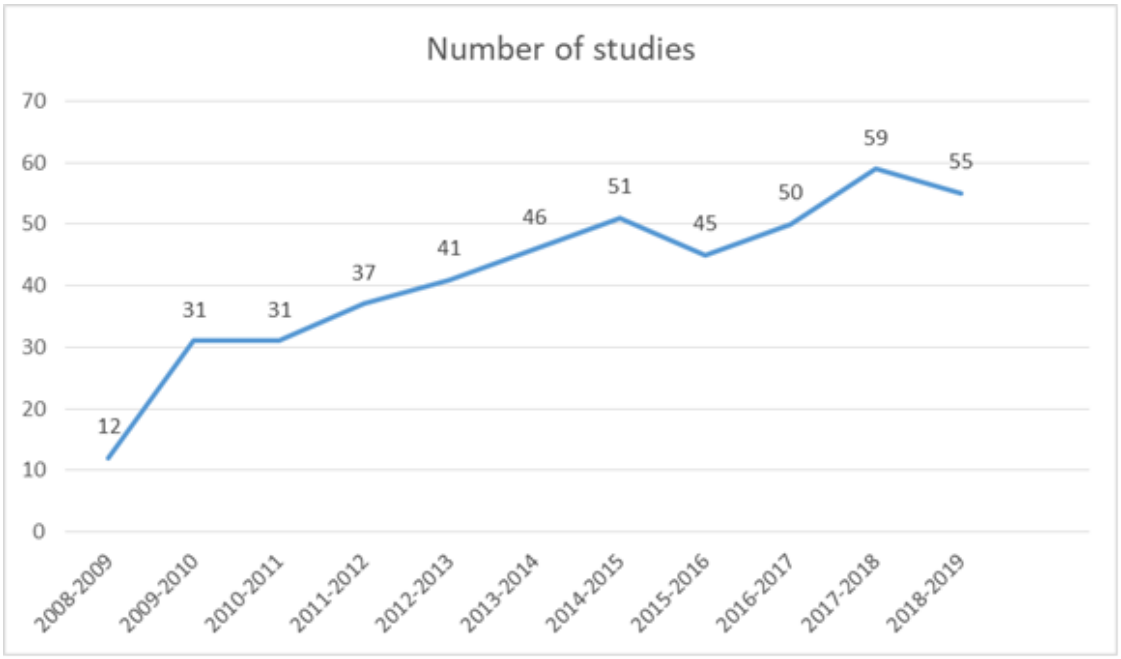


Figure 1 – Number of NIHR Portfolio Studies recruiting participants year on year

Whilst there is a focus on delivering large scale portfolio research, there is also a significant amount of smaller scale research active in NTW, ranging from student research to pilot work for larger scale funding bids and service evaluation work. This important work provides evidence to develop and improve the quality of the NTW service provision.

4.2 Number of participants recruited to Portfolio studies

To ensure continued national research network funding, recruitment of participants to NIHR portfolio research remains the key measure for NHS organisations nationally. While this measure is sensitive to a range of factors such as study complexity, availability of research funding or outliers such as single high-recruiting projects, we can in NTW point to evidence of the successful delivery of national projects (Figure 2 below). The final total for NIHR portfolio recruitment in NTW in 2018/19 was 3174, well above the total of 1746 in the previous year. This is directly attributable to two projects which were large scale projects in both Mental Health and Dendron and it is predicted that this will show 2018/19 as an outlier year in terms of recruitment levels.

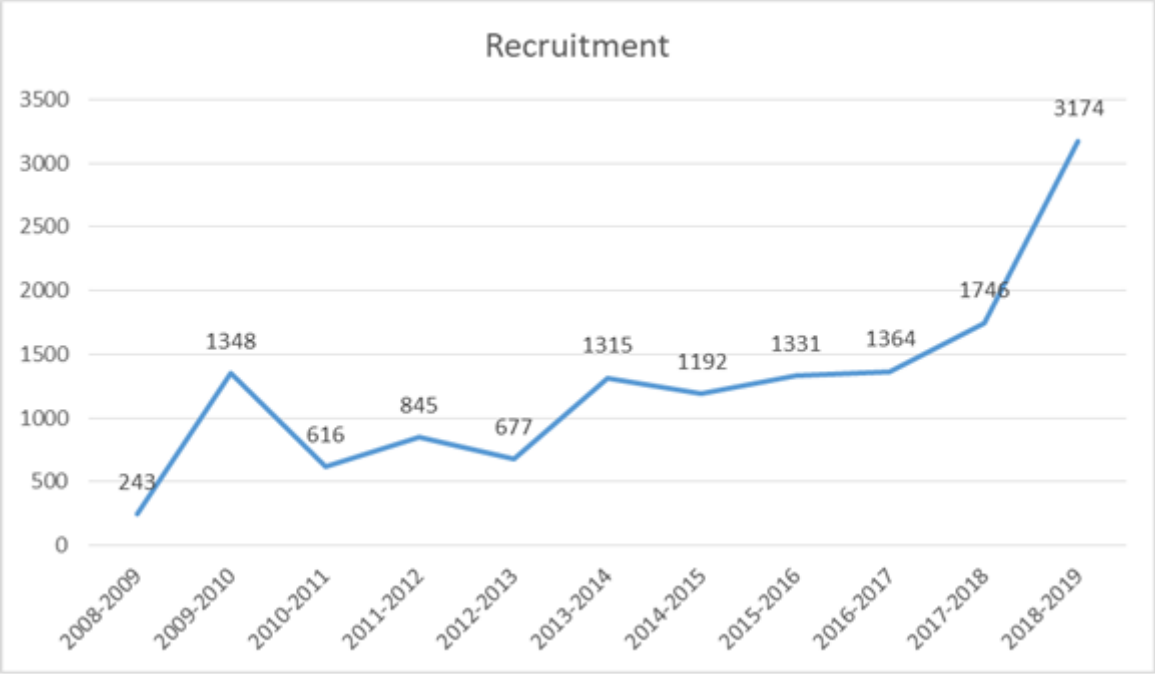


Figure 2 – Recruitment to NIHR Studies year on year

4.3 Commercial Research

Developing the Trust's capability to compete for commercial research, usually sponsored by pharmaceutical companies, has been a high priority this year. Although still relatively small scale in comparison with the non-commercial portfolio of research, the commercial portfolio and trust infrastructure continues to grow. The focus in R&D this year has been to develop the infrastructure needed to support commercial trials.

2018/19 saw a great step forward in collaborative working between NTW and NuTH. This has been a success in terms of the use of the infrastructure for commercial clinical trials in rare diseases. Access to the Clinical Research Facility and Clinical Ageing Research Unit increases our capacity for commercial research and therefore our ability to attract future research from pharmaceutical sponsors.

5 Research Approvals

A national system for NHS approval, run by the Health Research Authority (HRA), brings together the assessment of governance and legal compliance with the independent Research Ethics Committee (REC) opinion provided through the UK Health Departments' Research Ethics Service. HRA approval provides participating NHS organisations the means to confidently assess, arrange and confirm local Capacity and Capability (C&C) to deliver the study. The C&C assessment completed by NTW R&D ascertains whether the Trust has the knowledge, expertise, patient population, research team capacity and local clinical services approval for any study approved via the HRA process.

Performance in Initiating and Delivering Clinical Research

NTW is measured on the time taken to assess C&C and to recruit the first participant to projects that are clinical trials. NTW reports directly on our research approvals process timescales for clinical trials, including commercial pharmaceutical projects, to the Department of Health (DH) through the Performance in

Initiating and Delivering Clinical Research (PID-CR) process. This is reported quarterly to the DH and publicised on the Trust external website.

In 2018/19 NTW had 11 clinical trials eligible for PID reporting. Of the 11 clinical trials initiated in 18/19, 8 were approved and recruited the first participant within 70 days. The average set up time was 13 days and the average time to first participant recruited was 31 days.

