# Board of Directors Meeting (PUBLIC)

**27 March 2019, 13:30 to 15:30**
**Conference Room, Northgate, NE61 3BP.**

## Agenda

### 1. Service User/Carer Experience

Mitford Unit - Autism Services

Information

Helen Percival, Nurse Consultant

### 2. Apologies

Information

Ken Jarrold, Chair

### 3. Declarations of Interest

Information

Ken Jarrold, Chair

### 4. Minutes of the previous meeting: Wednesday 27 February 2019

Decision

Ken Jarrold, Chair

4. Board Meeting in Public draft minutes 27.2.19.pdf (7 pages)

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

Discussion

Ken Jarrold, Chair

5. Action List.pdf (1 pages)

### 6. Chair's Remarks

Information

Ken Jarrold, Chair

### 7. Chief Executive's Report

Information

John Lawlor, Chief Executive

7a. CEO Report March 19 FINAL.pdf (6 pages)

7b. Appendix A - CE Report 27.03.2019.pdf (10 pages)

7c. Appendix B NHSP briefing - Proposals for changes to legislation.pdf (16 pages)

## Quality, Clinical and Patient Issues

### 8. Northgate (Past, Present and Future)

Discussion

Gary O'Hare, Executive Director of Nursing/ Chief Operating Officer

### 9. Annual Quality Priorities

Decision

Lisa Quinn, Executive Director of Commissioning and Quality

9. 19_20 final proposed quality priorities March 2019.pdf (9 pages)

### 10. Board Assurance Framework and Corporate Risk Register review of 2018/19

Decision

Lisa Quinn, Executive Director of Commissioning and Quality

10a. BoD - BAF Annual Review 18_19 (final).pdf (10 pages)

10b. BoD - BAF Annual Review 18_19 Q4 BAF (appendix 2).pdf (17 pages)

### 11. Commissioning and Quality Assurance Report (Month 11)

Decision

Lisa Quinn, Executive Director of Commissioning and Quality

11. Commissioning Quality Assurance Report - Month 11.pdf (7 pages)



## Workforce

### 12. National Staff Survey Results

Discussion

Lynne Shaw, Acting Executive Director of Workforce and

Organisational Development

## 13. Interim Workforce Implementation Plan - ICS response

Lynne Shaw, Acting Executive Director of Workforce and Organisational Development

- 13a. Workforce Implementation Plan - March 2019.pdf (2 pages)
- 13b. LETTER_Interim workforce implementation plan_DH and JH_06031.pdf (7 pages)
- 13c. 20190315 WIP NENC ICS response to comments.pdf (5 pages)

# Strategy and Partnerships

## 14. 2019-20 Operational Plan and approval of budgets

Decision

James Duncan, Executive Director of Finance and Deputy Chief Executive

# Regulatory (nothing on cycle)

# Minutes/Papers for Information

## 15. Committee updates

Information

Non-Executive Directors

## 16. Council of Governors' Issues

Information

Ken Jarrold, Chair

## 17. Any other Business

Ken Jarrold, Chair

## 18. Questions from the Public

Discussion

Ken Jarrold, Chair

# Date, time and place of next meeting:

## 19. Wednesday, 24 April 2019, 1:30 pm to 3:30 pm, Conference Room 1 and 2, Ferndene, Prudhoe, NE42 5PB.

Information

Chair

# Board of Directors Meeting (PUBLIC)

27 February 2019, 13:30 to 15:30
Board Room, St Nicholas Hospital, Gosforth, NE3 3XT

## Attendees

### Board members

Alexis Cleveland (Non-Executive Director) , Peter Studd (Non-Executive Director) , Miriam Harte (Non-Executive Director) ,
James Duncan (Executive Director of Finance and Deputy Chief Executive) ,
Lynne Shaw (Executive Director of Workforce and Organisational Development) , Les Boobis (Non-Executive Director) ,
John Lawlor (Chief Executive) , Gary O'Hare (Executive Director of Nursing and Chief Operating Officer) ,
Rajesh Nadkarni (Executive Medical Director) , Lisa Quinn (Executive Director of Commissioning and Quality Assurance) , Ken Jarrold (Chair) ,
Michael Robinson (Non-Executive Director)

### In attendance

Debbie Henderson (Deputy Director of Corporate Affairs and Communications) ,
Melanie Bash (Lead Consultant Clinical Psychologist (for item 1 only)) , Angela Shields (Clinical Lead (for item 1 only)) ,
Dr Dipo (Specialty Doctor (for item 1 only)) , Claire Hay (Occupational Therapist (for item 1 only)) ,
Simon Mason (Clinical Lead Chaplain (for item 14 only)) , Andrew Cole (Consultant Psychiatrist (for item 14 only)) ,
Esther Cohen Tovee (Director of AHPs and Psychological Services (for item 14 and 15 only)) ,
Janice O'Hare (Cumbria Programme Lead (item 13 only)) , Anne Moore (Group Nurse Director Safer Care (for item 16 only))

## Meeting minutes

### 1. Service User/Carer Experience

**Information**
Melanie Bash, Lead Consultant Clinical Psychologist/ Angela Shields, Clinical Lead/ Dr Dipo, Specialty Doctor/ Claire Hay, Occupational Therapist

Ken Jarrold opened the meeting and welcomed those in attendance.

A special welcome was extended to two service users and members of staff in support. The service users shared their personal experience of Mental Health Services provided by NTW, and described their experience of care and treatment in the Richardson Intensive Eating Disorder Service.

John Lawlor expressed his appreciation for sharing their story with the Board and acknowledged the lack of support services available to those suffering from eating disorders before they enter the hospital/acute environment. John suggested that the Trust engage with users of the service as part of the future development of services, particularly out-patient facilities.

Ken Jarrold thanked the service users on behalf of the Board for sharing their story and wished them the very best for the future.

### 2. Apologies

**Information**
Ken Jarrold, Chair

Apologies had been received from David Arthur, Non-Executive Director

### 3. Declarations of Interest

**Information**
Ken Jarrold, Chair

Gary O'Hare declared an interest in relation to item 13 and his dual role as Director of Nursing for NTW and CPFT. Janice O'Hare declared an interest in relation to item 13 and her role as Cumbria Programme Lead. There were no other conflicts of interest declared for this meeting.

### 4. Minutes of the previous meeting: Wednesday 23 January 2019

**Decision**
Ken Jarrold, Chair

Item 5 under Matters Arising should read "John Lawlor advised the Board Sarah Rushbrooke, Group Director and himself would meet with the *carer* in the near future…".

The Board of Directors approved the minutes of the meeting held 23 January 2019 as an accurate record subject to the above amendment.

4. BoD public meeting minutes 23-01-19.pdf

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

**Discussion**
Ken Jarrold, Chair

There was nothing on the action list to review and there were no matters arising.

5. Action List.pdf

## 6. Chair's Remarks

**Information**
Ken Jarrold, Chair

Ken Jarrold introduced the meeting and welcomed those in attendance.

Ken referred on the Board Away Day held on 26th February and was pleased that the Board had taken an opportunity to discuss in detail the operational plan and challenges for the next 12 months and beyond. A discussion also took place to reflect on the current challenges at a national level, the NHS Long Term Plan and its relationship with the wider Integrated Care System. Ken also took an opportunity to thank the CEDAR Programme Team for providing an update on the Trusts Estates Strategy.

The Board received and noted the Chair's Remarks.

## 7. Chief Executive's Report

**Information**
John Lawlor, Chief Executive

John Lawlor presented the Chief Executive's report and highlighted the record number of nominations received for the NTW Staff Excellence Awards scheduled to take place on 8th March 2019.

John briefed the Board on Cadabams Mental Healthcare Services in Bangalore, India and their visit to the Trust and its services in February. The Trust and Cadabams have committed to working in partnership to build on their shared set of values with agreement to take forward key areas of work around sharing good practice, training and development and exploring opportunities to providing mental health care to the poorest 40% of the population.

John referred to recent press coverage regarding proposals to re-develop the Centre for Ageing and Vitality, in Newcastle. This followed an agreement by Newcastle upon Tyne NHS FTs to sell the majority of the site to Newcastle University. The Trust have received assurance that its specialist older people's services and adult services, including the Hadrian Clinic, would remain on site to enable the changes proposed in the 'Deciding Together' process to be agreed and implemented.

In response to the request from the Department of Health and Social Care on preparing for an EU Exit, the Trust have undertaken a risk assessment and developed action plans which were shared with the Board at the development meeting held on 23rd January. Where appropriate, the Trusts plans would be shared with the NHS England EU Exit/Emergency Preparedness, Resilience and Response Team.

Ken Jarrold took an opportunity to comment on the development of an Enhanced Bed Management service to provide patients with an improved admission, treatment and discharge process.

The Board received and noted the Chief Executive's Update.

7. CEO Report Feb 2019.pdf

# Quality, Clinical and Patient Issues

## 8. Pharmacy and Medicines optimisation report

**Information**
Rajesh, Nadkarni, Executive Medical Director

Rajesh Nadkarni presented the Pharmacy and Optimisation Annual Report to the Board for 2017/18. The report provided an overview of work during the year including: the principles of medicines optimisation; the implementation of the robotic dispensing of medication compliance packs; developing the pharmacy workforce; and improvements in governance and process.

Miriam Harte commended the team, particularly in terms of the impact of pharmacy and medicines initiatives described in the report on patient care.

Ken Jarrold commented that changes in medication and medication management since the establishment of the NHS, had been one of the most significant advances in mental health services, and commended the team for their ongoing commitment to ensuring safe management of medicines.

The Board received the Pharmacy and Medicines Optimisation Report.

8a. Pharmacy and Medicines Optimisation Report 2017_18 Cover Sheet.pdf
8b. Pharmacy and Medicines Optimisation Report 2017_18 Presentation.pdf

## 9. Controlled drugs accountable Officer annual report

**Information**
Rajesh Nadkarni, Executive Medical Director

Rajesh Nadkarni presented the Controlled Drugs Accountable Officer Annual Report to the Board for 2017/18 and highlighted key developments throughout the year including updating of the Trust's Controlled Drugs Policy, regular controlled drugs stock checks and completion of a comprehensive controlled drugs audit. Rajesh made particular reference to the relocation of pharmacy controlled drug stocks to automated Omnicell Cabinets to optimise medicines security and reduce the risk of drug selection errors.

Alexis Cleveland commented that the risk based approach to the management of controlled drugs was also important.

The Board received the Controlled Drugs Accountable Officer Annual Report.

9. Controlled Drugs Accountable Officer Annual Report 2017_18.pdf

## 10. Commissioning and Quality Assurance Report (Month 10)

**Decision**
Lisa Quinn, Executive Director Of Commissioning And Quality Assurance

Lisa Quinn spoke to the Commissioning and Quality Assurance report to update the Board in relation to the Trust's position against the Single Oversight Framework, and referred to the slight reduction in sickness absence as well as an improvement in January sickness absence in comparison to January 2018.

The Sunderland Improving Access to Psychological Therapies Service reported an increase in relation to those cases moving to recovery which had been reported at 52.6% for the month. The Trust also reported seven inappropriate out of area bed days in January 2019.

In terms of the Trusts financial position, at month 10, James Duncan reported a year to date surplus of £2.9m, £1.0m ahead of plan. He also noted the Trust's finance and use of resources score of 1 and the forecast year-end rating of 3. The forecast surplus was £3.5m, including Provider Sustainability Funding of £2.0m, which was in line with the Control Total, although the Board recognised the risks to achieving this.

James noted an increase in pay costs and spending on temporary staffing and the need reduce this to achieve the planned spend and the 2018/19 Control Total. Work continued to improve efficiency and productivity and deliver the required staffing reductions.

James advised that as well as planning for the submission of the Trust's final Operating Plan for 2019/20 in April following Board approval in March, a significant amount of work was being undertaken on longer term planning, both at organisational level and at a wider system level.

Ken Jarrold emphasised the importance of being an organisation able to deliver on contracts and finance as a means to ensure the focus continued to be firmly on quality, safety and service user and carer experience.

The Board received the Integrated Commissioning and Quality Assurance report.

10. Commissioning & QA Report Month 10.pdf

# Workforce

## 11. Workforce Directorate Quarterly update

**Discussion**
Lynne Shaw, Acting Executive Director Of Workforce And Organisational Development

Lynne Shaw presented the Workforce Quarterly Update report to advise the Board on the key work and developments made since the last meeting.

Lynne highlighted the Trust's achievement of the 'Maintaining Excellence' standard with the Better Health at Work Award (BHAWA) for 2018, awarded to organisations who have sustained their health and wellbeing activity at 'Continuing Excellence' level for a substantial period of time. The BHAWA is a regional award scheme which recognises and endorses workplaces that motivate workers in developing a sustainable culture of health and wellbeing.

Ken Jarrold referred to strategic aim 'partnership working with Trade Unions (TUs)' and emphasised the importance of building on and maintaining the current strong relationships with TUs in NTW. Lynne agreed that the Trust continues to work in close partnership with TUs, but also stated that the teams were looking at further developing this, particularly in terms of the health and wellbeing agenda.

The Board received the Workforce Directorate Quarterly update.

11. Quarterly Workforce Report - Feb 19.pdf

## 12. Gender Pay Gap

**Discussion**
Lynne Shaw, Acting Executive Director Of Workforce And OD

Lynne Shaw advised Board members that legislation had been introduced which made it statutory for organisations with 250 or more employees to report annually on their gender pay gap and publish statutory calculations every year to show the size of the pay gap between male and female employees. Lynne reminded Board members of the six key requirements.

Lynne briefed the Board on the actions to reduce the Gender Pay Gap which included continuing to review internal processes with regard to recruitment, return to work and career development, and would actively encourage and support female doctors with applications for Clinical Excellence Awards (CEAs). The Trust is also developing an internal network group to look at proactive initiatives to support gender issues as well as supporting the Equality and Human Rights Commission's "Working Forward" campaign.

Miriam Harte noted the significant gap with regard to CEAs. Lynne noted that a significant amount of work had been carried out including providing support to female doctors in their applications, and advised that in terms of benchmarking, the Trust was not an outlier.

Alexis Cleveland reminded Board members of the distinction between gender pay gap and equal pay, but supported the further work being undertaken with regard to CEAs. John Lawlor asked if the information presented was prescribed and suggested including allocation of awards as a percentage of the entire cohort of male and female consultants.

Lynne also presented the Gender Pay Gap report on behalf of NTW Solutions, the Trust's subsidiary company and confirmed that no bonus payments were made within the reference period, resulting in no gender pay to report in this area.

With regard to NTW Solutions, Peter Studd confirmed that the report had been submitted to the NTW Solutions Board meeting in February and asked if wider benchmarking could be included in future reports, particularly comparisons between the public and private sector. Lynne confirmed that the reports were publicly available and agreed to incorporate this into future reports.

It should be noted that the median pay gap for NTW Solutions between 2017 and 2018 was not comparable. When the initial 2017 report was produced the company was still in its infancy. In respect of the 2018 figures, the Company had been established for 12 months. As the Gender Pay calculations look at the retrospective months' payroll a full month of enhanced, on call or unsociable work patterns has been calculated. The estates workforce in the UK generally remains heavily male dominated, from apprenticeship level right through to director level, whereas the facilities workforce in the UK generally was heavily female dominated.

The Board received the Gender Pay Gap Report for the Trust and NTW Solutions and approved the reports for publication on the Trust's website.

12a. Gender Pay Gap Report 2018Trust Board.pdf
12b. Gender Pay Gap NTW Solutions Report.pdf

# Strategy and Partnerships

## 13. Cumbria

**Decision**
Lisa Quinn, Executive Director Of Commissioning And Quality Assurance

Lisa Quinn presented the report to the Board which required consideration and approval of the Full Business Case (FBC) in relation to the transfer of Mental Health and Learning Disability Services in North Cumbria. It was acknowledged that the Board had received opportunity to review the FBC during its development at a number of meetings prior to final submission.

Lisa advised that the Case for Change had been predicated on wide engagement and listening events. The Board acknowledged that following submission of the draft FBC to NHSI, no concerns or issues had been raised by NHSI and correspondence had been received which reaffirmed the process which had been undertaken (appendix 6). Lisa referred to appendix 7 which confirmed that although services transferred would be subject to CQC inspection, aggregated ratings from the previously separate services would not be subject to inspection for up to two years post-transfer. The Board were advised however, that the CQC were currently undergoing a review of their inspection regime, and this could be subject to change at a later date. With regard to appendix 5, Lisa highlighted the letter of support from North Cumbria CCG and the support received from the CCG during the process to date.

Ken Jarrold recognised that this represented a significant decision for the Trust Board and joined Lisa in commending the work of Gary O'Hare and Janice O'Hare which underpinned the process to date.

Peter Studd referred to section 10 of the FBC regarding consultation and asked for further details of how this work would be undertaken. Lisa stated that a robust communication and engagement plan was under development which incorporate plans to engage with staff, Governors, key stakeholders and service users and formal consultation with staff would be undertaken as part of the planning for transfer of staff.

James Duncan referred to the letter from the CCGs confirming their position and non-recurring transitional support. Whilst it was acknowledged that contractual agreements were yet to be confirmed, support and commitment was in place from stakeholders for the purposes of supporting the approval of the FBC.

Alexis Cleveland agreed that throughout the transaction process the Board have given due regard to all conditions associated with the transfer and received assurance that the associated risks have been managed and mitigated appropriately and commended the report. Non-Executive Directors have received sufficient opportunity ask questions throughout the process. Lisa provided an overview of the conditions of transfer including: a commitment for revenue and not taking NTW services into deficit level in the first year; quality impact on NTW, reaffirmed by the letter received from the CQC; capital availability and support for future applications to the wider Integrated Care System, including support from regulators; and NTW involvement in any system changes in North Cumbria.

The Board discussed the current position relating to the number of areas which remained outstanding and were reassured that progress and would be resolved as part of the implementation process.

Ken Jarrold supported the FBC and thanked Lisa and the team for the assurance received throughout the process. He also reminded members of the Board that this was also an opportunity for both organisations to learn from each other to enhance the care and treatment for patients in the region.

Lisa advised that a letter to Cumbria Partnership NHS Foundation Trust would be compiled on behalf of the Board outlining the Board's decision and discussion at the meeting.

The Board of Directors approved the final NHS Improvement Self-Assessment and Full Business Case for the transfer of Mental Health and Learning Disabilities Services from Cumbria Partnership NHS Foundation Trust to Northumberland Tyne and Wear NHS Foundation Trust.

- 13a. Cumbria NHSI Self Assessment and FBC Final.pdf
- 13b. NTW North Cumbria MH&LD FBC Feb 19 Final.pdf
- 13c. Appendix 5 Letter of Support from North Cumbria CCG 13 February 2019.pdf
- 13d. Appendix 6 Letter of Support to Approach and Self Certification NHSI 30 January 2019.pdf
- 13e. Appendix 7 Letter to NTW regarding CQC position on ratings post merger or acquisition.pdf

## 14. Citizens Tyne and Wear MH Commission

**Discussion**

Simon Mason, Andrew Cole and Esther Cohen Tovee presented the report on the work of Tyne and Wear Citizens which established a Citizens Commission on Mental Health with nine key mental health themes being discussed by teams across three public events in Newcastle, Sunderland and Durham. The findings of the Commission were published as the report *'Living Well'* which highlighted 17 actions, which the Mental Health Action Team of Tyne and Wear Citizens has promoted, including several reflecting the Trusts mental health work-streams.

The Board were asked to consider the proposal to develop further the partnership between Tyne and Wear Citizens and NTW through the sponsorship of people to be trained as leaders in the practice of community organising, the benefits of which were outlined to the Board.

Miriam Harte commended the work of Citizen Tyne and Wear and referred to it as an ideal source of intelligence, particularly with regard to the Trust's aims and objectives relating to equality and diversity.

Margaret Adams, Public Governor and in attendance as an observer noted that the initiative appeared to be focused primarily in the North of the patch and asked if there were plans to extend the scope to South of the river. Simon advised that scope can often be limited in terms of capacity and demand however, plans are underway to grow capacity to organisations across Tyne and Wear.

Ken Jarrold agreed that by further supporting the work of Tyne and Wear Citizens, it could potentially further improve the relationship between the Trust and the service users and carers.

Ken and John also took an opportunity to inform Board members that Andrew Cole would be leaving the Trust in the near future and thanked him for his 30 years of service to NTW and his significant contribution to patient care.

The Board of Directors noted the Citizens Tyne and Wear Mental Health Commission update and approved the delegated authority to the Executive Team to take forward proposals for further support and sponsorship.

14a. Citizens T&W cover sheet.pdf
14b. Citizens T&W proposal.pdf

## 15. Psychological Services Strategy update

**Discussion**

Esther Cohen Tovee, Director Of AHPs And Psychological Services

Esther Cohen-Tovee presented the Board with an update on delivery of the Trust's Psychological Services Strategy 2017–22, previously approved by the Board in June 2017. The update also included the priorities for 2019. Les Boobis congratulated the teams on the service provided.

The Board noted the Psychological Services Strategy Update.

15. Psychological Services Strategy Feb 19 cover sheet.pdf

## 16. Nursing Strategy

**Discussion**

Gary O'Hare, Executive Director Of Nursing & Chief Operating Officer

Gary O'Hare introduced Anne Moore to present the Trust's Nursing Strategy which builds on the six existing strategic aims. The strategy will enable the achievement of Trust strategic ambitions through supporting delivery of the Trusts quality goals and priorities.

The strategy has been developed with input from service users, carers and nursing staff through discussion, presentation, nursing forums and team meetings, and is aligned to the Trusts Workforce Strategy, including leadership and health and wellbeing objectives.

The launch of the NTW Academy has also helped bring together multi professional education, learning and development. This will support the Nurse Academy in partnership with local Universities, enabling delivery of the 'Grow your Own' Nursing Strategy.

Whilst fully endorsing the strategy, Alexis Cleveland noted that the strategy did not include any measures of success or key performance indicators and welcomed future updates on progress to deliver the strategy.

Ken Jarrold made particular reference to the role of nurses in shaping patient experience and the core values outlined in the strategy. Ken also encouraged Board members to attend the Trust's Nursing Conference scheduled to take place on 6th March.

The Board received and noted the Nursing Strategy.

16a. Nursing Strategy - Front Street.pdf
16b. Nursing Strategy 2019-2024 Final Draft Trust Board.pdf



# Minutes/Papers for Information

### 17. Committee updates

**Information**
Non-Executive Directors

With regard to Resource Business and Assurance Committee, Peter Studd informed the Board of the appointment of Andrew Buckley, Non-Executive Director to the Board of NTW Solutions Limited. Andrew ill take up his post from 1st March 2019.

There were no other updates from Board Sub-Committees.

### 18. Council of Governors' Issues

**Information**
Ken Jarrold, Chair

Ken Jarrold briefed the Board on the recent Service User and Carer Group which provides a forum for service users and carers to discuss issues as well as receiving updates and presentations from the Trust.

