Board of Directors Meeting (PUBLIC)

03 July 2019, 13:30 to 15:30
Kiff Kaff, St. George's Park Morpeth
Northumberland NE61 2NU

Agenda

1. Service User/Carer Experience

St. George's Park Rehabilitation Carer Group

Information

Michelle Smitheram, Ward Manager, Kinnersley

2. Apologies

Information

Ken, Jarrold, Chair

3. Declarations of Interest

Information

Ken Jarrold, Chair

4. Minutes of the previous meeting: Wednesday 22 May 2019

Decision

Ken Jarrold, Chair

4. Draft Minutes_Board of Directors Meeting (PUBLIC)_220519 (4).pdf (7 pages)

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

Discussion

Ken Jarrold, Chair

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

6. Chair's Remarks

Information

Ken Jarrold, Chair

7. Chief Executive's Report

Information

John Lawlor, Chief Executive

7a. Chief Executive's Report Final.pdf (7 pages)

7b. Appendix 1 NHS Providers Briefing.pdf (5 pages)

7c. Appendix 2 - NHS Confederation.pdf (18 pages)

7d. Appendix 3. designing-integrated-care-systems-in-england.pdf (7 pages)

Quality, Clinical and Patient Issues

8. Service User and Carer Strategy

Governor and Service User Representatives.

8a. Service User-Carer Involvement Strategy final.pdf (8 pages)

8b. Service User-Carer Involvement Strategy Appendix.pdf (4 pages)

9. Commissioning and Quality Assurance Report (Month 2)

Discussion

Lisa Quinn, Executive Director of Commissioning and Quality

BoD Monthly Commissioning Quality Assurance Report - Month 2 updated version 3.pdf (6 pages)

Strategy and Partnership

10. Risk Management Strategy

Discussion

Lisa Quinn, Executive Director of Commissioning and Quality

10a. Risk Management Strategy - LQ.pdf (7 pages)

10b. Risk Management Strategy 2017-2022.pdf (12 pages)

Workforce

11. An NHS Workforce for the Future - Our Interim People Plan

Lynne Shaw, Acting Executive Director of Workforce and Organisational Development

11. Interim People Plan - LS.pdf (7 pages)

12. NTW Academy – Board Update

Discussion

Gary O'Hare, Executive Director of Nursing and Chief Operating Office

- 12a. NTW ACADEMY Board briefing front sheet June 2019.pdf (1 pages)
- 12b. NTW ACADEMY Board briefing June 2019.pdf (3 pages)
- 12c. Apprenticeship Business Plan May 19 update.pdf (8 pages)

13. NTW Academy – Opportunities for the Development of Managers and Leaders

Discussion

Gary O'Hare, Executive Director of Nursing and Chief Operating Office

- 13a. NTW Academy front sheet Opportinities for managers an.._.pdf (1 pages)
- 13b. NTW ACADEMY Managers and Leaders June 2019.pdf (5 pages)

14. Regulatory

There are no regulatory items for the July meeting

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, 7 August 2019, 1:30 pm to 3:30 pm, Training Room 4, Hopewood Park, Waterworks Road, Ryhope, Sunderland, SR2 0NB.**

Information

Chair

Board of Directors Meeting (PUBLIC)

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

NHS
Northumberland, Tyne and Wear
NHS Foundation Trust

Attendees

Board members

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

Apologies

Michael Robinson (Non-Executive Director), Peter Studd (Non-Executive Director)

In attendance

Jennifer Cribbes (Corporate Affairs Manager), Anna Foster (Deputy Director of Commissioning and Quality Assurance), Tony Gray (Head of Safety and Security), Debbie Henderson (Deputy Director Communications and Corporate Affairs), Damian Robinson (Group Medical Director, Safer Care)

Members of the Public

Bob Waddell (Staff Governor), Margaret Adams (Public Governor), Fiona Regan (Carer Governor), Mr Saint (Member of the Public)

Meeting minutes

1. Service User/Carer Experience

Information

Adam Watson delivered a verbal presentation to share his story and journey of recovery.

The Board thanked Adam for his very honest and open account of his experience and discussion took place in relation to the value of engaging with individuals with lived experience.

John Lawlor invited Adam to connect with the Trust to explore ways of helping to improve our services further.

The Board further thanked Adam and praised him for all his hard work.

2. Apologies

Information
Chair

Ken Jarrold opened the meeting and welcomed attendees.

Apologies were received from:
Peter Studd, Non-Executive Director.
Michael Robinson, Non-Executive Director.

3. Declarations of Interest

Information
Chair

There were no new conflicts of interest declared.

4. Minutes of the previous meeting: Wednesday 24 April 2019

Decision
Chair

The minutes of the meeting held on 24 April 2019 were agreed as a true and accurate record.

4. BOD Draft minutes 24 April 2019.pdf

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

Discussion
Chair

Action List
There were no actions to review at this meeting.

Matters arising
There were no matters arising.

5. BoD Meeting held in public Action List.pdf

6. Chair's Remarks

Information
Chair

Ken Jarrold provided a verbal update and made the Board aware that the Trust is reviewing the way it engages with service users and carers. Ken stated the importance of engagement with service users and carers and explained the new approach that is being shaped with the support of Vida Morris.

The Board recieved and noted the Chair's remarks.

7. Chief Executive's Report

Information
Chief Executive

John Lawlor spoke to the enclosed Chief Executive's report to update the Board on key areas.

Detail was provided in relation to the transfer of service from North Cumbria, Contract update, Investors in People, ICS Mental Health Workstream Regional Workshop, Panorama programme on Whorton Hall Hospital, Newcastle Health and Care - System Leadership Development Programme, Capital Funding for 2019/20, Launch of Productivity Metrics for Mental Health Community Services, Primary Care Networks and the NHS Providers Briefing on the future of NHS Boards in respect of partnership arrangements.

Discussion took place relating to the re-accreditation of Investors In People (IIP) and the significant debate and consideration made to renew accreditation due to the associated costs. Alexis Cleveland confirmed that she was happy that the Trust had decided to renew the accreditation

Lynne Shaw explained the process and timescales and advised that the IIP assessors may request to meet with Board members.

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

7.1 CE Report May 2019 DRAFT.pdf
7.2 CE Report - Appendix 1.pdf
7.3 CE Report - Appendix 2.pdf

Quality, Clinical and Patient Issues

8. State of the North East 2018: Public Mental Health and Wellbeing

Group Medical Director, Safer Care

Damian Robinson spoke to the enclosed report to update the Board on the key areas in the recent publication of Public Health England “State of the North East 2018: Public Mental Health and Wellbeing” published in February 2019.

Further information was provided in relation to the big issues. Discussion took place relating to the issue of deprivation and Children's mental health.

A significant discussion took place relating to the correlation in respect of self-harm being a potential predictor of suicide. This was also discussed in relation to the Trust's Zero Suicide plan.

Rajesh Nadkarni observed that work can be conducted with Primary Care Networks to develop a regional approach.

Ken welcomed the report and raised the importance of working with Service Users and Carers. Damian was asked to keep the Board sighted on developments.

Ken Jarrold raised the concept of social wealth and explained strengths in the area which included good health services, high levels of social inclusion and green areas.

The Board recieved and noted the State of the North East 2018: Public Mental Health and Wellbeing report.

8.1 State of the North East 2018 - summary for Board May 2019 - cover sheet.....pdf
8.2 State of the North East 2018 - summary for Board May 2019.pdf

9. Commissioning and Quality Assurance Report (Month 1)

Discussion
Executive Director Of Commissioning And Quality Assurance

Lisa Quinn spoke to the enclosed Integrated Commissioning and Quality Assurance Report for April 2019 (month 1) to update the Board on issues arising in the month and progress against quality standards.

It was explained that the Trust's position in month 1 was similar to the previous position at month 12. It was also explained that the Trust is performing well at an organisational level and that CCG and NHS England contracts had been signed.

Lisa brought the Board's attention to key challenges which included CPA metrics, access to services and clinical training targets.

James spoke to the finance section of the report and explained that the Trust's financial position at month 1 was broadly on track with the plan.

The Board received and noted the Commissioning and Quality Assurance Report (Month 1).

9. BoD Monthly Commissioning Quality Assurance Report - Month 1.pdf

10. Committees Terms of Reference

Decision
Executive Director Of Commissioning And Quality Assurance

Lisa Quinn spoke to the enclosed Committees' Terms of Reference report and explained that the Terms of Reference for Board meetings, Sub-Committees and Assurance meetings are reviewed on an annual basis. Lisa advised that all of the Terms of Reference had been reviewed by the relevant meetings prior to its inclusion in the report.

Lisa requested that the Terms of Reference for the Charitable Funds and Corporate Decisions Team be deferred to the October Board meeting to allow amendments to be made. The Board approved this request.

Alexis Cleveland requested an amendment to the Quality and Performance Committee Terms of Reference, to change the Non-Executive members from 2 to 3.

It was agreed that the amendment would be made and that Debbie Henderson would issue the approved Terms of Reference to the relevant individuals.

The Board recieved and approved the Terms of Reference.

10. Board Sub Committee ToR Annual Review 2019.pdf

11. Safer Staffing Levels (Quarter 4)

Discussion
Executive Director Of Nursing And Chief Operating Officer

Gary O'Hare spoke to the enclosed safer staffing report which included exception data and analysis of all ward staffing against safer staffing levels for Quarter 4.

Gary brought the Board's attention to the section of the report that highlighted wards that were outside of the agreed staffing levels during the quarter and the explanation for this within the narrative.

It was noted that there had been a reduction in Nursing Bank and Agency Usage.

Alexis Cleveland commented that the inclusion of narrative had improved the report and requested that future reports include any areas of concern.

The Board recieved and noted the Safer Staffing Levels report for the quarter 4 period.

11. Safer Staffing Levels Quarter 4 Report May 2019.pdf

Workforce

12. Workforce Directorate Quarterly update

Discussion
Acting Executive Director Of Workforce And Organisational Development

Lynne Shaw spoke to the enclosed quarterly Workforce report to update the Board on the key work and developments across the Trust.

Further information was provided in relation to the BAME recruitment event, work ongoing to support Reservists and Veterans and the new pay progression system for staff on agenda for change terms and conditions.

Lynne further made the Board aware that the Trust had been shortlisted for a Nursing Times Workforce Award for Pioneering oversees nurse recruitment in a mental health and disability NHS Trust.

The Board recieved and noted the Workforce Directorate Quarterly update.

12. Quarterly Workforce Report - May 2019.pdf

13. Freedom to Speak Up (6mth update)

Discussion
Acting Executive Director Of Workforce And Organisational Development

Lynne Shaw spoke to the enclosed Whistleblowing/Concerns Raised report to update the Board on issues raised and logged by the workforce team between October 2018 and March 2019.

It was explained that 7 cases had been reported and categorised as raising a concern. However, there had been a further 12 cases that had been raised directly with the Freedom to Speak Up Guardian during the same period. Lynne explained that there had been an emerging theme in the concerns raised which related to staff attitudes.

Lynne advised that the Freedom to Speak Up Guardian had increased his days from 1 day to 2 days and that 16 more champions had been trained.

In response to a question raised by Margaret Adams, Lynne explained that Neil Cockling is well recognised and that there were a number of posters throughout the Trust with Neil's photo and contact details. It was explained that a further campaign was required to make staff aware of the Freedom to Speak Up Champions.

John Lawlor further shared that he receives a number of e-mails from staff raising their concerns which may indicate that staff feel comfortable to raise concerns with senior staff in NTW.

In response to a concern raised by Les Boobis, Gary O'Hare explained that there are two Freedom to Speak up Guardians in Cumbria.

Lynne further explained that staff are encouraged to raise issues at a local level and therefore there are likely to be a lot more raised than those centrally logged that are just dealt with by local managers.

Ken Jarrold referred to the emerging theme of staff attitudes and suggested that a focus group is held to explore this further alongside the recent staff survey feedback.

13. Board report Whistleblowing and Raising Concerns Update - Nov18 - March.pdf

Regulatory

14. Annual Security Management Report

Discussion
Executive Director Of Nursing And Chief Operating Officer

Tony Gray spoke to the annual Security Management Report to update the Board on the security arrangements currently in place within the Trust. Tony explained that it was the 11th annual Security Management Report and that there is no legal requirement for the report to be produced.

Further information was provided in relation to the Lone Working System and Body Camera pilot.

Tony explained that the Board would receive a live demo of the Lone Working system at the July Board Development Meeting.

Ken Jarrold asked when the Trust would receive the evaluation from the body camera pilot. Tony explained that the pilot would be taking place over the next 3 months and it would be likely that the evaluation would be received in 6 months. Gary O'Hare explained that body camera technology has real potential in terms of safety for staff and service users. Gary further advised that the Board could receive the evaluation in a report or at a Board Development Meeting.

Alexis Cleveland thanked Tony for his work.

John Lawlor asked if there was an agreed methodology for obtaining feedback from service users. Tony explained that there was an agreed approach and confirmed that Paul Sams, Peer Support Worker was leading on the piece of work to obtain service user feedback.

In response to a question raised by James Duncan, Tony explained that the way drug-related incidents had been reported changed during the reporting period. Therefore, the increase could be a result of the new reporting system as well as an increase in incidents.

14. Security Management Annual Report - Board of Directors v2 Final-22 May 2....pdf

15. Board Self Certification to NHS Improvement (Condition FT4(8))

Decision
Executive Director Of Commisssioning And Quality Assurance

Lisa Quinn spoke to the enclosed Board Self-Certification to NHS Improvement report and explained that NHS Foundation Trusts are required by NHS Improvement to self-certify the declaration by 30 June 2019 to maintain their Provider Licence.

Lisa referred to the evidence provided within the report that demonstrates the Trust's compliance.

The Board was asked to confirm compliance in relation to Condition FT4(8) of the Provider Licence which confirms that the Trust has complied with required governance standards and objectives.

The Board approved that the Trust is compliant with Provider Licence Condition FT4(8).

15.1 BoD - FT4 - Corporate Governance Statement - Self Declaration.pdf
15.2 FT4 Self cert for signing.pdf

16. Provider License Self-Certification Annual Board Statement - Training of Governors

Decision
Deputy Director Communications And Corporate Affairs

Debbie Henderson spoke to the enclosed Board Self-Certification to NHS Improvement report in relation to Governor training. She explained that NHS Foundation Trusts are required by NHS Improvement to annually self-certify the declarations to maintain their Provider Licence. Debbie referred to the evidence provided which demonstrates the Trust's compliance and explained that NTW Governors are very active which was also recognised at the recent NHS Providers Governors showcase event.

Debbie advised that the Council of Governors, at their meeting on the 17 May 2018 confirmed that they are happy to recommend to the Board of Director's completion of the Board Statement, confirming that the Trust has provided the necessary training to its Governors during 2018/19.

The Board approved the Trust's compliance with Governors' Training.

16. Provider License Self-Cerr CoG training 2018-19.pdf

17. Board Self-Certifications G6(8) CoS7(3)

Decision
Executive Director Of Commisssioning And Quality Assurance

Lisa Quinn spoke to the enclosed Board Self-Certification to NHS Improvement report and explained that NHS Foundation Trusts are required by NHS Improvement to self-certify the declarations by 31 May 2019 to maintain their Provider Licence.

Lisa referred to the evidence provided within the report that demonstrates the Trust's compliance.

The Board was asked to confirm compliance in relation to Condition G6(3) of the Provider Licence which confirms that the Trust complies with the NHS Act 2009, Health Service Act 2012 and has regard to the NHS Constitution.

The Board was further asked to confirm compliance with Condition CoS7(3) that the Trust has the required resources available to provide services if providing commissioner requested services.

The Board approved that the Trust is compliant with Provider Licence Condition G6(3) and CoS7(3).

17.1 BoD - G6 and CoS7 - Compliance with Licence Declaration - May 2019 v2.pdf
17.2 G6 Self Cert for signing.pdf

18. Contract update

Discussion
Executive Director Of Commisssioning And Quality Assurance

Lisa Quinn spoke to the enclosed report to provide the Board with an update on 2019-20 contract negotiations. Lisa confirmed that NTW had agreed and signed all local CCG and NHSE contracts.

In response to a question raised by Alexis Cleveland, Lisa explained that the guidance relating to the Mental Health Investment Standard is now more specific.

The Board recieved and noted the Contract update.

18. Contracts Update 2019-20.pdf

19. Quality Account Approval

Decision
Deputy Director Of Commissioing And Quality Assurance

Anna Foster spoke to the enclosed Quality Account Report and explained the extensive engagement process undertaken to support its development. Anna further explained that the draft Quality Account had been reviewed at a number of the Trust's sub-committees and Council of Governors meetings.