NTW remain high on national league tables for our ability to set up a clinical trial and recruit a participant within a good timeframe.

6 Financial Report

NTW's research income for 2018/19 increased again on the previous year. This was largely due to two of the funding streams, NIHR grant income and commercial income, compensating for a reduction in RCF. For NIHR income this is mostly the result of two new large NIHR grants starting.

Income type	2014/15	2015/16	2016/17	2017/18	2018/19
			£		
Grant income	720,618	921,906	1,224,400	1,008,338	1,834,190
DH funding (RCF)	240,182	298,152	295,965	263,901	159,246
NIHR network funding	1,107,677	1,022,157	1,030,550	1,005,060	931,372
Commercial income	81,588	100,251	173,928	134,150	156,846
Total	2,150,065	2,324,466	2,724,843	2,411,448	3,081,654

Table 1 – Research income figures 2013/14 to 2018/19

The usual annual allocations process for RCF was run with a range of very high quality applications of which 5 were funded. In addition the R&D office was funded for £60k to cover the costs to NTW of running these large scale grants.

Expenditure

As suggested above research income is received by NTW to cover the costs of engaging in clinical research. The majority of the income is spent on direct staff costs for working on specific research studies or for supporting a range of NIHR portfolio studies (chart 1). As per NHS spending guidelines the majority of income must be spent in the year it is received and must be spent on the purposes for which it is received (i.e. direct research). NTW is audited on this.

Other expenditure is to buy out clinical time for input on specific projects, in which case the funds go to the relevant clinician's team or CBU budget.

The full expenditure breakdown for 2018/19 is detailed in the table by category. Lines 3 and 7 are largely grant funding which goes to cover or backfill medical or non-medical time working on research respectively.

NTW Research expenditure 2018/19		
1 Non Pay Costs	**Expenses, office and travel**	318230.4
2 Other Direct Research Costs	**Transferred to other collaborators**	1223803
3 Medical - Time (backfill)	**Transferred to cost centres within NTW**	96467.29
4 CRO (Research Staff)	**Staff costs for research delivery team**	985166.8
5 Admin		70647.23
6 Management time	**R&D management and project management**	117119.4
7 Non-medical backfill	**Non-medical research time e.g. psychology**	209341.7
8 Pharmacy		27480
9 Misc		33398
Total		3081654

Table 2 – Expenditure 2018/19

7 Communications

The sixth annual NTW Research and Development Conference was held in May 2018. The event was well attended and feedback was highly positive, with talks and posters from within the Trust and from external partners who have undertaken research within NTW.

We are becoming more active on social media and now have 330 twitter followers. We are using social media to advertise research projects (with ethical permission) and encourage NTW sponsored trials to use social media and web sites. We are utilising social media to promote research initiatives and are developing training videos and promotional videos. One example being a short YouTube video promoting International Clinical Trials Day in which some R&D team members and a service user encouraged people to "Be Part of Research", which was the NHS theme for the day.

We have started to work with the North East and North Cumbria Clinical Research Network project management team to utilise surveymonkey to gather staff opinions and experience of research around the trust. We hope this will support us to improve the service we offer and identify training needs.

Collaborating with local universities, the Research Design Service, the ACCs, Medical Education and the AHSN, we are regularly advertising a range of events and training opportunities in the R&D Bulletin.

We continue to have a presence at various local mental health and research events and this supports the number of people signed up to the Research Registers and Case Register.

8 Workforce

Developing the research workforce has been a key strand of the NTW research strategy and we have had success in 2017/18 through developing non-medical Principal Investigators (PIs). We now have a second Nurse Consultant leading an NIHR Portfolio study as a local PI, Kate Chartres, in the LD Maestro study with the Sunderland Liaison Psychiatry team.

In addition we have invested funds from the NIHR Clinical Research Network in providing training sessions for both internal NTW staff and external research partners in GDPR and Data Protection in research, MHRA readiness training, HRA processes and NHS approvals, and also promoting the availability of Good Clinical Practice (GCP) training and research awareness sessions. This is part of ongoing upskilling of the workforce in readiness and preparation for MHRA inspections.

AHP Research Champion for North East and North Cumbria: National Institute for Health Research (NIHR) and Council for Allied Health Professionals Research (CAHPR).

This new 'bridging leadership role' has been set up in a partnership between the NIHR and CAHPR to place 'champions' in each of the 15 local Clinical Research Network areas in England. The roles are voluntary but do come with some funding to provide regional activities to promote and support AHP research strategy objectives. NTWs Dr Simon Hackett - Principal Arts Psychotherapist, who also has an Honorary Senior Clinical Lectureship at Newcastle University, was successful in being chosen as the first AHP Research Champion for NE&NC (and the only appointment from a mental health NHS Trust nationally). Dr Hackett has been active in developing this new role in the region and has also been creating links that will support NTWs own strategic ambitions for AHPs. Due to the success of the first pilot year of this programme the NIHR have now extended the roles for a further 12 months.

9 Patient and Public Involvement (PPI) in Research

NTW has a strong track record in involving service users and carers in research, with some particular research projects having led to multiple awards and national recognition. The challenge is now to make this involvement a systematic part of all of NTW's research, as some areas have stronger and more established PPI than others.

Developing Grant Applications and Developing Projects

NTW R&D actively encourages and supports PPI involvement in developing protocols and participant facing documents. There is a focus of PPI contributions in sponsorship submission reviews and amendments. An example of good practice is an established PPI group to support study design and give some oversight support to an HTA grant that will examine the efficacy of Pramipexole in the treatment of bipolar depression. This project will see NTW and Newcastle Univerity work collaboratively with PPI involvement at multidisciplinary, multinational trial management groups.

The General Data Protection Regulation and research information

Members of the NTW R&D team are establishig a PPI group to work on the GDRP wording that now needs to be included in participant facing research documents. This PPI group will look at the information required and develop an easy read document that can be used by all researchers in mental health. No other organisation nationally are approaching this work and it is hoped that this work can be shared with the Health Research Authority to improve the information given out nationally to mental health research participants.

Regional Creating Connections Group

NTW R&D have regular representation at a regional PPI meeting. This meeting brings together PPI leaders at NHS trusts and Higher Educational Insitutes from around the region and leads on good practice in PPI for research. NTW actively contributes towards this group.

The NTW Research Register

The NTW Mental Health Research Register is now well established and has 649 members who receive regular newsletters, information about current and published research and any other relevant information. Members are invited to focus groups regarding new research grants and other projects. Public engagement events are held approximately 4 times a year and the register enables us to reach a broad and varied audience for these events. These events increase awareness of local and national research which increases NTW capacity to conduct research through public, patient and clinician participation.

DeNDRoN Case Register

Regionally, the research case register continues to be a very valuable tool for recruitment into our dementia and Parkinson's' disease studies. During 2018/19:

- **195** new participants have joined the Case Register.
- **208** participants have been approached and **156** of those recruited into a research study.
- There are currently **1146** particpants active on the DeNDRoN Case Register.

Neurology Research Register

Our neurology department continue to grow research capacity and the neurology research register is becoming inceasingly research active. There are **55** members currently signed up.

10 Quality Assurance

Quality Assurance from NTW as research sponsor ensures that research operating from and within our trust is safe and ethical, legal and well-led at inception and throughout the duration of the research.

Audits in 2018-2019
Audit is a core part of Quality Assurance and ensures studies are operating to regulatory compliance and Good Clinical Practice GCP. Findings from audit provide an opportunity for learning and corrective action. In 2018-2019 there were 26 studies audited in total, 21 sponsored and 5 hosted.