### 19. Any Other Business

**Information**
Ken Jarrold, Chair

There was no other business to discuss.

### 20. Questions from the Public

**Discussion**
Ken Jarrold, Chair

There were no questions from the public

## Date, time and place of next meeting:

### 21. Wednesday, 27 March 2019, 1:30pm to 3:30pm, Conference Room, Northgate, Morpeth, NE61 3BP.

**Information**
Chair

Northumberland, Tyne and Wear NHS Foundation Trust

## Board of Directors Meeting

**Action Sheet as at March 2019**

| Item No. | Subject | Action | By Whom | By When | Update/Comments |
|---|---|---|---|---|---|
| **Outstanding** | | | | | |
| (5) 26.09.18 | Crisis Team phone lines | The Board to receive an update in relation to the Crisis Team phone lines | Gary O'Hare | 24/04/19 | |
| (19) 24.10.18 | Board Assurance | The Board to receive an assurance map for agenda items that require formal approval. | Board Secretary | 24/04/19 | |
| (14) 23.01.19 | Visit feedback themes report | Review the format of the Visit feedback themes report. | Anthony Deery | 24/04/19 | |
| **Complete** | | | | | |
| (14) 23.01.19 | Non-Executive Director Service visits | Service visit programme to be developed for Non-Executive Directors | Board Secretary | 24/04/19 | Discussion with Non-Executive Directors and Chair 27/2/19. Service visits have commenced and schedule of visits currently being populated for 2019/20 |

**Northumberland, Tyne and Wear NHS Foundation Trust**

**Board of Directors Meeting**

| | |
|---|---|
| **Meeting Date:** | 27 March 2019 |

| | |
|---|---|
| **Title and Author of Paper:** | Chief Executive's Report<br>John Lawlor, Chief Executive |

| | |
|---|---|
| **Paper for Debate, Decision or Information:** | Information |

**Key Points to Note:**

**Trust updates**

1. NTW Academy update
2. Staff Awards
3. 5th NTW Annual Nursing Conference
4. CEDAR Programme Board update

**Regional updates**

5. NHS Improvement / NHS England Changes and Director Team for North Region
6. ICS and ICP Developments

**National updates**

7. NHS Workforce Disability Equality Standard
8. NHS Staff and Learners' Mental Wellbeing Commission
9. Clinically-led review of NHS access standards
10. Consultation on Legislative Changes



| | |
|---|---|
| **Outcome required:** | For information |

**Chief Executive's Report**

**27 March 2019**

## Trust updates

### 1. NTW Academy update

We have 5 Nurses commencing the Advanced Clinical Practitioner Programme following an apprenticeship route in late March. The role is open to AHPs too but there were no applicants this time other than from nursing. We expect to have a second small cohort later in 2019. The programme takes 2-3 years (part-time release) depending on the entry point of the individual. This is great news for us in National Apprenticeship Week (week commencing 4th March 2019) as we further develop our apprenticeship nursing pathway by building on our 39 pre-registration apprentices who began their programmes in January and the expected second cohort of circa 25 starting in July.

With the new pre-registration apprentice nurses in January and those expected in July, alongside partnership working with University of Sunderland to accept 'NTW BSc Hons students' through a non HEE commissioned route, we will have 102 additional trainee nurses in our system than a year ago. We are expecting this to reduce slightly in number in the next 2 years to give us a sustainable amount of circa 50-60 additional qualified nurses per year by the end of 2021 as predicted in the Nursing Business Case 2018.

### 2. Staff Awards

On Friday 8th March 2019 the Trust held its annual staff awards at the Civic Centre in Newcastle. It was a lovely evening hosted by Steve and Karen from Metro Radio's Breakfast show. Following a record 731 nominations, 21 awards were announced on the night to individual teams who have made a significant contribution to the Trust. It was fabulous opportunity to showcase all of the amazing work which goes on in NTW and what makes the Trust a great place to work.

### 3. 5th NTW Annual Nursing Conference – Delivering Compassion in Practice: Shaping the Future

The fifth NTW Annual Nursing Conference celebrating the success and progress of the Nursing Strategy 2015-2019 took place on 6th March. The event was attended by approximately 300 staff from the Trust including Service Users, Students, Support Workers, Qualified staff and Senior Managers together with external agency guests including CCG and University partners.

The event showcased the progress against the Nursing Strategy and highlighted the significant innovation and practice development against the six strategic aims. Gary O'Hare highlighted the uniqueness of nursing in making a difference to patients and families and how proud he was of the achievements nurses had made both within and external to the Trust.

Presentations highlighted the Trust approach to 'growing our own' practitioners and investing in staff to develop to an extended scope of practice. The Nursing Academy

12 month progress report demonstrated the strides made as a significant enabler to support the development of our nursing workforce.

The impact of the presentation from external speaker Carolyn Cleveland demonstrated, through her personal story of loss, how important empathy and compassion are to patients, families and practitioners equally. The session was a powerful display of the emotional impact on a personal level, and reminded everyone of the efforts everyone makes each day to do a good job and the impact it has personally.

Margaret Kitching, Chief Nurse for the North, NHSE spoke in support of Ruth May (recently appointed Chief Nursing Officer) and her plans to develop the future vision for nursing and how NTW will engage in this process. Margaret also commended the Trust for the significant examples of innovation she observed in the stands and through discussions with staff.

Several workshops were well attended and there were numerous displays and interactive stands again highlighting nursing and multi professional team working. The event launched the Nursing Strategy for the next 5 years.

You can upload the video which was produced from the Nursing Conference: **here**

**4. CEDAR Update**

The Strategic Outline Case (SOC) for the CEDAR Project is being considered by the NHS Improvement Capital Panel in April, and the Trust has received a number of queries on the case by the national team. These have been responded to. All interim moves to support the programme have now been agreed and are in the process of being actioned.

After detailed consideration the CEDAR Board has agreed a preferred location for the integrated secure facilities on the Northgate site, with the development now to be progressed on the southern part of the site. Discussion with stakeholders including staff and local councils have commenced. The Trust has also received confirmation that it will no longer have to test the alternative funding route of a Regional Health Infrastructure Company in its Outline Business Case. This follows the Chancellor's statement regarding PFI in his Autumn Statement.

**Regional updates**

**5. NHS Improvement / NHS England Changes and Director Team for North Region**

It has been announced that Ian Dalton will stand down and that Simon Stevens will become the joint Chief Executive of NHSE and NHSI. This had previously been rejected on the basis that as each organisation is established in statute it is required that each have its own Chief Executive. As part of the new arrangements, a Chief Operating Officer will be appointed across both organisations, who will act as nominal Chief Executive of NHSI for legislative purposes. The two chairs of both organisations will remain in place. As a result of this further changes in aligning the two organisations and their structures are expected.

The regional teams for NHSI/E have been announced with some appointments still to be made. This confirms that Richard Barker will be the Regional Director for the North East and Yorkshire, with other key appointments being Tim Savage as Director

of Finance, Margaret Kitching as Chief Nurse, Mike Prentice as Medical Director, Daniel Hartley as Director of Workforce and Organisational Development and Robert Cornall as Director of Commissioning.

**6. ICS and ICP Developments**

Work continues on developing the operational and longer term plan for the North East and North Cumbria Integrated Care System (ICS). Due to the changes to NHS Improvement and NHS England described above there has been some delay in developing the national plans for taking the ICS model forward. As a result it is not expected that there will be any further change to the status of the North East and North Cumbria for 1st April 2019 (under the Aspirant ICS Programme it had been expected to be formally announced as an ICS from that date). However, this has not affected the ongoing work and a conference on 6th March took place to take forward thinking on Governance. Work is now ongoing on actioning the outcomes of this workshop.

There has also been a review of the work-streams across the ICS and these have now been reduced to five. These are Workforce, Digital, Prevention, Optimising Healthcare and Mental Health. In addition the existing work on Learning Disabilities through the Transforming Care Programme has been recognised. Finally a workshop is planned for the 30th April to take forward he work of the Mental Health Work-stream and to support the development of the mental health elements of the ICS Five Year Plan.

**National updates**

**7. NHS Workforce Disability Equality Standard**

The NHS Workforce Disability Equality Standard (WDES) comes into force on 1st April 2019 and is a set of specific measures (metrics) that will enable NHS organisations to compare the experiences of disabled and non-disabled staff. This information will then be used by organisations to develop a local action plan and enable them to demonstrate progress against the indicators of disability equality. The WDES is important because research shows that a motivated, included and valued workforce helps to deliver high quality patient care, increased patient satisfaction and improved patient safety.

The implementation of the WDES will enable NHS Trusts and Foundation Trusts to better understand the experiences of their disabled staff. It will support positive change for existing employees and enable a more inclusive environment for disabled people working in the NHS. Like the Workforce Race Equality Standard on which the WDES is in part modelled, it will also identify good practice and compare performance regionally and by type of Trust. A detailed report will be brought to Trust Board in April detailing the requirements of the WDES and recommendations for how we will meet those requirements.

**8. NHS Staff and Learners' Mental Wellbeing Commission**

The HEE draft Health and Care Workforce Strategy for England to 2027- Facing the Facts, Shaping the Future - announced a new Commission on the mental wellbeing of NHS staff and learners.

The Commission was led by Sir Keith Pearson, former Chair of Health Education England, and by Professor Simon Gregory, Director and Dean of Education and Quality, Midlands and East, as Programme Clinical Director.

An interim report was presented to the Secretary of State for Health and Social Care in summer 2018 and the final report builds on the literature review and research findings of that interim report working with a Commission panel of subject advisors and experts.

The panel heard from staff working in the NHS whose wellbeing has been adversely affected by workplace experiences, and from several families bereaved by the death of a loved one who ended their life while in the employment of the NHS. The Commission also heard from representatives of beacons of best practice where colleague wellbeing is supported and championed. In addition, visits took place nationwide to find out more about how organisations are valuing, supporting and caring for their staff and for learners on undergraduate clinical education placements or receiving postgraduate training.

The Commission's aim is to see an NHS where staff and learners are happy and feel fulfilled in their work, where they look forward to going to work and are proud of the care they provide to their patients. There is good evidence that happy staff are more compassionate and provide safer care.

The final report was published in February 2019 and was written to support the new NHS Long Term Plan. It has a total of 33 recommendations that are applicable to NHS organisations, learning institutions and the wider NHS Framework.
The summary report can be found **here**

The Trust is committed to supporting the wellbeing and health of its workforce and this work aligns with Strategic Aim 4 of the Workforce strategy: 'we will help staff to keep healthy, maximising wellbeing and prioritising absence management'. The recommendations and good practice detailed within the report are currently being reviewed and mapped to work already undertaken or including them for consideration as future actions within the Trust approach to the wellbeing and health agenda.

## 9. Clinically-led review of NHS access standards

Professor Stephen Powis, NHS National Medical Director, has published his interim report setting out proposals to update several existing standards.

The review proposes a number of changes to existing standards for mental health, cancer, physical urgent and emergency services and elective care. As set out in the NHS Long term plan, the review also introduces new standards for urgent and emergency mental health services.

The interim report states that the new standards will:

- introduce short waits for a far wider range of important clinical services
- provide standards that help improve clinical quality and outcomes
- lock-in short waits for A&E and planned surgery
- help, rather than penalise, trusts who modernise their care.

In relation to Mental Health the plans include continuing to expand access to talking therapies, perinatal mental health services and access to crisis care. In the next ten years the NHS 111 will be developed as the single point of access for anyone experiencing mental health crisis, enabling them to access 24/7 age-appropriate mental health community support. The interim report recommends the following standards be tested:

- Expert assessment within hours for emergency referrals and within 24hr for urgent referrals in community mental health crisis
- Access within one hour of referral to liaison psychiatry services and children and young people's equivalent in A&E departments
- Four-week waiting times for children and young people who need specialist mental health services
- Four-week waiting times for adults and older adult community mental health teams

The NHS Provider summary of the report is attached as *Appendix A.*

## 10. Consultation on Legislative Changes

The NHS Long Term Plan included suggested legislative changes to help implement the plan easier and faster. These changes will have far-reaching implications for the development of the NHS over the next ten years. The proposals centre on a number of areas:

- Reducing the role of the competition and markets authority in the NHS
- Making it clearer on the route to avoid competitive tendering processes in the interests of patient care
- Changing payment systems in the NHS
- Enabling the formal creation of integrated care organisations
- Enabling NHSI/E to enforce mergers and acquisitions
- Setting capital limits for NHS Foundation Trusts (this is already done for non-FTs)
- Enabling the creation of joint management and governance arrangements across commissioners and providers

NHS England are inviting patients, clinicians, NHS Leaders and partner organisations as well as national professional and representative bodies to provide their views on these potential proposals for changing current primary legislation relating to the NHS.

A helpful summary from NHS Providers is attached as *Appendix B* and Board members are invited to submit comments to James Duncan Deputy Chief Executive by 5th April, which will inform an organisational response to be submitted by the deadline of 25th April. You can access the link **here**

12 March 2019

on the day BRIEFING

NHS Providers

# Clinically-led review of NHS access standards

**Professor Stephen Powis, NHS National Medical Director, has published his interim report setting out proposals to update several of the existing performance standards set out in the NHS constitution handbook. The review was commissioned by the Prime Minister to ensure that NHS performance measures reflect and encourage the latest medical practice and support the delivery of the long term plan. This briefing provides a summary of the proposals. For further information, please contact: Claire.helm@nhsproviders.org.**

## Overview

The review proposes a number of changes to existing standards for mental health, cancer, physical urgent and emergency services and elective care. As set out in the NHS Long term plan, the review also introduces new standards for urgent and emergency mental health services

The interim report states that the new standards will:

- introduce short waits for a far wider range of important clinical services
- provide standards that help improve clinical quality and outcomes
- lock-in short waits for A&E and planned surgery
- help, rather than penalise, trusts who modernise their care.

The proposed new standards will be piloted and evaluated during 2019/20 which will form a transition year between the old targets and updated standards.

## Mental health

There are currently several access standards that apply to a limited number of mental health services covering access to talking therapies, starting treatment for psychosis and eating disorder treatment for children and young people.

The Long term plan outlines how the NHS will continue on the current trajectory of substantially expanding mental health services to deliver parity of esteem with physical health services. The plans include continuing to expand access to talking therapies, perinatal mental health services and access to crisis care. In the next ten years the NHS 111 is the single point of access for anyone experiencing mental health crisis can access 24/7 age-appropriate mental health community support.

The Long term plan also sets out a range of other goals for crisis, community service, and new care models. A few of the changes for urgent and emergency mental health service and the projected trajectory for coverage are included in the review and set out below.

**Projected trajectory for transformation in urgent and emergency mental health services**

| | Current | 19/20 | 20/21 | 21/22 | 22/23 | 23/24 | 27/28 |
|---|---|---|---|---|---|---|---|
| Expected % of adult liaison services at core 24 | 30% | 40% | 50% | 59% | 64% | 70% | 100% |
| Expected % of adult community mental health crisis services that are 24/7 | 45% | 70% | 100% | 100% | 100% | 100% | 100% |
| Expected % of urgent & emergency community and liaison children and young people's services at core 24 | 24% | 30% | 35% | 47% | 70% | 100% | 100% |

## Proposed mental health standards

The review recommends that the following standards be tested. In addition consideration will be given to any thresholds that might accompany the standards:

| | Measure | Clinical rationale | Implications for patient care |
|---|---|---|---|
| 1 | Expert assessment within hours for emergency referrals; and within 24 hours for urgent referrals in community mental health crisis services. | While for many people with urgent mental health needs, A&E is appropriate, consensus among clinicians, patients and commissioners is that many urgent mental health needs could be met more effectively in the community.<br><br>Appropriate response times will need to be explored as part of testing. Many local areas have already set a | Rapid assessment of needs to determine urgency, and clear communication of expected next steps to the patient or referrer. Many needs will be met on the telephone or by facilitating access to non urgent support.<br><br>When people are assessed as having urgent or emergency needs, they will need timely face-to-face assessment from a |

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| | | local target of four hours, for example. However, the severity and need of individual patients will need to be taken into account – some patients will need a quicker response. | specialist mental health professional. |
| 2 | Access within one hour of referral to liaison psychiatry services and children and young people's equivalent in A&E departments. | Patients of all ages presenting in A&E in crisis require quick assessment to determine risk. If they are not seen quickly, the A&E environment can exacerbate symptoms and they may leave without treatment, potentially with risk of serious harm or suicide. Managing patients who have not been assessed adds pressure and anxiety to staff. | Someone experiencing a mental health crisis would receive a response from the liaison mental health service within one hour. |
| 3 | Four-week waiting times for children and young people who need specialist mental health services. | Waits for treatment for children and young people's mental health services vary significantly from referral to treatment. Long waits can impact both clinically and on the individual waiting for treatment. | Maximum of four weeks from referral to an assessment and start of treatment or plan in NHS funded services and/or appropriate sign posting or interface with other services, including outside the provider and specialist community services. |
| 4 | Four-week waiting times for adult and older adult community mental health teams. | Clear waiting times are to be incorporated into the design of new integrated primary and community mental health services, to ensure that all individuals are seen within a clinically appropriate time. | Maximum of four weeks from referral to an assessment and start of treatment or plan in NHS funded services and/or appropriate sign posting or interface with other services including outside the provider and specialist community services. |

## Testing the mental health standards

Pilots to test the four-week commitment for children and young people's mental health are already underway. NHS England has asked pilot sites to set out what it would take for them to reach a four-week waiting time, track progress, and improve over the next three years.

In 2019/20, selected Integrated Care System (ICS) and Sustainability and Transformation Partnership (STP) areas will receive additional funding, working with primary care networks and other local partners, to deliver improved and more integrated community mental health care for adults and older people with moderate to severe mental health needs. As part of this, local areas will test the four-week waiting time standard.

The review states that the urgent and emergency mental health standards will be brought together with the wider changes in urgent and emergency care and tested together.

# Cancer

There are currently nine specific cancer standards that have been in place in their current form since 2009. They measure the time taken to see a specialist following an urgent referral from a GP, the time to receive treatment from diagnosis and other standards depending on the occurrence.

One pillar of the NHS Long term plan is to improve early detection of cancer and to bring cancer survival rates in line with other comparative countries. The proposals set out in the review offer a faster diagnosis standard, bring together existing urgent referral routes into one standard and guarantee treatment is started quickly.

Under the new standards people will have the expectation of diagnosis within one month and treatment to start within two months.

## Proposed cancer standards

The review recommends that following standards be tested:

| | Measure | Clinical rationale | Implications for patient care |
|---|---|---|---|
| 1 | Faster Diagnosis Standard: Maximum 28- day wait to communication of definitive cancer / not cancer diagnosis for patients referred urgently (including those with breast symptoms) and from NHS cancer screening. | Urgent cases include:<br>• those referred by their GP with urgent cancer symptoms;<br>• those referred by their GP with breast symptoms;<br>• those referred by cancer screening services. | More explicit focus on measuring and incentivising early diagnosis, which is linked to improved survival rates.<br><br>Improves on current two-week waiting time, as measures time to receive |

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| | | It is important that people are diagnosed quickly after referral so they can start treatment as soon as possible.<br><br>Patients will need to have their first appointment with a consultant well before the 28- day point to ensure communication of diagnosis within that timeframe. | diagnosis, rather than time to be first seen by a consultant.<br><br>Brings together existing urgent referral routes into one simple standard. |
| 2 | Maximum two-month (62-day) wait to first treatment from urgent GP referral (including for breast symptoms) and NHS cancer screening. | Includes urgent cases as above. Having a single headline measure, and ensuring the clinical guidance governing inclusion within it reflects modern clinical practice, adds clarity and greater focus on what really matters. | Brings together three existing urgent referral routes into one simplified standard. |
| 3 | Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients. | All cancer patients need to begin treatment quickly after the decision to treat is taken. | Maintains guarantee of swift start to treatment for all cancer patients. Brings together four existing treatment standards into one simplified standard. |

## Testing the cancer standards

The review is yet to determine how the new standards will be tested and evaluated. The interim report commits to engagement with key stakeholders, including the cancer community in agreeing the approach.

Based on the findings, the new standards are expected to be rolled out from April 2020.

# Urgent and Emergency Care

The clinical review of ambulance standards in 2017 set out a range of new response time targets for the ambulance service. In addition to these there is one other urgent and emergency care standard - a maximum four hour wait in A&E from arrival to admission, transfer or discharge.

The four hour waiting time target has been in place since 2004. The review sets out a range of changes to urgent and emergency care services in the past 15 years which means that the standard is out of date. These include the introduction of NHS 111, specialist stroke services, trauma centres, heart attack centres and acute stroke units, and increased use of same day emergency care treatment.

The review sets out a list of shortcomings of the existing standard, all of which the review states are addressed by the proposed standards:

1. The standard does not measure total waiting times
2. The standard does not differentiate between severity of condition
3. The standard measures a single point in often very complex patient pathways
4. There is strong evidence that hospital processes, rather than clinical judgement, are resulting in admissions or discharge in the immediate period before a patient breaches the standard.
5. The standard is actually not well understood by the public who believe they will receive treatment within four hours.

The proposed changes in urgent and emergency care sit alongside other elements of the Long term plan including the improvements in community and reablement services which are aimed at reducing readmission to hospital.

## Proposed urgent and emergency care standards

The review recommends that following standards be tested:

| | Measure | Clinical rationale | Implications for patient care |
|---|---|---|---|
| Access standards | | | |
| 1 | Time to initial clinical assessment in Emergency Departments and Urgent Treatment Centres (type 1 and 3 A&E departments). | Focus on patient safety prioritisation and streaming to the most appropriate service, including liaison psychiatry and community mental health crisis services.<br><br>This needs to be easily understandable for patients, and is regarded by the public as important. | This will identify life-threatening conditions faster. It ensures timely clinical assessment to identify anybody who is in need of immediate treatment, and allows patients to be directed to the service and practitioner best able to meet their needs at an early stage in the patient's journey. |
| 2 | Time to emergency treatment for critically ill and injured patients. | Highest priority patients get high-quality care with specific time-to-treatments, with proven clinical benefit. | Complete a package of treatment in the first hour after arrival for life threatening conditions such |

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| | | | as:<br>• stroke;<br>• heart attack (MI-STEMI);<br>• major trauma;<br>• critically ill patients (including sepsis);<br>• acute severe asthma;<br>• mental health presentation |
| 3 | Time in A&E (all A&E departments and mental health equivalents). | Measure the mean waiting time for all patients. Strengthen rules on reporting prolonged trolley waits for admission, including reporting to the CQC. | Measures the time all patients are in A&E. Reduce risk of patient harm through long waits for admission or inappropriate admission. Reduce very long waits for those who need care. |
| 4 | Utilisation of Same Day Emergency Care. | Incentivise avoidance of overnight admission and improve hospital flow. | Identifies a group of patients with urgent healthcare needs who would benefit from rapid assessment and review by a senior clinician. The aim is to complete all diagnostic tests, treatment and care that are required in a single day, in order to avoid an unnecessary overnight hospital stay.<br><br>Reduction in overnight admissions and improved patient experience. |

Supporting indicator

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| 5 | Call response standards for 111and 999. | Assure a rapid response, and match patients (including mental health patients) to the service that best meets their needs. | Ensures that a patient's call is answered and assessed promptly when seeking help by telephone. Encourages patients to access out of hospital services, and to make use of telephone triage. |

## Testing of the urgent and emergency care standards

NHS England and NHS Improvement are identifying a number of sites to work with over the coming six months to field test the above measures. The sites will provide a spread in terms of geography, a range of urban, rural, and mixed communities and sites with varying current performance against the existing standard.