Anna explained that Trust auditors issued the Audit Committee with a draft assurance report in respect of the Quality Account and explained that the 2019-20 Quality Priorities had been approved by the Board in March 2019. The Board was asked to approve the Quality Report and the Statement of Directors' Responsibilities contained within the Quality Report.

Lisa Quinn thanked Anna, the team and Council of Governors who contributed to the development of the report.

Ken Jarrold, James Duncan, and Margaret Adams further commended the report.

Rajesh Nadkarni explained that he was pleased to see the inclusion of the Junior Doctors' Guardian within the report.

Alexis Cleveland requested an amendment to state 'one of 4' on page 3.

Ken Jarrold thanked Anna for her hard work developing the report.

The Board approved the Quality Account including the Statement of Directors' Responsibilities contained within the Quality Account Report.

19.1 BoD - quality acount 18-19 - Final version for Board May 2019.pdf
19.2 Draft Quality Account v2.2 Board version.pdf

Minutes/Papers for Information

20. Committee updates

Information
Non-Executive Directors

There was nothing to update from Committees.

21. Council of Governors' Issues

Information
Chair

Ken Jarrold commenced by referring to the work in relation to NTW's new approach towards engaging with Service User and Carers and advised that Governors would be closely linked with the process.

Ken made reference to the Council of Governors meeting on the 14 May and shared that he had been disappointed as a result of the acoustics in the room, room layout and the number of items on the agenda. Ken explained that work was ongoing to look at improving the meetings.

Ken informed the Board that Margaret Adams, Fiona Grant, Debbie Henderson and himself would be attending the Cumbria Partnership Council of Governors' General Meeting held in public on the 4 July 2019.

Margaret Adams updated the Board in relation to the recent NHS Providers Governors Showcase. It was explained to have been a very successful event with over 200 Governor delegates in attendance. Margaret described the amount of interest that the NTW stand had, particularly in relation to the membership phone cards, top tips and how we engage young members. It was further stated that other Trust's had thanked NTW for supporting them with their improvement journeys. They had also stated their appreciation to James Duncan.

Debbie Henderson informed the Board that work was commencing to update the Trust's constitution and Governors' constitution Group would be meeting regularly to complete the work.

22. Questions from the Public

Discussion
Chair

There were no questions from the public.

23. Any other Business

Chair

Ken Jarrold extended a further thank you to Adam Watson for attending and sharing his story with the Board.

Date, time and place of next meeting:

24. Wednesday, 3 July 2019, 1:30 pm to 3:30 pm, Kiff Kaff, St Georges Park, Morpeth, Northumberland, NE61 2NU.

Information
Chair

Northumberland, Tyne and Wear NHS Foundation Trust

Board of Directors Meeting

Action Sheet as at 3 July 2019

Item No.	Subject	Action	By Whom	By When	Update/Comments
Actions outstanding					
24.10.18 (19)	Board Assurance	The Board to receive an assurance map for agenda items that require formal approval.	Debbie Henderson	September 2019	To be included in the Board Report style guide currently under development
22.05.19 (10)	Committee Terms of Reference	ToR's for Corporate Decisions Team and Charitable Funds Committee to be submitted to the October meeting	Lisa Quinn/Debbie Henderson	October 2019	On track for submission to October meeting
Completed actions					
26.09.18 (5)	Crisis Team phone lines	The Board to receive an update in relation to the Crisis Team phone lines	Gary O'Hare	03.07.19	Complete
24.04.19 (17.1)	CEDAR Strategic Outline Business Case	Amendment, Senior Responsible Officer – Executive Director	James Duncan	22.05.19	Complete
27.03.19	Staff Survey Results	Provide an update to a future Board development session/away day on the actions/next steps to address areas for improvement	Lynne Shaw	22/05/19	Complete. Update provided to the May Board development session
22.05.19 (10)	Committee Terms of Reference	Small amendment to Q&P ToR to be made and issue approved ToR to the relevant RO's	Debbie Henderson	June 2019	Complete

Northumberland, Tyne and Wear NHS Foundation Trust

Board of Directors Meeting

Meeting Date:	3 July 2019

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

Paper for Debate, Decision or Information: Information

Key Points to Note:

Trust updates

1. North Cumbria
2. Learning Disabilities Update
3. Pedometer Challenge

Regional updates

4. ICS Status awarded for North East and North Cumbria
5. CEDAR update
6. The North Regional Talent Board

National updates

7. Capital Funding for the NHS in 2019/20
8. Report of finance and Operational performance for NHS Provider sector to 31st March
9. NHS Pension Scheme
10. NHS Confederation – the need to invest in the whole health care system
11. MIND Analysis of NHS Mental Health Spending
12. Designing Integrated Care Systems (ICSs) in England
13. Social Prescribing Event – 12 June 2019

Outcome required: For information

Chief Executive's Report

3 July 2019

Trust updates

1. **North Cumbria**
   As you are aware, Northumberland, Tyne and Wear NHSFT (NTW) and Cumbria Partnership NHSFT (CPFT) have been working together to improve the Mental Health and Learning Disability Services in the area. Both organisations and Regulators have approved the formal transfer of services from the 1st October 2019.

   I have recently met with Katherine Fairclough, CEO of Cumbria County Council to talk about our future working. In the next month or so, I am hoping to meet with other colleagues and partners in the Cumbria area including Healthwatch, Primary Care colleagues, other Local Authority colleagues and, with the Chairman, Local MPs and a meeting has also been arranged with the eight Integrated Care Teams in August with Lead clinicians overseeing integration work at a neighbourhood level.

   Perhaps more importantly, I have had the opportunity over the past few weeks to meet with some of our new colleagues from Cumbria who will be joining us from 1 October. During my recent visits to Carlisle, Penrith, Whitehaven and Workington, it's been very clear to see the commitment of staff to the patients and services they deliver. I was particularly interested in hearing about the things staff were most proud of and appreciate the importance of learning from each other as we move forward. Together, I am confident that we can deliver on our shared objective of providing the best possible services for those who need our help and support.

2. **Learning Disabilities Update**
   I'm sure everyone will be aware of the significant focus on learning disabilities and autism during May and June. This has included the publication of three reports: a report on children detained in hospitals; the CQC's report around segregation and prolonged seclusion; and the Learning Disabilities Mortality Review, learning from deaths programme (LeDer report). Aside from these reports, the BBC aired their Panorama programme on 22nd May regarding Whorlton Hall Hospital in County Durham, an inpatient facility for adults with learning disabilities and complex needs. I'm sure everyone will agree that the mistreatment of patients seen in the programme was both horrifying and distressing. We have worked closely with our partners and commissioners to ensure that everyone is being well supported and all service users have been safely transferred into alternative accommodation.

   We have all as an Executive Team supported our staff and services during this difficult period by spending time visiting some of our own learning and disabilities and autism services to offer reassurance that we, as a Board, have every confidence in the great job our staff are doing every day. This has also given me an opportunity to talk to, and listen to staff about how they've been emotionally affected. Our teams have also provided support to our partners as well as Healthwatch and community and voluntary sector organisations who may have been affected by the recent media coverage, including advice on where they can get help and support.

   Representatives from Skills for People and Sunderland People First attended our Board Away Day on 25th June which provided an incredible opportunity to talk to and listen to people with lived experience of learning disabilities and autism, as a service user and as a carer. We had a very powerful and important discussion about their perceptions and experiences, and importantly, how we can work together in the future

to enable people with a learning disabilities and/or autism to be a full member of society.

3. **Pedometer Challenge**
We are delighted to announce the winners of the 2019 Pedometer Challenge. Night Owls – Night Coordination Team, St George's Park the lead on their closest rival the Academy Army by 6,905 steps.

- 1st Night owls SGP 1,988,813 steps / 884 miles
- 2nd The Academy Army 1,981,908 steps / 881 miles
- 3rd Activities Team 1,961,643 steps / 872 miles

54 out of 58 teams completed the 2019 challenge. Our teams have walked an amazing 73,149,512 steps (which equates to thirty two thousand, five hundred and eleven miles) in the last 28 days.

The circumference of the Earth is 24,901 miles, so our teams here at NTW have walked more than once around the Earth in a four week period! Well done to everyone who took part in this year's challenge.

Regional updates

4. **ICS Status awarded for North East and North Cumbria**
The North East and North Cumbria has been awarded full Integrated Care System Status, alongside Buckinghamshire, Oxford and Berkshire West ICS and South East London ICS. We join the 14 Integrated Care Systems that have already been announced to bring the total of areas awarded ICS status to 17. That leaves 28 remaining STPs across the country, with the intention that all areas of England will be covered by an ICS by April 2021. The three additions means that 21 million people are now covered by an ICS, with the North East and North Cumbria representing the biggest in terms of both population coverage and geographical size.

It is good news that our region remains at the forefront of national developments, and the ICS will now be exploring with national and regional leaders the freedoms and delegated authority that will come with full ICS status. It is clear that partnership working is central to the development of the NHS Long Term Plan and that competition is being replaced by a more collaborative approach where this is in the interests of local people.

Simon Stevens, Chief Executive of the NHS said: "The Long-Term Plan showed how the NHS and its partners will improve care and help people live healthier day-to-day lives over the next decade. To meet these ambitions, every NHS organisation will need to intensify partnership working with others – including local councils and community organisations – for the good of those we serve.

We are now expecting guidance on the requirements for the development of the ICS Plans. This will both inform and be informed by the development of the Trust Strategic Delivery Plan in response to the LTP, which we plan to develop through the summer and autumn.

5. **CEDAR Update**

Work continues on the development of the Outline Business Case for the CEDAR Programme our capital scheme to rationalise our forensic services and implement agreed changes to our Gateshead and Newcastle adult acute wards. This is now planned to be presented to the Board in September. Planning for interim moves and work on the site has been impacted by the actions and issues arising from the closure of Whorlton Hall. As a result of this it is expected that the closure of the Tranwell Unit in Gateshead will be delayed until early October 2019. As at the present time there is no change to the timescales for delivery of the full programme.

Following discussions at the Board last month, the Project Team and Board continue to consider opportunities to maximise value from the scheme. The Strategic Outline Case has been signed off by NHSI/E's National Chief Financial Officer and is being presented to the Delivery, Quality and Performance Committee, a sub-committee of the NHSI/E Board, on the 27th June. An update will be provided at the Board regarding the outcome of this.

6. **The North Regional Talent Board**

The North Regional Talent Board is the second Regional Talent Board to be established across the country. It met formally for the first time in June 2018. On 5 June 2019 a masterclass was held in Leeds to launch The Aspire Together Programme. The session was well attended with provider Chairs, Chief Executives and other Executive Directors alongside many from the HR profession.

Dido Harding (Chair, NHS Improvement), Julian Hartley (Chief Executive, Leeds Teaching Hospitals NHS Foundation Trust) and Prerana Issar (Chief People Officer, NHSE/I) were all in attendance to support the launch and as this coincided with the publication of the Interim People Plan gave an overview of the plan and described how Talent Management was key in its successful implementation.

One of the aspirations for the Regional Talent Board is to create a talent pool of individuals who are ready now to take on director roles across the North of England. From 5 June 2019, nominations have been invited from individuals who aspire to work in director positions of either Chief Nurse/Director of Nursing or Director of Workforce/HR/OD, typically situated in a provider, commissioner or system role.

Nominations for individuals aspiring to move into all other director level roles or aspiring to take on such roles in another type of organisation e.g. arm's length bodies or the wider health and care sector, will be open in future nomination windows in 2020/21.

The Trust is currently looking at its own approach to Talent Management to complement this wider regional approach.

National updates

7. **Capital Funding for the NHS in 2019/20**

It has been widely reported that the capital budget for the NHS is overcommitted for the current year, 2019/20. STPs and Integrated Care Systems have been asked to review their collective capital plans and identify opportunities to reduce calls on capital funding in the current year. This work is ongoing and the Trust is fully involved in this as a member of the ICS Capital Strategy Group.

NTW submitted a very limited plan for the current year, and at 3.8% of turnover this represents one of the lowest plans across the ICS footprint. As reported to and agreed by the Board this budget is largely fully committed, with the vast majority required to take forward the CEDAR scheme, deliver interim schemes supporting this programme and delivering on our informatics agenda. We have therefore not identified any potential for delay or slippage on our current programme, given its importance in terms of strategic delivery and patient safety.

8. Report of finance and Operational performance for NHS Provider sector to 31st March

On 13th June NHS Improvement published its latest quarterly review for the quarter up to the year end. The NHS Provider sector ended the year with a deficit of £571m, £177m worse than plan, but better than the performance reported last year. It should also be noted that this figure included a benefit of £256m arising from a technical adjustment arising from taking PFI schemes into the NHS estate following the collapse of Carillion. In total, after taking out one-off measures, the sector ended with a deficit of around £5bn, £700m worse than the previous year. Providers overspent on capital by £400m, with a total spend of £3.9bn.

It should be noted that NHS capital spend is 4.5% of budget with the OECD average running at 8.5%. Department of Health and Social Care debt on provider balance sheets now stands at £14bn, an increase of £3bn in the year. However, it is worth noting that the rate of implied productivity, driven by activity increases, has doubled to 2.3%. As ever, a useful summary from MHS Providers is attached *(Appendix 1).*

9. NHS Pension Scheme

On 3 June 2019 the Government announced that it is to consult on changes to the NHS pension scheme rules. This is as a consequence of mounting pressure to support, in the main, senior medical staff who have been hit with large tax bills due to the current limits set by HMRC on the value of tax-free pension savings an individual can make over the course of a tax year and working lifetime. These tax implications are beginning to have an impact on service delivery as some senior medical staff are reducing hours, not carrying out overtime or leaving the NHS because they are potentially worse off when breaching the respective limits. Others are choosing to opt out of the Pension Scheme.

The proposal, known as the 50:50 option would allow clinicians to halve their pension contributions in exchange for halving the rate of pension growth and is being launched for consultation at the end of the month for a 12 week period.

There are a number of on-going discussions internally within the Trust as to how best we can support those affected and individuals are encouraged to seek independent financial advice before making decisions around this complex subject.

10. NHS Confederation – the need to invest in the whole health care system

The launch of the NHS Long Term Plan for England in January 2019 marked a significant change in the future direction of the health service. The plan provided welcome extra funding for the NHS and marked the dawn of a new era – one in which we will need to transform the way services are delivered to patients, service users and the public. At its heart was a vision for integrated health and care focused on population health, with greater investment and focus on community, primary care and mental health services, as well as an emphasis on prevention and health inequalities.

These measures are considered crucial in improving care for patients, reducing pressure on hospitals and other services, and in helping put the NHS on a sustainable path in the face of rapidly rising demand.

When the Plan was published, the NHS Confederation committed to working with member organisations to understand how they were responding to the Plan as we move towards making the vision a reality. This report *(Appendix 2 attached)* is the first output in that process and sets out views from health service leaders about their experiences of implementing the Plan so far. These views were gathered in a survey of NHS chairs, chief executives and system leaders spanning NHS trusts, clinical commissioning groups (CCGs) and integrated care systems (ICSs). It is published alongside new analysis from the independent charity The Health Foundation.

11. MIND Analysis of NHS Mental Health Spending

A report following an analysis into the variation of mental health spending across England has recently been published by the mental health charity, MIND. The report looked at the investment in Mental Health spending across the 42 NHS Sustainability and Transformation Partnerships (STPs) which found that the latest NHS figures show significant variation, with some areas spending almost half per person on mental health compared to other places (variation ranging from c£124 per person, to c£220 per person). For the North East and Cumbria, the NHS is predicted to spend c£203 per person.

Geoff Heyes, Head of Health Policy and Influencing at MIND said *"The treatment you get shouldn't depend on where you live….the NHS and Government have made it clear that mental health is a priority. Some local variation is to be expected but the scale of the difference is huge and we know that the need outstrips resource even in the areas that are performing well."*

The charity said the differences had the potential to affect the quality of care but, despite the variation, spending was still rising overall. The analysis showed all areas were increasing their mental health budgets in line with the overall increase in spending – part of a requirement set by the senior leadership in the NHS – however, despite this, big variations continued to exist demonstrated by the projected spending levels in 2018/19. The full data analysis can be found at:

https://www.mind.org.uk/news-campaigns/news/nhs-figures-reveal-mental-health-spending-postcode-lottery/

12. Designing Integrated Care Systems (ICSs) in England

A helpful document by NHS England is attached as *Appendix 3* which sets out the different levels of management that make up an Integrated Care System, describing their core functions, the rationale behind them and how they will work together.

13. Social Prescribing Event – 12 June 2019

Dr Nadkarni was involved with the Royal College of Psychiatrists and NHS England along with the National GP Leaders in discussing developments in relation to Social Prescribing and how they would form a core aspect of the personalisation and prevention agenda within the Long-Term Plan, and delivered by the Primary Care Networks. A number of models of care were discussed, some of which will have relevance to the North East and North Cumbria region.