Table 1. Audit Findings 2018-2019

Findings	Examples of discrepancies	Specific findings	Percentage of studies with this finding
Study Site Staff	• Incomplete or missing delegation logs • Missing, incomplete or out of date CV's • Missing or out of date GCP	26 minor findings	95 %
Approvals	• Approval letters not filed • Draft copy of IRAS form	15 minor findings	57 %
Legal	• Missing or expired indemnity certificates/statements	13 minor findings	49 %
Document Control	• Current versions not in file • Missing superseded versions • No version numbers • Unsigned protocols	12 minor findings	27 %
Consent procedures	• Consent forms completed incorrectly	6 minor findings	23 %
Data storage	• Patient data stored incorrectly • Consent forms stored with data	4 major findings	15%

The results from the audits in NTW showed that all studies audited had at least one minor finding, and the number of minor findings ranged from 1-7, with a mean average of 3. The most common finding was incomplete delegation log and/or research staff CVs and GCP certificates. Four of the studies audited showed a Major finding, these all related to incorrect storage of participant data. None of the studies showed Critical findings.

Plan for improvement in 2019-2020

Moving forward into the new financial year R&D will be launching the new Quality Management System. This library of Standard Operating Procedures (SOP) and Working Documents (WD), will proactively support training and acts as a reference guide for expected standards in research for NTW Sponsored Studies.
The new financial year will also see 'First Participant' Audits become live. This aims to improve awareness in the management of site files and data records/filing systems in a supportive way, thereby acting as a preventative measure to errors developing further into the lifecycle of the project.

11. Summary and next steps

The continued success of the NTW research strategy underpins the increase in research activity over the previous year and we are confident that the implementation of the strategy will develop the foundations for continued success and improvement. Developing and implementing new systems and processes as one of very few mental health trusts to provide sponsorship of CTIMPs will enable this to continue further.

As a further benefit our systems will provide greater assurance to the Board that the research happening in NTW is robust, complies with legal and best practice standards and leads to real benefits for those who use our services.

The next 12 months will see the start of the Applied Research Collabration, hosted by NTW, which will be launched on 1st October 2019. This is an opportunity for NTW to have significant involvement in a key regional initiative which will provide benefits in terms of applying and implementing research findings and improving and joining up practice across the region.

Further work on the NTW research strategy will progress; we are keen to develop further integration with clinical services to ensure that research is seen as an additional indicator of our oustanding status and not as a burden. The NHS constitution proposes that all users of NHS services are offerred the opportunity to take part in research which is relevant to them and we aim to meet this standard.

Appendix 1 – NTW Staff Publications April 2018 to March 2019

The Association Between Child and Family Characteristics and the Mental Health and Wellbeing of Caregivers of Children with Autism in Mid-Childhood.
Salomone E, Barrett B, Byford S, Charman T, Howlin P, Pickles A, Leadbitter K, Aldred C, Green J, **Le Couteur A,** McConachie H**, Parr J.R,** Slonims V, Cole-Fletcher R, Gammer I, Maxwell J, Tobin H, Vamvakas G. Journal of Autism and Developmental Disorders; 2018 Apr; 48(4) p. 1189-1198.

The Autism Family Experience Questionnaire (AFEQ): An Ecologically-Valid, Parent-Nominated Measure of Family Experience, Quality of Life and Prioritised Outcomes for Early Intervention.
Leadbitter K, Aldred C, **McConachie H, Le Couteur A,** Kapadia D, Charman T, Macdonald W, Salomone E, Emsley R, Green J. PACT Consortium. Journal of Autism and Developmental Disorders; 2018 Apr; 48(4) p. 1052-1062.

Diagnostic accuracy of dopaminergic imaging in prodromal dementia with Lewy bodies.
Thomas AJ, **Donaghy P,** Roberts G, Colloby SJ, Barnett NA, Petrides G, Lloyd J, Olsen K, **Taylor JP, McKeith I,** O'Brien JT. Psychological Medicine; 2018 Apr; 25.

Peripheral inflammation in prodromal Alzheimer's and Lewy body dementias.
King E; O'Brien JT, **Donaghy P,** Morris C, Barnett N, Olsen K, Martin-Ruiz C, **Taylor JP,** Thomas AJ. Journal of Neurology Neurosurgery and Psychiatry; 2018 Apr; 89(4) p. 339-345.

Drooling Reduction Intervention randomised trial (DRI): comparing the efficacy and acceptability of hyoscine patches and glycopyrronium liquid on drooling in children with neurodisability.
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Northumberland, Tyne and Wear NHS Foundation Trust

Board of Directors

Meeting Date: 4 September 2019

Title and Author of Paper: Workforce Quarterly Update – Michelle Evans, Acting Deputy Director of Workforce and OD

Executive Lead: Lynne Shaw

Paper for Debate, Decision or Information: Information

Key Points to Note:

WORKFORCE STRATEGIC AIMS:	✓
We will develop a representative workforce which delivers excellence in patient care, is recovery focussed and champions the patient at the centre of everything we do	✓
We will embed our values, improve levels of staff engagement, create positive staff experiences and improve involvement in local decision-making	✓
We will lead and support staff to deliver high quality, safe care for all	✓
We will help staff to keep healthy, maximising wellbeing and prioritising absence management	✓
We will educate and equip staff with the necessary knowledge and skills to do their job	✓
We will be a progressive employer of choice with appropriate pay and reward strategies	✓

The Workforce Directorate quarterly report outlines some of the key work and developments across the Trust. The report supports the six key aims of the Workforce Strategy which was ratified by the Trust Board in summer 2015 and refreshed in March 2017.

This paper includes updates on:

1. Project Choice
2. Cultural Ambassadors
3. Pride
4. Staff Survey 2019
5. Investors in People (IIP)
6. Talent Management
7. Wellbeing and Health Campaigns
8. Simulation - MELISSA
9. CPD Events
10. Neyber

In Other News:

Junior Doctor 2016 Contract Update
Changes to agency rules

Risks Highlighted: N/A

Does this affect any Board Assurance Framework/Corporate Risks?
Please state Yes or No No

Equal Opportunities, Legal and Other Implications: Various aspects of Employment Law

Outcome Required: Information Only

Link to Policies and Strategies: Workforce Strategy

Workforce Quarterly Report

4 September 2019

Strategic Aim 1

1. Project Choice

Project Choice is a supported internship programme for people aged 16-25 with learning disabilities, difficulties or autism. Health Education England supports the programme nationally. The focus is about preparing people to be ready for work and matching their skills to employment. NTW Academy has been the host for Project Choice since June 2017 and works across Durham and Darlington and North and South of Tyne.

The Project Choice team ensure there are placements across the Trust and wider support chain, looking specifically at entry-level jobs to make sure they find the right learner for the role. They also work closely with managers and the work based mentors to ensure that tasks are clearly understood.

The young learners spend a year within their internships with 3 placements, each one being 10-12 weeks. During this time the learner is very much part of the team and the Project Choice staff and the mentors work with the learner to develop their skill, abilities and confidence.

The current students celebrated their graduation at the end of July with an event at the Jubilee Theatre, attended by families, friends, mentors and the wider support staff. John Lawlor presented the certificates. Some of our students have moved into apprenticeships, some into work and some into further education – however all have achieved because of the determination, positivity and inclusive working from everyone involved. There are ongoing discussions within the Trust looking at how we can support the project further for the next intake of students.

2. Cultural Ambassadors

Three members of the Trust's BAME workforce were trained as Cultural Ambassadors by the RCN in July. The aim of the cultural ambassador is to help ensure fairness in how BAME staff and students are treated amid concerns that they are disproportionately subject to disciplinary action. Working towards the Cultural Ambassador Programme is key to our WRES actions. The programme involved a three-day training course for volunteers to increase their knowledge and understanding of relevant legislation and topics, including the Equalities Act, cultural intelligence, unconscious bias and influencing skills. The ambassadors are supported by mentorship throughout their involvement with the project.

The programme will shortly be launched and policies and procedures are currently being reviewed to reflect any changes required as a result of the introduction of the ambassadors.