The testing cycles will run in four to six week cycles from April 2019, with plans to roll out the final recommendations to all trusts this autumn. Trusts that are not a test site will continue to measure the existing standard.

# Elective care

There are currently three standards set out in the NHS constitution relating to elective care which cover how quickly a patient can expect to begin consultant led care, a diagnostic standard and a standard for those who have their operations cancelled at late notice.

It is evident that the introduction of the 18 week target had a significant impact in reducing the number of people waiting over a year for a routine operation.

The Long term plan states that the NHS will have a zero tolerance approach to people waiting over 52 weeks for a routine operation. The review argues that the extensive redesign of outpatients and diagnostics services over the next five years means that it is only right that changes to access standards to elective care are also considered.

The proposals put forward in the review see a continuation of a diagnostic standard but also says it will test two different approaches for measuring the waiting list. First, the tests will consider if the current thresholds are appropriate with the possibility of these being changed. Secondly, the testing will consider the impact of changing the measure to an average wait target.

## Proposed elective standards

The review recommends that following standards be tested:

| | Measure | Clinical rationale | Implications for patient care |
|---|---|---|---|
| Access standards | | | |
| 1 | Maximum wait of six weeks from referral to test, for diagnostic tests. | Ensure that patients are accessing diagnostic tests quickly, so that a diagnosis can be reached and treatment can begin in a | Need for more consistent achievement in all places. Achieve opportunity for faster overall pathway to diagnosis and decision and |

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| | | timely manner. | create a clear plan for treatment earlier. |
| 2 | Defined number of maximum weeks wait for incomplete pathways, with a percentage threshold.<br><br>OR<br><br>Average wait target for incomplete pathways. | Will test both approaches to consider the impact on prioritisation of care and reduction of long waits.<br><br>Every week counts for all patients in achieving an average, hence keeps focus on patients at all stages of their pathway. | Measure from the point of referral until treatment. Clock stops and starts will reflect new arrangements for outpatients. |

Supporting standards

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|---|---|---|---|
| 3 | 26-week patient choice offer. | Ensures that patients who have not accessed treatment within recommended timeframe, are able to choose whether to access faster treatment elsewhere in a managed way. | Faster care for many patients by re-directing to providers who can treat them more quickly. |
| 4 | 52-week treatment guarantee. | This is too long for any patient to wait and incentivising action to eliminate 52-week waits will focus on finding solutions to services that are unable to meet demand. | All patients must be treated within 52 weeks, with fines imposed on commissioners and providers who are jointly accountable if not. |

## Testing of the elective care standards

In line with the other changes, NHS England and NHS Improvement will field test variants of the two alternative approaches to the proposed elective access standards across a range of pilot sites with appropriate spread and mix. The review states that the testing approach is likely to involve a group of sites testing the use of average waiting times. Testing will seek to evaluate the changes to recording, changes to reporting, changes to operational process and the outcomes and experience for patients.

## Next steps

- The proposals for each distinct service area will be tested across pilot sites.
- During the testing phase, NHS England and NHS Improvement say they will engage with partners and key stakeholders. This will include the clinical community, and patients and the public through working with Healthwatch.
- NHS England and NHS Improvement will evaluate the testing for each proposal by applying the following principles to guarantee the changes:
  - promote safety and outcomes
  - drive improvement in patient experience
  - are clinically meaningful, accurate and practically achievable
  - ensure the sickest and most urgent patients are given priority
  - ensure patients get the right service in the right place
  - are simple and easy to understand for patients and the public
  - do not worsen inequalities
- The public will be consulted on any changes to the NHS constitution handbook
- The timeframe broadly sets six months for testing with rolling out in the autumn. The final recommendations are expected in spring 2020.

## NHS Providers view

**Responding to the announcement of plans to trial new NHS clinical standards, including new standards for mental health and cancer care, the deputy chief executive of NHS Providers, Saffron Cordery, said:**

"The key NHS targets have played a valuable role in improving access to care. They have become a widely recognised indicator of NHS performance. But clinical practice moves on so it is right to consider whether they remain relevant and reflect best practice.

"In order to win public confidence, it will be vital to ensure this process is clinically led and that any changes have been carefully tested and evaluated. Any roll out will need to be incremental and must have the full backing of the clinical community and leadership of NHS trusts. This is particularly important in view of the fact that performance against the current standards has slipped. We must guard against any sense of 'moving the goalposts' to bring the standards back within reach.

Ultimately, the decision to change the constitutional standards will lie with politicians. But it must be informed by clear and compelling evidence on best clinical practice – and driven by what is in the best interests of patients and service users."

01March 2019

# Proposals for possible changes to legislation

The NHS long term plan sets out NHS England's and NHS Improvement's (NHSE/I) view that the current policy direction towards collaboration and integration within local systems can "generally" be achieved within the current statutory framework, but that "legislative change would support more rapid progress". The plan included an overview of barriers to collaborative working which NHSE/I would like to address via legislative change. They have now published an engagement document, *Implementing the NHS long term plan: proposals for possible changes to legislation*, setting out their top level proposals for change. These were described in terms of the plan depending "mainly on collective endeavour", with local and national NHS bodies needing to work together to redesign care around patients.

There is an eight week period in which to submit responses to the proposals. This briefing document summarises NHSE/I's proposals and gives NHS Providers' initial analysis, as well as our press statement. We have also set out a number of questions for members, and would be grateful for your views and experiences – **please send any comments to Ferelith Gaze (ferelith.gaze@nhsproviders.org) by 22 March** to ensure they can be properly reflected in our response. You may also want to submit your own response – we suspect that different members may have different views on some of the proposals, depending on their particular circumstances.

## NHS Providers' overall view

The passage of these proposals will unfold against the backdrop of a number of difficult realities facing NHS legislation. There is the practical issue of Brexit dominating the parliamentary timetable for some time to come. There is the political sensitivity for the Conservative government in bringing forward health legislation after the Lansley reforms. There is also the tension between wishing to avoid further upheaval for the frontline, even while current structures may be presenting unnecessary barriers.

The long term plan, and the Secretary of State, have been keen to argue that any proposals should come from the NHS itself, rather than be politically driven, and that there should be a consensus in taking them forward. For the same reason, the proposals make piecemeal rather than wholesale changes to NHS legislation.

However, NHS legislation on issues of integration (and therefore competition) and on the scale proposed here need detailed, robust and transparent scrutiny. In particular, we would note that the proposals introduce the potential for both greater integration, but also greater intervention by the NHS arm's length bodies. We also need to consider whether alternative, non-legislative approaches would, in some cases, be more reasonable and proportionate. Where legislation is the appropriate response, given the complexity and sensitivity of NHS legislation, further consideration is needed as to how to avoid unintended

consequences. This will be particularly important since any individual changes on particular issues need to work within and maintain the clarity and consistency of the existing wider legal framework which will remain unchanged.

NHS Providers would therefore welcome member views on the overall direction of travel of these proposals.

# Summary and initial analysis of proposals

Below we summarise each of the proposals and give our initial analysis. We will develop this analysis in the coming weeks as we consider the implications of changes. We are seeking member feedback on the proposals, and your experiences of current legislation and regulations to develop the evidence base for our formal response to NHSE/I. We will also continue to seek to influence proposals, and involve trusts, over the coming weeks and months through a range of avenues. We are pleased that the document makes specific reference to the important of NHS Providers' involvement in the drafting process (para 41).

## Collaboration and competition

### Summary of proposals

NHSE/I are concerned that current competition requirements act as a drag on efforts to improve collaboration between NHS bodies and provide integrated care. The Competition and Markets Authority (CMA) has powers to investigate and intervene in proposed NHS mergers. As the NHS is a publicly funded service, democratically accountable to the Secretary of State and to Parliament, NHSE/I consider that the NHS should be able to make its own decisions in relation to mergers, taking into account the potential benefits for patients.

PROPOSAL 1: removing the CMA's duty to review foundation trust mergers

NHS Improvement has concurrent powers with the CMA to apply UK and EU competition law to the provision of healthcare services in England. NHSE/I do not think it necessary for these powers to be held in parallel, and their removal would allow greater focus on oversight of and support for improvement. NHS Improvement would still be able (through licence conditions) to prevent anti-competitive behaviour in certain circumstances where it is against patients' interests.

PROPOSAL 2: removing NHS Improvement's competition powers and duty to prevent anti-competitive behaviour

Under the 2012 Act, where there are sufficient objections to proposed licence conditions or the national tariff payment system, NHS Improvement must either refer the relevant proposals to the CMA or consult on a revised set of proposals. NHSE/I consider that NHS Improvement (with NHS England in the case of the tariff) should be able to reach final decisions on these matters without referral to the CMA, provided it has consulted on the proposals and given any concerns raised proper consideration.

PROPOSAL 3: removing the requirement for NHS Improvement to refer contested licence conditions or national tariff provisions to the CMA

## NHS Providers initial analysis

NHS Providers' view is that while competition can, in some circumstances, be one driver of quality and service improvement in the NHS, it must be applied carefully and sensibly to the ultimate benefit of patients. In other circumstances, over rigid application of competition principles can operate against the interest of patients. For example, a number of providers have been seeking to undertake mergers or acquisitions to address workforce challenges, enable better patterns of service delivery and drive efficiencies. However, the CMA's involvement in the merger approval process has, in the view of many providers, added unnecessary duplication, cost and complexity into the transaction process. We therefore think it likely that most providers will find it helpful to remove the CMA's duty to review provider mergers, as an overly stringent application of competition requirements to the NHS .

However, this proposal should be read in conjunction with proposal 10 (where NHS Improvement seeks the power to direct foundation trust mergers and acquisitions – see later in this document for our analysis). An unintended consequence could be that weakening the role of competition in the NHS also weakens provider board autonomy in the longer term, because the process of deciding service/institutional configurations is centrally directed rather than negotiated and there is no recourse to an independent third party

With regards to the proposal to remove the CMA's potential involvement in licence and tariff objections, this removes a final recourse for providers, albeit one mediated by NHS Improvement. The question to consider here is whether the presence of this backstop has the effect of encouraging robust and reasonable working practices by NHSE/I. It is worth remembering the scale of disagreement between the provider sector and NHSE/I on the framing of the tariff a few years ago when providers triggered the formal tariff objection mechanism. The Government has now amended the terms of that mechanism to make it much more difficult for providers to trigger. We assume members might want to try to secure a "quid pro quo" for the loss of the right of CMA referral, in the form of clear guarantees of what NHSE/I means when it says that it will seriously consider any objections.

## Questions for members on proposals 1 to 3

- What elements of the presence of the CMA in the mergers process have been a) beneficial and b) disadvantageous?
- How concerned are you by the proposal to remove the requirements on NHS Improvement to refer to the CMA (a) contested licence conditions and (b) contested national tariff provisions?
- Please could you let us know about any occasions that you have contested, or considered contesting, your licence conditions.
- Do you have any further comments or concerns about these proposals?
- Would you agree with the idea of securing a "quid pro quo" for loss of the right of CMA referral?

## Procurement rules

### Summary of proposals

Procurement of healthcare services in the NHS is carried out under two sets of regulations: the Procurement, Patient Choice and Competition Regulations (PPCC regulations; made under powers in the 2012 Act), and the Public Contracts Regulations 2015 (implementing EU rules on public procurement).

NHSE/I consider that NHS commissioners should be able to arrange for NHS providers to provide services without necessarily seeking expressions of interest from the wider market. Under the current system, protracted procurement processes incur potentially wasteful legal and administrative costs, and it can be difficult for NHS organisations to collaborate and use their collective resources in the most effective way.

NHSE/I propose that, rather than a necessary procurement process, it would, instead, be for commissioners to use their discretion. The key test in awarding a contract would be whether NHS commissioners were: obtaining "best value" from their resources, in terms of the likely impact on quality of care and health outcomes; whether they were acting in the best interests of patients; and whether they were actively considering relevant issues in making any decisions.

PROPOSAL 4: regulations made under section 75 of the Health and Social Care Act 2012 should be revoked and the powers in primary legislation under which they are made should be repealed and replaced by a best value test
PROPOSAL 5: removing NHS commissioners and NHS providers from the scope of Public Contracts Regulations, and instead making NHS commissioners subject to a best value test, supported by statutory guidance

The way in which the Public Contracts Regulations 2015 can be changed will depend in part on how the UK exits the EU. It will also depend on other legislative proposals which affect the nature of arrangements between NHS commissioners and NHS providers.

In rescinding the PPCC regulations, requirements in relation to patient choice are intended to continue under the standing rules given to commissioners and licence conditions for providers. The power to set standing rules in primary legislation would also be explicitly amended to require inclusion of patient choice rights.

### NHS Providers initial analysis

Careful analysis of these regulations is required. It would seem that greater commissioner discretion in procurement processes would be helpful in reducing the burden on trusts, particularly for community and mental health trusts whose services are more regularly subject to tendering. Yet further clarification is required in a number of areas. For example, there is considerable uncertainty about the nature of the amendments to the Public Procurement Regulations, and more widely, the extent to which competition rules will still apply to day-to-day procurement. The definition of and guidance around the "best value test"

will also need further clarification and consideration. Meanwhile, we should be mindful of the role of patient choice and how this would be enacted in absence of the regulations.

### Questions for members on proposals 4 and 5

- Rescinding these regulations seems likely to reduce the burden on trusts for retendering, but please let us know if you are aware that there are any elements of these regulations that are beneficial and would otherwise be lost.
- Do you have any further comments or concerns about these proposals? Are you, for example, happy with a return / move to greater commissioner discretion on whether to tender or not?

## National NHS payment systems

### Summary of proposals

Changes to the national tariff have been made for 2019/20 with the stated objectives of supporting providers and commissioners to work more collaboratively and develop a more aligned system of payments and incentives. The national tariff also already provides for a degree of flexibility, with providers and commissioners able to agree local payment approaches. However, NHSE/I consider that legislative changes could help further this approach.

PROPOSAL 6: on the tariff: (a) national prices can be set as a formula rather than a fixed value; (b) a power for national prices to be applied only in specified circumstances; and (c) allow in-year adjustments without consultation to some treatments within the tariff

Currently, providers can apply to NHS Improvement to make changes to tariff prices if agreement with local commissioners on modifications cannot be reached. NHSE/I view this as out of keeping with moves towards integrated care systems (ICSs) where commissioners and providers take shared responsibility for managing their collective financial resources.

PROPOSAL 7: once ICSs are fully developed, the power to apply to NHS Improvement to make local modifications to tariff prices should be removed

It is not currently possible to set national tariff prices for section 7a public health services commissioned by NHS England or CCGs on behalf of the Secretary of State. This has created difficulties where these services are part of a patient pathway for a particular service, for example, screening newborn babies' hearing as part of their mothers' maternity care.

PROPOSAL 8: national tariff can include prices for section 7a public health services

### NHS Providers initial analysis

We would question any broad power to adjust treatments in the tariff without any consultation, and will seek further clarification here. We will also consider further how the payment system would work in practice if prices are set as a formula rather than a fixed value and with national prices for certain circumstances.

We would also question whether it is an appropriate point to remove NHS Improvement's role in resolving disputes over local modifications to prices, even when ICSs are fully developed, as we can still foresee potential for provider / commissioner disagreement as long as there are separate, distinct, statutory entities. We would welcome member views on this. We agree with the ambition that modifications should be agreed locally. However, an emphasis on collaboration over competition and a drive towards integrated care systems are not sufficient drivers to ensure that disputes will not arise in the future. We are also aware that some trusts (for example University Hospitals Morecambe Bay) have used the local modification process to identify where a trust has a structural deficit that commissioners ought to be taking account of in its contracted pricing. We assume that this process will, in future, be part of each individual trust's discussion with NHSE/I on access to the new Financial Recovery Fund (FRF). But some might regard it as premature to remove this avenue for identifying a provider structural deficit before we can be sure that the FRF process will achieve a similar objective.

### Questions for members on proposals 6 to 8

- Please let us know your views on proposal 6, and in particular, national prices being set as a formula, and the power for national prices to be applied only in specified circumstances.
- Please could you let us know of any occasions where you have applied to NHS Improvement to make local modifications to tariff prices and the result of this application.
- Do you have any further comments or concerns about these proposals?

## Integrated care trusts

### Summary of proposals

The integrated care provider (ICP) contract provides for a situation where local health systems wish to bring some services together under the responsibility of a single provider organisation, supported by a single contract and a combined budget. However, in some cases, it may be difficult for commissioners to identify an existing organisation that could take on responsibility for a contract of this kind. It could be that a group of local GP practices and a provider of community, mental health and/or hospital services wished to come together. However, the existing legislative framework doesn't lend itself to these circumstances as a new NHS foundation trust cannot be established from scratch and the 2012 Act did not envisage the creation of new NHS trusts. NHSE/I therefore propose that the Secretary of State be given the power to be able to set up new integrated care trusts.

PROPOSAL 9: Secretary of State to be able to set up new integrated care trusts

Integrated care trusts would only be established where local commissioners wished to bring services together under a single contract and where it is necessary to establish a new special purpose organisational vehicle to do so, and where there has been appropriate local engagement. The resulting ICP would:

- Have a contractual duty to deliver and improve health and care for a defined population
- Act as a provider of integrated care with the freedom to organise resources across a range of services

- Be run in a way that involves the local community and the full range of health care professionals
- Be accountable to commissioners for its performance

Taken together with the procurement proposals, this power to establish a new trust would also support the expectation in the long term plan that the ICP contract should be held by public statutory providers.

### NHS Providers initial analysis

While we understand that this proposal could create some helpful flexibility within the system, we are cautious about its implementation. Whether created from existing entities or newly formed, establishing a new trust is a considerable undertaking. We need to be clear on when this would be pursued, and how this would be driven, and what consideration would be given to potentially valid alternatives (such as a merger). We would be keen to have assurances that new trusts would not be set up without the explicit support of all partners in the local health economy in question. There also need to be appropriate protections for existing NHS providers serving the area. There might, for example, be a possibility that the threat of creation of a new integrated trust could be used as leverage to get an existing trust to behave in a particular way. In our discussions with NHSE/I over this clause we asked for specific protection for providers but this has been translated as "appropriate local engagement".

The duties, autonomy, governance and accountabilities of a new form of trust require careful consideration, not least since the proposal is to create a new type of trust rather than a foundation trust, and enabling vertical integration between secondary and primary care may mean establishing an organisation with a different composition from the current model. We will also explore how these trusts will be able to integrate services across a local system, with primary care particularly in mind.

### Questions for members on proposal 9

- To what extent do you think this proposal presents your local system with an opportunity, particularly to develop more integrated models of care?
- What provisions or protections for NHS trusts and foundation trusts would you consider important as part of taking this proposal forward?
- Do you have any further comments or concerns about these proposals?

## Mergers and acquisitions

### Summary of proposals

In some circumstances, NHSE/I believe that plans to improve the management of local health services through mergers and acquisitions can be frustrated by the reluctance of one local trust to consider such a change. NHS Improvement can already direct NHS trusts in this respect. However, it can only take equivalent action in relation to NHS foundation trusts in the event of trust special administration – that is, where there is a serious failure or risk of failure.

## PROPOSAL 10: NHS Improvement to have targeted powers to direct mergers or acquisitions involving NHS foundation trusts, in specific circumstances only, where a clear patient benefit has been shown

NHSE/I are proposing that NHS Improvement should have the power to direct NHS foundation trusts to:

- Enter into arrangements to consider and/or to prepare for a merger or acquisition with an NHS trust or other NHS foundation trust
- Merge with an NHS trust or other NHS foundation trust
- Be acquired by another NHS foundation trust

Such an approach would change organisational accountability in a local system, and is distinct from changes to service provision. Decisions on service changes would remain a matter for local commissioners and providers, subject to national tests (such as strong patient engagement, preservation of patient choice, a clear clinical benefit, and support from local clinical commissioners).

## NHS Providers initial analysis

In our view, any proposal for NHS Improvement to hold a broad power of direction over foundation trust mergers and acquisitions would cut across the ability of FT boards to carry out their responsibilities and be held properly accountable to the public for the quality of care they provide. That said, we know there are circumstances in which some members would welcome greater direction from the centre with regard to the structure of the local providers in their area, particularly if circumstances arise where one trust is unreasonably preventing a change in organisational form that every other member of a local system supports.

We have been debating the scope of this power with NHSI for some time. We argued that a general power to direct was wholly inappropriate. The proposals therefore talk about a targeted power for use in specific circumstances only. We recognise, however, that some members are likely to still have concerns.

We believe that greater clarity is needed as to the circumstances under which this power would be used (for example, how is the need for a merger or acquisition determined and how does NHS Improvement become involved). Would the power, for example, be more acceptable, if NHSE/I committed that it would only be used after a trust had been given the opportunity to determine for itself whether it was sustainable in a standalone form, and NHSI and all other providers in the area disagreed with the answer. It therefore feels important to explore alternatives have been considered, and whether would it be more effective and appropriate for NHS Improvement to hold a role more akin to arbiter in the event of local system dispute than director of that system).

This proposal also needs to be considered in conjunction with a number of other proposals. These include proposal 1, as the CMA would not have a role in investigating and intervening such changes; proposal 9, and the ability to create new integrated care trusts; and proposal 11, relating to NHS Improvement's direction of FT capital spending given the further impact on governance and control.

## Questions for members on proposal 10

- We would argue strongly against a broadly drawn power for NHS Improvement to direct mergers and acquisitions on the basis that it interferes with appropriate trust autonomy and accountability. Please could you tell us:
  - If you agree with that stance
  - If there are alternative approaches to such a power, such as an arbitration role for NHS Improvement, which you would consider to be more helpful in your local system
  - The circumstances, if any, under which you would consider an 'in extremis use' of this power to be appropriate
- Do you have any further comments or concerns about these proposals?

# Capital spending

## Summary of proposals

There is an urgent need to invest in NHS buildings and facilities, and a more coordinated and collaborative approach to planning capital investment is required to support this. NHSE/I see that, while parliament approves an annual financial envelope for capital expenditure across the Department of Health and Social Care and the NHS, the lack of mechanisms to set capital spending for NHS foundation trusts is a barrier to a more collective approach. It can therefore be that, because of uncertainty around foundation trust capital spending, it is necessary to constrain or delay capital spending by trusts that may be more urgent or address higher priority needs. The inability of NHSE/I to control capital spend by FTs and, they argue, the inaccurate forecasting of such spend, also means that the risk of the NHS breaking its overall capital spending limit, is too great.