Dr Nadkarni was involved in the first invited meeting of the UK Improvement Alliance on 13 June 2019. The meeting brought forward a number of improvement-focussed

organisations, including provider trusts and Quality Observatories across the country. The Trust was represented by Dr Nadkarni and members of Trust Innovation. The National Director of LEAN Transformation at NHS Improvement, Alan Martyn, also articulated his vision including the development of specific models for improvement practice within the NHS. The alliance agreed shared goals and ways in which to support the members and other contributors and to further disseminate models of improvement across the wider NHS.

on the day BRIEFING

NHS Providers

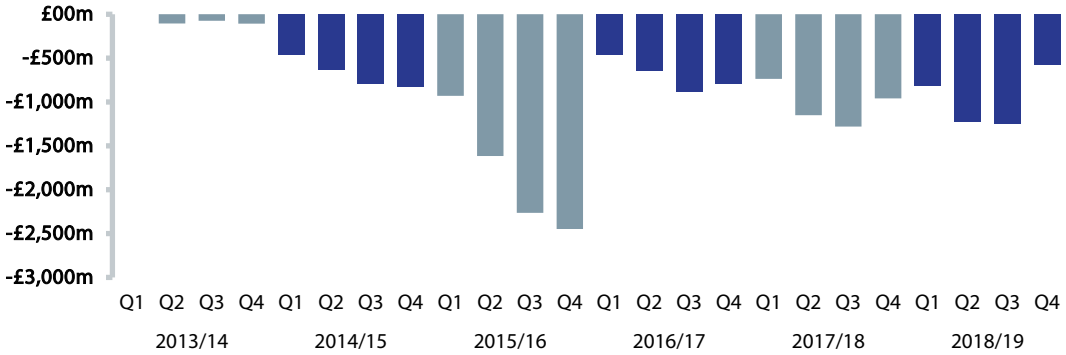
2018/19 Quarter 4 finances and performance

NHS Improvement (NHSI) has released the quarter four (Q4) finance and operational performance figures for the provider sector. These figures cover the period 1 January to 31 March 2019. This briefing summarises the key headlines for those figures we as well our view of what they mean. If you have any feedback or questions regarding this briefing please contact: david.williams@nhsproviders.org and adam.wright@nhsproviders.org.

Key headlines

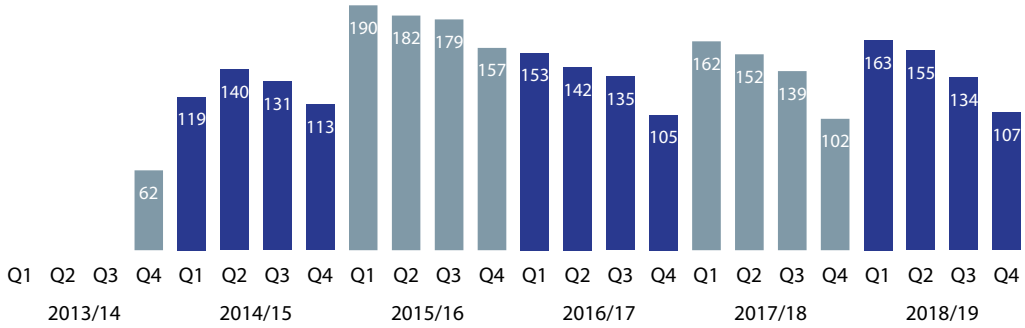
- The provider sector deficit was £571m at year end, £177m worse than the planned deficit of £394m. However the NHS as a whole is in balance due to surpluses on the commissioner side.
- The underlying deficit – which removes non-recurrent measures including the provider sustainability fund – is £5bn. This is a deterioration of £700m in a year.
- This outturn includes £256m of technical adjustments resulting from the transfer of two Carillion hospitals onto trust books. Removing the impact of this one-off event, the deficit is £827m. This is a £159m improvement on 2017/18 and a £90m improvement on the forecast at Q3.
- Providers have overspent on capital. Capital spending totalled £3.9bn in 2019/20 - this was less than forecast, but £400m more than the amount the DHSC was reported to have allocated. NHSI highlight that the OECD average health service capital budget is worth 8.9% of the revenue spend – for the NHS, it is 4.5%.
- DHSC debt on provider balance sheets now totals £14bn – an increase of £3bn over the past year.
- Providers delivered £2.2bn of recurrent efficiencies in 2018/19, plus a further £1m of one-off savings. This means provider cost improvement programmes (CIPs) delivered savings totalled 3.6% of turnover. This closely resembles performance in 2017/18, although the proportion of recurrent savings has dropped slightly.
- Emergency admissions rose 5.4% year on year in 2018/19. Admissions to major "type one" accident and emergency departments was 7% higher in Q4 than a year earlier.
- Over 7 million people were either discharged or admitted within four hours during Q4 – 380,000 more than a year earlier.
- The number of vacancies at Q4 stood at 96,348 whole time equivalents – or 8.1% of the total workforce. This is an improvement of over 2,000 on a year earlier. However within those figures, nursing vacancies are up by nearly 4,000 – this has been offset by cuts in the number of vacancies for non clinical staff and doctors.

YTD surplus/deficit for FT and trust sector combined

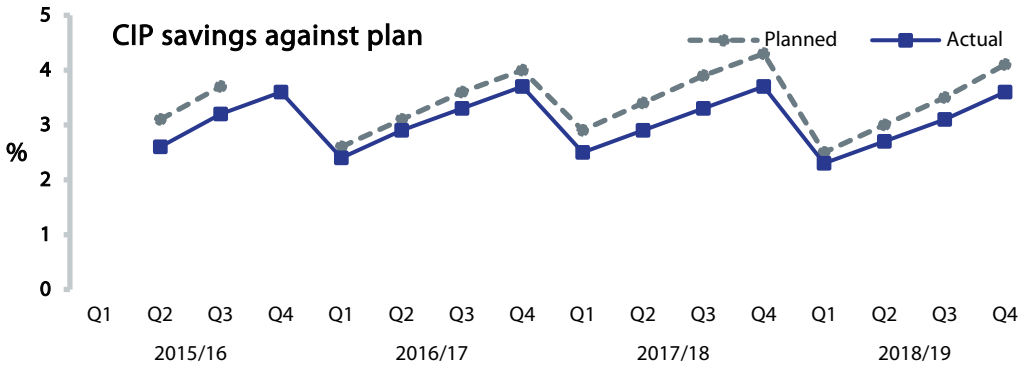


- 107 of 230 trusts finished the year in deficit – a slight deterioration on 2017/18, when 102 were in the red. The deficit remains heavily concentrated in the acute sector – two thirds of acute trusts are in deficit. Acute providers account for 83% of all trusts in deficit.

Number of providers in deficit

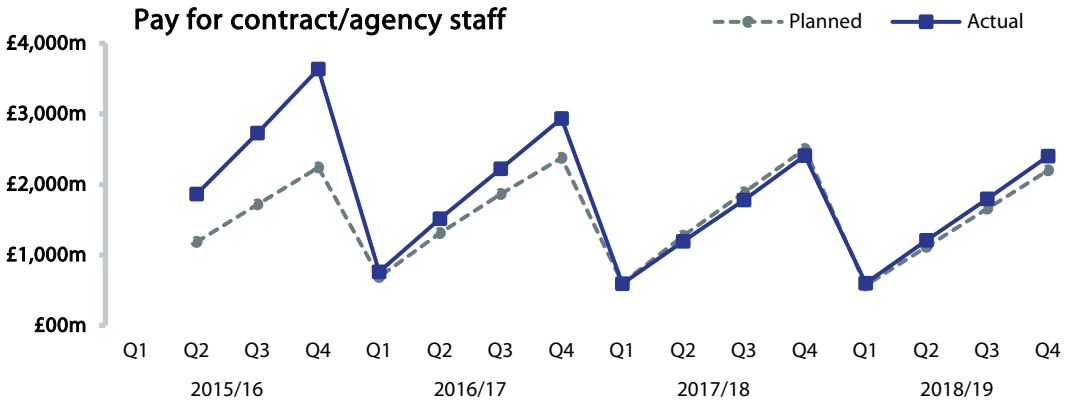


- When provider sustainability funding is taken into account, 70 providers were off plan at the end of the year. For 33 trusts, the adverse variance from plan totalled more than £10m. The main reasons why providers fell behind plan were under-delivery of CIPs, plus unplanned emergency activity, which led to £191m less elective income than planned and £248m more spent with non NHS providers than expected.



Other key year-end finance data

- **Implied productivity.** The rate of productivity in the NHS has almost doubled in a year, from 1.2% in 2017/18, to 2.3% in 2018/19. This has been driven by activity growth rather than cost reductions.
- **Marginal rate emergency tariff.** CCGs have increased the amount of money they are withholding from trusts via the marginal rate emergency tariff (MRET). The total lost to trusts via MRET was £78m – up 17% a year ago. MRET has been abolished for 2019/20.
- **Non-pay cost pressures.** Due to rising emergency demand, providers have overspent on non-pay costs by £924m compared to plan. The largest areas of overspent were clinical supplies and services, non-NHS providers, and premises.
- **Agency and bank expenditure.** Providers spent £2.40bn on agency staff in 2018/19 – a minimal improvement on the £2.41bn spent in the previous year, and exceeding the ceiling set by NHSI of £2.2bn for the year. The overspend has been driven by the number of shifts: the average price paid per shift is down by more than 5%.



Key performance information at Q4

- Overall A&E performance improved slightly in Q4 compared with a year earlier: for 2019/20 performance stood at 85.1% against the four hour standard, compared with 85% a year earlier.
- 12 hour trolley waits for the quarter was significantly lower than Q4 2017/18 at 1,465 – a drop of 800 year on year.
- There were 6.63 million non-elective admissions in the year to date, 2.1% above plan and 5.4% more than the same period last year.
- Quarterly performance against the 18 week referral to treatment (RTT) standard was 86.7%, down from 87.3% in Q4 2017/18.
- The number of patients waiting longer than 52 weeks is improving significantly. In Q4 2018/19, there were 1,154 patients waiting over a year for treatment – about half the number at the end of Q3, and 2,756 a year earlier.
- There has been a sharp deterioration in performance for cancer waiting times. Against the 62 day standard for urgent referrals, performance stood at 82.3% at the end of 2017/18. For Q4 2018/19, performance had dropped to 77.4%. The national target is 85%.
- The waiting list for diagnostic tests is getting longer: at the end of Q4 it stood at 1 million – up 2.4% in a year. 2.53% of patients waited longer than six weeks for a diagnostic test: a year earlier the figure was 2.07%.
- Performance against ambulance response time targets is improving. For the first time, trusts are now hitting two of the six standards – both for Category 1 calls. Category 2 remains a challenge for some trusts, NHSI reports. There is significant improvement on all standards compared with a year ago.
- The sector managed to achieve all mental health performance standards and improved across several performance and outcome measures.

NHS Providers press release: Significant wins for patients but we are a long way off where we want and need to be

Responding to the year-end report on the performance of the provider sector, published by NHS England and NHS Improvement, the chief executive of NHS Providers, Chris Hopson said:
"These figures show trusts are working flat out to ensure good quality care for patients in an extremely challenging environment, with demand rising to record levels.
"In that context what we see here is a strong financial performance.
"The overall provider sector deficit, at £571 million, was a significant improvement on last year's figure, and £90 million better than previously forecast. "Once again, trusts have delivered impressive savings at 3.6% of turnover, alongside a further improvement in productivity.
"Yet the emphasis on quality was sustained.

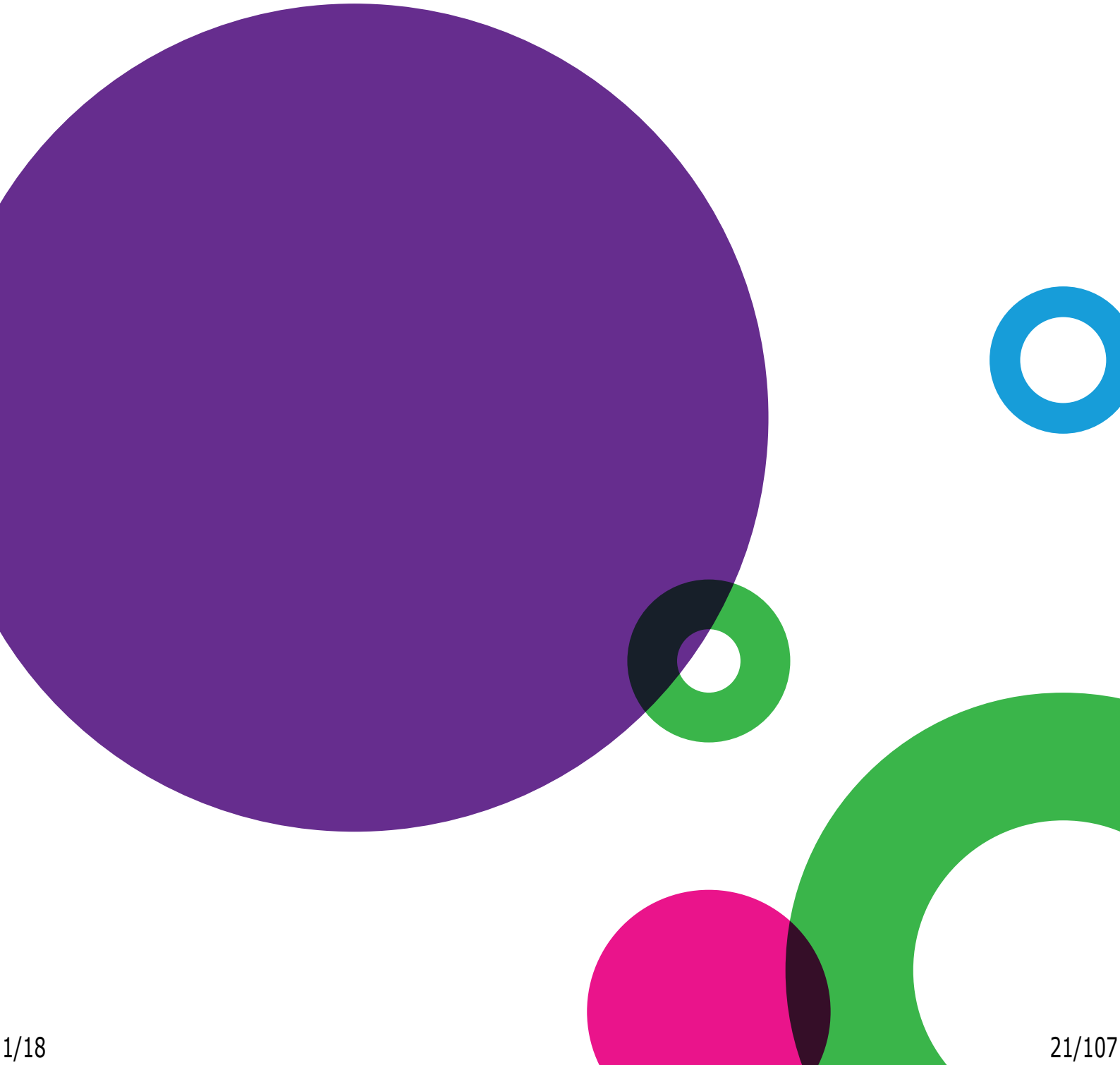
"It was particularly heartening to see the proportion of trusts rated good or outstanding by the Care Quality Commission rising to nearly 60%, with the numbers up by 9% over the course of the year.
"And, despite enormous pressures, we have seen a big improvement in ambulance response times.
"There has also been good progress in reducing the longest delays, of 12 months or more, for routine surgery. NHS England said trusts should aim to reduce these by 50%. In fact they were down by 63%.
"However there is no getting away from the scale of the difficulties facing trusts, reflected in this report.
"It is clear that we are slipping further away from achieving the constitutional standards that patients rightly expect, and there is no realistic chance of recovering them without significant extra investment together with a clear plan setting out how this will be done.
"We also have to acknowledge that the push to improve the financial position is still far too reliant on one-off savings. These generated more than £1 billion in savings – far more than planned. This approach is not sustainable.
"Then there is the biggest challenge of all – workforce. We still have more than 96,000 vacancies, equivalent to 8% of the workforce which, on the current rate of improvement from the end of Q1 to the end of Q4 would take 7 years to fill.
"Finally, while we welcome this report's focus on the significant widespread capital problems facing providers, it is clear to us that these difficulties have now reached a point of crisis, which must be addressed urgently. The fact that trusts have breached the capital allocation from government shows the importance they place on investing, where possible, to guarantee patient safety.
"Trusts are doing all they can, and have scored some significant wins for patients, in responding to growing demand. But across a range of issues, including finances, performance targets and workforce challenges, the provider sector is a long way off where we want and need to be."