3. Pride

The Pride season is well underway and so far the LGBT+ Staff Network alongside the Patient Information Centre and other Trust representatives have attended the Northumberland Pride in June and Newcastle Pride in July. The Trust will also attend the

Cumbria Pride which is taking place on 28 September, where our recruitment team will have a presence to encourage attendees to apply for posts across the Trust.

Strategic Aim 2

4. **Staff Survey 2019**

Preparations are underway ahead of the 2019 Staff Survey. The survey will begin in mid-September and will end in November 2019. A communications plan has been developed for the duration of the survey to encourage completion.

5. **Investors in People (IIP)**

The Trust achieved the Investors in People and Health and Wellbeing Best Practice Awards firstly in 2010 and subsequently in 2013 and 2016. Reaccreditation is due in September 2019.

The Investors in People standard sets out the criteria for high performance through people. The framework benchmarks the effectiveness of leadership and management practices in the organisation.

There have been 252 individuals invited to attend one to one or group sessions with an IIP assessor. Staff awareness sessions for these staff were held across the main Trust sites from 19-23 August. These sessions provided general information about the award and what to expect at the meeting in a bid to allay any fears/concerns individuals may have. The assessment meetings are scheduled for the week commencing 16 September 2019.

Strategic Aim 3

6. **Talent Management**

A talent management model is currently being developed for NTW that will support a career pathway into management at various levels. This will be supported by the development of career pathways across a variety of professions and disciplines which will support staff to move around in their career through a structured programme of support, mentorship and qualifications.

In addition, terms of reference for a talent management Board and forum have been drafted in order to support the decision making around internal and external developments.

Staff awareness sessions were run jointly between NTW Academy and members of the Workforce and OD Directorate in July to discuss the proposals and gather feedback to further develop the plans. A pilot of the management pathway is being planned for the near future.

Strategic Aim 4

7. **Health and Wellbeing Campaigns**

Pedometer Challenge – May 2019

NTW's fourth Pedometer Challenge (following on from the highly successful events in **2013**, **2015** and **2017**) took place for four weeks in May. The challenge coincided with National Walking month and Mental Health Awareness week. 58 teams registered for the challenge and 54 teams completed. The teams walked a total of 73,149,512 steps which equates to 32,511.00 miles.

Night Owls, the winning team made up of St Georges Park night shift workers Ali Burnage, Jane Straker, Mick Dixon and Sam Burns, walked to victory with an amazing 1,988,813 steps /884 miles.

Three members of the winning team were presented with INTU gift vouchers and 'Pedometer Winner 2019' T-shirts by John Lawlor (Chief Executive) and Lynne Shaw (Acting Director of Workforce and OD).

Health and Wellbeing Survey

The third NTW Health and Wellbeing Survey was launched on 3 June 2019. This is in line with the North East Better Health at Work Award, a regional award scheme which recognises and endorses workplaces that motivate staff in developing a sustainable culture of health and wellbeing. The Trust continues to retain the North East Better Health at Work Award at Maintaining Excellence level. The Wellbeing Survey is now closed and an analysis is being undertaken. The analysis will inform wellbeing and health priorities for the coming year.

Health and Wellbeing Day, Neurological and Specialist Services – June 2019

This event was organised by the South Locality Group as an opportunity to focus on their personal Health and Wellbeing. The Health and Wellbeing team were invited to support the event sharing a range of information on a number of topics including stress and mental Health together with how to access occupational health services, staff benefits and local clubs and exercise offers.

Annual Members Meeting (AMM) - Raising Awareness of Menopause

Building on requests for information on the Menopause the Health and Wellbeing team attended the AMM to provide a range of information about Menopause symptoms and advice on how to manage these symptoms. A number of discussions took place with both female and male staff. Staff who attended the stall said that they were encouraged to see that the Trust was highlighting Menopause and taking positive action in organising a Menopause Support Group – a number of staff put their names forward to be part of this group which is due to be launched imminently.

Strategic Aim 5

8. **Simulation – MELISSA (Mobile Educational Learning Improving Simulation Safety Activities)**

As part of the Medical Education Annual Conference, MELISSA was invited to the Trust.

MELISSA is a training and simulation double decker bus that has been designed to deliver healthcare education and training across the North East and North Cumbria.

On board, MELISSA has a comfortable seating area, simulation equipment including mannequins, audio visual equipment, a clinical suite and a control room.

MELISSA is suitable for all types of training and ideal for reaching teams in more remote and rural parts of the region who sometimes do not have easy access to training facilities. Over 50 staff visited MELISSA.

9. **CPD Events April – Aug 2019**

The Medical Development Team aims to provide high quality, informative and educational CPD events to medical colleagues and other professions, both internally and externally to the Trust. Through attending CPD events, medical colleagues are able to gather evidence of ongoing CPD for their appraisal and revalidation. The CPD programme has expanded over the last 12 months with positive feedback received from events. Over the last quarter the following sessions have been delivered:

- Work Life Balance – 8 May 2019
- ECG Event – 14 May 2019
- Reducing Violence & Challenging Behaviour - Positive & Safe – 23 May 2019
- GP Update – 12 June 2019
- Management of Eating Disorders in Adults – 19 June 2019

Feedback for all events was very positive with delegates requesting a repeat of some of the sessions. An ongoing programme of CPD is in place.

Strategic Aim 6

10. **Neyber**

Financial concerns can have a detrimental impact on staff Wellbeing and Health with growing evidence on the pressure and stress caused by financial worries both impacting on performance and absence from work.

The Trust has partnered with Neyber who is the first private company in the UK to offer financial education and salary deducted lending through UK employers. They currently work with a wide number of NHS and other public sector organisations and their ethical approach has made them the first UK alternative lender to be accredited by the UK Lending Standards Board.

The introduction of Neyber will provide another element/choice around financial wellbeing. The service will provide financial education and information to our staff, as well as flexible options of loans with repayments directly from salary. There is also a helpline to discuss best options available. In addition, Neyber offer an online portal where staff can access advice on a wide range of topics linked to financial wellbeing to ensure they are informed to make the right decisions regarding finances.

Preparations are underway to finalise the internal processes with the scheme to be launched in October 2019.

In other news:

Junior Doctor 2016 Contract updates

The amended 2016 terms and conditions for doctors in training came into effect from 7 August 2019 following agreement between the British Medical Association (BMA) and NHS Employers. The terms will be introduced in a phased implementation taking into account operational implications of the changes for employers.

Some of the changes to the contract include

- Increases to weekend and night shift (shifts ending after midnight) pay
- £1000 a year extra for all less than full time trainees (LTFT)
- A fifth nodal point on the payscale at the level of ST6
- Section 2 transitional pay protection extended until 2025
- Improved GP mileage and confirmed supernumerary status
- Improvements in rest and safety entitlements with no more pay-to-stay when too tired to drive
- Contractualised NROC (non–resident on Call) / LTFT (less than full time) rostering guidance
- Guaranteed Annual paylift of 2% each year for the next four years.

Changes to Agency Rules - NHSI

NHS Improvement has confirmed that following consultation, they have made two changes to agency rules with effect from 16 September 2019.

The changes will be:

- A restriction on the use of off-framework agency workers to fill non-clinical and unregistered clinical shifts.
- A restriction on the use of admin and estates agency workers, with exemptions for IT and special projects.

The Trust had already committed to a reduction in the use of agency and is currently reviewing the way in which it will fill these posts for short term requirements.

Michelle Evans
Acting Deputy Director of Workforce and OD

Northumberland, Tyne and Wear NHS Foundation Trust

Board of Directors Meeting

Meeting Date: 4 September 2019

Title and Author of Paper: North East and North Cumbria Integrated Care System – Memorandum of Understanding for NHS Clinical Commissioning Groups and NHS Foundation Trusts.

Executive Lead: John Lawlor, Chief Executive

Paper for Debate, Decision or Information: Information

Key Points to Note:
A slightly revised version of the draft ICS MoU is attached.