PROPOSAL 11: NHS Improvement to have powers to set annual capital spending limits for NHS foundation trusts

NHSE/I say they would want to avoid, where possible, cutting across the freedoms that FTs have to build up funding reserves or borrow money. The power to set annual spending limits would not prevent FTs from using their funding reserves for capital investment, but it would mean that they would need to agree with NHS Improvement, working with local health systems, when to make large capital investments.

## NHS Providers initial analysis

Capital maintenance and investment is a key part of service delivery, and we question the circumstances under which NHS Improvement would be better placed to make a decision here than the trust board, especially bearing in mind that the consequences for under-investment will sit with the trust. Whilst we recognise the risks around breaking capital limits, we would argue that this risk has been elevated by the poor quality and opaqueness of the capital allocation process operated by NHSE/I and the Department of Health and Social Care. It is this, rather than trust failings, that is the largest contributor to inaccurate trust capital spend forecasting.

Subject to member views, NHS Providers intends to oppose this proposal. While appropriate controls over capital spending are necessary, we would question whether a legislative response which blurs trust autonomy and accountability is appropriate, especially when more proportionate and collaborative approaches could be pursued. For example, NHS Providers has argued for some time that a more robust capital bidding and prioritisation regime is needed in order to give trusts certainty over the coming years and frame their investments within a set of strategic priorities.

### Questions for members on proposal 11

- Please could you let us know of any instances within your local system where there have been disputes around capital spending?
- Please could you let us know of any instances in your local area where NHS Improvement has used its powers in relation to NHS trusts (as opposed to NHS foundation trust) capital spending, and the results of this?
- What complications or opportunities do you foresee central direction of capital creating for your trust and/or local system?
- If there is a need for greater accuracy in forecasting capital expenditure to reduce the risk of exceeding the aggregate NHS capital limit, are there other ways in which this could be achieved that avoid the need for NHSI to have a power of direction over FT capital spending?
- Do you have any further comments or concerns about these proposals?

## Provider and commissioner joint working

### Summary of proposals

NHSE/I want NHS organisations to work with each other as ICSs to jointly plan and improve care delivery. However, they believe that establishing ICSs as distinct, new organisational entities would involve a complex reassignment of functions that currently sit with CCGs and trusts. Instead, they propose to change primary legislation to remove barriers to collaboration, and make legal provisions to allow CCGs and NHS providers to take joint decisions.

**PROPOSAL 12: NHS providers and CCGs to be able to create joint committees**

**PROPOSAL 13: NHS England to be able to publish guidance on joint committee governance and appropriate delegation**

Joint committees would not remove the existing responsibilities of CCGs and NHS providers. Joint committees would be required to act openly and transparently, and would need to work in a way that avoids conflicts of interests (for example, a commissioner would not be able to delegate to decisions on purchasing services to a joint committee).

NHSE/I also view it as sensible to allow NHS providers to form their own joint committees (CCGs can already do so). These could include representation from other bodies, such as primary care networks, GP practices or the voluntary sector. These committees could bring local care providers together to set up clinical services networks, a single estates strategy or shared IT, HR and pharmacy services.

Legislation currently specifies that CCG governing bodies must include a registered nurse and a doctor who is not a GP, neither of whom should be working for a provider where the CCG has commissioning arrangements. NHSE/I view it as inconsistent to allow GPs to sit on governing bodies but prevent the designated nurse and doctor from working for other local providers, and see this rule as too limiting for CCGs to plan services effectively.

PROPOSAL 14: allowing CCGs more freedom to have governing body members who work as clinicians for local providers

Joint roles may be a way of improving integrated care. While joint appointments can already be made, NHSE/I recognise that the legislation is ambiguous and organisations can leave themselves open to challenge in the future for the appointments they make.

PROPOSAL 15: making it easier for CCGs and NHS providers to make joint appointments

## NHS Providers initial analysis

The NHS is clearly in transition from a system focussed on individual CCGs / providers to one focussed on integrated local health and care systems. In the absence of legislation creating local health and care systems as formal legal entities to replace trusts and CCGs, we recognise the potential power of joint committees to help speed this transition. We believe there are currently two main uses of the joint committee approach: to bring groups of providers together into a common decision making structure; and as a means of cross system decision making covering both CCGs and providers in more advanced local systems.

However, as we understand the current proposals, the creation of a joint committee would mean that a trust could then be bound, potentially against its will, to decisions made by that committee even while the trust retains its accountability for those decisions. There will be some who are concerned by such a lack of clarity over how responsibilities are held, not least given the level of risk managed at trust level. Others might also highlight the potential absence of challenge within this model, as otherwise provided by non-executive directors (NEDs) within a trust's unitary board. The value of NEDs is recognised – and has been consistently strengthened over time – within the governance codes for the private sector, and we would encourage the same within the NHS.

We are therefore keen to understand how different members see the balance of benefit / risk here, weighing up the benefit of being able to speed the transition to integrated local systems against the risk of losing the clarity of accountability of current unitary trust boards. NHSE/I's proposals provide the protection that the creation of joint committees is a matter for local discretion. It would be helpful to understand if this is sufficient protection or whether this needs further definition (e.g. what happens if one member of a local system refuses to accept a joint committee all other members of that system support).

Regarding steps to enable joint provider-commissioner appointments, while we recognise the intention here to support system working, we need to be equally mindful that the purchaser-provider split is being maintained. Whether and where a joint appointment creates conflicts for the incumbent, or blurs board accountability, needs careful consideration.

### Questions for members on proposals 12 to 15

- Have you explored the creation of a joint committee? If so, for what purpose and to what benefit? Equally, have you tried and failed to set up such a committee and if so, why did it fail?
- Are there any circumstances under which you can envisage your trust creating a joint committee (in any given combination of other trust(s) or CCG(s))? And what protections do you think are needed?
- Have you sought to make any joint appointments with a CCG to date? If so, please could you outline the key considerations for your trust in doing so.
- Do you have any further comments or concerns about these proposals?

## Shared duties for providers and commissioners

### Summary of proposals

NHS bodies are already bound by strong duties to provide or arrange high quality care and financial stewardship as individual organisations. However, NHSE/I do not believe that these are sufficient to ensure local systems plan and deliver care across organisational boundaries in ways that secure the best possible quality of care and health outcomes for local communities.

**PROPOSAL 16: a shared duty for CCGs and NHS providers to promote the triple aim of better health for everyone, better care for all patients, and efficient use of NHS resources, both for their local system and for the wider NHS**

NHSE/I believe that this change would support the goal of strengthening the chain of accountability for managing public money within and between NHS organisations. The legal duties that currently apply might be amended or extended to ensure consistency and support this triple aim.

### NHS Providers initial analysis

We suspect that whilst most members will be supportive of the policy intent of this proposal, some might have reservations about it being added to existing duties, even recognising that they may be refined in parallel. A shared duty in this manner might, to some, seem to be in tension with trust boards' accountabilities for their organisation and organisational delivery. Further general duties may generate conflicts and it may be prudent to re-emphasise existing legislation and its policy intent rather than adding an extra layer.

### Questions for members on proposals

- If your existing duties remained as they are, do you foresee any conflicts arising from the addition of a triple aim duty shared across local systems, including with CCGs?
- Do you have any further comments or concerns about these proposals?

## Joined up commissioning

### Summary of proposals

Commissioning responsibilities are split across CCGs, NHS England and local authorities, meaning that public health, primary care, hospital care and specialist services are organised by different bodies. NHSE/I want to join up commissioning without major organisational restructuring.

**PROPOSAL 17: removing the barriers that limit the ability of CCGs, local authorities and NHS England to work together and take decisions jointly**

NHSE/I identify barriers to joined up commissioning as including:

- The inability of CCGs holding delegated functions (for example, commissioning primary medical care on behalf of NHS England) to then enter into formal joint decision-making arrangements for that function with neighbouring CCGs or local government (as this would constitute unlawful double delegation)
- The public health functions carried out by NHS England on behalf of the Secretary of State (such as national screening and immunisation programmes) cannot be jointly commissioned by NHS England and one or more CCGs, making it harder to take account of local issues
- CCGs working together cannot currently make joint decisions other than by formally merging.

**PROPOSAL 18: (a) NHS England can allow groups of CCGs to collaborate to arrange services for their combined populations; (b) CCGs can carry out delegated functions as if they were their own; and (c) groups of CCGs in joint and lead commissioner arrangements can make decisions and pool funds across their functions**

**PROPOSAL 19: NHS England can commission, or jointly commission, or delegate to groups of CCGs, section 7a public health functions**

These changes would empower CCGs to make joint decisions and promote integration, although NHS England would retain its overall responsibilities. NHS England would also be required to consult on any plans to delegate services to CCGs.

Services that form part of care pathways can include services commissioned variously by NHS England, CCGs or local authorities. For example, CCGs commission services for patients with kidney disease, NHS England for patients with kidney failure. Such splits can hinder efforts to organise care around the needs of patients, as has been the case in integrating specialist mental health services with community-based mental health and social care services. NHSE/I believe that CCGs should be more involved in decisions around specialised services, but the only mechanism currently available is for full responsibility for individual services to be transferred to all CCGs. Yet this would not be appropriate for services which need to be planned on a larger population scale.

**PROPOSAL 20: NHS England can enter into formal joint commissioning arrangements with CCGs**

## NHS Providers initial analysis

NHS Providers has raised a number of concerns around fragmented commissioning pathways, especially relating to mental health and specialised services. We also note the success of pilots to transfer responsibility for specialised commissioning of some forensic mental health services to providers and the desire to speed up and extend this approach. We would therefore welcome steps to streamline commissioning and support improvements to patient care. Wee are also mindful of other concurrent changes taking place, particularly the closer working of NHS England and NHS Improvement with the appointment of joint regional directors, and the potential growing role for providers in undertaking tactical commissioning or lead provider roles. We will be interested to understand how powers would be shared between CCGs, local authorities and NHS England, and also to understand the impact of these proposals on the commissioner-provider relationship at every level. We will also urge that providers are appropriately consulted as CCGs work more closely together to promote service integration.

## Questions for members on proposals

- If you have experienced joint commissioning by NHS England and a CCG, do you have any concerns arising from that process which may be relevant here? Have there been any benefits or lessons learned to feed into these changes?
- Do you have any further comments or concerns about these proposals?

# National leadership

## Summary of proposals

There are limits on how far NHS England and NHS Improvement can work together. For example, there is no provision to formally carry out functions jointly, there are constraints on sharing board members, and they have separate accountability arrangements to the Secretary of State. This causes unhelpful and cumbersome bureaucracy for both organisations. NHSE/I are instead looking to go further in speaking with one voice, setting consistent expectations across the health system, developing a single oversight and support framework, bringing together national work programmes, and using collective resources more efficiently.

PROPOSAL 21: NHS England and NHS Improvement should be brought together more closely beyond the limits of the current legislation, whilst clarifying the accountability to Secretary of State and Parliament

PROPOSAL 22: closer working should be achieved by: either (a) creating a single organisation which combines all the relevant functions of NHS England and NHS Improvement; or (b) leaving the existing bodies as they are, but provide more flexibility to work together, including powers to carry out functions jointly or to delegate or transfer functions to each other, and the flexibility to have non-executive Board members in common



At present, there are different legislative arrangements for the accountability between the Secretary of State and each of NHS England, Monitor and the Trust Development Authority. If a single body were created, accountability would need to be appropriately defined. Moreover, the Health and Social Care

Select Committee has recommended that all national NHS arm's length bodies (ALBs) act in a more joined-up way, particularly on priority areas such as prevention of ill-health and workforce education and training. Responsibility for these issues sits in different organisations, specifically Public Health England and Health Education England.

PROPOSAL 23: enable wider collaboration between ALBs by establishing new powers for the Secretary of State to transfer, or require delegation of, ALB functions to other ALBs, and create new functions of ALBs

### NHS Providers initial analysis

These proposals are a further significant shift in the way the NHS is led at a national level, with important implications for trusts and their leaders. While increased coordination and consistency is welcome, there remain significant risks within this approach which need careful consideration. These include the importance of understanding provider needs, risks and the task set for them, as well as a proportionate approach to regulation and support which take account of continuing lines of provider autonomy and accountability. There are also some who believe that the formal merger of NHSE/I would create a single organisation that was too large to function effectively and, potentially, represented too great a concentration of power. We are therefore interested in members' views on whether full; merger or greater working together is seen as preferable. We will seek greater clarity around these proposals and how NHSE/I would envisage their future relationship with the sector, whether they are acting as a single or more aligned entity.

While there is a logic for giving the Secretary of State greater power to transfer responsibility between arms length bodies we would be keen to hear from members if they think such an approach would bring increased risks or disadvantages.

### Questions for members on proposals

- What is important for your trust in its relationship with NHS Improvement to see maintained in the future closer working arrangements of NHSE/I?
- Where would you see increased coordination and alignment as most beneficial to your trust?
- Would you prefer to see NHSE/I to fully merge or work more closely together, and why?
- What risks or disadvantages can you see to the Secretary of State having greater power to transfer responsibilities between arms length bodies?
- Do you have any further comments or concerns about these proposals?

## Our press statement

Responding to the consultation on proposed legislative changes, the chief executive of NHS Providers, Chris Hopson said:

"The NHS has spent the last five years trying to find ways to create integrated local health and care systems within a legislative framework based on competition and individual institutions. This isn't a straightforward

task. It adds risk, uncertainty and complexity to the job of frontline leaders already grappling with significant financial, demand and workforce challenges.

"As the service works to fulfil the ambitions of the NHS long term plan, it makes sense to review whether we can make enabling changes through legislation, recognising that there are other possible ways of addressing the tensions between the current legislative framework and the desired direction of future travel.

"It is vital that we consider any changes carefully, work through the detail and co-create any changes with those affected, as the Health and Social Care Select Committee has suggested. We therefore welcome NHS England's and NHS Improvement's first step in announcing this engagement exercise and their commitment to a process of co-production.

"We will consult NHS foundation trusts and trusts, but we think there are proposals here that the provider sector will welcome and find helpful. We will wish to explore with providers the cumulative effect of the proposals, and we will want to talk to our members about two particular areas.

"First, the principle of trust boards being completely accountable for all that happens within their trust, and having the appropriate power and freedom to discharge that responsibility effectively, is central to the way the NHS currently works. It is the key governance mechanism to manage the level of safety, clinical, operational and financial risk inherent in the frontline delivery of hospital, mental health, community and ambulance services. As much as we all support integrated care within local health and care systems, we must approach anything that cuts across this clear trust board accountability with caution. We will therefore want to look very carefully at the proposals for NHSE/I to take powers to direct trust level merger and acquisition activity and set their capital limits.

"The second is how we manage the transition from an NHS legal framework based on competition and individual institutions to one of collaborative, integrated local health and care systems. The changes proposed are targeted as they seek to avoid a wholesale restructure and another top down re-organisation. However, they do create something of a halfway house and we must ensure that this half way house would deliver more effectively for patients than what we currently have, and that it would be robust, appropriate and consistent. We will therefore want, for example, to carefully consider proposals such as joint committee decision making between commissioners and providers and the ability of the Secretary of State to create new integrated trusts in this context."





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**Northumberland, Tyne and Wear NHS Foundation Trust**

**Board of Directors**

**Meeting Date:** 27th March 2019

**Title and Author of Paper:** 2019-20 Quality Priorities Proposal
Anna Foster, Deputy Director of Commissioning & Quality Assurance

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

**Paper for Debate, Decision or Information:** Decision

**Key Points to Note:**

1. The purpose of this paper is to update to the Trust Board with proposals for quality priorities in 2019-20. Trust Board is asked to approve the proposals being put forward.

2. The 18-19 Quality Account will be finalised in May 2019. This will include final reported progress against this year's quality priorities and agreed quality priorities for 2019-20.

3. This paper has also been taken at Corporate Decision Team Quality and Quality and Performance Committee for their approval of the proposals for Quality Priorities 2019-20.

**Risks Highlighted:** none

**Does this affect any Board Assurance Framework/Corporate Risks:** No

**Equal Opportunities, Legal and Other Implications:** n/a

**Outcome required:** for information only

**Link to Policies and Strategies:** none

NHS
Northumberland, Tyne and Wear
NHS Foundation Trust

# Board of Directors

## 27 March 2019

## Quality Priority setting 2019-20

## PURPOSE

To provide assurance to Trust Board with an update of progress towards development of Quality Priorities for 2019-20, following engagement with stakeholders in the period November 2018 to January 2019 and discussion of draft proposals at Trust Board meeting (closed) in February 2019.

## 2018/19 QUALITY PRIORITIES

1. In 2018-2019 the Trust has been working towards four quality priorities which support the three long term quality goals included in the NTW strategy. These are:
    a. Improving the impatient experience
    b. Waiting times
    c. Embedding Triangle of Care
    d. Embedding Trust Values

2. The first two quality priorities listed above were implemented with the expectation that they would remain in place for 3 years, therefore it is proposed that these continue into 2019-20 with quarterly milestones set out in Appendices 1&2.

3. It is proposed that the Embedding Triangle of Care work would continue but would no longer be classed as a Trust Quality Priority. Progress will in future be monitored through regular updates to the Service User & Carer Involvement & Experience Group and assurance provided through the Trust Quality & Performance Committee.

4. It is proposed that the Embedding Trust Values work would continue but would no longer be classed as a Trust Quality Priority. Progress will in future be monitored through regular updates to the Corporate Decision Team – Quality sub group and assurance provided through the Trust Quality & Performance Committee.

## DETERMINING NEW QUALITY PRIORITIES FOR 2019-2020

5. A major new quality priority is proposed in 2019/20, relating to the new Equality, Diversity & Inclusion Strategy. This has been developed in conjunction with stakeholders (including staff), locality groups and the Equality & Diversity Lead. Detailed quarterly milestones are attached at Appendix 3.

6. A further new quality priority has been developed following discussion at the Trust Board, evaluating the impact of staff sickness on the quality of care delivered. Detailed quarterly milestones are attached at Appendix 4.

7. Therefore the four proposed quality priorities for 2019-20 are as follows:

| | |
|---|---|
| Safety: | Improving The Inpatient Experience |
| Clinical Effectiveness: | Equality, Diversity & Inclusion |
| | Evaluating the impact of staff sickness on Quality |
| Service User & Carer Experience: | Improving Waiting Times |

**RECOMMENDATIONS**

The Trust Board is asked to consider/debate the proposed 2019/20 quality priorities, including the quarterly milestones as set out in Appendices 1-4, and approve the proposals within the report.

**Anna Foster**
**Deputy Director of Commissioning & Quality Assurance**
**March 2019**

**Appendix 1**

| **Improving the inpatient experience** | |
|---|---|
| **Safe** | |
| Rationale | Evidence suggests that high bed occupancy negatively impacts upon the quality and experience of inpatient care. The Royal College of Psychiatrists recommend an occupancy rate of 85% as optimal for effective care; this allows for timely admissions to 'local' beds and greater levels of direct patient care.<br><br>Moving towards and maintaining optimal bed occupancy in the Trust's Adult, Older Peoples and Learning Disability wards will be enabled by the implementation of the Trusts Bed Utilisation Marginal Gains project.<br><br>Working towards eliminating inappropriate out of area bed placements.<br><br>Working towards reducing internal OAT within NTW beds. |
| Quarters 1 to 4 Milestones | Continue to monitor average bed occupancy on adult and older people's mental health wards against the baseline period (January to March 2018).<br><br>Continue to monitor average patient days receiving inappropriate out of area treatment (OAT).<br><br>Implement reporting average patient days receiving OAT within NTW<br><br>Continue to monitoring service user and carer experience (metrics: Points of You and 'travel' themed complaints). |

**Appendix 2**

| **Access and Waiting Times** | |
|---|---|
| **Experience** | |
| Rationale | To ensure Trust services are responsive and accessible, and that no-one waits more than 18 weeks to access community services. |
| Quarters 1-4 milestones | • Continue to reporting waiting times to treatment for adult and OPS MH services<br>• Split CYPS waiting times reporting into pathways (using 2nd contact as treatment proxy), monitor and report using new format<br>• Continue to monitor and report Gender Dysphoria, adult ADHD diagnosis and adult ASD diagnosis waiting times |

**Appendix 3**

| **Equality, Diversity & Inclusion Strategy** | |
|---|---|
| **Clinical Effectiveness** | |
| Rationale | By removing the barriers that people with protected characteristics face in accessing our services, we will improve the quality of care for all. This Quality Priority complements Equality, Diversity & Inclusion Strategy 2018-2022.<br><br>The initial phase of the quality priority will allow locality groups time to establish local needs before deciding what actions are necessary to meet them.<br><br>Progress against this quality priority will be monitored via the Trust Equality, Diversity & Inclusion Steering Group.<br><br>Nb following feedback from the Trust Board in February 2019, the milestones have been expanded to include a broader range of protected characteristics. |
| Quarters 1-4 milestones | See overleaf |