NHS CONFEDERATION

Unfinished business

The need to invest in the whole health and care system

June 2019



The NHS Confederation

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

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

Foreword

The Long Term Plan in January 2019 set the future direction for the NHS in England. Backed by £20 billion of additional funding, the health service is now set to deliver changes that should help to keep millions of people independent and in their own homes over the next ten years. This can and should be an exciting time of renewal.

The NHS Confederation is working closely with its members to gauge their views on the plan and to assess what they see as the barriers and enablers on this journey.

This report, published alongside analysis from The Health Foundation, is the first output in that process. It reveals a strong commitment and real enthusiasm for the key planks of reform articulated in the plan. It shows that leaders across the NHS in England, spanning trusts, clinical commissioning groups and integrated care systems, are optimistic and keen to deliver the plan's vision: more services in the community, backed by technology and new models of care.

Indeed, it is clear that there is near universal support for creating a system of integrated health and care, which will be focused on population health, with greater investment and focus on community, primary care and mental health services. It is seen as the only way of creating a sustainable future for the health and the care system in the face of rising demand.

At the same time though NHS leaders have serious concerns. This is a service which already has 100,000 vacancies, is struggling to cope with ever rising demand, and is faced with a chronic lack of investment in buildings, equipment and other critical infrastructure. Combined with the drastic cuts to social care and public health, these factors continue to mean we have a service struggling to cope, with extra demand on A&E and other front-line NHS services.

Many of these underlying challenges sit outside the NHS England budget and are the responsibility of government and they must be addressed in the forthcoming spending review. Failure to do so will put the ambitions of the NHS plan in jeopardy.

This report is a temperature check six months on from the publication of the plan. It is justifiably optimistic – there is too much doom and gloom around the NHS, but we also need to be realistic about what is still needed to make the plan work and we need a honest debate about what is feasible. It is now time for politicians to be straight with the public about what can and cannot be delivered over the next decade.

Niall Dickson
Chief Executive, NHS Confederation

Key points

The launch of the NHS Long Term Plan for England in January 2019 marked a significant change in the future direction of the health service. The plan provided welcome extra funding for the NHS and marked the dawn of a new era – one in which we will need to transform the way services are delivered to patients, service users and the public. At its heart was a vision for integrated health and care focused on population health, with greater investment and focus on community, primary care and mental health services, as well as an emphasis on prevention and health inequalities. These measures are considered crucial in improving care for patients, reducing pressure on hospitals and other services, and in helping put the NHS on a sustainable path in the face of rapidly rising demand.

When the plan was published, the NHS Confederation committed to working with our members to understand how they were responding to the plan as we move towards making the vision a reality. This report[1] is the first output in that process and sets out views from health service leaders about their experiences of implementing the plan so far. These views were gathered in a survey of NHS chairs, chief executives and system leaders spanning NHS trusts, clinical commissioning groups (CCGs) and integrated care systems (ICSs). It is published alongside new analysis from independent charity The Health Foundation.[2]

1. Health service leaders support the direction of travel in the long-term plan

Health leaders told us that overall the plan was permissive and created the right environment for partnership working and that the vast majority of organisations were on board with the vision.

2. Leaders are concerned about their ability to meet workforce challenges

Workforce continues to be the most serious challenge facing the NHS. Sixty-five per cent of respondents told us they were either not very or not at all confident that their local health systems would be able to meet their staffing needs. With a shortage of more than 100,000 staff, the case for greater investment in education and training for both our existing health and care workforce, and new entrants could not be more compelling.

3. Reducing the pressure on hospitals will be challenging

Central to the long-term plan is an expectation that the NHS will reduce demand for acute care through better integration and prevention. However, only one in four respondents (25%) believed their local health systems would reduce significantly the rate of growth in acute activity as a result of the reforms in the plan. Many areas of the country have already been pioneering service changes designed to keep people well and living independently in the community but funding cuts to social care and public health are undermining this work. We also need to get better at sharing the learning about what works between local areas.

1 All figures in this report are rounded to the nearest whole number, therefore some bar charts may not total 100 per cent.
2 The Health Foundation (2019), *Investing in the NHS Long Term Plan: Job done?*

4. Constrained capital spending is having a significant impact on local health systems

Recent years have seen significant reductions in capital expenditure. More than eight in ten respondents (85%) said that a lack of NHS capital investment has inhibited the ability of local health systems to deliver the goals of the long-term plan. The future development of health and care services is reliant on adequate investment in buildings, equipment and digital technology. Historically low levels of capital investment are a significant problem for local leaders seeking to modernise services and improve their efficiency.

5. Leaders are extremely doubtful about their ability to deliver on the long-term plan without increased social care funding

Nine in ten health leaders (90%) responding to our survey were not confident that the NHS would be able to deliver the package of health reforms set out in the long-term plan without a long-term financial settlement for adult social care. Social care is in crisis and the day to day impact on the health service is of serious concern. The impact on some of the most vulnerable people in our society is hard to overstate and it will continue to have significant knock-on effects on primary, community and hospital services until better funding and a more sustainable social care system is developed.

6. An increased emphasis on prevention is welcome, but funding cuts are getting in the way of delivery

Four in five survey respondents (80%) said reductions in public health funding have already restricted the ability of their local health system to deliver NHS services either somewhat or to a great extent.

The cuts to public health services such as smoking cessation, sexual health and drug and alcohol services will inevitably create health problems that could have been avoided. The reductions in public health funding are simply storing up problems for the future which could be avoided with action now. This is a false economy that needs to be addressed.

Call to action

There is much to do to implement the long-term plan and local leaders are now very engaged in turning the vision into reality. Their commitment to delivering the plan is not in doubt despite the challenging nature of the ask.

But the message from this survey is clear. If the government wants the laudable ambitions of the plan to be met then it must complete the 'unfinished business' of the funding settlement for the health and care system. This will require government to provide the additional investment needed for social care, capital investment, education and training and public health in the forthcoming spending review. These crucial areas of funding were excluded from the five-year NHS funding settlement that kicked in from 1 April 2019. Failure to address this will put the ambitions of the NHS plan in jeopardy, and patients will not feel the full benefits of the extra £20 billion of NHS funding.

Introduction

The launch of the NHS Long Term Plan in January 2019 marked a significant change in the future direction of the health service, backed up by £20 billion of extra funding and a vision for integrated health and care focused on population health. It also promised that communities would get a greater say in how services were planned and delivered.

This was to be achieved through sustainability and transformation partnerships (STPs) and ultimately ICSs, with all parts of the country set to be part of an ICS by April 2021. ICSs are sub-regional vehicles for planning care, which are tasked with ensuring there is greater collaboration and partnership working across trusts, CCGs and other parts of the local health and care system and local government. In return for the investment, health systems were told they would be expected to deliver significant efficiency improvements, driven in large part by putting in place the proposed reforms.

When the plan was published, the NHS Confederation welcomed the ambition but warned that it was weakest in its articulation of how local leaders would be supported to improve health systems from the bottom up. We called for clarity about how the plan would be implemented and promised to work with, and to support, our members to understand how they were experiencing this change in direction as they worked to make the vision a reality.

This report is the first output in that process and sets out views from health service leaders about their experiences of implementing the long-term plan to date. These views were gathered in a survey of NHS chairs, chief executives and system leaders spanning NHS trusts, CCGs and ICSs. We received 64 responses from leaders representing all English regions and the commissioner, acute, mental health, community, primary care, independent and voluntary sectors, as well as those leading ICSs and STPs.

The responses highlight front-line leaders' support for the vision of the long-term plan, but also their concerns about the impact of financial and workforce pressures on their ability to implement the plan's reforms. This report is published alongside a Health Foundation briefing,[3] which analyses the challenges for health and care following the publication of the plan. Their analysis highlights the need for a plan for how we will moderate acute and specialist activity. It also calls on the government to match its investment in the elements of the NHS budget for which NHS England has responsibility with additional funding for capital, social care, workforce and public health in the forthcoming spending review. The views of senior leaders captured in our survey echo this analysis.

3 The Health Foundation (2019), *Investing in the NHS Long Term Plan: Job done?*

Survey findings

The findings of our survey reveal that NHS leaders support the vision of the NHS Long Term Plan, but that they recognise the scale of the challenge ahead and identify several key barriers that will impede progress. Here we outline the main findings:

1 Health service leaders support the direction of travel in the long-term plan

Publication of the plan marked an attempt to shift emphasis away from top-down, centrally directed approaches to planning healthcare to a model that is much more locally-led. We strongly welcomed this, and in our report *Letting local systems lead*, published ahead of the plan, we said that close partnership working at a local level was the only way of addressing the serious, systemic problems facing the service.

In this, our first major member survey since the launch of the plan, health leaders told us that on the whole the plan was permissive and created the right environment for partnership working. The vast majority of organisations are on board with the vision, according to this survey.

When we asked whether respondents felt the long-term plan was sufficiently permissive to allow local health systems to focus on what matters most to their communities, six in ten (62%) agreed that this was the case. Equally encouragingly, three quarters of respondents (75%) agreed that their own organisation was fully engaged in the work of their local STP/ICS and supported its priorities, and 56 per cent agreed that local health systems represented the right approach for partnership working between the NHS and local government.

More than six in ten (62%) agreed that primary care networks were the right approach to driving more integrated, community-based health and social care. There was also a high degree of confidence that local health systems were on course to achieve ICS status by the April 2021 deadline, with 61 per cent answering that this was the case.

These answers indicate that there is significant support within the health service for the principles of local leadership set out in the plan. One respondent described it as "an incredibly powerful document", adding: "Its realisation is dependent on the development of capability and capacity at place in terms of ongoing service improvement, but also transformation through reimagining our services for the future needs of our populations." Another said clinical leadership and involvement across pathways had "never been better locally", adding: "We need to ensure this is focused on."

Perhaps the most well-received element of the long-term plan has been its emphasis on allowing the knowledge and expertise that exists in health and care systems to inform service improvement through meaningful local partnership. In comments provided alongside survey answers, some health leaders reiterated their support for local partnership working but raised concerns that emerging partnerships should be given sufficient space to achieve their full potential.

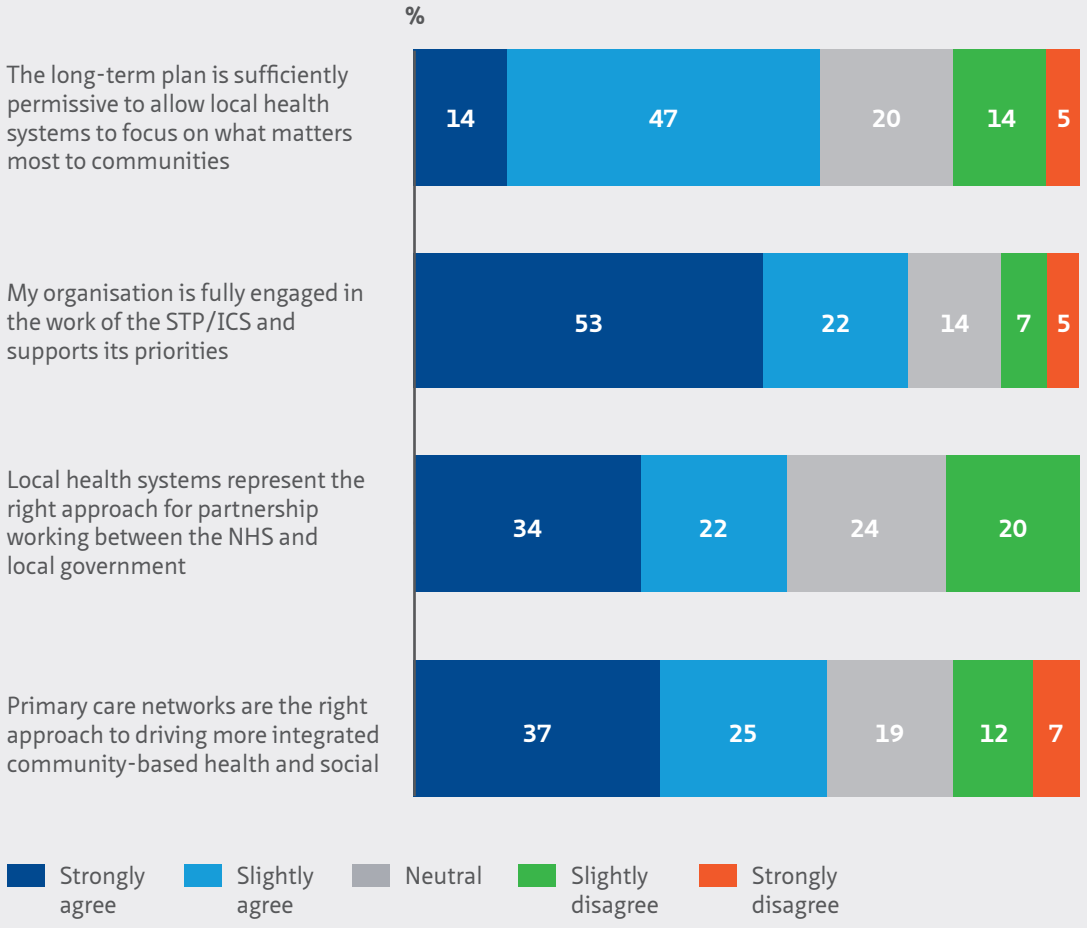
One respondent said: "Primary care networks are a good approach, but please give them time to mature." Another warned that measures such as provider control totals "stand

in the way of" greater collaboration. A third urged that greater emphasis should be given to supporting and developing the work of integrated care partnerships, as "ICSs don't necessary suit clinically sensible geographies to support improvements in clinical pathways and flow".

When we asked respondents to identify the three most important enablers that would help them to implement the plan, the answers given were wide ranging, but often related to permitting more local determination. Themes mentioned multiple times as the most important enabler included better funding/resourcing (19%), better planning and data (15%), improved workforce capacity/planning (15%), integration (12%) better relationships and partnership working (9%), and leadership (9%) .

Of the group of people who identified a finance/resourcing enabler as being most important, several highlighted the potential for more locally controlled financial decision-making, for instance through capitated budgets and system control totals, and through devolving all the money and "not bidding for short term pilots". One respondent noted that competition between providers not only exists for patients, but also for a finite pool of skilled staff.

Figure 1: Support for the NHS Long Term Plan



2 The challenges to implementation remain the same

Health leaders told us that the challenges they face when trying to implement change remain largely the same as last year. In our *Letting local systems lead* report, when we asked respondents to prioritise the three most significant pressures facing the NHS from a list of eight, recruitment and retention was first, followed by increasing demand and then deficits.

This time when asked to describe the most significant barrier facing their local health system, workforce shortfalls (33%) and finance (21%) were again most commonly cited. Specific issues mentioned relating to finance included social care funding cuts, local authority funding cuts, rising demand, perverse incentives relating to the payment by results system, provider and structural deficits and a lack of funding for capital investment.

We explore these issues further below but what is interesting is that many of the issues raised related to the wider funding of the health and care system (i.e. social care and public health) and the unfinished elements of the NHS settlement.

3 Leaders are concerned about their ability to meet workforce challenges

With workforce dominating as the most serious challenge facing respondents, it is unsurprising that health leaders are pessimistic about the impact this issue is having on health systems.

Sixty five per cent of respondents told us they were either not very or not at all confident that their local health systems would be able to meet increased demand for staff as a result of the plan. When asked to identify particular roles or sectors where their local health system was experiencing particularly severe workforce shortages, mental health staff (both nursing and psychiatrists and psychologists) were frequently highlighted, as were GPs, community and primary care nurses and general nursing roles.

Reasons given for these problems included a view that more time and resources were needed to train and build the teams needed; a lack of practical workforce measures; and new roles that are "too prescribed". One respondent said: "The scale of plans, infrastructure and finances [is] woefully inadequate to meet the size of the task". Another said: "Hope is not a plan".

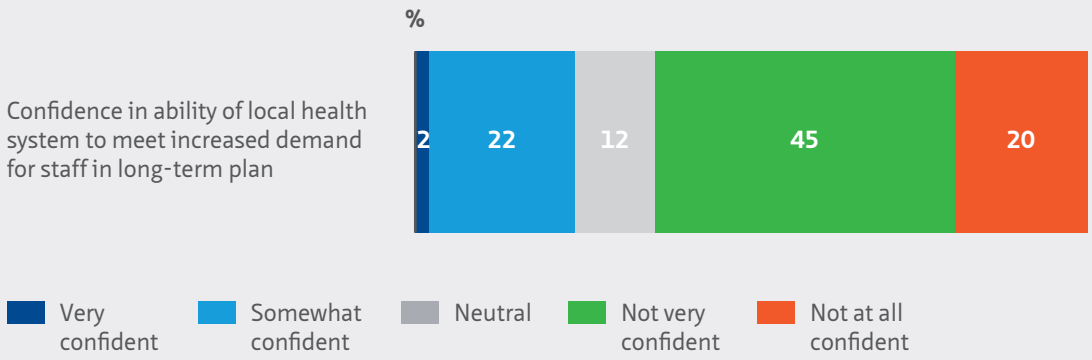
However, there were some positive comments, including that the labour market was providing greater choices for new entrants, that the apprenticeship scheme, along with initiatives to support people with disabilities and ex-offenders to return to work, was improving the workforce pipeline and that a growth in new roles such as practitioner assistants and clinical pharmacists was welcome. One respondent stressed the need to work with local authority colleagues to ensure that training programmes for local people were in place.