The feedback received from the earlier version of the draft ICS MoU has been taken account under a number of key principles including the importance of strong clinical leadership, the continuing statutory responsibilities of constituent organisations, and the role of lay members and Non Executives in the ICS through the proposed Partnership Assembly.

One consistent area of feedback has been to clarify the relationship between the ICS and ICPs, so there is now a revised section on the ICS governance with a greater role for the ICPs – rather than the Health Strategy Group as in the previous version.

Our comments have been taken account of so the Board is asked to adopt the MoU to support our role as a leader across the ICS.

Risks Highlighted to Board : None to note.

Does this affect any Board Assurance Framework/Corporate Risks?
Please state **Yes** or **No No.**
If Yes please outline

Equal Opportunities, Legal and Other Implications: None to note

Outcome Required: Formal approval

Link to Policies and Strategies:

North East and North Cumbria Integrated Care System

Memorandum of Understanding for NHS clinical commissioning groups and foundation trusts

Introduction and Context

1. This Memorandum of Understanding (Memorandum) is an understanding between the North East and North Cumbria NHS organisations within our ICS. It sets out the details of our commitment to work together to realise our shared ambitions to improve the health of the 3.1 million people who live in our area, and to improve the quality of their health and care services.

2. In working together as a system we will place the people we serve, and the communities in which they live, at the centre of our decision-making, alongside a commitment to clinical leadership at every level of our ICS, and to an appropriate balance between primary, community and acute care.

3. Our ICS is not a new organisation, but a new way of working to meet the diverse needs of our citizens and communities. It does not seek to introduce a hierarchical model; rather it provides a mutual accountability framework, based on principles of ICP subsidiarity, to ensure that we have collective ownership of the delivery of our shared priorities.

4. Although this MOU has a focus on collaboration between NHS organisations, the next stage of our ICS development will be to engage with our partners, in local authorities and beyond, to develop shared priorities and the optimal governance arrangements to oversee their delivery.

5. The Memorandum is not a legal contract. It is not intended to be legally binding and no legal obligations or legal rights shall arise between the Partners from this Memorandum.

A new approach to collaboration

6. Our approach to collaboration begins in each of our fourteen local authority areas which make up the North East and North Cumbria. These places are the primary units for partnerships between Local authorities, NHS commissioners and providers, independent sector providers and the wider public and voluntary sector, working together with the public and patients to agree how to improve health and wellbeing and improve the quality of local health and care services.

7. In seeking to work together we will recognize the operational and financial pressures of our Local Government and other partners, and work with them to optimise the use of our resources in the interests of the people we serve.

8. Place-based working, overseen by Health and Wellbeing Boards, is key to achieving the ambitious improvements in health outcomes that we all want to see. As an ICS we are clear that subsidiarity is vitally important and operated wherever appropriate. It is in our 'places' where the majority of services will continue to be commissioned, planned and delivered.

9. It is also intended to establish an ICS Partnership Assembly that will provide a strategic view on issues where working at scale makes sense and adds value, with inclusive representation from NHS organisations (both non-executive and executive) and partners from each of our ICPs (see below). The ICS Partnership Assembly will help to shape and endorse our strategic priorities -

and make recommendations to statutory decision makers - so that local plans are complemented by a common vision and a shared plan for the North East and North Cumbria as a whole.

Working at scale as an Integrated Care System

10. Although we recognise that local relationships and place-based activity takes precedent, we must also ensure strong connections through to the overall aims and objectives of the ICS. In addition, we must deliver the constitutional standards and deliver the best possible care for patients and the best possible experience for staff.

11. As one of the largest ICSs our operating model is different to other places, as we work across three broad levels of scale.

- **Neighbourhood and Place** – this is the main focus for partnership working between the NHS and local authorities in our cities, boroughs and counties, where primary care networks (serving populations of 30,000-50,000) operate within local authority/current CCG areas of between 150,000 to 500,000 people. Services commissioned and delivered at this level will be predominantly community based, with flexibility to adapt to local circumstances and need.

- **Integrated care partnerships** – will cover populations of around one million (with the exception of North Cumbria, which has unique geographical and demographic features). These are partnerships of neighbouring NHS providers and commissioners, working with their local authorities and other partners, to deliver safe and sustainable predominantly hospital-based health and care services for the people in their area.

- **Integrated care system** – covering a population of circa 3.1 million people, focussed on key strategic priorities for 'at scale' working allowing all NHS and partner organisations to:
  - Collectively prioritise based on a shared understanding of need and areas of underperformance
  - Act with 'one voice' to represent the North East and North Cumbria and therefore be in a better position to access resources that support our shared priorities.
  - Set stretching and consistent service standards – especially for vulnerable groups – and ambitious targets to improve patient and staff experience
  - Manage risks and pressures better together as a system
  - Share and spread best practice
  - Reduce duplication and develop shared functions where appropriate

Our principles, values and behaviours as a collective senior leadership community:

12. To operate as an effective integrated health and care system we commit to working beyond organisational boundaries. We will build our collective capacity to better manage the health of our population, striving to keep our people healthier for longer and reducing avoidable demand for health and care services. We will:

- Act collectively, demonstrating what can be achieved with strong system leadership
- Speak with one voice, where appropriate, in relation to matters relating to national health and care policy
- Maintain an unrelenting collective focus with our partners on improving health outcomes, based on the principle of prioritising patient first, then system and organisation

- Recognise the continued strengths of each organisation and treat each other with respect, openness and trust, whilst also working as part of an ICS to identify shared priorities and where possible to collectively manage risk.
- Place innovation and best practice at the heart of our collaboration, ensuring that our learning benefits the whole population,
- Maximise opportunities for system-wide efficiencies
- Consider opportunities to manage our resources within a shared financial framework.

ICS Planning in Progress

13. To tackle the challenges of continuous improvement, and to ensure the sustainability of our services, NHS and other Partners are already developing six priority workstreams:-

    I. **Population Health and Prevention** – making fast and tangible progress on improving population health through more effective screening and public awareness to better prevent, detect and manage the biggest causes of premature death in the North East and North Cumbria: cardiovascular disease, respiratory disease and cancer.

    II. **Optimising Health Services** – setting clinical standards and coordinating initiatives across the ICS to find sustainability solutions for those of our health services under the greatest pressure. This workstream will coordinate the work of our Clinical Networks, including the Cancer Alliance, Urgent Care Network and others, and manage the dependencies between the service improvement and reconfiguration proposals as they are developed by each ICP, and maintaining an oversight on quality across our patch.

    III. **Digital Care** – Use digital technology to drive change, ensure our systems are inter-operable, and improving how we use information technology to meet the needs of care providers, patients and the public, helping clinicians to share information and our patients to manage their healthcare.

    IV. **Workforce Transformation** – building a future workforce for our ICS, with the right skills and flexible support arrangements to enable them to work across multiple settings whilst working collectively to ensure we can recruit and retain staff in priority areas.

    V. **Mental Health** - improving outcomes for people who experience periods of poor mental health, particularly those with severe and enduring mental illness, and doing more improve the emotional wellbeing and mental health of children and young people, and breaking down the barriers between physical and mental health services.

    VI. **Learning Disabilities** – transforming care for people with learning disabilities and autism and improving the health and care services they receive so that more people can live in the community, with the right support, and close to home.

Our governance

14. We will always respect the principle of subsidiarity, and the ongoing responsibilities and accountabilities of statutory CCGs and foundation trusts for services commissioned and delivered at 'place' level. The ICS cannot and will not replace or override the authority of ICS members' boards, councils and governing bodies. Instead, the ICS's governance has been designed to provide a strategic mechanism for collaborative action and common decision-making for issues which are best tackled on a wider scale.

15. The proposed governance model for the ICS has two main features;
    - The development of a strategy and shared priorities, through a Health Strategy Group and Partnership Assembly.
    - The execution of these priorities through an ICS Management Group and then the ICPs themselves.