**Draft Equality & Diversity Quality Priority Milestones 2019/2020:** ***(nb it is proposed that the actions are incorporated into the existing Equality, Diversity & Inclusion Action Plan)***

| | Lead/team: | Quarter 1 | Quarter 2 | Quarter 3 | Quarter 4 |
|---|---|---|---|---|---|
| 1 | **Locality Groups** | • Collate data on local third sector, voluntary and other groups | • Develop action plans to develop links & raise awareness among teams of local community links | • Raise awareness of SOMIS through services<br>• Commence inclusion of actions in Q&P reports<br>• Provide recent case studies as evidence of actions taken | • Implement SOMIS recording<br>• Monitor & report progress against local action plans<br>• Provide recent case studies as evidence of actions taken |
| 2 | **Equality & Diversity Lead** | • Share locality baseline E&D info with groups<br>• Develop action plan template<br>• Conduct analysis of BAME population use of Trust services<br>• Establish links with local BAME forums<br>• Report progress against action plan | • Report progress against action plan | • Report progress against action plan | • Report progress against action plan |
| 3 | **NTW Academy** | • Scope masterclasses in cultural awareness | • Scope masterclasses in cultural awareness | • Implement masterclasses | • Implement masterclasses |
| 4 | **Chaplaincy Team** | • Advise localities of local faith & community group links | • Locality Groups to develop action plans to develop links & raise awareness among teams of local faith and community links | • Locality Groups to report progress again action plans | • Locality Groups to report progress again action plans |
| 5 | **Commissioning & Quality Assurance** | • Scope RIO enhancements required to meet SOMIS<br>• Commission NEQOS to undertake in depth population analysis & benchmarking by PC<br>• Commence analysis of experience data by PC | • Required RIO changes re SOMIS completed.<br>• Baseline SOMIS measure calculated | • Receive and share NEQOS population analysis<br>• Commence analysis of outcomes measures data by PC | • Monitor recording of SOMIS<br>• Commence review of PoY format to include more PC data |
| 6 | **Accessible Information Standard Group** | • Audit of Rio to ensure that accessible information fields are being completed in an adequate manner<br>• Compare to Summer 2018 Audit<br>• Report findings to EDI/BDG | • Accessible Information Standard Policy to be developed and approved<br>• Weekly question to ascertain awareness of the standard and give a link to the policy | • Develop resources on dedicated intranet page to raise awareness and support staff in the delivery of the Accessible Information Standard<br>• Communications Campaign to highlight the availability of training packages | • Monitor the uptake of training packages. |
| 7 | **BAME Staff Network** | • Engage with BAME staff seeking network links | • Training of Cultural Ambassadors<br>• Communications to raise awareness of the Cultural Ambassadors Initiative.<br>• Baseline of Discipline and Grievance information prior to the start of the | • Report progress against Workforce Race Equality Standard action plan | • Report progress against Workforce Race Equality Standard action plan |

| | Lead/team: | Quarter 1 | Quarter 2 | Quarter 3 | Quarter 4 |
|---|---|---|---|---|---|
| | | | • implementation of Cultural Ambassadors<br>• Publication of WRES Actions | | |
| **8** | **Disability Staff Network** | • Prepare submission for the Workforce Disability Equality Standard | • Publish Workforce Disability Equality Standard action plan | • Report progress against Workforce Disability Equality Standard action plan | • Report progress against Workforce Disability Equality Standard action plan |
| **9** | **LGBT+ Staff Network** | • Develop resources to raise awareness and support staff in implementing the SOMIS<br>• Develop LGBT+ allies programme | • Develop resources to raise awareness and support staff in implementing the SOMIS<br>• Develop LGBT+ allies programme | • Develop LGBT+ allies programme | • Develop LGBT+ allies programme |
| **10** | **Mental Health Staff Network** | • Engage with staff seeking network links | • Engage with staff seeking network links | • Develop resources to raise awareness about the purpose of the network | • Develop resources to raise awareness about the purpose of the network |
| **11** | **Communications Team** | • | • Plan campaign to raise awareness of SOMIS | • Implement SOMIS campaign | • |

**PC = protected characteristic SOMIS = Sexual Orientation Monitoring Information Standard**

**Appendix 4**

| **Evaluating the impact of staff sickness of quality** | |
|---|---|
| **Clinical Effectiveness** | |
| Rationale | The link between staffing levels and patient outcomes is well documented.<br><br>The Trust has experienced elevated staff sickness absence rates during 2018-19. While there are many staff health and wellbeing initiatives in place, aimed at reducing these absences, there has been little evaluation of the impact of sickness absences on the quality of care delivered. Comparative analyses, broken down into locality groups and CBUs where possible, will be undertaken as follows: |
| Quarter 1 milestones | Determine methodology for conducting a comparative analysis of staff sickness absence rates and factors such as:<br><br>• HONOS outcomes data<br>• staff survey feedback (specific questions re sickness)<br>• age/absence reason/gender/ethnicity/length of service data from ESR<br>• Relevant complaints<br>• Relevant Points of You feedback<br>• CQC community survey findings<br>• Use of temporary staff<br>• Average bed occupancy<br>• Caseload sizes (community teams)<br>• Waiting times (community teams)<br><br>Establish a measure of "continuity of care" for community services, taking into consideration data available relating to patient contacts, staff undertaking patient contacts, care co-ordinator information. |
| Quarter 2 milestones | Undertake a comparative analysis of staff sickness absence rates and relevant factors for inpatient settings.<br><br>Report findings to CDT-Q |
| Quarter 3 milestones | Undertake a comparative analysis of staff sickness absence rates and relevant factors for community settings including continuity of care measure.<br><br>Report findings to CDT-Q |
| Quarter 4 milestones | Undertake a comparative analysis of staff sickness absence rates and relevant factors for specialist inpatient settings.<br><br>Report findings to CDT-Q |

For more info see this 2018 report: https://www.picker.org/wp-content/uploads/2014/12/Risks-to-care-quality-and-staff-wellbeing-VR-SS-v8-Final.pdf

**Northumberland, Tyne and Wear NHS Foundation Trust**
**Board of Directors**

Meeting Date: 27th March 2019

Title and Author of Paper: Annual Review of Board Assurance Framework and Corporate Risk Register – Julie Robson, Corporate and Quality Governance Manager

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

Paper for Debate, Decision or Information: Information

**Key Points to Note:**

1. To provide the process followed to review the Risk Appetite in preparation for 2019-20.
2. To provide the process followed to review current risks moving into 2019-20.
3. To provide a review of risk movement through 2018-19.

Risks Highlighted:

As highlighted in the paper.

Does this affect any Board Assurance Framework/Corporate Risks?

Yes – Report detailing the review of the Board Assurance Framework and Corporate Risk Register.

Equal Opportunities, Legal and Other Implications:

Addressed in Board Assurance Framework and Corporate Risk Register

Outcome Required:

1. To share with the Board of Directors the process in hand to review the risk appetite and BAF in preparation for 2019-20.
2. To note the movement in risks through 2018-19.
3. To provide an end of year BAF and CRR to the Board of Directors.

Link to Policies and Strategies:

Risk Management Strategy and Risk Management Policy

# Annual Review of Board Assurance Framework and Corporate Risk Register 18/19

## Purpose

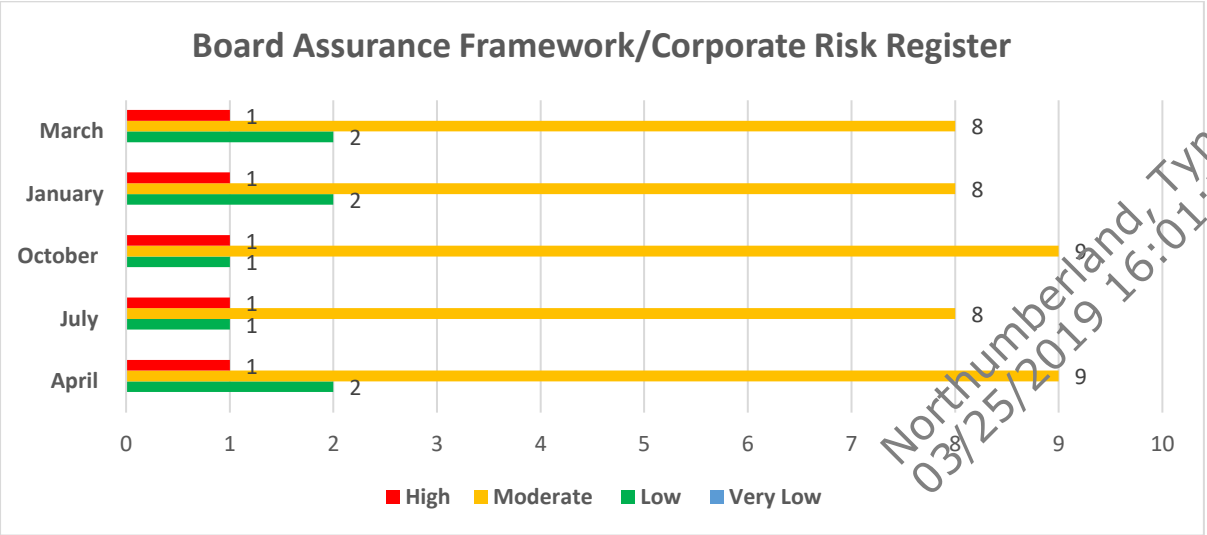
The Northumberland, Tyne & Wear NHS Foundation Trust Board Assurance Framework/Corporate Risk Register (BAF/CRR) identifies the strategic ambitions and key risks facing the organisation in achieving the strategic ambitions.

This paper provides:

- Overview of the risks currently held on the Board Assurance Framework/Corporate Risk Register
- A review of the risks held on the Board Assurance Framework/Corporate Risk Register over the past year which includes changes to risk scores and actions.
- The questionnaire document which has been presented to Board of Directors to ask if risks are still appropriate and whether they should be carried forward to 2019-2020.
- The questionnaire to review the current risk appetite scores
- Consideration of issues not currently captured on the Board Assurance Framework/Corporate Risk Register.

## 1.0 Board Assurance Framework and Corporate Risk Register: Current Position

The below graph shows a summary of both the overall number and grade of risks held on the Board Assurance Framework/Corporate Risk Registers as at March 2019. In the quarter there has been no change to the number of risks held on the BAF/CRR. Please see Appendix 1 for full BAF/CRR.



### 1.1. Risk Appetite

There are currently 9 of the risks held on the BAF/CRR which are exceeding risk appetite and 2 which are within risk appetite, these are shown in the table below.

| Risk Ref | Risk description | Risk Appetite | Current Risk Score |
|---|---|---|---|
| SA1.2 | Restrictions of Capital Funding nationally and lack of flexibility on PFI leading to failure to meet our aim to achieve first class environments to support care and increasing risk of harm to patients through continuing to use sub optimal environments | Finance/VfM (12-16) | **10** |
| SA1.3 | That there are adverse impacts on clinical care due to potential future changes in the clinical pathways through changes in commissioning of Services. | Quality Effectiveness (6-10) | **12** |
| SA1.4 | The risk that high quality, evidence based and safe services will not be provided if there are difficulties in accessing services in a timely manner due to waiting times and bed pressures resulting in the inability to sufficient sufficiently responsive to demands. | Quality Effectiveness (6-10) | **16** |
| SA1.1 | If the Trust were to acquire additional geographical areas this could have a detrimental impact on NTW as an Organisation. | Compliance/ Regulatory (6-10) | **12** |
| SA3.2 | Inability to control regional issues including the development of integrated new care models and alliance working could affect the sustainability of MH and disability services. | Quality Effectiveness (6-10) | **12** |
| SA4.1 | That we have significant loss of income through competition and national policy including the possibility of losing large services and localities. | Finance/VfM (12-16) | **20** |
| SA4.2 | That we do not manage our resources effectively through failing to deliver required service change and productivity gains including within the Trust FDP | Finance/VfM (12-16) | **15** |
| SA5.1 | That we do not meet compliance and quality standards | Compliance/ Regulatory (6-10) | **15** |
| SA5.2 | That we do not meet statutory and legal requirements in relation to Mental Health Legislation | Compliance/ Regulatory (6-10) | **12** |
| SA5.5 | That there are risks to the safety of service users and others if we do not have safe and supportive clinical environments. | Quality Safety (1-5) | **10** |
| SA5.9 | Inability to recruit the required number of medical staff or provide alternative ways of multidisciplinary working to support clinical areas could result in the inability to provide safe, effective, high class service | Quality Effectiveness (6-10) | **12** |

**Key:** Red exceeding risk appetite, amber within risk appetite and green below risk appetite.

**2.0 Board Assurance Framework and Corporate Risk Register: Annual Review of changes to BAF/CRR**

The BAF/CRR are reviewed routinely with the each of the Executive Director Leads and during the period April 2018 to March 2019 the following movement occurred:

**2.1 Quarter 1**

Escalation/De-escalation of risks:

- There was a decrease in the number of risks held on the BAF/CRR from 12 to 10. 1 risk was de-escalated, and 2 risks were merged SA1.9 and SA4.2 with a new risk description provided.

Changes in risk scores:

- 2 risks had residual risk scores reduced (SA3.2, SA4.2)
- 1 risk had residual risk score increased (SA1.4)
- 1 risk which had the target risk score amended in line with risk appetite (SA1.3)

Actions Completed:

- 5 risks had actions completed and moved to controls (SA1.2, SA1.3, S1.4, SA5.1, SA5.2)

Exceeding Risk Appetite:

- 8 out of 10 of the risks exceeded risk appetite.

**2.2 Quarter 2**

Escalation/De-escalation of risks:

- There was an increase in the number of risks held on the BAF/CRR from 10 to 11. A risk was escalated in relation to "if the Trust were to acquire additional geographical areas this could have a detrimental impact on NTW as an Organisation" SA1.10.

Changes in risk scores:

- 1 risk had residual risk score increased (SA1.4)

Actions Completed:

- 1 risk had actions completed and moved to controls (SA1.4)

Exceeding Risk Appetite:

- 9 out of 11 of the risks exceeded risk appetite during quarter 2.

**2.3 Quarter 3**

Escalation/De-escalation of risks:

- The number of risks on the BAF/CRR remains the same as quarter 2.

Changes in risk scores:

- 1 risk had residual risk score reduced (SA1.2)

Actions Completed:

- 5 risks had actions completed and moved to controls (SA1.2, SA1.10, SA4.2, SA5.1, SA5.9)

Exceeding Risk Appetite:

- 9 out of 11 of the risks exceeded risk appetite during quarter 3.

**2.4 Quarter 4**

Escalation/De-escalation of risks:

- During quarter 4 the number of risks on the BAF/CRR remains the same as quarter 3:

Changes in risk scores:

- There have been no changes to risk scores during Quarter 4

Actions Completed:

- 5 risks had actions completed and moved to controls (SA1.4, SA1.10, SA5.1, SA5.5, SA5.9)

Exceeding Risk Appetite:

- 9 out of 11 of the risks exceeded risk appetite during quarter 4.

The table below provides a summary of the changes to each of the risks held on the BAF/CRR over the year April 2018 to March 2019.

| Risk Info. | Risk Description | Risk Appetite | Current Risk Score | Change in Risk Score | Length of Time Exceeded Risk Appetite | Changes to actions |
|---|---|---|---|---|---|---|
| SA1.2<br>Risk Ref 1681<br><br>James Duncan | Restrictions of Capital Funding nationally and lack of flexibility on PFI leading to failure to meet our aim to achieve first class environments to support care and increasing risk of harm to patients through continuing to use sub optimal environments | Financial and value for Money | 10 | 09/01/19 change in residual risk rating from 15 to 10 (5x3 to 5x2 due to the completion of actions in relation to ICS Bid) | Risk is within risk appetite and has remained so since identification | Actions complete in relation to:<br>* ICS Supported nationally and funding identified |
| SA1.3<br>Risk Ref 1682<br><br>Lisa Quinn | That there are adverse impacts on clinical care due to potential future changes in clinical pathways through changes in the commissioning of Services | Quality Effectiveness | 12 | Target risk score amended from 4x1 to 4x2 in line with risk appetite | Risk has continued to exceed risk appetite during the year. | Action complete in relation to:-<br>* Contract negotiations for the coming year |
| SA1.4<br>Risk Ref 1683<br><br>Gary O'Hare | There is a risk that high quality, evidence based safe services will not be provided if there are difficulties accessing services in a timely manner due to waiting times and bed pressures resulting in the inability to sufficiently respond to demands | Quality Effectiveness | 16 | 04/09/18 change in residual risk increased from 4x3 to 4x4<br>Further actions added | Risk has continued to exceed risk appetite during the year. | Action complete in relation to:<br>* creating capacity to care workstreams have now been established and monthly updates to the BDG |
| SA1.10<br>Risk Ref 1680<br><br>Lisa Quinn | If the Trust were to acquire additional geographical areas this could have a detrimental impact on NTW as an organisation | Compliance and Regulatory | 12 | There has been no change in the risk score since identification of risk | Risk has continued to exceed risk appetite during the year. | Actions complete in relation to:<br>* OBC and approval by Board to move to FBC<br>*Completion of the review of capacity to deliver<br>* identification of risks and mitigations<br>* Board approval for transfer of services following consideration of FBC<br><br>Actions Added:-<br>* Further actions to develop robust implementation plans and agree contract<br>* Monthly dialogue with Trust Board<br>* Contract agreed |
| SA3.2<br>Risk Ref 1685<br><br>John Lawlor | Inability to control regional issues including the development of integrated new care models and alliance working could affect the sustainability of MH and disability services | Quality Effectiveness | 12 | Change in residual risk score reduced from 4x4 to 4x3 | Risk has continued to exceed risk appetite during the year. | No change to actions during the year. But additional controls and assurance in relation to partnership groups added. |
| SA4.1<br>Risk Ref 1686<br><br>Lisa Quinn | That we have significant loss of income through competition, choice and national policy including the possibility of losing large services and localities. | Financial and value for Money | 20 | There has been no change in the risk score since identification of risk | Risk has continued to exceed risk appetite during the year. | No change to actions during the year. |

| Risk Info. | Risk Description | Risk Appetite | Current Risk Score | Change in Risk Score | Length of Time Exceeded Risk Appetite | Changes to actions |
|---|---|---|---|---|---|---|
| SA4.2<br>Risk Ref 1687<br><br>James Duncan | That we do not manage our resources effectively through failing to deliver required service change and productivity gains including within the Trust FDP | Financial and value for Money | 15 | Change in residual risk score reduced from 5x4 to 5x3 | Risk is within risk appetite and has remained so since identification | Actions complete in relation to:<br>* Workforce plan and capacity to support internal change - combined with action in relation to capacity to care initiatives<br>Actions added:-<br>* 5 year operational plan approval - Sept 2019<br>* Operational Plan 19/20 submission April 2019<br>* Reporting on plan to be revised March 2019<br>* Annual budget and delivery sign off March 2019 |
| SA5.1<br>Risk Ref 1688<br><br>Lisa Quinn | That we do not meet compliance & Quality Standards | Compliance and Regulatory | 15 | There has been no change in the risk score since identification of risk | Risk has continued to exceed risk appetite during the year. | Additional control added in relation to:<br>* Self Assessment of Leadership and Governance Board Report (January 2019)<br>* Internal Audit Report of Well Led Self Assessment - Substantial Assurance |
| SA5.2<br>Risk Ref 1691<br><br>Rajesh Nadkarni | That we do not meet statutory and legal requirements in relation to Mental Health Legislation | Compliance and Regulatory | 12 | There has been no change in the risk score since identification of risk | Risk has continued to exceed risk appetite during the year. | Actions complete in relation to:<br>*CQC MHL Reviewer visit themes/issues:<br>*CQC/MHA reviewer session to be delivered at learning and improvement group: CQC/MHL reviewer session delivered at learning and development group in November 2018<br><br>Actions added in relation to:<br>* New process now in place with extra ordinary meeting to take place in March 2019 to allocate themes to ensure they are being addressed with progress to be reported back to the MHL |
| SA5.5<br>Risk Ref 1692<br><br>Gary O'Hare | That there are risks to the safety of service users and others if we do not have safe and supportive clinical environments. | Quality Safety | 10 | There has been no change in the risk score since identification of risk | Risk has continued to exceed risk appetite during the year. | Actions complete in relation to:-<br>* Identified training funding and staff eligible for training Development of a centralised management and service delivery model for SALT and dysphagia to maximise deployment of existing dysphagia trained SALTs<br>* all the management actions have been completed. Medical devices inventory is now held within the CAFM system (moved to control and assurance) |
| SA5.9<br>Risk Ref<br><br>Gary O'Hare | Inability to recruit the required number of medical staff or provide alternative ways of multidisciplinary working to support clinical areas could result in the inability to provide safe, effective, high class services | Quality Effectiveness | 12 | There has been no change in the risk score since identification of risk | Risk has continued to exceed risk appetite during the year. | Actions complete in relation to:-<br>* the streamlining of recruitment process – medical recruitment function has moved to the medical staff team and is now a control with assurance<br><br>Control added - international recruits have arrived in the Trust and are in post and deployed across the Trust |

## 3.0 BAF/CRR: Are the current Risks relevant for 2019-20?

The Board of Directors have received a survey to seek their individual views on current risks continuing into 2019-20 (Appendix 2).

This outcome will be considered through the Board development session in March and results will be shared in the April 'Going forward' BAF/CRR.

The Board of Directors will be considering current risks and future risks in the light of the operational plan presented to the Board in March.

## 4.0 BAF/CRR: Consideration of Issues not captured on BAF/CRR

The Board of Directors will consider through the Board development session in March whether there are risks not yet captured, which going forward, impact on the delivery of the Trust's Strategic Ambitions.

To note there are a number of operational issues that are reported to the Board of Directors through the Risk Management process that are being held and managed at the appropriate levels of the organisation. Through the use of the Risk Appetite the Board of Directors will see risks managed and held at lower levels of the organisation that are breaching the risk appetite. Examples include:

- Access and Waiting Times
- Sickness
- Staff capacity
- Environmental shortfalls

## 5.0 BAF/CRR: Annual Review of Risk Appetite

The Board of Directors have received a survey to seek their individual views on the current risk appetite framework (Appendix 3). This framework has been in place for 2 years and has been reviewed annually.

## 6.0 Recommendations

The Board of Directors are asked to:

- To note the process in hand with the Board of Directors to review the risk appetite and BAF in preparation for 2019-20.
- To note the movement in risks through 2018-19.
- To recieve an end of year BAF/CRR.

| | | | Looking forward to 2019/20, are the below risks still appropriate? | | |
|---|---|---|---|---|---|
| Risk Ref | Risk Owner | Risk Description | Yes | No | Un-decided |
| SA1.10 Risk Ref 1680 | Lisa Quinn | If the Trust were to acquire additional geographical areas this could have a detrimental impact on NTW as an organisation | | | |
| SA1.2 Risk Ref 1681 | James Duncan | Restrictions of Capital Funding nationally and lack of flexibility on PFI leading to failure to meet our aim to achieve first class environments to support care and increasing risk of harm to patients through continuing to use sub optimal environments | | | |
| SA1.3 Risk Ref 1682 | Lisa Quinn | That there are adverse impacts on clinical care due to potential future changes in clinical pathways through changes in the commissioning of Services | | | |
| SA1.4 Risk Ref 1683 | Gary O'Hare | There is a risk that high quality, evidence based safe services will not be provided if there are difficulties accessing services in a timely manner due to waiting times and bed pressures resulting in the inability to sufficiently respond to demands | | | |
| SA3.2 Risk Ref 1685 | John Lawlor | Inability to control regional issues including the development of integrated new care models and alliance working could affect the sustainability of MH and disability services | | | |
| SA4.1 Risk Ref 1686 | Lisa Quinn | That we have significant loss of income through competition, choice and national policy including the possibility of losing large services and localities. | | | |
| SA4.2 Risk Ref 1687 | James Duncan | That we do not manage our resources effectively through failing to deliver required service change and productivity gains including within the Trust FDP | | | |
| SA5.1 Risk Ref 1688 | Lisa Quinn | That we do not meet compliance & Quality Standards | | | |
| SA5.2 Risk Ref 1691 | Rajesh Nadkarni | That we do not meet statutory and legal requirements in relation to Mental Health Legislation | | | |
| SA5.5 Risk Ref 1692 | Gary O'Hare | That there are risks to the safety of service users and others if we do not have safe and supportive clinical environments. | | | |
| SA5.9 Risk Ref | Gary O'Hare | Inability to recruit the required number of medical staff or provide alternative ways of multidisciplinary working to support clinical areas could result in the inability to provide safe, effective, high class services | | | |

| Looking forward to 2019/20, are there any other issues which need to be considered for inclusion on BAF/CRR |
|---|
| |

Appendix 3

| Category | Risk Appetite | Current Risk Appetite Score | Is this score still appropriate? | | If no, proposed new score |
|---|---|---|---|---|---|
| | | | Yes | No | |
| Clinical Innovation | NTW has a MODERATE risk appetite for Clinical Innovation that does not compromise quality of care. | 12-16 | | | |
| Commercial | NTW has a HIGH risk appetite for Commercial gain whilst ensuring quality and sustainability for our service users. | 20-25 | | | |
| Compliance/Regulatory | NTW has a LOW risk appetite for Compliance/Regulatory risk which may compromise the Trust's compliance with its statutory duties and regulatory requirements. | 6-10 | | | |
| Financial/Value for Money | NTW has a MODERATE risk appetite for financial/VfM which may grow the size of the organisation whilst ensuring we minimising the possibility of financial loss and comply with statutory requirements. | 12-16 | | | |
| Partnerships | NTW has a HIGH risk appetite for partnerships which may support and benefit the people we serve. | 20-15 | | | |
| Reputation | NTW has a MODERATE risk appetite for actions and decisions taken in the interest of ensuring quality and sustainability which may affect the reputation of the organisation. | 12-16 | | | |
| Quality Effectiveness | NTW has a LOW risk appetite for risk that may compromise the delivery of outcomes for our service users. | 6-10 | | | |
| Quality Experience | NTW has a LOW risk appetite for risks that may affect the experience of our service users. | 6-10 | | | |
| Quality Safety | NTW has a VERY LOW risk appetite for risks that may compromise safety. | 1-5 | | | |
| Workforce | NTW has a MODERATE risk appetite for actions and decisions taken in relation to workforce. | 12-16 | | | |

NHS
Northumberland, Tyne and Wear
NHS Foundation Trust

# Board Assurance Framework and Corporate Risk Register

# 2018-19

| Risk Ref | 1681 |
|---|---|

NHS
Northumberland, Tyne and Wear
NHS Foundation Trust

**Strategic Ambition: 1**
Working together with service users and carers we will provide excellent care, supporting people on their personal journey to wellbeing.