With a significant shortage of more than 100,000 staff, the case for greater investment in education and training, both of our existing health and care workforce, and the new entrants that will be needed to plug the gap, could not be more compelling. The survey

results reveal that the level of concern about this issue among system leaders remains very high.

Without enough people we cannot deliver the services that people expect. Additional investment in education and training is needed urgently.

Figure 2: Workforce challenges



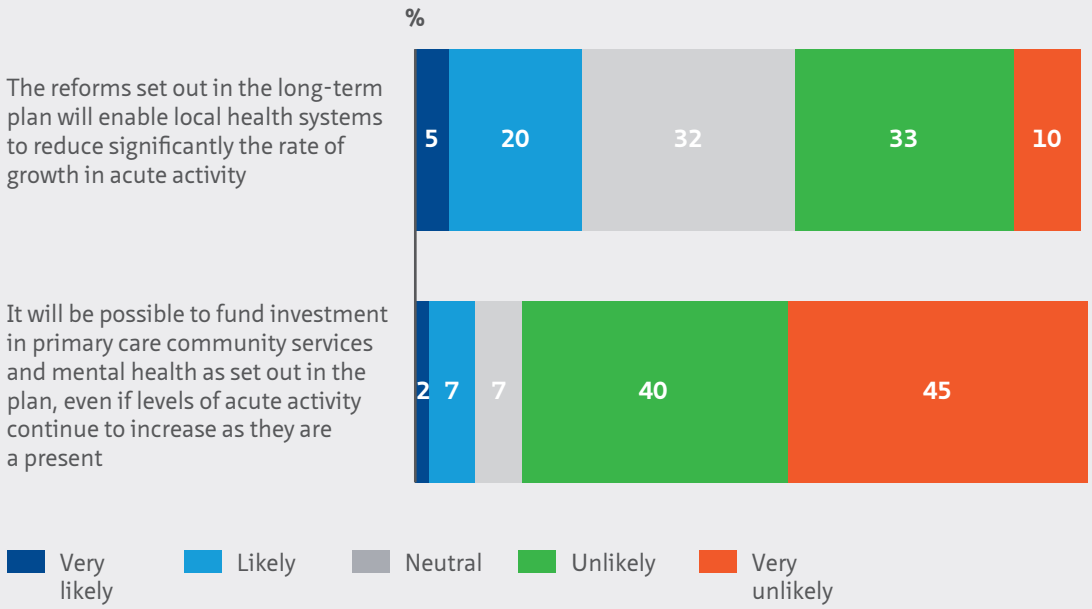
4 Reducing the pressure on hospitals will be challenging

In 2018, the government committed to increasing the funding available to the NHS by an average of 3.4 per cent annually for the five years starting from April 2019.

Outlining the overarching approach to spending this extra money, the long-term plan set out an expectation that in order to repay this funding boost, which has outstripped investment in other public services, the NHS will be expected to deliver better productivity. Central to this is an expectation that the NHS will reduce demand for acute care through better integration and prevention. The blueprint for achieving this better integration and prevention is the changes to care delivery models set out in the plan.

At present senior leaders are not confident in their ability to deliver this as only one in four respondents (25%) believed the reforms set out in the long-term plan would enable local health systems to reduce significantly the rate of growth in acute activity. This is important, as acute care comprises a large proportion of the NHS budget, and the acute sector is projected to receive below average funding increases in the coming years. Even more significantly, only 8 per cent agreed that it would be possible to fund investment in primary care, community services and mental health as set out in the plan, if levels of acute activity continue to increase as they are at present.

Figure 3: The challenge of reducing acute activity growth



At the centre of the plan is a clear focus on population health and a new service model rooted in primary care and community services. Many areas of the country have already been pioneering service changes designed to keep people well and living independently in the community and in turn relieve the pressure on hospitals and urgent care services. The changes to service models proposed in the plan are likely to increase the ability to make progress with this issue locally.

But this is a complex and challenging task and gathering evidence to demonstrate the extent to which different initiatives are able to have a direct impact on acute activity is difficult. Moreover, the picture has been confused for as the NHS has embarked on this work, investment in prevention and social care has been subject to significant cuts. Hence it is not clear to what degree and over what timescale it will be possible to slow growth in acute activity. The survey findings are unsurprising in view of this.

There are no easy answers to this dilemma but as organisations across the country step up their work to slow the rate of acute activity growth, it will be important to have a means of assessing at scale what works and in what circumstances. In order to achieve this, a methodical approach to understanding the relationship between different interventions and changes in the rate of activity will be necessary. A means of sharing findings between geographies could enable health systems to move faster than might have otherwise been possible is also needed.

Related to this, we consider that it will be important to ensure that local systems have the freedom to focus their efforts on the areas likely to have the greatest impact dependent on their local circumstances. We would therefore encourage the arm's length bodies to ensure that in implementing the plan, there is sufficient flexibility for local health systems to focus in the short to medium term on the areas that are likely to yield the most

significant results. We believe that adopting a phased approach, rather than one that includes expectations about wholesale adherence to centrally mandated targets, is likely to achieve the greatest impact in the long term.

Examples of work undertaken to reduce pressure on hospitals

Enhanced support for care homes in Nottinghamshire

The Principia vanguard in Rushcliffe, Nottinghamshire, set up an enhanced support service for care homes. This involved regular visits to care homes from a named GP providing proactive health checks and medicines reviews, with advocacy and independent support provided to residents and their families by Age UK and improved training and support for care home staff. Analysis by the NHS England Improvement Analytics Unit found the intervention group had A&E attendances and emergency hospital admissions 29 per cent and 23 per cent respectively lower than matched controls. Local leaders are now looking to replicate the service across the Nottingham and Nottinghamshire ICS patch. East Leake GP and Rushcliffe CCG clinical lead, Dr Stephen Shortt said: "Building strong relationships with the care home managers is the key to the success of this project. It's about creating better functioning teams of clinicians and care givers who, although they might work in different organisations, come together around the needs of the individual and take responsibility for improving patients' outcomes as efficiently as possible."

Safe Havens in Hampshire and Surrey

Surrey and Borders Partnership Mental Health Foundation Trust set up a mental health drop-in in Aldershot, Hampshire – Safe Haven, operating as an evening service for people in need of mental health support out-of-hours. A plateau in A&E attendances with a diagnosis in a psychiatric category appeared to coincide with a rapid increase in attendances at the service, suggesting the service had slowed growing demand on the A&E department. Four further Safe Havens have subsequently been commissioned across Surrey (Epsom, Redhill, Woking, Guildford) as well as a North East Hampshire service in Aldershot. All these are commissioned on a recurring basis by the local CCG collaborative, and in 2017/18 the concept was expanded to open four Children and Young People's (CYP) Haven drop in services across Surrey in partnership with Surrey County Council. These have been designed to meet a similar need in ten to 18 year olds. The trust has limited the hours where people can drop in for wellbeing and peer support to one or two-hour sessions per venue. This enables the service to focus on people experiencing a mental health crisis who are attending as an alternative to A&E.

5 Constrained capital spending is having a significant impact on local health systems

Recent years have seen significant reductions in available capital funds for NHS organisations, as well as constrained public health spending. The government spending review, expected this Autumn, presents an opportunity to address this, as public health, social care and capital spending fall under the terms of the spending review rather than the NHS England budget.

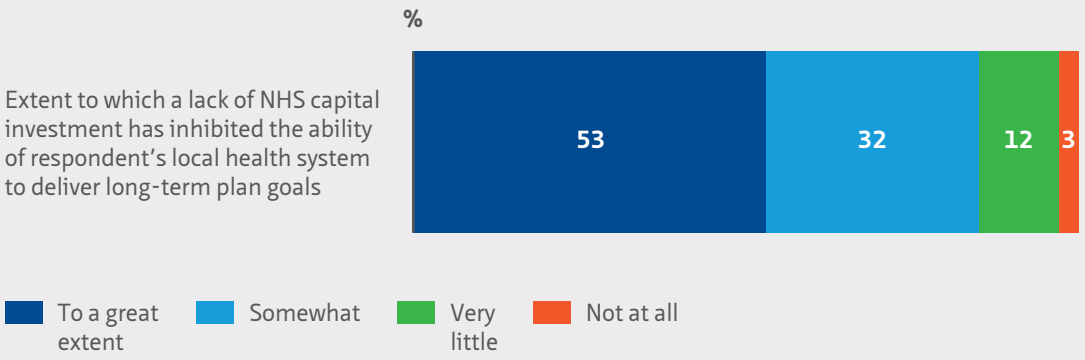
Leaders told us they were feeling the brunt of restricted capital spending. More than eight in ten respondents (85%) said that a lack of NHS capital investment has inhibited the ability of local health systems to deliver long-term plan goals either somewhat or to a great extent, with a majority (53%) indicating that a lack of capital investment had inhibited them to a great extent.

Viewpoints on capital funding from health leaders included that "capital will soon be the limiting factor as the ways we deliver urgent care change [...] and we cannot invest to change infrastructure" and "lack of capital precludes my trust from making necessary environmental improvements for safe care, efficient deployment of staff and improved staff wellbeing".

One respondent pointed out that they had not had a major capital health build for 40 years. Another described a "huge backlog" of investment required in community facilities, and a third said: "Our system has many old buildings in the wrong place that cannot be adapted to support modern pathways." Yet another respondent said: "Lack of capital is a complete block."

The future development of health and care services is reliant on adequate investment in buildings, equipment and digital technology. Historically low levels of capital investment are a significant problem for local leaders seeking to modernise services and improve their efficiency.

Figure 4: Capital challenges



6 Leaders are extremely doubtful about their ability to deliver long-term plan goals without increased social care funding

Research commissioned last year by the NHS Confederation[4] found that funding for adult social care would need to increase by 3.9 per cent a year to meet the needs of an ageing population and an increasing number of younger adults living with disabilities.

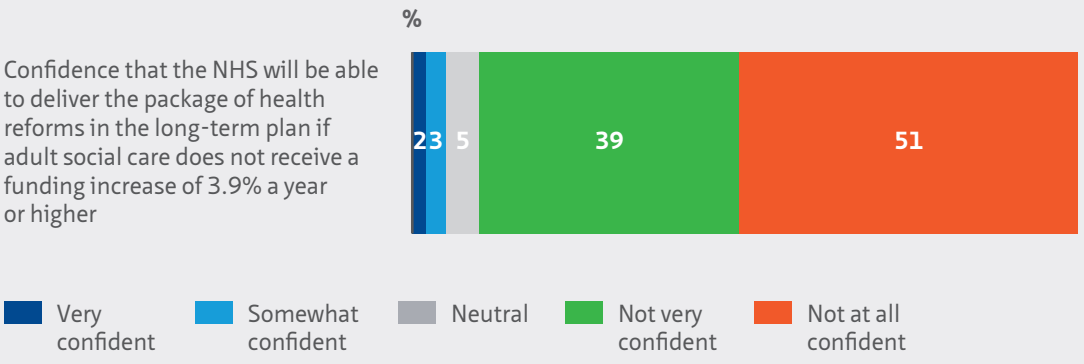
Nine in ten (90%) of health leaders responding to our survey were not confident that the NHS would be able to deliver the package of health reforms set out in the plan without a funding increase at this level for adult social care.

In an indication of the strength of feeling over this issue within the NHS leadership community, more than half of people answering the question (51%) said they were "not at all" confident. This was the strongest expression of a lack of confidence possible in response to the question. Comments made by survey participants included: "Social interventions are more important than medical in the elderly, our biggest consumers of hospital activity", and "adult care is already under severe strain – I'm not sure that 3.9 per cent goes far enough".

Respondents pointed out that while a vibrant social care system and market is critical, the current provider-led model is not working, requiring top-ups to make the business viable. But there was a suggestion that by changing how services operate, it might be possible to lessen the impact of social care funding cuts. One respondent said: "In our local area, system transformation has reduced care home placements and delivered real savings".

Social care is in crisis and the day to day impact on the health service is of serious concern. The impact on some of the most vulnerable people in our society is hard to overstate and it will continue to have significant knock-on effects on primary, community and hospital services until better funding and a more sustainable social care system is developed.

Figure 5: Impact of insufficient social care funding



4 Institute of Fiscal Studies and The Health Foundation (2018), *Securing the future: Funding health and social care to the 2030s*

7 Increased emphasis on prevention is welcome, but funding cuts are getting in the way of delivery

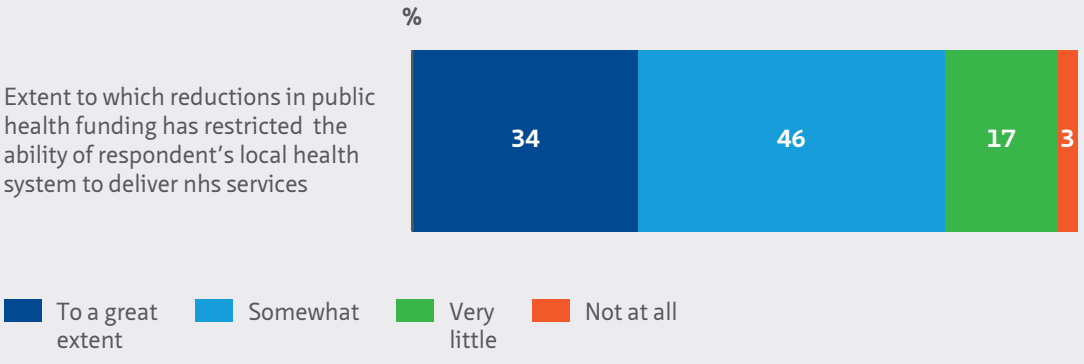
The long-term plan envisages improved public health and prevention services as a key component of a drive to reduce pressure on healthcare by reducing demand. Respondents were supportive of the increased emphasis on prevention in the plan and keen to emphasise the importance of a planned approach to prevention, with 45 per cent thinking it likely or very likely that implementing the prevention measures set out in the long-term plan would lead to a significant reduction in demand for health services. Some warned that prevention measures must be started now to prevent demand in ten years' time, and that investment in prevention would only lead to a significant reduction in demand in the long-run if it was consistently resourced. This time lag must be noted in national calculations about impact, they warned.

But four fifths of survey respondents (80%) considered that reductions in public health funding have already restricted the ability of their local health system to deliver NHS services either somewhat or to a great extent.

One respondent noted that "the level of public health funding was low to begin with, but the reduction by local authorities is problematic. There is a danger that the NHS now starts investing in public health initiatives that are not co-ordinated with local authorities, leading to inefficiency". Another added that a number of screening programmes had "gone backwards".

The cuts to public health services such as smoking cessation, sexual health and drug and alcohol services are inevitably likely to lead to greater costs to the NHS and the creation of health problems for patients that could have been avoided. The reductions in public health funding are simply storing up problems for the future.

Figure 6: Impact of reductions in public health funding



8 A need to ensure that behaviour and ways of working are consistent with the vision

We surveyed leaders prior to the publication of implementation guidance for the long-term plan and, at this point, opinion was fairly split over the coherence of roles and responsibilities across the service and the arm's length bodies. When asked whether the plan provides a coherent picture of the roles and responsibilities of STPs and ICSs, 36 per cent agreed that it does and 46 per cent disagreed.

However, only just under a quarter (24%) agreed that there was no conflict between the messages about local leadership in the plan and the approach to implementation being taken by the arm's length bodies in practice. This suggests that NHS England and Improvement need to do more to ensure that the change in approach is embedded in their ways of working.

One respondent warned: "The plan could be permissive, but it could also be used by regulators in a traditional fashion." This leader suggested that change should be locally led, and for this reason the information provided to date had achieved the right level of detail. They added: "The only things that arguably need to be stronger [are] demonstration of partnership with local authorities in terms of care solutions, the essential role of place in terms of delivery [and] that with [the] agreement [of] regional teams, asks of systems need to be managed at timescales that are appropriate for the maturity of the system."

These comments illustrate the delicate balance that NHS England and NHS Improvement will need to maintain in issuing implementation guidance that is clear, whilst maintaining an enabling approach that supports local decision making.

Conclusion

Health leaders welcome and support the long-term plan's aims, and in particular its emphasis on local leadership and population health. Engagement in the approach and support for partnership working is strong. However, they are also aware of the challenges ahead and the scale of the task should not be underestimated.