16. NB the development of our governance arrangements is an iterative process, and will be kept regularly under review. Their chief purpose is to provide mechanisms to build consensus and ensure delivery of agreed priorities, but they do not over-ride the statutory authority of CCG governing bodies and trust boards.

Development of our ICS strategy

17. **The ICS Health Strategy Group (HSG)** will be a quarterly meeting, with membership encompassing CEOs of each of our statutory NHS organisations, alongside clinical leaders and representation from our emerging primary care networks, the Association of Directors of Adults and Children's Social Services, the Directors of Public Health Network, Public Health England, and the Academic Health Science Network.

18. In conjunction with the ICS Partnership Assembly (see below), and ensuring the principle of ICP subsidiarity, the role of the HSG will be to
    - Agree an overall ICS strategy based on an understanding of both shared challenges, and the objectives in the Long Term Plan – and the priority workstreams that will deliver these priorities.
    - Develop a single leadership architecture, including system rules, behaviours and leadership development.
    - Share information and showcasing effective practice from across the ICS

19. The development of an **ICS Partnership Assembly** is now in discussion with our partners, but will have a key role in shaping our shared priorities for collaboration across health and care, and the wider determinants of health – including, for example, inclusive economic development, the environment, and climate change– that can drive improvements in population health. This Assembly will have an independent chair and vice-chair, and its membership is likely to comprise nominated representatives from each ICP, which could include Health and Wellbeing Board chairs as well as lay members and non-executive directors from NHS organisations. How this body is constituted will be subject to further discussions with our partners over the coming months.

Execution of priorities

20. The **ICS Management Group** will meet monthly, under the chairmanship of the ICS Executive Lead, with two CEO-level representatives from each of our ICPs (one NHS commissioner and one NHS provider), plus senior clinical leaders, representatives from tertiary acute and mental health providers, and NHS England/NHS Improvement.

21. The role of the Management Group will be to
    - strengthen our system leadership capacity to tackle shared challenges
    - oversee the delivery of the LTP and the ICS's strategic priorities
    - provide mutual support and accountability for the development of our ICPs

- manage performance challenges and ensure robust oversight of emerging service quality issues
- jointly develop plans as a system to bridge financial gaps, and agree systems for prioritising, distributing and holding each other to account for transformation funding.
- Assess the recommendations emerging from our ICS workstreams, referring them on to ICPs for implementation if the proposals are supported

22. The ICS Management Group will have a symbiotic relationship with the **governance arrangements of each ICP**. These arrangements are now under development in each of our ICPs, and will need to agree their own governance model, including the relationship between the ICP and their constituent statutory bodies, as well as the role of clinical leaders and non-executive and lay members.

23. The ICS Management Group will ensure mutual accountability by focusing on the delivery of strategic macro-level system work - with the ICPs taking forward a detailed work programme that fits the needs and requirement of their local populations.

24. It will be the responsibility of the ICP Leads to feedback from the Management Group and agree locally how ICS workstream recommendations are best ratified and implemented in their ICPs. ICP leads will also escalate any local challenges to the ICS Management group for consideration of how best the wider system can provide support.

Mutual Financial Accountability

25. The ICS has a key role in supporting organisations and ICPs to collectively drive financial sustainability and improve productivity. As an ICS, we have agreed a set of principles for working together which include adopting a transparent, open-book approach to financial planning, in year reporting and a collective approach to financial risk management.

26. NHS organisations within our ICS are committed to working in collaboration to drive a system response to the financial challenges we face and to take the necessary actions to achieve financial sustainability within the resources available. NHS organisations within our ICS have already committed to the delivery of the 19/20 ICS operational plan, which demonstrated full sign up to delivery of organisational control totals.

27. The ICS will also play a key role through relevant working groups, such as the ICS Finance Leadership Group and Strategic Capital Working Groups, to provide guiding oversight and advice on ICS capital investment priorities and productivity and efficiency opportunities where this is appropriate to do so. This will include oversight of system level efficiency programmes informed by the Rightcare, Model Hospital and GIRFT programmes.

28. Working within our ICS, each ICP is now developing comprehensive 5 year financial plans in support of the NHS Long Term Plan commitments to 2023/24. ICP plans, underpinned by common financial planning assumptions, but tailored to local priorities and circumstances will form the foundations upon which the overarching ICS system long term plan will be constructed.

29. Once plans are established, each ICP will need to engage in collective performance management through open and transparent discussions, peer challenge and support. Local financial governance and accountability arrangements will be established within each ICP and principles associated with management of risk have been agreed. ICPs will take appropriate supportive

action should individual organisations within the community be unable to deliver on agreed plans.

30. In the event that the ICP collective is unable to support delivery of agreed ICP plans, the ICS will open discussions across the wider North East and North Cumbria NHS system to determine whether flexibility exists to offset deteriorating performance in one ICP against improving performance in another.

Conclusion

31. Through this Memorandum the NHS organisations in the North East and North Cumbria ICS commit to
    - working together in partnership to realise our shared ambitions to improve the health of the 3.1 million people who live in our area
    - take a collaborative approach to improving population health, and to ensure the quality and sustainability of their health and care services.

Signed: Chief Executive

……..

Signed: Chair

…….

Date:

NORTHUMBERLAND TYNE AND WEAR NHS FOUNDATION TRUST

Board of Directors Meeting

Meeting Date: Wednesday 4 September 2019

Title and Author of Paper: Emergency Preparedness , Resilience and Response (EPRR) Annual Report 2018 / 19 (Including NHS England Core Standards Assessment 2019 / 20) Author of Paper in response to this report – Tony Gray - Head of Safety , Security and Resilience Craig Newby - Deputy Head of Safety , Security and Resilience Tim Docking – Deputy Chief Operating Officer (Director of EPRR)

Executive Lead: Gary O'Hare, Executive Director of Nursing and Chief Operating Officer (Accountable Emergency Officer)

Paper for Debate, Decision or Information: Information

Key Points to Note: • Successful test of decant facilities as part of Pelican 3 live scenario • Update provided on significant work undertaken in response to EU-Exit • NHS England Core Standard Submission received by NHS England and CCG's identifies Substantially Compliant for Core Standards with 1 minor action point listed at Appendix A. • Deep Dive information in relation to severe weather – substantially compliant with 2 action points listed at Appendix A. • Forward Plan included.

Risks Highlighted to Board: None
Does this affect any Board Assurance Framework/Corporate Risks? No Please state **Yes** or **No** If Yes please outline
Equal Opportunities and Legal and Other Implications: None
Outcome required: Noted for Information, and Decision made on Non-Executive Director for EPRR
Date for completion: N/A
Links to Policies and Strategies: • Emergency Preparedness , Resilience and Response Policy • Incidents Policy • Security Management Policy • Central Alert System Policy

NHS
Northumberland, Tyne and Wear
NHS Foundation Trust

Emergency Preparedness , Resilience and Response Annual Report 2018 -2019

Caring | Discovering | Growing | Together

Index

1. Introduction

This report provides an annual update in relation to activity of Emergency Preparedness, Resilience and Response (EPRR) from April 2018 to March 2019. This report also includes the NHS England Core Standards Assessment for 2019 / 20, which then forms part of forward plan for the Trust's EPRR systems support the Trust in ensuring it is prepared to respond to all events planned and unplanned, in an ever changing environment, and this has been facilitated over the last year. This is important with the national focus on terror related events and cyber security incidents on the increase. The Trust is well placed and actively involved in local plans to improve and respond to the areas should the need arise. The Trust has been involved with a number of live incidents and supported Pelican 3 as a system wide test scenario of a mass casualty event.
The EPRR Team has been heavily focused on local and national plans over the last year in preparation for EU-Exit and the Board was updated on these plans throughout the year, the work progress as we plan again for a further outcome in October.

2. Background

The Health and Social Care Act 2012 requires all NHS organisations to plan for, and respond to a wide range of incidents that could impact on health or patient care. This includes significant incidents or emergencies such as prolonged periods of pressure on services, extreme weather conditions, infectious disease outbreaks or a major transport accident. The programme is referred to as (EPRR).