**Corporate Risk:**
Restrictions on capital funding nationally and lack of flexibility on PFI leading to a failure to meet our aim to achieve first class environments to support care and increasing the risk of harm to patients through continuing use of sub-optimal sub-optimal environments.

**Risk Rating:**

| | Impact | Likelihood | Score | Rating |
|---|---|---|---|---|
| Risk on Identification | 5 | **3** | 15 | **Moderate** |
| Residual Risk (with current controls in place): | 5 | **2** | 10 | **Low** |
| Target Risk (after improved controls): | 5 | **1** | 5 | **Very Low** |
| **Risk Appetite:** | | | **Finance/VfM** | **Within** |

| Controls & Mitigation<br>(what are we currently doing about the risk) | Assurances/ Evidence<br>(how do we know we are making an impact) | Gaps in Controls<br>(actions to achieve target risk ) |
|---|---|---|
| 1. CEDAR Programme Board Established with key Partners.<br>2. CEDAR Programme Delivery<br>3. CERA Programmes<br>4. Business Case approved for interim solution for WAA and Newcastle/Gateshead. Building programme in place<br>5. ICS supported nationally and funding identified<br>6. CEDAR Business Case process in place | 1. Minutes of CEDAR Programme Board<br>2. CEDAR Documents NTW 1718 23 Capital Planning<br>3. CERA Documents.<br>4. Business Case Document<br>5. ICS - Bid Document<br>6. Business case cycle for board meetings. | 1. Asset sales identified - reporting through RBAC on progress to be commenced April 2019 |

**Ref:** SA1.2

**Review Comments: Residual risk score reduced from 5x3 to 5x2 due to actions being completed in relation to ICS bid outcome and building programme in place for Newcastle/Gateshead**

| Executive Lead: Deputy Chief Executive | Board Sub Committee: RBAC | Updated/Review Date: 9 January 2019 |
|---|---|---|

| Risk Ref | 1682 |
|---|---|

NHS Northumberland, Tyne and Wear NHS Foundation Trust

**Strategic Ambition: 1**
Working together with service users and carers we will provide excellent care, supporting people on their personal journey to wellbeing.

| **Corporate Risk:** | **Risk Rating:** | **Impact** | **Likelihood** | **Score** | **Rating** |
|---|---|---|---|---|---|
| That there are adverse impacts on clinical care due to potential future changes in clinical pathways through changes in the commissioning of Services. | Risk on Identification | 4 | **3** | 12 | **Moderate** |
| | Residual Risk (with current controls in place): | 4 | **3** | 12 | **Moderate** |
| | Target Risk (after improved controls): | 5 | **1** | 5 | **Very Low** |
| | **Risk Appetite:** | **Quality Effectiveness:** | | | **Exceeded** |

| **Controls & Mitigation** (what are we currently doing about the risk) | **Assurances/ Evidence** (how do we know we are making an impact) | **Gaps in Controls** (Actions to achieve target risk) |
|---|---|---|
| 1.Integrated Governance Framework<br>2.Agreed contracts signed and framework in place. for managing change<br>3.Locality Partnership arrangements<br>4. Well led action plan complete<br>5. All CCG contracts agreed | 1. Independent review of governance-Process Amber/Green rating assessment.<br>2.Contract monitoring and contract change reporting process to CDT and RBAC.<br>3. Updates from Locality Partnership meetings<br>4. Well led action plan document.<br>5. Contract documentation. | 1. Move towards lead/prime provider models and alliance contracts by April 2019<br>2. Contract negotiations ongoing for the coming year to ensure that consideration is given to impact on clinical care - April 2019 |

**Ref:** SA1.3

**Review Comments: additional action in relation to contract negotiations for the coming year has been added - to be reviewed quarterly next review due April 2019**

| **Executive Lead: Executive Director of Commissioning & Quality Assurance** | **Board Sub Committee: RBAC** | **Updated/Review Date:** January 2019 |
|---|---|---|

| Risk Ref | 1683 |
|---|---|

NHS
Northumberland, Tyne and Wear
NHS Foundation Trust

**Strategic Ambition: 1**
Working together with service users and carers we will provide excellent care, supporting people on their journey to wellbeing.

Principal Risk:
There is a risk that high quality, evidence based safe services will not be provide if there are difficulties accessing services in a timely manner due to waiting times and bed pressures resulting in the inability to sufficiently respond to demands.

| **Risk Rating:** | **Impact** | **Likelihood** | **Score** | **Rating** |
|---|---|---|---|---|
| Risk on identification (Feb 2012): | 4 | **4** | 16 | **Moderate** |
| Residual Risk (with current controls in place): | 4 | **4** | 16 | **Moderate** |
| Target Risk (after improved controls): | 4 | **1** | 4 | **Very Low** |
| **Risk Appetite:** | **Quality Effectiveness** | | | **Exceeded** |

| **Controls & Mitigation** (what are we currently doing about the risk) | **Assurances/ Evidence** (how do we know we are making an impact) | **Gaps in Controls** (actions to take to achieve target) |
|---|---|---|
| 1.Integrated Grovernance Framework.<br>2.Performance review monitoring and reporting incl compliance with standards, indicators,CQINN.<br>3.Operational and Clinical Policies and Procedures.<br>4. Annual Quality Account.<br>5. CQC Compliance Group.<br>6. Trustwide access and waiting times standard group established.<br>7. Waiting times dashboard<br>8. Creating capacity to care workstreams are established | 1.Independent review of governance against Well-Led Framework January 2016<br>1/2/4.External Audit of Quality Account<br>1.Operational Plan 2016/17 reviewed by NHSI.<br>2.Reports to CDTQ,Q&P and QRG's.<br>3. Compliance with policies reviewed annually<br>5. CQC review rated outstanding.<br>6. Minutes of access and waiting times standard group.<br>7. Monitoring of the waiting times dashboard<br>8. Monthly updates to BDG | 1. Monitoring and Delivery of Operational Plan 18/19<br>2. Delivery of 5 Year Trust Strategy 2017-2022 and supporting strategies.<br>3. Complete Access and Waiting times Standard Gro Group work plan.<br>4. Internal Audit 18/19 - please see audit plan |

**Ref:** SA1.4

**Review Comments: Update action and control detailing workstreams that are established**

| **Executive Lead: Executive Director of Nursing and Chief Operating Officer** | **Board Sub-Committee: Q&P** | **Reviewed: 05 March 2019** |
|---|---|---|

| Risk Ref | 1680 |
|---|---|

Northumberland, Tyne and Wear NHS Foundation Trust

**Strategic Ambition: 1**
Working together with service users and carers we will provide excellent care, supporting people on their personal journey to wellbeing.

**Principal Risk:**
If the Trust were to acquire additional geographical areas this could have a detrimental impact on NTW as an Organisation.

**Risk Rating:**

| | Impact | Likelihood | Score | Rating |
|---|---|---|---|---|
| Risk on identification (May 2017): | 4 | **4** | 16 | **Moderate** |
| Residual Risk (with current controls in place): | 4 | **3** | 12 | **Moderate** |
| Target Risk (after improved controls): | 4 | **2** | 8 | **Low** |
| **Risk Appetite:** | **Compliance & Regulatory** | | | **Exceeded** |

| Controls & Mitigation (what are we currently doing about the risk) | Assurances/ Evidence (how do we know we are making an impact) | Gaps in Controls (Actions to achieve target risk) |
|---|---|---|
| 1. Joint Programme Board | 1. Minutes of meetings | 1. Ongoing dialogue with Trust Board - Monthly |
| 2. Due Diligence | 2. Due Diligence Report | 2. Robust implementation plans development |
| 3. Exec Leadership | 3. Identified Exec Leadership | 3. Agreed contract |
| 4. Specific Capacity Identified | 4. Identified NTW Team | |
| 5. Clear Oversight by Trust Board | 5. Board Development Sessions | |

**Ref:** SA1.10

**Review Comments: Updated actions as complete and agreed new actions**

| Executive Lead: Executive Director of Commissioning and Quality Assurance | Board Sub Committee: RBAC | Last Updated/Reviewed: 5 March 2019 |
|---|---|---|

| Risk Ref | 1685 |
|---|---|

NHS
Northumberland, Tyne and Wear
NHS Foundation Trust

**Strategic Ambition: 3**
Working with partners there will be "no health without mental health" and services will be "joined up"

**Principal Risk:**
Inability to control regional issues including the development of integrated new care models and alliance working could affect the sustainability of MH and Disability Services.

**Risk Rating:**

**Risk Appetite:**

| | Impact | Likelihood | Score | Rating |
|---|---|---|---|---|
| Risk on identification (May 2017): | 5 | **4** | 20 | **High** |
| Residual Risk (with current controls in place): | 4 | **3** | 12 | **Moderate** |
| Target Risk (after improved controls): | 4 | **2** | 8 | **Low** |
| **Quality Effectiveness** | | | | **Exceeded** |

| Controls & Mitigation (what are we currently doing about the risk) | Assurances/ Evidence (how do we know we are making an impact) | Gaps in Controls (Actions to achieve target risk) |
|---|---|---|
| 1. Executive and Group leadership embedded in each CCG/LA area to ensure that MH and disabilities services are sustainable. | 1. Successfully influenced service models across a number of localities. | 1. ICP leadership arrangements to be confirmed |
| 2. Leadership of the ICS MH workstream. | 2. Established close relationships with senior clinicians, managerial leaders across acute trusts and some GP practices. Regular updates/monitoring of ICS via Exec/CDT/BOARD Papers from MH ICS workstreams | 2. To be the lead/prime provider for MH and disabilities across the NTW Footprint |
| 3. Involvement in DTDT programme for OP and acute MH services | 3. Regular updates via Execs/CDT/Board | 3. Finalise the implementation plan for STP MH workstreams |
| 4. Member of Gateshead care partnership | 4. Regular updates via Execs/CDT/Board | 4. Delivery of NCM business strategy |
| 5. Member of Exec group for MCP in Sunderland | 5. Regular updates via Execs/CDT/Board | |
| 6. Member of the ICS Health Strategy Group | 6. Regular updates via Execs/CDT/Board | |
| 7. Member of North and Central ICPs | 7. Regular updates via Execs/CDT/Board | |
| 8. Member of Northumberland Transformation Board | 8. Regular updates via Execs/CDT/Board | |
| 9. Member of the Newcastle Joint Exec Group | 9. Regular updates via Execs/CDT/Board | |

| | | |
|---|---|---|
| **Ref:** SA3.2 | | |
| **Review Comments: Debbie Henderson reviewed risk and confirmed that there is no change** | | |
| **Executive Lead: Chief Executive** | **Board Sub Committee: Board** | **Last Updated/Reviewed: 19/03/2019** |

| Risk Ref | 1686 |
|---|---|

NHS
Northumberland, Tyne and Wear
NHS Foundation Trust

**Strategic Ambition 4**
The Trusts Mental Health and Disability Services will be sustainable and deliver real value to the people who use them.

**Principal Risk:**
That we have significant loss of income through competition, choice and national policy,including the possibility of losing large services & localities.

**Risk Rating:**

| | Impact | Likelihood | Score | Rating |
|---|---|---|---|---|
| Risk on identification May 2009): | 4 | **4** | 16 | **Moderate** |
| Residual Risk (with current controls in place): | 5 | **4** | 20 | **High** |
| Target Risk (after improved controls): | 5 | **2** | 10 | **Low** |
| **Risk Appetite:** | **Finance/VfM** | | | **Exceeded** |

| Controls & Mitigation (what are we currently doing about the risk) | Assurances/ Evidence (how do we know we are making an impact) | Gaps in Controls (actions to take to achieve target) |
|---|---|---|
| 1. Agreed contracts in place and process for variations for managing change<br>2. Locality Partnerships<br>3. New Models of Care for CAMHS Tier 4<br>4. Business Case and Tender Process<br>5. Achievement of contractual standards | 1. NTW1617 27 Agreements - Substantial Assurances with no issues of note<br>1. NTW 1718 22 Commissioning income Monitoring - Substantial Assurance<br>2 & 3 Quarterly partnership meetings minutes.<br>4. NTW1617 36 Responding to Tenders - Substantial Assurance<br>5. Monitored via Commissioning Report Monthly | 1. Internal project structure for future Forensic services and specialist childrens services<br>2. Central locality to develop proposals for future or forensic services<br>3. Seek agreement of Recovery programme with Northumberland CCG<br>4. Small areas of non compliance with Quality standards being monitored with action in place |

**Ref:** SA4.1

**Review Comments: Reviewed action: agreement of recovery programme now closed**

| Executive Lead: Executive Director of Commissioning and Quality Assurance | Board Sub-Committee: RBAC | Updated/Review Date: 06 March 2019 |
|---|---|---|

| Risk Ref | 1687 |
|---|---|

NHS Northumberland, Tyne and Wear NHS Foundation Trust

**Strategic Ambition: 4**
The Trusts Mental Health and Disability Services will be sustainable and deliver real value to the people who use them.

**Corporate Risk:**
That we do not manage our resources effectively through failing to deliver required service change and productivity gains included within the Trust FDP

| **Risk Rating:** | **Impact** | **Likelihood** | **Score** | **Rating** |
|---|---|---|---|---|
| Risk on Identification | 5 | **3** | 15 | **Moderate** |
| Residual Risk (with current controls in place): | 5 | **3** | 15 | **Moderate** |
| Target Risk (after improved controls): | 5 | **2** | 10 | **Low** |
| **Risk Appetite:** | **Financial/VfM** | | | **Exceeded** |

| **Controls & Mitigation** (what are we currently doing about the risk) | **Assurances/ Evidence** (how do we know we are making an impact) | **Gaps in Controls** (Actions to achieve target risk) |
|---|---|---|
| 1. Integrated Governance Framework | 1. Annual governance statement, quality account, quality account/annual accounts. | 1. Delivery of creating capacity to care initiatives |
| 2. Financial Strategy/FDP | 2. Operational Plan 18/19 agreed by NHSI. | 2. Internal audit review of capacity to care programme to be agreed in internal audit plan |
| 3. Financial and Operational Policy and procedure | 3. Policy and PGN NTW 1718 26 payroll expenditure, NTW 171839 cashier | 3. Operational plan 19/20 due for submission 04-Apr-19 |
| 4. Quality Goals and Quality Account | 4. External audit of quality account | 4. 5 year plan to be approved by the Board in Sep-19 |
| 5. Accountability Framework | 5. Accountability framework reports | 5. Annual Budget and Delivery plan sign off at Mar-19 Board |
| 6. Quarterly review of financial delivery | 6. Quarterly review delivered at RBAC | 6. Reporting on plan to be revised Mar-19 Board |
| 7. Programme agreed for capacity to care and Trust innovation capacity expanded | 7. Capacity to care programme | |
| 8. Going Concern Report | 8. Going Concern Report Audit Committee 04/18 | |

**Ref: SA4.2**

**Review Comments: James Duncan reviewed risk - Identified further actions which are added. James at next review to look at reducing the likelihood score**

| **Executive Lead:** Deputy Chief Executive/Executive Director of Nursing and Chief Operating Officer | **Board Sub Committee: RBAC** | **Updated/Review Date: 19/03/2019** |
|---|---|---|

| Risk Ref | 1688 |
|---|---|

NHS
Northumberland, Tyne and Wear
NHS Foundation Trust

**Strategic Ambition: 5**
The Trust will be a centre of excellence for Mental Health and Disability.

| **Corporate Risk:** | **Risk Rating:** | **Impact** | **Likelihood** | **Score** | **Rating** |
|---|---|---|---|---|---|
| That we do not meet compliance & Quality Standards | Risk on Identification | 5 | **3** | 15 | **Moderate** |
| | Residual Risk (with current controls in place): | 5 | **3** | 15 | **Moderate** |
| | Target Risk (after improved controls): | 5 | **1** | 5 | **Very Low** |
| | **Risk Appetite:** | **Compliance/Regulatory:** | | | **Exceeded** |

| **Controls & Mitigation**<br>**(what are we currently doing about the risk)** | **Assurances/ Evidence**<br>**(how do we know we are making an impact)** | **Gaps in Controls**<br>**(Actions to achieve target risk)** |
|---|---|---|
| 1. Integrated Governance Framework.<br>2.Trust Policies and Procedures.<br>3.Compliance with NICE Guidance.<br>4.CQC Compliance Group-review of compliance and Action Plans.<br>5.Performance Review/Integrated Commissioning and Assurance reports.<br>6. Accountability Framework meetings<br>7. Regulatory framework of CQC and NHSI.<br>8. Agreement of Quality Priorities | 1.Independent review of governance amber / green rating<br>2. Compliance with policy and procedures<br>3. CQC MHA Visits and completed action plans NTW1718 09 CQC Process-Substantial Assurance<br>4. Reports and updates to board sub committees<br>5. Reports/updates to board sub sommittees<br>6. Accountability Framework document<br>7. NTW1718 09 CQC process substantial assurance<br>8. Monitoried via reports/updates | 1. Well led action plans complete<br>2. Clinical Audit 18/19 - Please see audit Plan<br>3. Small areas of non-compliance with quality standards to be monitored with action plans in place |

**Ref:** SA5.1

**Review Comments: Action added re: small areas of non-compliance with quality standards**

| **Executive Lead: Executive Director Commissioning & Quality Assurance** | **Board Sub Committee: Q&P** | **Updated/Review Date: 06 March 2019** |
|---|---|---|

| Risk Ref | 1691 |
|---|---|

NHS
Northumberland, Tyne and Wear
NHS Foundation Trust

**Strategic Ambition 5**
The Trust will be a centre of excellence for Mental Health and Disability.

| **Corporate Risk:** | **Risk Rating:** | **Impact** | **Likelihood** | **Score** | **Rating** |
|---|---|---|---|---|---|
| That we do not meet statutory and legal requirements in relation to Mental Health Legislation | Risk on Identification | 4 | **3** | 12 | **Moderate** |
| | Residual Risk (with current controls in place): | 4 | **3** | 12 | **Moderate** |
| | Target Risk (after improved controls): | 4 | **2** | 8 | **Low** |
| | **Risk Appetite:** | **Compliance/Regulatory:** | | | **Exceeded** |

| **Controls & Mitigation**<br>**(what are we currently doing about the risk)** | **Assurances/ Evidence**<br>**(how do we know we are making an impact)** | **Gaps in Controls**<br>**(Actions to achieve target risk)** |
|---|---|---|
| 1.Integrated Governance Framework<br>2.Trust Policies and Procedures relating to relevant Acts and practice<br>3.Decision Making Framework<br>Performance review/integrated performance reports<br>5. Mental Health Legislation Committee<br>6. Process for 135/136 legislation with external stakeholders<br>7. New process in place for monitoring themes from MHA Reviewer visits through MHL Steering Group<br>8. CQC MHA Reviewer session delivered at learning & development group in November 18 | 1.Independent review of governance<br>2. Compliance with policy/training requirement<br>NTW1617 33 MHA Section 17 - good level of assurance<br>NTW 1718 42 MHA Statutory functions - good level of assurance<br>3. Decision making framework document<br>4. Reports to Board and sub Committees<br>5. Minutes of Mental Health Legislation Committee<br>6. 135/136 action plan complete<br>7. MHL Group papers and updates<br>8. Minutes and papers from Learning and Development Group | 1. IA 1415/NTW/30: MHA Patients Rights Complete management actions and await outcome of re-audit undertaken during Q2 18/19<br>2. Improvement review of MHA Training - 77.8%<br>3. Internal Audit 18/19 - Please see audit plan<br>4. Clinical Audit 18/19 - Please see audit plan<br>5. New process now in place with extra ordinary meeting to take place in March 2019 to allocate themes to ensure they are being addressed with progress to be reported back to MHL Steering Group - to review progress in 6 months<br>6. To monitor the effectiveness of process for monitoring and reporting on themes from MHA Reviewer visits |



| **Ref:** SA5.2 | | |
|---|---|---|
| **Review Comments: Risk reviewed - no change to risk score** | | |
| **Executive Lead: Executive Medical Director** | **Board Sub Committee: MHL Group** | **Updated/Review Date: 08 March 2019** |

| Risk Ref | 1692 |
|---|---|

NHS
Northumberland, Tyne and Wear
NHS Foundation Trust

**Strategic Ambition: 5**
The Trust will be a centre of excellence for Mental Health and Disability.

| **Corporate Risk:** | **Risk Rating:** | **Impact** | **Likelihood** | **Score** | **Rating** |
|---|---|---|---|---|---|
| That there are risks to the safety of service users and others if we do not have safe and supportive clinical environments. | Risk on Identification | 5 | **3** | 15 | **Moderate** |
| | Residual Risk (with current controls in place): | 5 | **2** | 10 | **Low** |
| | Target Risk (after improved controls): | 4 | **2** | 8 | **Low** |
| | **Risk Appetite:** | **Quality Safety:** | | | **Exceeded** |

| **Controls & Mitigation (what are we currently doing about the risk)** | **Assurances/ Evidence (how do we know we are making an impact)** | **Gaps in Controls / Further actions to achieve target risk 2016/17)** |
|---|---|---|
| 1.Integrated Governance Framework.<br>2.Trust Policies and Procedures.<br>3.Reporting and monitoring of complaints, litigation,incidents etc.<br>4.National Reports on Quality and Safety.<br>5. The medical devices management actions have now been completed and are managed effectively | 1. Annual review of Governance Framework.<br>2. Policy Monitoring Framework including Auditable standards, KPI and Annual review.<br>3.Safety Report to Board Sub Committee and Board.<br>4. Performance reports to Q & P<br>5. Devices appropriately managed and audited | 1. Internal Audit 18/19 - please see audit plan<br>2. Outcome and completion of deciding together April 2019<br>3. Delivery of OP Interim Plan<br>4. Identification of supervision capacity |



**Ref:** SA5.5

**Review Comments: Action completed and control added re: medical devices and fire safety internal audit**

| **Executive Lead: Executive Director of Nursing and Chief Operating Officer** | **Board Sub Committee: Q&P** | **Updated/Review Date: 06 March 2019** |
|---|---|---|

| Risk Ref | 1694 |
|---|---|

NHS
Northumberland, Tyne and Wear
NHS Foundation Trust

**Strategic Ambition: 5**
The Trust will be a centre of excellence for Mental Health and Disability.

**Principal Risk:**
Inability to recruit the required number of medical staff or provide alternative ways of multidisciplinary working to support clinical areas could result in the inability to provide safe, effective, high class services.