Workforce and activity growth pressures remain enduring challenges for health systems and respondents to our survey are uncertain that the plan's proposals are sufficient enough to resolve some of these deep-seated issues.

Additional investment in education and training to train and build the workforce needed is urgent and we urge the government to ensure that this is delivered in the next spending review.

Work is already underway – and has been for some time – to test new service models that may offer at least a partial route to mitigating some of the challenges of acute activity growth. But this is a difficult task and we would suggest that steps are taken to ensure learning is shared systematically so that all systems can learn from how best to tackle this issue.

We would also encourage the arm's length bodies to ensure that in implementing the NHS Long Term Plan, there is sufficient flexibility for local health systems to focus in the short to medium term on the areas that are likely to yield the most significant results. We believe that adopting a phased approach, rather than one that includes expectations about wholesale adherence to centrally mandated targets, is likely to achieve the greatest impact in the long term.

Above all, though, we would urge government to complete the funding settlement for the health and care system and provide the additional investment needed for social care, capital investment, education and training and public health in the forthcoming spending review. The level of concern about the impact of the cuts in recent years among senior leaders in the NHS is very worrying and reflects their daily experience of the significant knock-on effects on health and care services.

The ability of local systems to deliver the long-term plan must be in doubt without this additional investment.

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Designing integrated care systems (ICSs) in England

An overview on the arrangements needed to build strong health and care systems across the country

The NHS Long-Term Plan set the ambition that every part of the country should be an integrated care system by 2021.

It encourages all organisations in each health and care system to join forces, so they are better able to improve the health of their populations and offer well-coordinated efficient services to those who need them.

This overview is for all the health and care leaders working to make that ambition a reality, whether in NHS acute or primary care, physical or mental health, local government or the voluntary sector.

It sets out the different levels of management that make up an integrated care system, describing their core functions, the rationale behind them and how they will work together.

June 2019

Introduction

Since 2016, health and care organisations have been working together in every part of England in sustainability and transformation partnerships (STPs). These are a pragmatic way to join up planning and service delivery across historical divides: primary and specialist care, physical and mental health, health and social care. They are also helping to prioritise self-care and prevention so that people can live healthier and more independent daily lives.

The partnerships have begun to agree shared priorities and to make practical improvements. For example, ensuring that people can get a wider range of treatments closer to where they live or work, at a time convenient for them. Or that those who regularly use different services feel like they are dealing with just one team, who make time to understand their full health or care needs and goals.

Integrated care systems (ICSs) accelerate this work. The first 14 were confirmed in 2018, including two areas with health devolution agreements (Greater Manchester and Surrey). They cover a range of urban and rural geographies, with wide variation in population size and system complexity.

The NHS Long-Term Plan confirmed that all STPs are expected to mature so that every part of England is covered by an integrated care system by 2021. NHS England and NHS Improvement have worked with local teams to develop a consistent approach to how systems are designed, and the NHS Long-Term Plan set this out, highlighting three important levels at which decisions are made:

- **Neighbourhoods (populations circa 30,000 to 50,000 people)** - served by groups of GP practices working with NHS community services, social care and other providers to deliver more coordinated and proactive services, including through primary care networks.
- **Places (populations circa 250,000 to 500,000 people)** - served by a set of health and care providers in a town or district, connecting primary care networks to broader services including those provided by local councils, community hospitals or voluntary organisations.
- **Systems (populations circa 1 million to 3 million people)** - in which the whole area's health and care partners in different sectors come together to set strategic direction and to develop economies of scale.

Precise numbers will vary from area to area. In the earliest ICSs, they range from Gloucestershire, with a population of 528,000 and one recognised 'place', to the larger West Yorkshire & Harrogate with a population of 2.7 million and six recognised 'places'. The exact shape of each system will depend on local factors such as demography and need, and reflect where effective local collaboration is already established.

This work follows years of partnership between NHS and council teams at different levels. Many of the earliest ICSs, and other areas that are making great progress joining up services, build on a long history of planning and providing person-centred care for residents, and on councils' strategic plans to improve health and wellbeing.

They also incorporate learning from initiatives such as the 50 'vanguards' that tested and refined new care models. In the most successful of these vanguards, NHS providers and commissioners, councils, care homes and others developed more preventive approaches to care and saw significant reductions in emergency admissions.

Effective, collaborative leadership – with clear, common purpose, drawing support from all parts of the system including different professional teams – has consistently been shown to be essential to developing the partnership culture needed to create and sustain systemwide improvement.

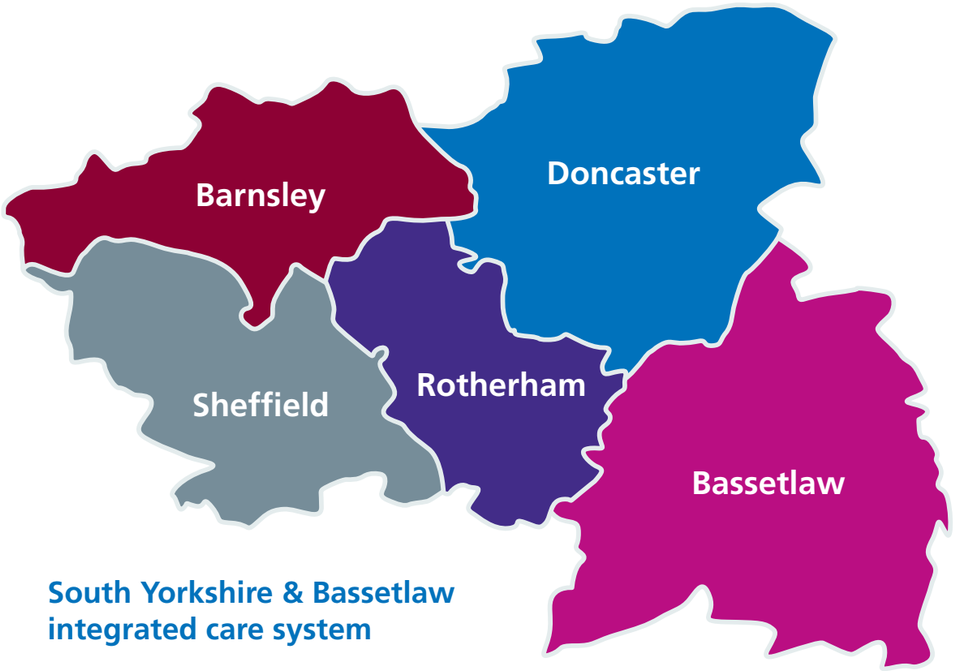
Each area is at a different stage in its journey, with even the earliest integrated care systems refining their approach as relationships and infrastructure mature. While some features are common to the most mature systems (such as behaviour that promotes collaboration at every level), priorities and solution will rightly vary between areas in reflection of different local geographies and histories of collaboration.

Systems work most effectively where functions at different levels are designed to support and complement each other – a truly interconnected approach. This overview is to help local leaders think through where functions should sit in their system; maximising resources, galvanising collective effort and systematically improving care for residents.

Overview of integrated care system and their priorities from the NHS Long-Term Plan

Level	Functions	Priorities from the NHS Long-Term Plan
Neighbourhood (c.30,000 to 50,000 people)	• Integrated multi-disciplinary teams • Strengthened primary care through primary care networks – working across practices and health and social care • Proactive role in population heath and prevention • Services (e.g. social prescribing) drawing on resource across community, voluntary and independent sector, as well as other public services (e.g. housing teams).	• Integrate primary and community services • Implement integrated care models • Embed and use population health management approaches • Roll out primary care networks with expanded neighbourhood teams • Embed primary care network contract and shared savings scheme • Appoint named accountable clinical director of each network
Place (c.250,000 to 500,000 people)	• Typically council/borough level • Integration of hospital, council and primary care teams / services • Develop new provider models for 'anticipatory' care • Models for out-of-hospital care around specialties and for hospital discharge and admission avoidance	• Closer working with local government and voluntary sector partners on prevention and health inequalities • Primary care network leadership to form part of provider alliances or other collaborative arrangements • Implement integrated care models • Embed population health management approaches • Deliver Long-Term Plan commitments on care delivery and redesign • Implement Enhanced Health in Care Homes (EHCH) model
System (c.1 million to 3 million people	• System strategy and planning • Develop governance and accountability arrangements across system • Implement strategic change • Manage performance and collective financial resources • Identify and share best practice across the system, to reduce unwarranted variation in care and outcomes	• Streamline commissioning arrangements, with CCGs to become leaner, more strategic organisations (typically one CCG for each system) • Collaboration between acute providers and the development of group models • Appoint partnership board and independent chair • Develop sufficient clinical and managerial capacity
NHS England and NHS Improvement (regional)	• Agree system objectives • Hold systems to account • Support system development • Improvement and, where required, intervention	• Increased autonomy to systems • Revised oversight and assurance model • Regional directors to agree system-wide objectives with systems • Bespoke development plan for each STP to support achievement of ICS status
NHS England and NHS Improvement (national)	• Continue to provide policy position and national strategy • Develop and deliver practical support to systems, through regional teams • Continue to drive national programmes e.g. Getting It Right First Time (GIRFT) • Provide support to regions as they develop system transformation teams	

What do these look like in a local system?



South Yorkshire & Bassetlaw integrated care system

	**36 neighbourhoods** with population of **30 - 50k**. At this level, primary care will be strengthened by working together in network.
	**Five places** with populations between **250 - 500k**. At this town / city / council level, health and care will work together more closely.
	**One system** with a population of **1.5m**. At this level, strategic planning and improvements can take place for the benefit of all as well as having an overview of system finance and performance.

We will now consider the three levels – neighbourhood, place and system – in more detail.

Neighbourhoods
(populations circa 30,000 to 50,000 people)

'Neighbourhoods' are the cornerstone of integrated care. Based on natural geographies, population distribution and need, and previous work across different professional teams, these networks draw on a wide range of professional skills including: GPs, care homes and home care, pharmacists, community and mental health teams, and the voluntary sector.

They will give community-based care through urgent community response and recovery support, by helping residents to age well and by guaranteeing NHS support to those living in care homes. By putting in place seamless care for both physical and mental health, they will allow the NHS and its partners to give care (including secondary care) as close to people's homes as possible.

Primary care networks, enabled by the new GP contract, are central to this. They will build on the experience of local partnerships already in place, and initiatives such as 'Primary Care Home', which have built locality-wide teams across organisational boundaries, often expanding what is offered in GP practices and other community settings.

As a minimum, primary care networks will consolidate this work to ensure extended hours access to GPs and to reduce day-to-day pressures by allowing NHS and local government services to share functions or staff. More mature networks will use increasingly sophisticated data to identify and give more proactive care to those at risk of unnecessary hospital admission and will use new technology and tools such as social prescribing to help people to care for themselves where appropriate.

Joining up services from a range of professionals

An integrated care 'hub' in Weymouth brings together a GP, community geriatrician, therapists, community nurses, social workers and mental health professionals to proactively support those at risk of hospitalisation. Early evaluation suggests a 10 per cent reduction in acute bed days for those treated, and improved staff experience. The ICS has supported the model to spread, with ten integrated care hubs now covering the whole county.

Improving care quality and experience with home visits

In West Berkshire, integrated paramedic home visiting gives residents rapid, one-stop care that takes account of their whole needs. Thanks to closer collaboration between primary care, social care and voluntary services, more are now treated at home. This has improved care quality, use of resources and staff experience, reduced deterioration and length of stay, and allowed the system to manage demand more evenly throughout the day. In the first seven months, 96 attendances were avoided, and 75 sessions of GP time saved.

Population health in Lancashire

Lancashire neighbourhoods including Chorley and Skelmersdale are developing 'population health management' approaches, to improve local people's health results, reduce inequalities and address the broad range of individual, social and environmental factors that affect these. To do this, GPs, councils, community organisations and others are building shared information and understanding about how different groups of residents live their lives. For example, bringing different data sources together to identify how those with two or more long-term conditions can best be supported to prevent complications and live independently.

Places
(populations circa 250,000 to 500,000 people)

This level may match local council boundaries or the natural geographies at which services are delivered. It will include clusters of primary care networks, linking these to care providers such as one or more acute hospital, care homes, mental health and community providers, local government and voluntary or community organisations.

Together, these will make a shared assessment of local need, plan how to use collective resources and to join up what they offer – including beyond traditional health and care services – to make best use of overall public and community resources.

Two crucial pieces of work are driven at 'place' level, both relying on collaboration and joint decision-making. These are clinical care redesign (simplifying and standardising care pathways across a whole area) and population health management (making better use of data to improve how health and care services address wider health determinants such as housing, environmental quality and access to good employment and training).

They may also be the level at which some local services are integrated and managed such as rapid response teams to support people with learning disabilities.

In the absence of a legal basis for statutory (NHS and local council) commissioners to form decision-making committees with statutory providers, the 'board' at place level will normally operate according to an NHS alliance agreement or initially with a lighter touch memorandum of understanding. ICSs will also be expected to work closely with health and wellbeing boards, the established statutory forum that brings together local leaders from different parts of the system, which will often coincide with place level.

Joining up health and care in line with local council areas

The six places in West Yorkshire & Harrogate (Bradford District and Craven, Calderdale, Harrogate, Kirklees, Leeds and Wakefield) are developing integrated care services, scaled up as appropriate for differing population needs. For instance, partners in Wakefield (including NHS organisations, the council, housing providers, fire service and voluntary and community sector) are working together to keep residents safe and well in their own homes via two 'connecting care' hubs.

Place-based commissioning in a combined authority

Ten areas in Greater Manchester are moving to place-based joint commissioning between local government and CCGs, in line with local council/ health and wellbeing board boundaries. Together, these will join up health and care services at scale, drawing on relationships with Greater Manchester's Mayor and Combined Authority, transport authority, police, fire service, housing providers and the voluntary sector.

Improving productivity by better reflecting patients' needs

The 'Better Together' alliance in Mid Nottinghamshire, which includes the county council alongside CCGs, NHS trusts and others, separates patients into different groups based on their risk levels. This has helped to improve care and timeliness for patients, avoiding unnecessary hospital admissions and bed days. Over time, it is expected to lead to all NHS providers in the area working through a single contract alliance.

Systems
(populations circa 1 million to 3 million)

The 'system' level provides strategic leadership across the whole population of the ICS. This will include overseeing a single plan covering both operational and long-term transformation priorities (building on, and aligning place-level plans), and managing financial performance against a system control total that encompasses CCGs and NHS providers.

It will take responsibility for delivering high quality services and access, reducing unwarranted clinical variation and addressing health inequalities. Other functions that will be undertaken at system-wide level include NHS workforce planning, agreeing how to make the best use of capital, estates and digital infrastructure, and spreading good practice that emerges at place level over a wider scale.

Clinical, managerial and support functions will be provided at system level when they can most efficiently and effectively be delivered once; for example, where analytical capacity or business intelligence capability is in short supply.

System leaders will take collective responsibility for financial and operational performance, typically through a systemwide board which includes all NHS partners. New governance arrangements will support this, enabling timely action on system-wide challenges.

Sharing information and freeing staff to work across a county

Dorset ICS developed the 'Dorset Care Record', a single, confidential system allowing health and care professionals across the whole county to see the same information about patients. Joining up information in this way means that people no longer need to repeat their story to different teams, and improves care by enabling a more comprehensive and up-to-date understanding of their whole needs.

The ICS has also introduced workforce 'passports' so staff can move freely between any organisation in the county. This allows people to develop different skills and perspectives and encourages them to stay in the system by providing a wider pool of career options.

Moving to a single accountable officer across commissioners

Five of the earliest ICSs (Dorset, Surrey Heartlands, North Cumbria, Gloucestershire and Bedfordshire, Luton and Milton Keynes) have appointed joint accountable officers across constituent CCGs. This has helped them to simplify commissioning arrangements, enabling a single set of system-wide decisions in line with agreed local needs and aspirations.

NHS England and NHS Improvement – national and regional support and oversight

NHS England and NHS Improvement's seven regional teams are responsible for holding systems to account, supporting their development and making interventions where necessary. ICSs will agree system-wide objectives with their regional director and be accountable for systemwide performance against these objectives.

National and regional teams will work together, steered by regional directors to encourage and support all systems to take on greater collaborative responsibility for improving quality of care, focusing on population health and improving their use of NHS resources.

Quality, safety and performance issues should be addressed as close to the system as possible.

The overall principles of this approach will be to:

- help to design the right support and intervention for local health systems, ensuring NHS England and NHS Improvement create maximum value and avoid unnecessary burden;
- decide when and how to intervene in systems, providers or CCGs in their region, or – where the seriousness of the intervention requires a national decision – make the relevant recommendations to the decision-making group;
- be responsible for managing all interventions with – or seeking information or assurances from – systems, providers or CCGs;
- treat performance management and improvement as a continuum, rather than in terms of fixed check points;
- help develop standardised national approaches to improvement and performance, but have discretion to allow systems, providers or CCGs to depart from standardised approaches where they are performing well.