Core Standards and supporting guidance from NHS England set out the parameters for Trusts to adhere to in relation to Emergency Preparedness. The Trust is also required by the Health and Social Care Act (2008) Regulated Activities Regulations (2010) to have plans in place for dealing with emergencies.

The Civil Contingencies Act 2004 (CCA) provides the framework for emergency preparedness in the UK. Although Mental Health Trusts do not currently have statutory obligations under the CCA, the Department of Health and NHS England require all NHS providers to adhere to the principles of the Act.

3. Governance Arrangements

3.1 Responsible Officers

The Trust has in place an Accountable Emergency Officer, this role is undertaken by the Executive Director of Nursing and Chief Operating Officer. This role is supported by the Deputy Chief Operating Officer in his capacity as Director of EPRR.

The operational functions of EPRR are now carried out by the Head of Safety, Security and Resilience supported by the Deputy Head of Safety, Security and Resilience. These two roles are also the Trust's Accredited Security Professionals and Competent Health & Safety Professionals, which has benefitted the alignment of the EPRR agenda.

The Head and Deputy Head of Safety, Security and Resilience have a planned monthly meeting with the Director of EPRR, to bring forward a plan and agree any actions over the following month.

3.2 EPRR Policy

There were minor changes to the Trust's Emergency Preparedness, Resilience and Response Policy – NTW (O)08 in May 2019 to reflect the change of Director lead. There were also updates to both the Cold Weather Plan and the Heatwave Plan to reflect changes from national documents.

3.3 Meetings Arrangements

The Terms of Reference and membership were reviewed and it was agreed to move to quarterly EPRR meetings across the Trust, reporting into the Trust's Quality and Performance Committee as a sub group of the Board.

The meetings have had a new focus and new agenda, and have been well attended and chaired by either the Executive Director of Nursing and Chief Operating Officer (AEO) or the Deputy Chief Operating Officer (Director of EPRR), no meetings have been cancelled in 2018 /19.

4. External Governance Arrangements

The Trust is required to have attendance at a number of planned external meetings.

4.1 Local Health Resilience Partnership

The Local Health Resilience Partnership (LHRP) is a strategic forum to facilitate health sector preparedness and planning for emergencies. It is jointly chaired by NHS England and a Director of Public Health and meets bi-monthly. The Head of Safety, Security and Resilience as a senior manager and decision maker represents the Trust at the LHRP, on behalf of the Director of EPRR and AEO. The Trust has had representation at these meetings throughout the year.

4.2 Health & Social Care Resilience Group

The regional Health and Social Care Resilience Group is a multi-agency practitioner level group, responsible for co-ordinating the development of resilience arrangements, capability and capacity to respond to emergencies and major incidents. The Head of Safety, Security and Resilience represents the Trust on this group. The Trust has had representation at these meetings throughout the year.

4.3 Business Continuity Forum

This meeting supports the local NHS England approach to EPRR, and is a networking meeting for EPRR / Business Continuity Leads in Trust's, both the Head and Deputy Head of Safety, Security and Resilience are members of this meeting. The Trust has had representation at these meetings throughout the year.

5. Incidents Occurring within the Trust

The EPRR meeting receives a quarterly update on both serious infrastructure incidents affecting the Trust as well as all other low level infrastructure incidents which over time may impact on business continuity. The following table gives a breakdown of the Trust activity. There have been 2 serious incidents recorded that potentially or actually impacted on services as below.

Incident Date	Incident Number	Cause 1	Department	Details Of Incident
25/10/2018	320662	IN08 Gas Leak	Estates Department NGH	TW, housing contractor on land next to Northgate Hospital have put a digger bucket through the gas main feeding a significant part of site, rupturing the gas main.
14/12/2018	326352	IN04 Server Failure	Informatics Infrastructure SNH	Network issues started at St Nicholas Hospital which resulted in loss of access to RiO, telephony and any other network services run from that site. Major failure for anyone based at St Nicholas Hospital, loss of access to Intranet and RiO for all users.

The first incident resulted in a complete loss of heating and hot water for all patients on the Northgate Site, for a number of hours throughout the night, external contractors and NTW Solutions work to restore the service, with the heating and hot water restored just before midnight. Business continuity plans worked well with extra blankets and boilers for hot-water as required.

The second incident was unusual, whilst the incident itself was relatively low level, the impact across the Trust was significant and meant that the Trust lost all IT systems, most communication systems, and all ways of escalations between sites for a number of hours on a Friday afternoon. The IT Team worked to resolve the issues, and everything was restored after 4 hours. IT have reviewed their business continuity plans to prevent and mitigate this incident from occurring.

All Infrastructure Incidents

Cause 1	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Total	%
IN01 Loss Of Telecommunications	3	3	1	1	4	4	3	4	4	1	1	4	33	15.21
IN02 Loss Of Electricity	1	0	1	5	1	4	2	5	2	1	1	0	23	10.60
IN03 Loss Of Water	1	0	0	2	0	0	0	1	0	0	0	1	5	2.30
IN04 Server Failure	0	0	0	1	0	1	0	0	2	0	0	1	5	2.30
IN05 IT Network Failure	1	2	2	3	3	17	6	8	6	11	7	2	68	31.34
IN07 Lift Failure	0	0	0	1	0	0	2	0	0	0	2	0	5	2.30
IN08 Gas Leak	0	0	0	0	0	0	1	0	0	0	0	0	1	0.46
IN09 Failure Of Fixture & Fittings	3	4	1	0	1	1	0	3	2	0	1	2	18	8.29
IN10 Rio Issues	0	2	1	1	2	3	0	0	4	0	1	1	15	6.91
IN11 Flooding	0	2	2	3	2	0	0	0	0	0	1	0	10	4.61
IN12 Loss Of Heating	0	0	0	0	0	0	0	1	2	2	2	2	9	4.15
IN13 Environmental Issue	1	0	0	0	1	3	1	1	1	2	1	3	13	5.99
IN15 Environment Too Hot	0	0	2	7	2	0	0	1	0	0	0	0	12	5.53
	10	13	10	24	16	33	15	24	23	17	16	16	217	100.00

It can be seen from the table above that infrastructure incidents account for a very small percentage of the 42,500 incidents reported in the Trust last year, however each incident is reviewed in detail to see if the re-occurrence can be prevented. The majority of incidents relate to IT / networks and loss of communications (both landline and mobile phones) and these are reviewed by the infrastructure team. Some of these issues relate to activity out-with of the Trust control due to external outage. Business continuity plans can be seen to be working in these incidents, with plans being escalated to reduce impact on clinical services. It is also noticeable that infrastructure incidents have increased by 75 from the previous year (increase of 50%), the rise is indicative of where EPRR sits within the Safety function of the Trust that oversees incident reporting, and indicates previously under-reported activity. It is also acknowledged that all incident reporting increased by over 10% in the last year.

The EPRR Group receives regular reports on all incidents including the review of serious incidents, and monitors actions, improvements and any changes to Business Continuity Plans as required.

6. Incident Co-ordination Centres

NHS England requires all NHS funded organisations to have the ability to establish an Incident Coordination Centre (ICC) to respond to a major incident.

The Trust maintains a centre at St Nicholas Hospital – Conference Meeting Room to provide a strategic response to incidents affecting the whole of the Trust. There are also centres at St Georges Park and Hopewood Park to manage the local response during incidents and provide a point for coordination of any reporting requirements during an incident.

The Trust also operates a virtual Skype system for the requirements of ICC, this technology will be used more in future, and will mirror the requirements of live events when dialling into multi-agency conversations.

Each centre has been assessed to the standards set by NHS England.

7. Internal Audit

There was no internal audit carried out in the last 12 months, the Trust maintained it's good level of assurance and completed all the actions identified in the management responses.