**Risk Rating:**

| | Impact | Likelihood | Score | Rating |
|---|---|---|---|---|
| Risk on identification (April 2018): | 4 | 4 | 16 | Moderate |
| Residual Risk (with current controls in place): | 4 | 3 | 12 | Moderate |
| Target Risk (after improved controls): | 4 | 2 | 8 | Low |
| **Risk Appetite:** | **Quality Effectiveness** | | | Exceeded |

| Controls & Mitigation (what are we currently doing about the risk) | Assurances/ Evidence (how do we know we are making an impact) | Gaps in Controls (Actions to achieve target risk) |
|---|---|---|
| 1. Workforce Strategy<br>2. RPIW Medical Recruitment<br>3. NTW International recruitment competency process<br>4. OPEL Framework<br>5. MDT Collegiate Leadership Team in place<br>6. All seven fellowship international recruits arrived into the Trust in December 2018<br>7. The medical recruitment functions have been moved to the medical staffing team | 1. Delivery of worforce strategy<br>2. RPIW Medical Recruitment outcomes papers<br>3. NTW Recruitment competency documents.<br>4. OPEL Framework Documents.<br>5. MDT leadership advice and support available<br>6. All still in post and deployed across the Trust<br>7. The medical staffing team manage the medical recruitment function | 1. Complete international recruitment campaign. Quartely updates<br>2. Implementation of Medical Induction Programme 2018 - quarterly updates |

**Ref: SA5.9**

**Comments: Updated action and added control re: medical recruitment functions to medical staffing team**

| Executive Lead: Executive Director of Nursing and Chief Operating Officer | Board Sub Committee: Q&P | Last Updated/Reviewed: 5 March 2019 |
|---|---|---|

| Internal Audit Plan | | | | | | |
|---|---|---|---|---|---|---|
| Review Area | 2018/19 | | | | | |
| | Q1 | Q2 | Q3 | Q4 | BAF/CRR Ref | Final Issue Date |
| Head of Audit Opinion | | | | • | | |
| Assurance Framework | | | | • | | |
| Leadership, Management and Governance (WELL-LED) | | • | | | | |
| Complaints and claims | | • | | | | |
| Research and Development | | | • | | | |
| Third Party Assurance | | | | • | | |
| Risk Management | | | | • | | |
| IM&T Governance, Controls & Strategy (incl.GDE) | | | • | | SA1.7 | |
| GDPR | • | | | | SA1.7 | |
| Network Continous Testing - Server Operational Management | | • | | • | SA1.7 | |
| Penetration Test | | | • | | SA1.7 | |
| Desktop management: Windows 10 deployment | | • | | | SA1.7 | |
| TAeR System - IT General Controls | | | • | | SA1.7 | |
| IAPTUS System - IT General Controls | | | • | | SA1.7 | |
| UK CRIS Research System | • | | | | SA1.7 | |
| TRAC System - NTW Solutions system | | • | | | SA1.7 | |
| IT Security Incident Management | | | • | | SA1.7 | |
| Information Governance Toolkit | | | | • | SA1.7 | |
| Premises Assurance Model | | • | | | SA5.5 | |
| NHS Improvement Single Oversight Framework - Finance/UoR | | | | • | SA5.5 | |
| Security Management | • | | | | SA5.5 | |
| Patient Experience | | • | | | SA5.1 | |
| Performance Management and Reporting | | • | | | | |
| Quality Account | | | | • | SA1.4 | |
| Waste Management | • | | | | | |
| Fire Safety | • | | | | | |
| Organisational Culture | | | • | | | |

| Review Area | 2018/19 | | | | | |
|---|---|---|---|---|---|---|
| | Q1 | Q2 | Q3 | Q4 | BAF/CRR Ref | Final Issue Date |
| Joint Working Arrangements | | | | • | | |
| Capital Procurement | | | • | | | |
| Salary Overpayments | | • | | | SA4.2 | |
| Procurement (Rolling Programme) | | • | | | SA4.2 | |
| Key Financial Systems | | | • | | SA4.2 | |
| Cashiering Services | • | | | | SA4.2 | |
| Patient Monies and belongings | • | | | | SA4.2 | |
| Non-Pay PAYE | | • | | | SA4.2 | |
| Losses and Special Payments | | • | | | SA4.2 | |
| Charitable Funds | • | | | | SA4.2 | |
| Recruitment and Selection (inc DBS) | | | | • | SA1.4 | |
| Time and Attendance | | | • | | | |
| Medical Revalidation | • | | | | | |
| Medical Job Planning | • | | | | | |
| Professional Registration | | | | • | | |
| Occupational Health Service | | • | | | | |
| Staff Appraisal | | | | • | | |
| Skills and Training | | | • | | | |
| Monitoring of Absence | | | | • | | |
| Local Level Clinical Audit Process | | | | • | | |
| Mortality Reporting | | | • | | SA5.1 | |
| Incident Mangement (excl. Serious Incidents) | | • | | | | |
| Mental Health Act Rolling Programme (patient rights/CTO) | • | | | • | SA5.2 | |
| Medical Devices | | | • | | SA5.5 | |
| Medicine Management | • | | | | | |
| Medicine Management EPMA | | | | • | | |
| Health and Safety | | | • | | | |
| Domestic Homecide | • | | | | | |

| Clinical Audit Plan | | | | | | |
|---|---|---|---|---|---|---|
| Review Area | 2018/19 | | | | | |
| | Q1 | Q2 | Q3 | Q4 | BAF/CRR Ref | Final Issue Date |
| Clinical Supervision | | | • | | SA5.5 | |
| Nutrition | | | • | | | |
| Seclusion | | • | | | SA5.1 | |
| Care Coordination (North) | | • | | | SA5.1 | |
| Care Coordination (Central) | | | • | | SA5.1 | |
| Care Coordination (South) | | | | • | SA5.1 | |
| Clustering | | | • | | SA5.1 | |
| POMH - UK National Audit: Assessement of the side effects of Depot Antipsychotics and Physical Health Monitoring | | | | • | SA5.1 | |
| Medication Summaries and Discharge Letters | • | | | | SA5.1 | |
| Domestic Homicide Investigation action plan | | • | | | | |
| Mental Health Act Patient Rights | • | | | | SA5.2 | |
| Mental Health Act CTO | | | • | | SA5.2 | |

**Northumberland, Tyne and Wear NHS Foundation Trust**

**Board of Directors**

**Meeting Date:** 27th March 2019

**Title and Author of Paper:** Integrated Commissioning & Quality Assurance Report (Month 11 February 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 28th February 2019.

2. Ongoing priority areas continue to be waiting times, sickness absence and information governance training.

3. The Trustwide appraisal figure has reduced to 84.7% this month, which is below the Trust standard of 85%.

**Risks Highlighted:** waiting times, physical health and CQUIN

**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, 2017/18 NHS Standard Contract, 2017-19 Planning Guidance and standard contract, 2017-18 Accountability Framework

## Executive Summary:

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

4. There have been two Mental Health Act reviewer visits received since the last report relating to Ward 31a and Aidan. There were actions which had been resolved along with some remaining as unresolved from previous visits Wards 3 and 4 at Walkergate Park have been added to the CQC Mental Health Act reviewer visit schedule

5. NHS England and South Tyneside fully achieved the contract requirements during month 11. There are a number of contract requirements largely relating to CPA metrics and seven day follow up which were not achieved across other local CCG contracts during the month

6. Seven of the ten CQUIN scheme requirements have been internally forecast to be achieved for Quarter 4, however there are risks identified to quarter 4 delivery in relation to elements of the physical health CQUIN (discharge summaries), improving services for people with mental health needs who present to A&E and Transitions out of Children's and Young People's Mental Health Services.

7. The number of people waiting more than 18 weeks to access services has decreased this month in both adult and children's community services with the exception of Sunderland South Tyneside CYPS.

8. 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 MHA Combined Training (77.2% was 77.5% last month) and PMVA Basic Training (79.3% was 80.1% last month).

9. Reported appraisal rates have decreased to 84.7% in the month Trustwide, which is below the Trust standard.

10. When comparing the January 2019 provisional figure (6.24%) to the February 2019 provisional figure (5.92%), the in month sickness has improved by 0.32%, however the confirmed January 2019 in month figure is 6.1% which is a reduction of 0.14% on the previously reported figure. The 12 month rolling average sickness rate has increased to 5.79% in the month.

11. At Month 11 the Trust has a year to date surplus of £4.1m which is £1.4m ahead of plan. The Trust's finance and use of resources score is currently 1 and the forecast year-end rating is a 3.

Other issues to note:

- The NHS Improvement model hospital now includes data in relation to Leadership and Improvement, clinical service lines and opportunities.

- Sunderland IAPT service has reported an increase in relation to those moving to recovery which has been reported at 56.2% for the month.

- The numbers entering treatment for Sunderland IAPT service has not been achieved in month 11.

- The number of follow up contacts conducted within 7 days of discharge has decreased in the month and is reported at 95%. In 2019/20 we will start to monitor follow ups within 72 hours of discharge.

- There were thirty seven inappropriate out of area bed days reported in February 2019.

- Information Governance training is reported at 93.1% at the end of February 2019 and work is ongoing to improve this.

- Doctors in training figures have been collated manually this month due to the continuing ongoing technical issues outside of NTW relating to the transfer of the training records. Work is ongoing to produce these figures electronically and will be available via the dashboards in April 2019.

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

- There has been a decrease in the number of clusters undertaken at review in February 2019.

- The Data Quality Maturity Index has been published for Quarter 2 2018-19 and is reported at 95.8% which is a slight decrease from Quarter 1 (96%)

# Commissioning and Quality Assurance Summary Dashboard – February 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 has been two Mental Health Act reviewer visits during the month to Ward 31a and Aidan ward. There were actions noted as resolved and some remained unresolved from previous visit |

## 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 |
|---|---|---|---|---|---|---|---|
| 100% | 90% | 90% | 90% | 100% | 86% | 62% | 75% |

NHS England and South Tyneside contracts achieved the contract requirements during month 11. However, there are a number of contract requirements largely relating to CPA metrics, seven day follow up and IAPT numbers entering treatment which were not achieved across other local CCG contracts during the month. Sunderland IAPT service has reported an increase in those moving to recovery in the month, now at 56.2%

There has been one Commissioner quality visit during the month to Cleadon Ward at Monkwearmouth Hospital.

The Specialised Mental Health data submission quality score has remained static at 91.5% at the last submission and work is ongoing to improve this further

### CQUIN - Quarter 4 internal assessment RAG rating:

| Staff Health | Physical Health | Improving MH needs at A&E | CYPS Transitions | Alcohol and Tobacco | Health & Justice | Recovery colleges for medium and low secure | Discharge & Resettlement | CAMHS Inpatient Transitions | Reducing Restrictive Practices |
|---|---|---|---|---|---|---|---|---|---|

There is a current risk to the Physical Health CQUIN at Quarter 4 due to challenges providing GPs with summary care plan information and discharge summaries within required timescales. A risk has also been identified to the Improving services for people with mental health needs who present to A&E CQUIN due to an increase in reported attendances. Elements of the CYPS Transitions CQUIN have been forecast as amber.

## Internal

### Accountability Framework

| North Locality Care Group Score: Feb 2019 | | Central Locality Care Group Score: Feb 2019 | | South Locality Care Group Score: Feb 2019 | |
|---|---|---|---|---|---|
| 4 | The group is below standard in relation to CPP metrics and training elements | 4 | The group is below standard in relation to CPA metrics and a number of internal requirements | 4 | The group is below standard on 7 day follow up, the IAPT access target and a number of internal requirements. |

## Quality Priorities: Quarter 4 internal assessment RAG rating

| Improving the inpatient experience | Improve Waiting times for referrals to multidisciplinary teams | Implement principles of the Triangle of Care | Embedding Trust Values |
|---|---|---|---|

### Waiting Times

The number of people waiting more than 18 weeks to access services has decreased in the month for adults and children's community services. While 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:

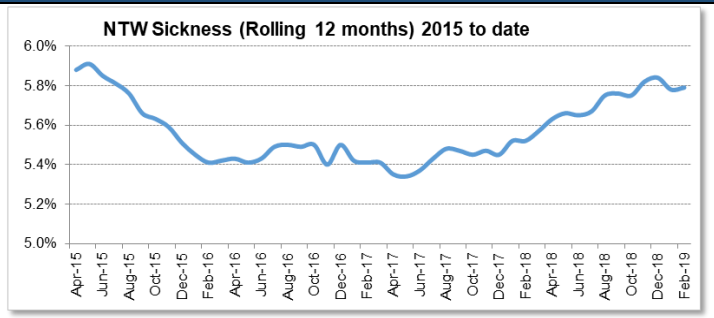
| Number of courses Standard Achieved Trustwide: | Number of courses <5% below standard Trustwide: | Number of courses Standard not achieved (>5% below standard): |
|---|---|---|
| 15 | 2 | 2 |

Clinical risk training (81.3%) and Information Governance (93.1%) are within 5% of the required standard, MHA combined training (77.2%) and PMVA basic training (79.3%) remain at more than 5% below the standard.

### Appraisals:

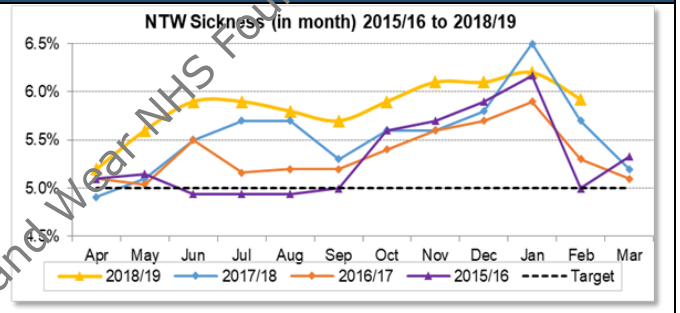
Appraisal rates have decreased to 84.7% in February 19 (was 85.6% last month).

### Sickness Absence:




The provisional "in month" sickness absence rate is above the 5% target at 5.92% for February 2019

The rolling 12 month sickness average has increased to 5.79% in the month




## Finance

At Month 11, the Trust has a surplus of £4.1m which is £1.4m ahead of plan. Agency spend is £6.6m which is £0.8m below the trajectory of our NHSI allocated agency ceiling of £8.0m but £2.0m above Trust planned spend. The forecast surplus is £6.5m, including Provider Sustainability Funding (PSF) of £3.5m (£2.0m core and £1.5m incentive funding). The Trust is forecasting the receipt of £1.5m matched incentive funding as it now expects to exceed its core control total excluding PSF by that amount.

The Trust's finance and use of resources score is currently a 1 and the forecast year-end risk rating is a 3.

The main financial pressures relate to pay, slippage on financial delivery plan schemes and reductions in secure services income. The Trust needs to reduce pay costs and spending on temporary staffing (agency, bank and overtime) to achieve planned spend and deliver its plans for next year. Work is ongoing to improve efficiency and productivity and deliver the required staffing reductions.

# Financial Performance Dashboard

## NTW Income & Expenditure

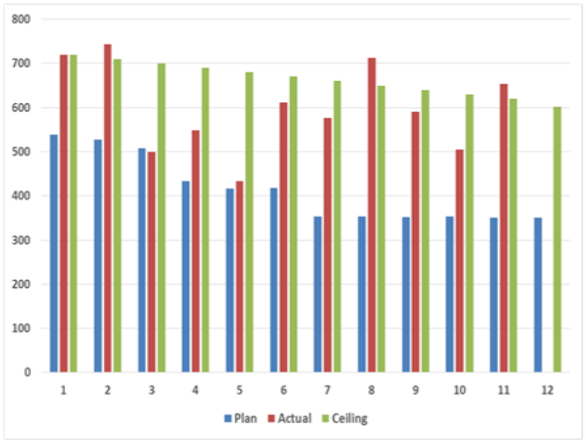
| | YTD Plan £m | YTD Actual £m | YTD Variance £m |
|---|---|---|---|
| Income | 294.8 | 293.4 | 1.4 |
| Pay | (232.6) | (232.8) | 0.2 |
| Non Pay | (59.5) | (56.5) | (3.0) |
| **Surplus/(Deficit)** | **2.7** | **4.1** | **(1.4)** |

## Control Totals

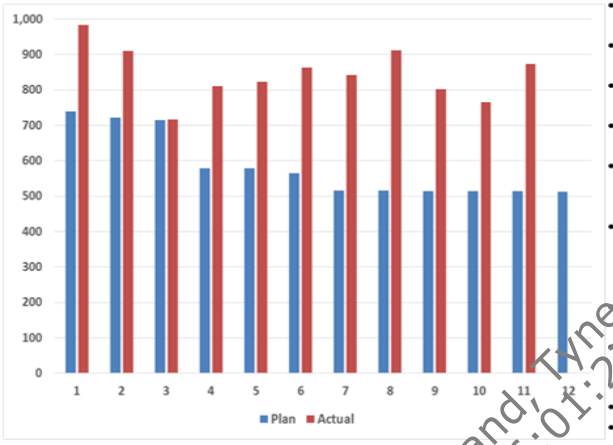
| | YTD Plan £m | YTD Actual £m | YTD Variance £m |
|---|---|---|---|
| North | 22.5 | 23.5 | (1.0) |
| Central | 22.8 | 20.8 | 2.0 |
| South | 26.6 | 27.6 | (1.0) |
| Central Depts | (69.2) | (67.8) | (1.4) |
| **Surplus/(Deficit)** | **2.7** | **4.1** | **(1.4)** |

| Key Indicators | YTD | Forecast |
|---|---|---|
| Risk Rating | 1 | 3 |
| Agency Spend | £6.6m | £7.4m |
| FDP Delivery | £11.0m | £12.6m |
| Cash | £25.0m | £24.0m |
| Capital Spend | £5.9m | £8.2m |

## Agency Spend




## Bank Spend




## Key Issues/Risks

- Surplus/Deficit - £4.2m surplus at Mth11 which is £1.4m ahead of plan.
- Control Total – The Trust is forecasting a surplus of £6.5m which meets its £3.5m Control Total.
- Risk Rating – The use of Resources rating is a 1 at Mth11 & the forecast year-end rating is a 3.
- Pay costs increased this month and were higher than plan.
- Main pressures - Pay overspends in a number of areas, slippage on FDP schemes and reductions in secure services income.
- Agency Spend – Agency ceiling is £8.0m and Trust planned spend is £4.9m in 18/19. Spend at Mth11 is £6.6m which is £0.8m below the NHSI allocated ceiling trajectory but £2.0m above plan.
- Financial Delivery Plan - Savings of £11m have been achieved at Mth11 which is in line with plan. In addition to its planned £12.6m efficiency savings the Trust needs to deliver £2.3m of service retractions to support Northumberland CCG's Recovery Plan.
- Cash – £25.0m at Mth11 which is £6.2m above plan.
- Capital Spend - £5.9m at Mth11 which is £5.8m less than plan.



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

| | 04/02/2019 | | 11/02/2019 | | 18/02/2019 | | 25/02/2019 | |
|---|---|---|---|---|---|---|---|---|
| Medical | 90 | 15 | 95 | 15 | 95 | 15 | 95 | 16 |
| Qual Nursing | 60 | 5 | 55 | 5 | 61 | 5 | 70 | 5 |
| Unq Nursing | 452 | | 491 | | 482 | | 429 | |
| A&C | 61 | | 78 | | 93 | | 76 | |
| | **663** | **20** | **719** | **20** | **731** | **20** | **670** | **21** |

In February the Trust reported an average of 20 price cap breaches (15 medical and 5 qualified nursing). In February 3 medics were paid over the price cap, with one being paid over £100 per hour.

**Northumberland, Tyne and Wear NHS Foundation Trust**

**Board of Directors**

**Meeting Date:** 27 March 2019

**Title and Author of Paper:** Interim Workforce Implementation Plan - Lynne Shaw, Acting Executive Director of Workforce and OD

**Executive Lead:** Lynne Shaw, Acting Executive Director of Workforce and OD

**Paper for Debate, Decision or Information:** Information

**Key Points to Note:**

- Letter received on 6 March 2019 from Baroness Dido Harding and Julian Hartley who are leading the work on the Workforce Implementation Plan: emerging priorities and actions
- Sets out five emerging themes and potential actions for 2019/20, asking for input around the following areas by 15 March 2019:
  - i) We can make a significant difference to our ability to recruit and retain staff by making the NHS a better place to work
  - ii) If our workforce plan is to succeed we must start by making real changes to improve the leadership culture in the NHS
  - iii) Although there are workforce shortages in a number of professions, disciplines and regions, the biggest single challenge we currently face nationally is in the nursing and midwifery profession
  - iv) To deliver on the vision of the 21st century care set out in the Long Term Plan will not simply require 'more of the same' but a different skill mix, new types of roles and different ways of working
  - v) We must look again at respective roles and responsibilities for workforce across the national bodies and their regional teams, ICSs, and local employers to ensure we are doing the right things at the right level.
- Response letter from ICS/STP Lead | North East and North Cumbria

**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**: N/A

| | |
|---|---|
| **Outcome Required:** | Information |

| | |
|---|---|
| **Link to Policies and Strategies:** | NHS Long Term Plan<br>Workforce and OD Strategy |

Wednesday 6 March 2019

To:

NHS trust and foundation trust chief executives and chairs

NHS clinical commissioning group accountable officers and chairs

Dear colleague,

**Interim Workforce Implementation Plan: emerging priorities and actions**

Following the recent publication of the *NHS Long Term Plan*, we have been tasked by the Prime Minister and Secretary of State for Health and Social Care to develop an interim Workforce Implementation Plan, as part of the overall Implementation Plan for the *NHS Long Term Plan (LTP)*.