The regions continue to have a role in managing system development and performance; with this responsibility shifting to the system as it matures. Therefore, regional teams will need to adopt different approaches to regulating systems based on their maturity.

Some functions, such as ambulance services, specialised commissioning or emergency preparedness may be best arranged in line with scale of delivery or prevalence of need. This may sometimes be at a geography that is sub-regional but wider than system-wide.

In more mature systems, the regional role increasingly becomes that of a critical friend, providing the system with further autonomy regarding regulation, avoiding engaging with individual organisations without the knowledge of the system and reducing the number of formal meetings.

Over time, we envisage that NHS regional teams and overall operation will become leaner and more strategic, as systems take on more self-development and self-assurance as they progress to becoming thriving ICSs.

NHS England and NHS Improvement's national team will remain the overall centre for policy and strategy development including overall health system strategy, the NHS provider landscape and heath commissioning strategy.

Maturity matrix for integrated care systems (ICSs)

The integrated care system maturity matrix has been developed to outline the core characteristics of systems as they develop. These were developed from observing and talking to the earliest ICSs, and from the objectives set out in the NHS Long-Term Plan.

It is based on similar tools used by the Local Government Association and others, who have experience in supporting system development and change. It provides a consistent framework for all regions and systems across the country.

The matrix outlines the core capabilities expected of emerging ICSs, developing ICSs, maturing ICSs and thriving ICSs. For a system to be formally named an ICS, they will need to meet the attributes of a maturing ICS.

It uses a progression model which shows a journey rather than a series of binary checklists, recognising that systems will not develop all domains at the same pace and will therefore have varying levels of maturity across each domain. By doing this, it seeks to support more nuanced and reflective discussions about system maturity.

System maturity matrix – five domains, four stages

System progression

	Emerging	Developing	Maturing ICS *System formally named an ICS and minimum level of maturity for all systems to reach by April 21*	Thriving ICS
System leadership, partnerships and change capability	• Leadership team that lacks authority with no collectively-owned local narrative or sense of purpose. • Lack of transparency in ways of working. • Little progress made to finalise system vision and objectives or embed these across the system and within individual organisations. • Minimal meaningful engagement with primary care, local government, voluntary and community partners, service users and the public.	• All system leaders signed up to working together with ability to carry out decisions that are made. • An early shared vision and objectives, starting to build common purpose and a collectively-owned narrative among the broader leadership community including primary care. • Plans to increase the involvement of local government, voluntary and community partners, service users and the public in decision-making at system, place and neighbourhood.	• Collaborative and inclusive multi-professional system leadership and governance; including local government and the voluntary sector. • Clear shared vision and objectives, with steady progress made visible to stakeholders and staff. • Dedicated capacity and supporting infrastructure being developed to help drive change at system, place and neighbourhood level (through PCNs). • Effective ongoing involvement of voluntary and community partners, service users and the public in decision-making at system, place and neighbourhood levels. • A culture of learning and sharing with system leaders solving problems together and drawing in the experiences of others.	• Strong collaborative and inclusive system leadership, including local government and the voluntary sector, with a track record of delivery. • Transparent and robust governance, with multi-professional leadership aligned around the system and system working closely with health and wellbeing boards. • A proactive approach to the identification and development of future system leaders at all levels. • Dedicated clinical and management capacity and infrastructure to execute system-wide plans. • A narrative that is well understood and strongly supported by the public and staff, outlining how integrated care is delivering on the ambitions of communities, with demonstrable impact on outcomes.
System architecture and strong financial management and planning	• Limited understanding of system architecture across the footprint and limited plans to organise delivery around neighbourhood, place and system. • Fragmented commissioning landscape with few agreed plans to streamline arrangements. • System not in financial balance and unable to collectively agree recovery trajectory. • Lack of system wide plans on workforce, estates and digital.	• Clear plans to organise delivery around neighbourhood, place and system. • Plans to streamline commissioning, typically with one CCG that is leaner and more strategic. • Good understanding of system financial drivers and efficiency opportunities, with a shared plan to address issues. • System wide plans being developed to address workforce, estates and digital infrastructure.	• System is working with regional teams to take on increased responsibility for oversight. • Plans to streamline commissioning are underway. • System has credible plans for meeting system control total and, where not already achieved, for moving towards system financial balance • System wide plans for workforce, estates and digital infrastructure being implemented. • System is managing resources collectively and signed up to the ICS financial framework.	• System has progressed to the most advanced stage of oversight progression – i.e. self-assurance, with clear communication and relationships with regional team. • Streamlined commissioning arrangements fully embedded across all partners. • System is in financial balance and is sharing financial risk using more sophisticated modelling of current and future population health and care needs. • Incentives and payment mechanisms support objectives and maximises impact for the local population. • Improvements in workforce, estates and digital infrastructure being seen across the system. • System is managing resources collectively and signed up to the ICS financial framework.

System progression

	Emerging	Developing	Maturing ICS *System formally named an ICS and minimum level of maturity for all systems to reach by April 21*	Thriving ICS
Integrated care models	• Limited use of national and local data to understand population health and care needs. • Limited thinking about how to scale up primary care and how to integrate services at neighbourhood or place • Minimal collaboration or engagement across providers.	• Early development of the 5 service changes within the LTP, and care models aiming to: - address unwarranted clinical variation; - integrate services around the needs of the population in neighbourhoods; - integrate services vertically at place; - collaborate horizontally across providers at the system and/or place level. • PCNs developing clear vision for integrated care models and transforming population health. • Some understanding of current and future population health and care needs using local and national data. • Plans in place to support interoperable access to care records across health and social care providers.	• PCNs implementing new or redesigned care models with partners to meet population need – that is enabling integrated provision of health and care within neighbourhoods. • Integrated care teams operating at neighbourhood and place bringing together PCNs, mental health, social care and hospital services as per the triple integration set out in the LTP. • Starting to implement plans to: - address unwarranted clinical variation; - deliver the 5 service changes in the LTP; - tackle the prevention agenda and address health inequalities. • PHM capability being implemented including segmenting and stratifying population using local and national data to understand needs of key groups and resource use.	• Integrated teams demonstrating improvement in outcomes. • Fully mature PCNs across the system delivering care with partners that meets population needs. • Implementing priorities in prevention and reducing health inequalities as part of care model design and delivery. • Full population health management capability embedded at neighbourhood, place and system levels which supports the ongoing design and delivery of proactive care. • Implementation of the 5 service changes set out in the LTP demonstrating improvement in health outcomes.
Track record of delivery	• Slow progress towards delivering national priorities especially the 5 service changes set out in the LTP. • Lack of relative progress in delivering constitutional standards without system agreement to work together to support improvements. • Weak system operating plan developed and system unable to make collective decisions around system funding.	• Evidence of progress towards delivering national priorities especially the 5 service changes set out in the LTP. • Improved delivery of constitutional standards. • System operating plan in place that demonstrates a shared set of principles to start to manage finances collectively.	• Evidence of tangible progress towards delivering national priorities especially the 5 service changes set out in the LTP. • Consistently improving delivery of constitutional standards with credible system plans to address risks. • Robust system operating plan and system financial management in place, with a collective commitment to shared financial risk management. • Robust approach in place to support challenged organisations and address systemic issues.	• Evidence of delivering national priorities especially the 5 service changes set out in the LTP. • Delivery of constitutional standards including working as a system to mitigate risks. • Demonstrating early impact on improving population health outcomes. • Consistently delivering system control total with resources being moved to address priorities. • As issues emerge, leaders join forces to tackle them as a system including when under pressure.
Coherent and defined population	• A meaningful geographical footprint that respects patient flows • Where possible contiguous with local authority boundaries; where not practicable has clear arrangements for working across local authority boundaries • Covers an existing STP of sufficient scale (~1m pop or more)	• A meaningful geographical footprint that respects patient flows • Where possible contiguous with local authority boundaries; where not practicable has clear arrangements for working across local authority boundaries • Covers an existing STP of sufficient scale (~1m pop or more)	• A meaningful geographical footprint that respects patient flows • Where possible contiguous with local authority boundaries; where not practicable has clear arrangements for working across local authority boundaries • Covers an existing STP of sufficient scale (~1m pop or more)	• A meaningful geographic footprint that respects patient flows • Where possible contiguous with local authority boundaries; where not practicable has clear arrangements for working across local authority boundaries • Covers an existing STP of sufficient scale (~1m pop or more)

Key

LTP – Long Term Plan; PCNs – Primary Care Networks; UEC – Urgent and Emergency Care; PHM – Population Health Management

ICS will drive forward five major practical service changes set out in the LTP – These are: (1) boost out-of-hospital care, and finally dissolve the historic divide between primary and community services; (2) re-design and reduce pressure on emergency hospital services; (3) give people more control over their own health, and more personalised care when they need it; (4) implement digitally-enabled primary and outpatient care; and (5) increasingly focus on population health and local partnerships with local authority-funded services.

Freedoms and Flexibilities for 2019-20

System progression

	Emerging	Developing	Maturing ICS *System formally named an ICS and minimum level of maturity for all systems to reach by April 21*	Thriving ICS
Oversight	• Systems can provide advice and guidance on individual organisations within the system to support conversations • NHSEI will use a single performance, oversight and assessment framework	• Systems will develop and implement a plan to support ICS development, which will be reviewed and agreed with NHSEI • NHSEI will invite system leadership to attend and contribute to discussions relating to individual organisations within the system • NHSEI will consult the system position before any escalation action/ intervention is approved and enacted through a single identified lead • NHSEI will align roles within the regions to support systems	• ICSs will agree and implement system-wide objectives agreed with regional teams, covering care quality and health outcomes, reductions in inequalities, implementation of integrated care models and improvements in financial and operational performance • ICSs will conduct and contribute to the assurance and improvement of individual organisations performance • NHSEI will keep ad hoc data requests and routine reporting outside the performance framework and agreed ICS objectives to a minimum, and coordinate through an identified lead • NHSEI will not engage with individual Trusts or CCGs without the knowledge of the ICS • NHSEI will co-locate regional roles within the ICS to provide bespoke support requested by the ICS	• ICSs will lead the assurance of all individual organisations • ICSs will agree and coordinate any trust or CCG intervention carried out by NHSEI, other than in exceptional circumstances • ICSs will be able to lead and shape how gathering any data from individual organisations is managed where required • NHSEI will agree a minimum dataset with ICSs • NHSEI will embed regional resources within the ICS to operate under the direction of the ICS • NHSEI will undertake the least number of formal assurance meetings possible with individual organisations
Finance		• STPs will demonstrate strong financial leadership and governance for financial decision-making.	• ICSs will take up the 19/20 ICS financial framework • ICSs will commit to delivering the objectives of the relevant national programmes and report progress against this. Appropriate governance arrangements to account for use of funds will be in place before any funds are released • NHSEI will delegate authority for the direction of transformation funding from national programmes to the system, where possible	• ICSs will take up the 19/20 ICS financial framework
Planning	• Organisational financial recovery plans will be developed with the system leaders to ensure consistency with five year system-level strategic plans, with system efficiency plans overseen by a system efficiency board • NHSEI will lead review and assurance of organisational and system operating plans. • NHSEI will work with the system to develop and strengthen these plans	• NHSEI will work in partnership with system leaders to review organisational and system operating plans	• Organisations that are in financial surplus will play an active role in the development and delivery of financial recovery plans of organisations within their ICS • NHSEI will support system leaders to assure organisational plans, and will work in partnership with system leaders to ensure system operating plans are sufficiently robust.	• ICSs will lead assurance of organisational plans. • System operating plans will have a light touch review by the NHSEI
Support	• Intense support, regionally led and nationally coordinated	• Based on needs identified in development plan • ICS Accelerator Programme TBC • Access to regional and national subject-matter expertise where required	• ICS Development Programme	• ICS Development Programme • Expectation to work alongside regional and national teams to support less developed systems

Find out more

Keep up to date on how health and care is changing:
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Together:

Service user and carer involvement strategy

Caring | Discovering | Growing | **Together**

Background

This strategy builds upon the previous Service User and Carer Involvement Strategy (2016).

The involvement and engagement of service users carers and staff has been implicit throughout the development of this strategy. This has been achieved through joint workshops, discussion groups and development sessions. Across all of the engagement events conversations have been encouraged amongst people in attendance to consider and respond to the following key questions:

- What does ideal involvement look like?
- What has worked well/not worked so well in the past?
- How do we get to where we want to be?

Appendix one provides the detail behind the strategy development.

Context

The NHS five year forward view says that we need to engage with communities and citizens in new ways, involving them directly in decisions about the future of health and care services. The latest report from NHS England states 'Making progress on our priorities and addressing the challenges the NHS faces over the next two years cannot be done without genuine involvement of patients and communities.'

Traditional approaches to the way we deliver care arguably emphasises the expertise of health and care workers. It is important to acknowledge that there are two sets of experts: experts who have professional training and acquired experience, who make the best use of research and theories and experts who have personal lived experience of distress (or of caring for a loved one) and recovery, discovery and resilience.

It is important that we recognise expertise by lived experience on equal terms as professional expertise. This suggests a different kind of relationship between health professionals and service users.

It's about involvement:

- Ensuring that service users and carers are at the heart of everything we do
- Sharing knowledge and expertise
- Working with service users and carers as equal partners

NHS England defines service user and carer involvement as:

- "The process by which people who are using or have used a service become involved in the planning, development and delivery of that service."

Our definition of involvement:

When we asked people 'what is involvement?' they said:

- Wherever possible service users and carers collaboratively work **together** with staff in the design, delivery and development of services **(Service design and delivery, workforce)**

- Service users, carers and staff work **together** to make sure that the Trust is able to deliver and develop services that are safe, effective, caring, responsive and well-led (**What's working well and why?)**

- It's about dialogue: being listened to, feeling valued, sharing our views, coming to a mutual understanding, making decisions **together** and working **together** to implement solutions and developments **(Communication)**

- Service users, carers and staff work **together** to make sure that the people we employ share our values and have the skills that are required of them to do what is needed and to develop our work **(Recruitment and selection and training)**

- Service users, carers and staff are **together**, recognised as leaders and given equal opportunity to develop their leadership capabilities **(Leadership)**

When we asked people to identify the signs that involvement is working, they said:

"It's about a change in culture: We need to see and feel that things are different. This should be demonstrated through the words and actions of everyone."

Involvement is about making sure that we

- Devolve power, choice and control to people using services, their carers, communities and to frontline clinical staff. It's about us all working together
- Regard the people who use and deliver our services as an asset, as contributors, as a resource
- Encourage service users, carers and frontline clinical staff to take more responsibility and to share the responsibility for the way we deliver care and manage our services together
- Do all that we can encourage active participation in all that we do

Involvement is not about

- Asking for service users and carers opinions on ideas, plans, or proposals developed by health and care staff
- Offering choice between options developed by health and care staff
- Asking service users and carers ‘what do you want?’ with the expectation that health and care staff will be expected to deliver this and then defending your inability to deliver by saying, ‘yes, but…’
- Inviting ‘one or two’ service users or carers onto committees or interview panels
- Defining this group of people only by their status as ‘consumers’ of services and not by the attributes they may have

Why is this strategy of relevance, now?

The Trusts strategy, **Caring, Discovering, Growing: Together** highlights both the challenges and opportunities that we need to address over the next five years. This means everyone working differently and ‘smarter’. It means altering or completely reshaping services giving people better quality and experience for less money. It means reinvesting any money saved in more and better services and so extending access to care. Only by getting everyone involved and working together, will a network of services be provided which can meet the changing needs of people in the 21st century within the limits of the budgets available. Our Trust is committed, as part of this strategy to work with service users and carers in partnership, to provide excellent care, supporting people on their personal journey to wellbeing.

“Service users and carers should be at the heart of everything we do and getting this right is the single most important thing we can do to achieve our strategic ambitions.”

NTW Five Year Strategy, 2017

Together, service user and carer involvement strategy - strategy on a page

Our seven strategic ambitions:

Embedding the strategy: Making it feel real

Strategies feel real when they become embedded into the way we work; when people start to take practical actions.

1. The first step is to talk to others about the strategy, to have conversations together. Not everyone will agree with the content and some may perceive the ambitions as a threat to the way they work.

2. The second step is for each and every one of us to think about what each of the ambitions means and to reflect on what we might need to do in order to achieve our ambitions. Change happens because we want it to.

3. The third step is for groups of service users, carers and staff to talk about the strategy together. To agree on and to develop joint actions. To work together.