8. Exercises

NHS England Core Standards for Emergency Preparedness require NHS Providers to undertake exercises to ensure their readiness for their response to incidents.

The following are the exercises that the Trust has been involved in over the last year:-

Operation Stephenson

Exercise Pelican 3

The scenario

Terrorist related incident involving gunfire and explosions within a busy city centre location (based within a shopping centre). The scenario involved physical injuries to around 200 people, 36 of these being children. This was a locally based incident; however casualties were dispersed across the whole of the North East and Cumbria. The locality of the incident meant NTW were designated as the lead MH trust. Planning assumptions were used for day 3 recovery workshop modelled against similar types of incident.

- Day 1 involved NTW testing a number of responses, these being:
  - Details of service users residing within the cordoned area
  - How Addiction services would manage if Mary Street was within the cordoned area.
  - Making Meadow View available as a decant facility
  - Monitoring capacity of Psychiatric Liaison Services

- Day 3 of this exercise was specifically designed to test the psycho-social recovery phase of the incident and interventions for PTSD; primarily for mental health providers and covering 3 months post incident.
- Tests carried out on Day 1 were positive and highlighted good practice
- The recovery phase of day 3 highlighted a number of potential business delivery concerns that need further action by a number of agencies and plans are being put in place, the Trust will support these plans.

9. EU – Exit

Since September 2018, the Trust has been putting plans in place in line with Department of Health & Social Care guidance / NHS England Guidance and local agreements to produce a risk assessment in respect of both a deal / no-deal scenario. The Board was updated on our risk assessment and plans in place covering the 7 key areas as follows:-

- Supply of medicines and vaccines
- Supply of medical devices and clinical consumables
- Supply of non-clinical consumables, goods and services
- Workforce
- Reciprocal healthcare
- Research and clinical trials
- Data sharing, processing and access

Our risk assessment has been shared as part of local and national plans, and as part of our communication strategy, information has been provided for patients and carers on our Trust website.

10. Forward Plan

The forward plan for last year, had all actions completed. This years forward plan includes one action from core standards and a number of actions in relation of transition of North Cumbria Services, planned for later in the year, as well as continual work in preparation for EU-Exit

11. NHS England Core Standards Submission – 2019 / 20

NHS England undertakes an annual assurance process against a set of core standards for Emergency Preparedness, Resilience and Response (EPRR).

The assurance process for 2019/20 was received on 26 July 2019 from NHS England, with the self-assessment and statement of compliance returned to NHS England by 10 September 2019. It is a requirement of the assurance process that the statement of compliance is reported to the Board of Directors / Governing Body Meeting.

There are 68 core standards questions of which 54 apply to Mental Health care providers.

Of the 54 Core Standards, there are 1 standard of partial compliance, these are listed in Appendix A, with the appropriate actions and evidence to prove compliance.

This year there is an additional deep dive in relation to severe weather planning and assessment, there are 2 standards of partial compliance, these are listed in Appendix A, with the appropriate actions and evidence to prove compliance.

In view of these three areas, the Trust is able to report a Substantial level of compliance. Actions to achieve full compliance with the standards have been added to the EPRR work-plan for 2019 / 20, to be managed by the Strategic EPRR Group.

The Partial compliance actions will be overseen by the EPRR Group.

12. Conclusion

There has been major benefits to the Trust of integrating the Emergency Preparedness, Resilience and Response portfolio to the existing Safety and Security arrangements of the Trust since January 2018, and this can be seen with this being the first annual report covering a whole year of responsibility, with more effective cover for clinical and operational teams, and an ability to make information more accessible, timely and transparent across the Trust.

The Trust now has a fully embedded information system available to all via the Trust Intranet under the Safer Care section, which covers:-

- Business Continuity Plans
- Heatwave Planning
- Cold Weather Planning
- Policy and supporting guidance
- EU-Exit Information

Other benefits have included a streamlined and specific internal EPRR – Central Alert System, mirroring the existing clinical system in use, to disseminate timely information to clinical and operational teams.

Within the local Healthcare system The Trust representatives are called on more than ever before to support local resilience issues, and the Trust EPRR leads have supported NHS England regional team to fully understand the risk profile and capacity and demand issues for Mental Health Services, this has resulted in the Trust EPRR leads supporting a number of local and national projects, to ensure that Mental Health and Learning Disability services are fully considered.

Appendix A

Emergency Preparedness, Resilience and Response (EPRR) Assurance 2019-20

STATEMENT OF COMPLIANCE

Northumberland, Tyne & Wear NHS Foundation Trust has undertaken a self-assessment against the NHS England Core Standards (v2.3).

Following the self-assessment, and in line with the definitions of compliance stated below, the organisation declares itself as demonstrating the following level of compliance against the 2019-20 standards as: **Substantially compliant**

Overall EPRR assurance rating	Criteria
Fully	The organisation is 100% compliant with all core standards they are required to achieve.
Substantial	The organisation is 89-99% compliant with the core standards they are required to achieve.
Partial	The organisation is 77-88% compliant with the core standards they are required to achieve.
Non-compliant	The organisation compliant with 76% or less of the core standards they are required to achieve.

Where areas require further action, this is detailed in the organisations *EPRR Work Plan* and will be reviewed in line with the organisation's governance arrangements.

I confirm that the above level of compliance with the EPRR Core Standards has been or will be confirmed to the organisation's board / governing body.

Signed by the organisation's Accountable Emergency Officer

08/08/2019 — *Date of board / governing body meeting*

08/08/2019 — *Date signed*

Emergency Preparedness, Resilience and Response (EPRR) Core Standards 2019/20 Action Plan / Annual Work Programme

Identification Route	Section	Core Standard	Action Required	Lead	Timescale	Evidence
EPRR Core Standards (2019 / 2020)	Co-operation	The Accountable Emergency Officer, or an appropriate director, attends (no less than 75%) of Local Health Resilience Partnership (LHRP) meetings per annum.	Previously agreed that Head of Safety , Security and Resilience would attend on behalf of Trust representing AEO / Director of EPRR , this standard was challenged by a number of EPRR leads but has remained, this will be raised again as an action	Tony Gray / Gary O'Hare / Tim Docking	September 2019	Minutes of LHRP meeting
EPRR Core Standards (2019 / 2020) Deep Dive	Flood Response	The organisation has reference to its role and responsibilities in the Multi Agency Flood Plan in its arrangements. Key on-call/response staff are clear how to obtain a copy of the Multi Agency Flood Plan	The Trust guidance will be strengthened to link into all LA Flood Plans across the Trust Boundaries x 7.	Tony Gray	December 2019	Flood Plans
EPRR Core Standards (2019 / 2020) Deep Dive	Risk Assess	Evidence that the there is an entry in the organisations risk register detailing climate change risk and any mitigating actions	To be considered by Executives / Directors.	Gary O'Hare	December 2019	Trust Risk Register
Department of Health and Social Care / NHS England Guidelines	EU-Exit preparations	N/A	Maintain and update risk assessment and test assumptions in readiness for 31st October 2019	Tony Gray / Gary O'Hare / Tim Docking	October 2019	EU-Exit planning meeting minutes / Checklist and NHS England assurance processes

North Cumbria Services Mobilisation Group	Workstream Plan	N/A	Update all EPRR information to include North Cumbria Services, including escalation processes, on-call arrangements, business continuity plans	Tony Gray	October 2019	Safer intranet page, Trust Policy and Guidance
EPRR testing regime	Trust Policy	N/A	Conduct system wide test for EPRR across 4 localities.	Tony Gray / Tim Docking	April 2020	Test plan , and outcomes
NHS England Cold Weather Planning / Heatwave Planning	National guidance	N/A	Devise alerting system to cover both North East and Cumbria for escalation processes.	Tony Gray	October 2019	Trust Guidance
Cumbria Local Health Resilience Partnership meetings	National requirement	N/A	Appropriate attendance and support across 2 x LHRPs.	Tony Gray	October 2019	Minutes / attendance list