The Interim Plan will be published in early April and will include a 2019/20 action plan together with a more detailed vision of how our workforce will transform over the next ten years. A full implementation plan will follow within two months of the conclusion of the Comprehensive Spending Review.

At this critical point in our work, we are seeking your views on our thinking so far and potential actions for 2019/20, following the last five weeks of intensive engagement with a broad range of partners from across the NHS, think tanks, regulatory bodies, academia and trade unions. This is consistent with our commitment to an inclusive and collaborative approach to developing the Plan, as well as maximising the value of your contributions in view of the pressing timescale.

To deliver 21st century care for our patients, we will need a transformed workforce – engaged, motivated and supported; with compassionate and inclusive leadership and working in positive cultures; with sufficient nursing staff and the right number of staff across all disciplines and all regions. We know that we don't simply need more of the same, but also a new skill mix which is more responsive to local patient and population needs. Finally, these actions will need to be delivered through a new workforce operating model where the right activities are done at the right level, whether this is employers, Integrated Care Systems (ICSs), regional or national bodies.

This letter sets out the emerging vision, potential 2019/20 actions and some key questions on each of these five emerging themes, on which we would really value your input.

**Theme 1: We can make a significant difference to our ability to recruit and retain staff by making the NHS a better place to work.**

**Our vision**: We know many people feel the NHS is a great place to work, but people tell us it could be much better. We know that the added stress from gaps in rotas can cause burnout, while the Pearson report on NHS staff and leaners' mental wellbeing sets out some of the most serious cases of harm to our people's mental health and wellbeing. Similar themes emerge from

the recently published results of the 2018 NHS Staff Survey where worryingly more people have reported experiencing bullying harassment and abuse in their workplace in the last 12 months.

We need to make the NHS an employer of excellence – valuing, supporting, developing and investing in our people. To do this we must create a modern employment culture fit for the 21st century, to meet the expectations of the people joining the NHS now and retain the people currently working in the NHS. This means significantly increasing flexible working through a combination of technology and a change in HR practices, giving people greater choice over their working patterns and helping them achieve a better work-life balance. Our people should expect a varied career and the ability to maintain a portfolio of personal and professional interests.

We need to widen participation in both education and training, and NHS careers, so that the workforce in 10 years' time better reflects the population it serves. It means maximising the contribution of both our clinical and non-clinical workforce, as well as our volunteers and the broader workforce.

We must prioritise the physical and mental health and wellbeing of our staff. All NHS staff should expect to work in an environment where their concerns are welcomed and taken seriously, and they don't suffer any negative consequences if they raise concerns. We must weed out discrimination, violence, bullying and harassment across the NHS, and provide better support for people who have been at the receiving end of unacceptable behaviours and actions.

Much of this starts with good line management practices – focussing on the management basics such as ensuring staff are able to take their breaks, have access to hot food, somewhere to rest and recharge, and a manager who thanks them when they work late.

**Potential actions for 2019/20**

- Consultation on a new deal with staff, building on the NHS Constitution, setting out what they can expect from the NHS as a world-class and modern employer
- Associated campaign to engage all our people; framework to support Boards on how to engage with their people; good practice case studies of employers that are at the vanguard on this agenda
- Further action to improve health and wellbeing, including implementing the recommendations from the recently published *NHS staff and learners' mental wellbeing commission*
- Next steps on tackling violence and aggression, and bullying and harassment
- Embedding the Workforce Race Equality Standard and consulting on Workforce Disability Standard
- Expanding the NHS Improvement retention programme to all trusts and developing an equivalent program for Primary Care
- Streamlining induction and training processes, and passporting training and qualifications across different employers and settings
- Review of the impact of pensions policy on retention and options to resolve

**Key questions**

- Have we captured the key areas we need to focus on in 2019/20 to make the NHS a better place to work? Is anything missing or less of a priority?
- We are keen to ensure that this workstream is relevant to all parts of the NHS, are there specific actions we should consider to ensure we capture the needs of staff working in the community and primary care?
- What more can we do nationally to create the right conditions for success?

**Theme 2: If our workforce plan is to succeed we must start by making real changes to improve the leadership culture in the NHS.**

**Our vision:** Our ability to continue to recruit and retain the best staff depends on us creating a positive and engaging culture – a culture which needs to start at the very top of the NHS. There is clear evidence that organisations with highly engaged staff deliver high quality and sustainable care for patients. It is no coincidence that these organisations also use established quality improvement methods, which draw on staff and service users' knowledge and experience to continuously improve services.

It is also clear that this positive leadership is not consistently demonstrated across the system in national bodies, providers or commissioners. If we are to deliver the promise of the LTP we need to acknowledge this and improve our leadership culture and capacity. We need to support and encourage our very best leaders to take on the most difficult roles, and create a pipeline of clinical and non-clinical talent ready to take on Board leadership positions in future.

We all recognise the increased need for system collaboration and service transformation means new and different leadership challenges, in particular for our most senior people. These challenges also apply to the senior leaders of the national bodies as we come together to establish new structures and ways of working. This provides a valuable opportunity to co-produce a new deal with our leaders that sets out the 'gives and gets'.

This is not just about Board leadership. Middle management often sets the culture of our organisations for our front-line staff. We need to do more to embed strong management skills and support and develop our middle managers to lead through engagement and improvement, rather than command and control.

**Potential actions for 2019/20**

- Review of the support provided to challenged organisations by NHSI/E to ensure it reflects the inclusive and compassionate leadership we know delivers
- Develop a consistent, whole system approach for identifying, assessing, developing, deploying and supporting our talent to include:
    - rolling out regional talent boards
    - resources to support development of system leadership skills
    - consulting on common job descriptions, competency, values and behaviour frameworks for board level roles and other recommendations from recent reports by Tom Kark QC and Sir Ron Kerr
    - reviewing investment in talent management programs for all our staff
- Co-production of new 'leadership compact' between NHS Improvement/NHS England and Chief Executive Officers/Accountable Officers and Chairs which will set out the, values, behaviours and competencies expected of senior leaders, and the support and development those senior leaders should expect in return
- Review of the national oversight frameworks to ensure they are reflecting the inclusive and compassionate leadership we know delivers, specifically the Care Quality Commission/NHS Improvement well-led framework, NHS Improvement Single Oversight Framework and NHS England Improvement and Assessment Framework to enable measurement of culture, leadership, inclusion and organisational health

**Key questions**

- Do you agree that improving the leadership culture in the NHS is critical if we are to address our workforce challenges? If so, have we got the right immediate actions to create the conditions for local systems and organisations to improve? Is anything missing or less of a priority?

**Theme 3: Although there are workforce shortages in a number of professions, disciplines and regions, the biggest single challenge we currently face nationally is in the nursing and midwifery profession**.

**Our vision:** We currently have vacancies across all branches of nursing, with the most significant shortages in mental health, learning disability and community nursing. We have also seen a decline in mature students choosing to train as nurses. Our initial analysis suggests that this position is unlikely to improve in the near future without a serious focus on the supply, development and retention of the nursing and midwifery workforce.

We recognise the urgent need to boost entrants to nursing and midwifery courses, and we are examining all available options. In addition, there are actions that we can take in 2019/20, within existing budgets, including a focus on improving retention, reinvigorating the undergraduate nursing pipeline, and recruiting overseas nurses.

In parallel, we must increase our efforts to make nursing a more attractive career choice, so we have more entrants to the profession. We will also need to maximise system capacity by more actively engaging with our Higher Education Institutions (HEIs) to ensure there are enough places for those wanting to enter education and training.

We must explore the routes into the profession, focussing on maximising the contribution of the apprenticeship and new Nursing Associate routes. We know we also need to bridge the gap from education to employment by supporting our nurses better to manage this transition. We will explore an expansion of Health Education England's RePAIR initiative to stem attrition during training; the role of a job guarantee scheme to match graduates with employers; increase the focus on newly qualified nurses in NHS Improvement's retention programme; and enable our nurses to move within and between employers and sectors, so they can have fulfilling careers.

Finally, we must foster a culture of continuous development that supports our nursing and midwifery staff to meet their personal aspirations, as well as meeting the needs of the NHS through the development of new and advanced practice.

**Potential actions for 2019/20**

- 5,000 expansion of clinical placements for impact September 2019 intake
- New annual campaign and targeted approaches to school leavers, in particular 15 to 17-year olds (linked to volunteering and work experience programmes to maximise opportunities for exposure to health careers)
- Review of current Return to Practice processes to determine whether these can make a further contribution to increasing supply
- Details of the job guarantee offer, and an approach to preceptorship and early career support as part of an expanded retention programme

**Key questions**

- Do you agree that our highest priority for further investment is nursing and midwifery?
- Are these the right actions in the short to medium term and is this the right direction of travel? Have we missed anything critical?

**Theme 4: To deliver on the vision of 21st century care set out in the LTP will not simply require 'more of the same' but a different skill mix, new types of roles and different ways of working.**

**Our vision:** To deliver the model of care set out in the LTP will require the transformation of our workforce. While this is already underway in some parts of our workforce, with the introduction of critical new roles such as Physician Associates and Nursing Associates, we must accelerate our efforts to bring about a different skill mix and new ways of working to meet patient and population need. The creation of a more flexible and adaptive workforce will require the further development and upskilling of our people to enable us to make the best use of their talents, as well as ensuring we can get the most from critical new roles and our wider workforce of volunteers and partners.

To deliver truly population-based care we will need to change the way we work, with multidisciplinary team models across professions, care settings and organisations becoming the norm. We will need to facilitate this movement of staff by recognising relevant skills and training acquired in different settings, and removing barriers to integrated care provision. We will also need to harness the potential of technology to enable our people to work more flexibly and spend more time with patients, as well as equip them with the skills needed to operate in a world constantly evolving as a result of digital and genomic innovation.

The Apprenticeship Levy represents an important opportunity to widen participation and secure valuable new skills for our workforce, and ICSs will need to work together to use the levy funding available to them to secure the skills required locally. The newly established National Academy of Advancing Practice will also lead development of and agree the standards for multi-professional credentials, which are another means of safely and effectively widening the skill mix of our workforce.

We must ensure that we fully embed and maximise the contribution made by new roles, such as Nursing Associates and Physician Associates, including by planning for a sustainable pipeline and clarifying career pathways. We now have a shared national definition of advanced level practice. During 2019/20 we will support employers to identify and fully utilise this part of our workforce, including by updating ESR so that we are able to track numbers of advanced practitioners and better plan their deployment.

It is clear that we have not been investing sufficiently in Continuing Professional Development (CPD) and the development of our workforce more broadly. We know that this has an important bearing on the morale, and ultimately the retention, of our people. It is also a critical enabler of new and extended practice which will enable our people to adapt to the changing skill mix that will be required in the future. This is why we want to review how current funding is being targeted to ensure it is being used to upskill our people.

Finally, our people will need to be equipped to make the most of the digital age. We will use a range of learning programmes to drive digital skills leadership for system and organisational leaders through both the established Digital Academy and other education providers, providing the development for change leaders and aspiring leaders. We will launch an easy to use learning hub where content on everything from robotics to genomics will be easily accessible to all.

**Potential actions for 2019/20**

- Tools and good practice case studies to support systems to maximise the use of the apprenticeship levy
- 4 new multi-professional credentials and details of the next set for development
- Review of priorities areas for CPD investment

- Establishment of sustainable NHS Digital Academy; plans to ensure new areas such as AI are included in curricula; establishment of a board level leadership development model; and a digital workforce planning exercise

**Key questions**
- Are these the right actions in the short to medium term and is this the right direction of travel?
- What other actions could we take to transform the skill mix of our workforce and enable new ways of working?

**Theme 5: We must look again at respective roles and responsibilities for workforce across the national bodies and their regional teams, ICSs, and local employers, to ensure we are doing the right things at the right level.**

**Our vision:** The LTP is clear that the main organising unit of our health system will be ICSs, and all local health economies will move to become ICSs over the next 5 years. It is clear that different organisations and geographies have different workforce demands, different cultures and different local labour markets, so the way we recruit, retain and develop our people is going to be critical to the success of ICSs.

We will clarify the respective roles and responsibilities of the national bodies, aligning these under a shared strategic vision, to eliminate duplication and provide an enhanced support offer for local systems. This will mean supporting the development of more robust local workforce plans, that together inform national plans, and are more than a product of simply reconciling activity and finances. We must equally equip systems to transform their workforce, helping them to identify skills gaps, think creatively about how to address these and remove any barriers to new ways of working.

We will therefore seek to devolve more workforce activities to local systems, with the accompanying resources, as they are ready. These decisions will be informed by a framework that allows for benchmarking to determine whether the necessary enablers are in place and codifies the support that emerging ICSs can expect from NHS Improvement/NHS England and Health Education England regional teams.

Finally, we understand that to plan our workforce effectively we need a single, real time, workforce dataset available to national, system and local bodies. We must also take steps to address the gaps in our workforce data, beginning with Primary Care.

**Potential actions for 2019/20**
- Clarity about the roles and responsibilities of the national bodies and their regional teams, STPs/ICSs and local employers on workforce, with a roadmap for greater devolution of responsibilities and resources to STPs/ICSs and the support offer from regional teams
- Details of the critical path to establish single, real time, workforce dataset available to national, system and local bodies, built up from local systems

**Key questions**
- Do you agree we should devolve more responsibility for workforce to regions and STPs/ICSs?
- What activities would best be done at STP/ICSs level, and what enablers are required to make this a reality?

**How you can feedback to us**

We are very keen for your rapid input on all the areas outlined by 15th March, and you can feedback by:

- Emailing the team on nhsi.ltpworkforce@nhs.net
- Posting a question or comment on TalkHealthandCare https://dhscworkforce.crowdicity.com/category/browse

Our people are the NHS's greatest asset. We believe that we can achieve significant change in the coming financial year working with everyone who wants to make a difference on the people agenda – unleashing creativity to make better use of the financial resources we have currently and providing support to address challenges at the right level of the system.

Thank you in advance for making the time to respond.

Yours

Baroness Dido Harding
**Chair, NHS Improvement**
**Chair, Workforce Implementation Plan**

Julian Hartley
**Chief Executive, Leeds Teaching Hospitals NHS Trust**
**National Executive Lead, NHS Workforce Implementation Plan**

Join our Journey

North East and North Cumbria

15 March 2019

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Baroness Dido Harding, Chair,
NHS Improvement

Julian Hartley, National Executive Lead,
NHS Workforce Implementation Plan

Dear Dido and Julian,

**Interim Workforce Implementation Plan: Emerging Priorities and Actions - Response from the North East and North Cumbria STP /Emergent ICS**

Thank you for your letter dated 6 March and the invitation to share views on thinking so far and the potential actions for 19/20.

This letter forms the response from the North East and North Cumbria STP and we have sought views from our STP leaders and partners to inform the content.

We welcome the opportunity to influence and shape the workforce agenda, notably the opportunity arising within Theme 5 to look at respective roles and responsibilities for workforce moving towards greater local ownership. We want to work with you and national partners on bringing much needed change to our collective approach to workforce.

We see this as moving to a position where the workforce agenda is locally owned and directed, bringing a much needed shift from the current fragmented position amongst many partners. We firmly believe this will enable us to be better placed to meet the needs of our local populations and deliver great employment experiences and opportunities across health and care in the region.

We recognise there is a lot of information in this response, and equally, in those responses from our colleagues and partners. For ease our 3 key points are set out in summary below:

1. Our STP leaders collectively and actively support Theme 5 and welcome a devolution of responsibility for workforce to our region.

2. We passionately support Theme 1 and agree the NHS needs to become a better place to work. Whilst this will focus on significant areas of work (staff engagement, training etc) it also needs to be about the smaller but symbolic issues and the things which really matter to staff.
   As we shift our patient narrative to 'what matters to you?' this approach now equally needs to apply to staff if we truly aspire to be a 'world class and modern employer'.

3. We agree with Theme 2 in that the importance of leadership and culture, at all levels (especially leading by example from national leaders) is critical if we are to successfully address our workforce challenges.

**Theme 1: We can make a significant difference to our ability to recruit and retain staff by making the NHS a better place to work**

We strongly support work in this area and have already established a 'Becoming a great place to work' stream within our regional workforce programme. For too long, the focus has been predominantly on recruitment and supply and we need to continue to move to more of a balance across recruitment **and retention** agendas.

As a system, we support working towards better employment experiences for all our staff, and in the spirit of integrated care systems, we aspire for this to be across the full range of health and care services. We need more local control to be able to do this.

Employment experiences flow from the culture of an organisation and require a strong focus on the **small things which matter to staff**. This is about good employee engagement and treating people with respect. We believe these include a greater emphasis on environments and facilities, for example appropriate rest facilities, the right equipment to do the job, access to WiFi, food and lockers (as per any 'world-class and modern employer').

We believe there is a requirement to **lead by example**, not solely supporting further action on health and wellbeing but a fundamental mind set shift to work with the workforce as members of our local populations, supporting them and their families to lead healthier lives.

We collectively need to **change the narrative to talk more positively** about careers in health and care, shining a light on excellent practice, positive stories and experiences and create **better and deserved employment experiences for staff with protected characteristics**.

We wish to see a **mandating of streamlining work** relating to recruitment, training and occupational health processes so that as staff move around our services, they do so in a safe, efficient, and simplified way, being respectful of their time and prior knowledge. Expand this work to include, for example, pass porting and in the spirit of 'one NHS' a standardised suite of core workforce policies and procedures and regional redeployment processes.

Community and primary care staff often work to a broad range of terms and conditions and **some standardisation of terms is viewed as helpful**, whilst the whole sector considers it would benefit from **improved funding and access to CPD and protected learning time.**

Equally, where small numbers of staff don't align with NHS values and the culture we aspire to, we **need to be able to work with flexibility and speed to end employment** without protracted HR processes.

And finally, we fully **support the review of the impact of pension policy** on retention and options to resolve. Given the arising pressures and changing work patterns for colleagues, (of particular concern, some of our senior clinicians whose experience and knowledge we need to retain) we seek a firm commitment to do so.

**Theme 2: If our workforce plan is to succeed we must start by making a real change to improve the leadership culture in the NHS**

We welcome your clear acknowledgement that positive leadership is not consistently demonstrated across the system in national bodies, providers or commissioners and the intention to produce a new deal with leaders. The tone for all our work, at national, regional and local level arises from this and as set out earlier, we are strong in our view about **'leading by example'** and the importance of **compassionate, collective leadership** from, and for all. We agree leadership culture, at all levels, is critical if we are to successfully address our workforce challenges. We need to move from a commitment to change, to doing so in practice.

At a local level we need to be **supported to take appropriate risks, to innovate and to be trusted** to try out new things, reviewing and learning from our actions as we go. We aim to be bold and courageous and need support from our national partners to be so, with a recognition that successful change requires engagement, collaboration and time to implement and embed.

Whilst leadership at all levels is important, we need to **support, develop and trust the line managers and supervisors** across services, equipping them to develop strong, supportive working relationships with their staff. It is the strength of these personal relationships that often critically impact on the issues within theme 1, good employment experiences and retention of staff.

**Theme 3: Although there are workforce shortages in a number of professions, disciplines and regions, the biggest single challenge we currently face nationally is in the nursing and midwifery profession**

We agree that the highest priority for further investment is nursing and midwifery but this must **not be at the cost of neglecting other workforce challenges**, notably GPs and paramedics, or the opportunities to work differently, to explore wider workforce transformation or the importance and contributions of the multi-disciplinary team and other professions.

There is strong support within the region to ensure appropriate support for primary care nursing and specifically points relating to the return of on-site nursing schools, ensuring time for training, work experience opportunities, creating appropriate placements, student pathways, wider incentives (for example affordable housing offers), expanding work with schools and volunteering.

We have had requests to re-establish bursaries for nurse training and **to reform the apprenticeship levy**, supporting salaries and work place mentorship and inclusion of solutions to all including the primary care workforce.

**Theme 4: To deliver on the vision of 21st century care set out in the LTP will not simply require 'more of the same' but a different skill mix, new type of roles and different ways of working**

We welcome the information within this section and believe that this holds the key to **unlocking some of the workforce solutions**, yet brings some of the greatest challenges. Any workforce transformation, aligned to ICSs, needs to be considered across health **and care**, and this presents challenges to long established ways of working, professional and organisational boundaries. We need support at a national level from ALBs and colleges to develop and deliver this new and different way of working and seek to work proactively and positively with a wide range of local partners on our workforce challenges, including for example, housing, education, the voluntary sector, patients and their carers.

We support the potential actions and are firm in our view that **flexibility and adaptability of the workforce** (training and employment models, working across sectors, being digitally enabled) **lies at the heart of this** along with a clear **focus on the wider determinants of health**, promotion, prevention and self-management and with greater devolution, can drive this locally through the ICS.

**Theme 5: We must look again at respective roles and responsibilities for workforce across the national bodies and their regional teams, ICSs, and local employers, to ensure we are doing the right things at the right level**

We strongly agree with, and **look forward to, more devolved responsibility** for workforce to regions and STPs/ICSs. We have a number of high performing organisations in the region and we are building on our successes and relationships, working together to become an integrated care system.

Workforce is one of our top priority areas for focus, essential to the delivery of high quality, safe services and we have established a regional workforce programme and regional Board to oversee this work.

With the devolution of greater responsibilities, we believe we can **design, develop and deliver regional workforce solutions** which will meet our local needs and serve our local populations in accordance with the priorities of the ICS. We do recognise this won't always be easy given some of our current challenges and historic workforce shortages, notably in the medical workforce.

We would welcome the opportunity to **create a single, coordinated and joined up regional approach to the workforce agenda**, focusing on economies of scale and driven by population health data. This will require the **management and deployment of resources at regional level, with arising responsibility and accountability, notably those currently within HEE and the Leadership Academy.**

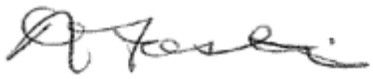
We seek **greater transparency about current use and distribution of resource** by ALBs along with a **review of current decision making structures** but would welcome greater responsibility for recruitment, CPD and other workforce funding and the alignment of HEE staff under the management of the ICS, **working together to ensure resources and efforts are deployed to meet locally owned strategic workforce needs, priorities and innovations**.

We value the continuation of national work on NHS workforce systems, notably ESR and NHS Jobs and the work which is building to strengthen and profile the NHS HR profession, its value and contribution and we hope to see further work on this led by the new Chief People Officer.

In summary we welcome the direction of travel and suggested areas for focus. We need to move towards greater recognition and rewards for good people management practice and position the workforce agenda as a core, essential component of an overall approach to quality, performance and resources; all of which are needed for high quality, safe, effective services.

We support the overall vision, notably the delegation of responsibilities to ICS level and look forward to shaping an implementation plan and offering our region as a pilot or early adopter for resulting change.

Yours sincerely



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