4. The fourth step is for the organisation, as a whole, to think about what it might need to do differently, in order to support the embedding of the strategy. Staff should not do this in isolation however, all staff (including corporate and business teams) need to think about how they involve service users and carers, as equal partners, in this work. Working together.

Along the way we need to bring people with us, we need to embrace and support each other and recognise that change means different things to different people. This strategy will challenge the beliefs of some people. We cannot legislate for its implementation. Change will happen because the time is right and because people want to change.

How will we know we have made a difference?

We have identified a series of strategic ambitions that identifies way forward, and have emphasised the importance of everyone making sure that the doing of it, is part of their business. So far we have heard about many practical suggestions from those of you who have attended some of the engagement events that might help us to embed the strategy; to make it real. We don't want to be prescriptive about this though. We want you to drive these changes. We will do what we can to support you and our Council of Governors and Board of Directors will ensure that we are able to deliver on it.

Glossary of terms used:

Co-production - Co-production is where service users, carers and staff share power to plan and deliver services together, recognising that both partners have a vital contribution to make. Co-production acknowledges that service users and carers are experts in their own circumstances and capable of making decisions, while professionals must move from being fixers to facilitators. Co-production requires a relocation of power towards service users and carers. Where activities are co-produced, both services and communities become far more effective agents of change.

Engagement - Engagement is about understanding and involving the different groups interested or impacted by the work you do, and building relationships with them. The purpose can be to develop a long-term conversation and dialogue, or to reach a specific goal through collaboration. But good engagement isn't a tick-box exercise – it needs to employ different routes and techniques to reach groups and make sure they are involved. Engagement is about listening, hearing and attending to needs and by doing so we value, care for and respect others.

Equal partners - Ensures that the people who use our services, our staff, partner agencies and the wider public are fully engaged and involved in all aspects of the planning, shaping and delivery of our services; and that individuals are fully involved in their own care and support. Equal partners covers many levels of involvement and inclusion, each implying a different level of relationship between service providers, patients/service users, carers and citizens.

Inclusion - Inclusion is 'the state of being included.' It is used by rights activists to promote the idea that all people should be freely and openly accommodated without restrictions or limitations of any kind. It is described by some as the practice of ensuring that people feel they belong, are engaged, and connected. It is a universal human right whose aim is to embrace all people, irrespective of race, gender, disability or other attribute which can be perceived as different.

Involvement - Service user involvement is the active participation of a person with lived experience of distress in shaping their personal health plan, based on their knowledge of what works best for them. As the wider benefits of inclusion have become apparent and recognised, it has also come to mean the active inclusion of the perspectives of service users collectively in the design, commissioning, delivery and evaluation of services, as well as in policy development locally and nationally. This has been the accepted definition for many years, though progress towards achieving genuine service user involvement across the health sector has been gradual.

Get Involved

Sign up to become a Northumberland, Tyne and Wear NHS Foundation Trust member

www.ntw.nhs.uk/membership ☎ 0191 245 6827 FREEPOST NTW MEMBERSHIP

Membership is completely free and as a member you can:

- Give your views on the Trust's plans and any issues that interest you
- Vote in the governor elections or stand as a governor yourself
- Receive regular information about the Trust

If you you would like to know more about the Service user and carer involvement strategy please contact the: Patient and Carer Engagement Team: 01670 501 816

UP PIC - June 2019 V1

Northumberland, Tyne and Wear NHS Foundation Trust

Developing the service user and carer involvement strategy

Appendix 1

Caring | Discovering | Growing | **Together**

These are peoples comments on developing the strategy. When we asked people to identify how we might achieve each of the strategic ambitions, this is what they said:

Service design and delivery – this is what we heard:

What does ideal involvement look like?

- Service users and carers are involved, as equal partners, in the design, delivery and evaluation of the way that care is provided

What has/has not worked in the past?

- Has: Some good examples of work e.g. recovery colleges
- Hasn't: This is not locally consistent

How do we get to where we want to be?

- Harness and learn from examples of good practice and build on it
- Grass roots involvement of service users and carers in all aspects of the way that care is shaped and delivered
- This ambition needs to be owned by everybody; built into the personal objectives of staff and teams, and we need to give serious consideration as to how we can nurture and support service users and carers to feel like they can make a difference and learn from their experiences, good and not so good

Training – this is what we have heard:

What does ideal involvement look like?

- Service users and carers are involved in the design and delivery of training and development initiatives

What has/has not worked in the past?

- Has: Examples of successful initiatives involving service users and carers leading on or co-producing training
- Has: Recovery college volunteers
- Has: Service user deliver insight/awareness into the pathway for individuals, tell the story, make it real at the Carer Champion Forum
- Hasn't: Some examples of good work but this is not consistent; not enough opportunities

How do we get to where we want to be?

- Go back to the beginning, grass roots, get the basics right
- Involvement needs to be at the heart of training and development initiatives

Communications – this is what we have heard:

What does ideal involvement look like?

- Service users and carers help shape the way that we communicate – helping to develop effective, accessible, targeted, meaningful and jargon free methods of communication

What has/has not worked in the past?

- Has: Service user involvement in the 'Write To Me' pilot to reduce the jargon and the ensuring that letters are sent to them first and copied to the GP
- Hasn't: Some good examples of work but this is not consistent
- Hasn't: Communication is often jargon laden and 'hit and miss,' it is not always easy to speak to the right person at the right time

How do we get to where we want to be?

- Harness and learn from what is good and build on it
- Involvement in the design and delivery of the Trust's communications strategies, communication tools and initatives

What works well and why - this is what we have heard:

What does ideal involvement look like?

- Service users and carers are involved, as equal partners, in all aspects of the assurance process - to ensure that our services are safe, effective, caring, responsive to people's needs and well led
- Examples of monitoring and evaluation initiatives could include meaningful involvement with Points of You questionnaire and the Care Quality Commission (CQC) inspection process

What has/has not worked in the past?

- Has: Service user identified for each ward area to assist in collecting feedback
- Hasn't: From the engagement work completed to date, few examples have been given. Question was asked; has service user and carer monitoring become a thing of the past? Clarity over what the word 'assurance' means was requested

How do we get to where we want to be?

- Grass roots involvement of service users and carers in all aspects of the assurance, monitoring and evaluation process; what's working well and why?

Recruitment and selection - this is what we have heard:

What does ideal involvement look like?

- Service users and carers involved in all aspects of the recruitment and selection process – designing jobs and job adverts, and developing interview questions, being on panels, being informed of outcomes

What has/has not worked in the past?

- Has: Some involvement in designing questions and on panels
- Hasn't: This is not consistent

How do we get to where we want to be?

- Involvement should not be an afterthought
- Develop a bank of people who want to and can be involved

Workforce - this is what we have heard:

What does ideal involvement look like?

- Service users, carers and staff have lived experience, and are valued for their unique insights and acquired expertise
- Service users and carers are employed on the basis of the contribution that they can make

What has/has not worked in the past?

- Has: Employment of peer support workers
- Has: Time to Change campaign
- Has: Volunteers participating in recovery colleges

How do we get to where we want to be?

- Review/revise recruitment and selection processes
- Grass roots involvement of service users and carers in workforce planning, policies and procedures

Leadership - this is what we have heard:

What does ideal involvement look like?

- Leadership development has a key role to play in improving our ability to deliver great care. Service users and carers have unique insights and acquired expertise and need to be embraced, as equals, as leaders
- Leadership development initiatives should be open to and directed at enhancing the capabilities and maximising the contribution of service users and carers

What has/has not worked in the past?

- Has: Successful programmes developed and provided for over 140 people in past five years
- Has: We have a dedicated resource and a committed number of people who want to make this work
- Has: We have more initiatives planned and have network of service users, carers and staff working on this, supported by key organisational leaders
- Has: The Trust is leading the way regionally and asking the local leadership academy to support the development of leadership initiatives for service users and carers
- Hasn't: Joint programmes comprising service users, cares and staff have not always worked well

How do we get to where we want to be?

- Continue to co-produce leadership development initiatives open to service users and carers
- Ensure service users and carers are afforded the same opportunities as staff, and that this is backed up at a regional and national level

Northumberland, Tyne and Wear NHS Foundation Trust

Board of Directors

Meeting Date: 3rd July 2019

Title and Author of Paper: Integrated Commissioning & Quality Assurance Report (Month 2 May 2019) – Anna Foster, Deputy Director of Commissioning & Quality Assurance

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

Paper for Debate, Decision or Information: Information & Discussion

Key Points to Note:

1. This report provides an update of Commissioning & Quality Assurance issues as at 31st May 2019.
2. The number of people waiting more than 18 weeks to access services has decreased this month in non-specialised adult services overall and within children's community services in Newcastle/Gateshead.
3. The Trustwide appraisal figure has decreased to 84.8% this month, which is below the Trust standard.
4. There has been one Mental Health Act reviewer visit report received since the last report relating to Tweed ward. There were actions which had been resolved along with one which remains unresolved from a previous visit relating to blanket restrictions.
5. The confirmed April 2019 sickness figure is 5.0%, achieving the Trust standard for the first time since 2017/18. The provisional May 2018 sickness figure is 5.49%. The 12 month rolling average sickness rate has decreased to 5.76% in the month.
6. Inappropriate out of area treatment bed days remain elevated, with 118 in May 2019 (104 in April 2019)

Risks Highlighted: waiting times

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).

2 There has been one Mental Health Act reviewer visit report received since the last report relating to Tweed ward. There were actions which had been resolved along with one which remains unresolved from a previous visit relating to blanket restrictions

3 There have been no Commissioner Quality Assurance visits this month.

4 NHS England and local CCG's did not meet all the contract requirements for month 2. The areas of underperformance continue to relate to CPA metrics, seven day follow up and in Sunderland IAPT numbers entering treatment.

5 All of the CQUIN scheme requirements have been internally forecast at month 2 to be achieved during the quarter.

7. The number of people waiting more than 18 weeks to access services has decreased this month in non-specialised adult services from 55 to 50. Within children's community services there has been a decrease in those waiting over 18 weeks in Newcastle/Gateshead.
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 Clinical Risk Training (76.9% was 77.4%) and PMVA Basic Training (79.3% was 79.9% last month).
9. Reported appraisal rates are slightly below the Trust standard this month and are reported at 84.8%.
10. The confirmed April 2019 sickness figure is 5.0%, achieving the Trust standard for the first time since 2017/18. This was provisionally reported as 5.23% in last month's report, highlighting an ongoing issue with delayed return to work recording. The provisional May 2019 sickness figure is 5.49%. The 12 month rolling average sickness rate has decreased to 5.76% in the month

11. At Month 2 the Trust has a year to date deficit of £1.2m which is £0.2m ahead of plan. The forecast surplus is £2.6m which includes £2.6m of Provider Sustainability Funding (PSF) which is in line with the control total. Agency spend is £1.2m which is £0.1m above Trust planned spend but £0.1m below the trajectory of our NHSI allocated agency ceiling of £7.9m. The Trust's finance and use of resources score is currently 3 and the forecast year-end risk rating is 2

Other issues to note:

- There are currently 18 notifications showing within the NHS Model Hospital site for the Trust.

- The Sunderland IAPT service moving to recovery rate was 55.6% for the month which is above the 50% standard.

- The numbers entering treatment for Sunderland IAPT service has not been achieved in month 2. The reported number in May who have entered treatment in the month is 572 against a target of 663.

- The number of follow up contacts conducted within 7 days of discharge has decreased in the month and is reported at 96.3%.

- The number of follow up contacts conducted within 72 hours of discharge is reported at 81.7% for May 2019.

- There were 118 inappropriate out of area bed days reported in May 2019 against a quarterly target of 144 days.

- The service user and carer FFT recommend score has remained at 89% this month which is in line with the national average.

- There has been a marginal decrease in the number of clusters undertaken at review in May 2019 and is reported below standard at 84.9%.

- The latest published Data Maturity Index Score relates to February 2019 and is reported at 90.6% which is an increase from 89.9% in January 2019. Work continues to review this data internally

Commissioning and Quality Assurance Summary Dashboard – May 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 one Mental Health Act reviewer visit report received since the last report relating to Tweed ward. There were actions which had been resolved along with one which remains unresolved from a previous visit relating to blanket restrictions

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
94%	90%	90%	90%	90%	93%	50%	50%

NHS England and all local CCG's did not achieve the contract requirements during month 1. The areas of underperformance continue to relate to CPA metrics, seven day follow up and in Sunderland IAPT numbers entering treatment
There have been no Commissioner quality visits during the month.
The Specialised Mental Health data submission quality score has decreased to 84.2% at the last submission and work is ongoing to improve this further. Nationally most areas have seen a reduction in the data quality score.

CQUIN - Quarter 1 internal forecast assessment RAG rating:

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

All of the CQUIN scheme requirements have been internally forecast to be achieved at Quarter 1

Internal

Accountability Framework

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

Quality Priorities: Quarter 1 internal forecast assessment RAG rating

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

Waiting Times

The number of people waiting more than 18 weeks to access services has decreased in the month for non-specialised adult services. The number of young people waiting to access children's community services has also decreased in month 2 in Newcastle/Gateshead. There are continuing pressures on waiting times across the organisation, particularly within community services for children and young people. Each locality group have developed action plans which continue to be monitored via the Business Delivery Group and the Executive Management Team.

Workforce

Statutory & Essential Training:

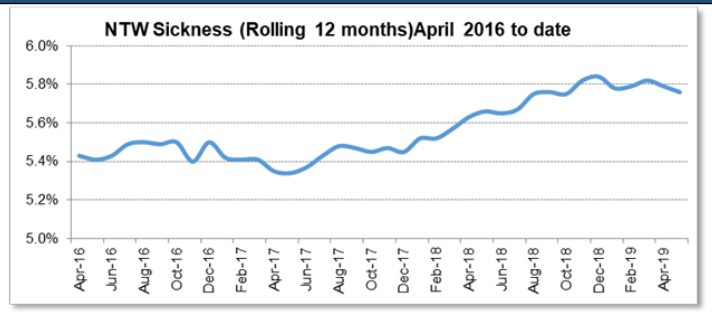
Number of courses Standard Achieved Trustwide:	Number of courses <5% below standard Trustwide:	Number of courses Standard not achieved (>5% below standard):
15	2	2

Information Governance (93.8%), MHA Combined training (80.6%) is within 5% of the required standard. Clinical risk training (76.9%) and PMVA basic training (79.3%) remain at more than 5% below the standard.

Appraisals:

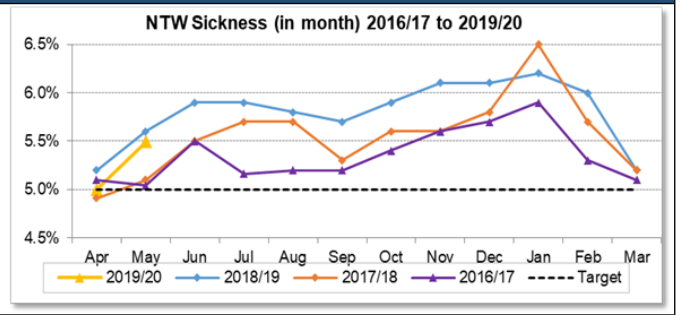
Appraisal rates have decreased to 84.8% in May 19 (was 85.0% last month).

Sickness Absence:



The provisional "in month" sickness absence rate is above the 5% target at 5.49% for May 2019

The rolling 12 month sickness average has decreased to 5.76% in the month



Finance

At Month 2, the Trust has a deficit of £1.2m which is £0.2m ahead of plan. The deficit is mainly due to a payment in April to top of the scale Agenda for Change staff for which income has not yet been received. The forecast surplus is £2.6m which includes £2.6m of Provider Sustainability Funding (PSF) which is in line with the control total.

Agency spend is £1.2m which is £0.1m above Trust planned spend but £0.1m below the trajectory of our NHSI allocated agency ceiling of £7.9m. The Trust's finance and use of resources score is currently 3 and the forecast year-end risk rating is 2.

Financial Performance Dashboard

NTW Income & Expenditure

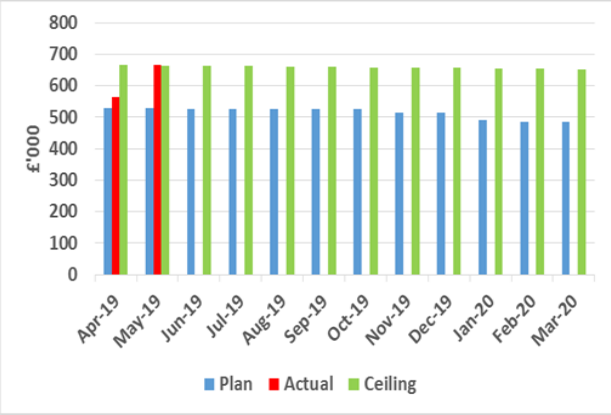
	YTD Plan £m	YTD Actual £m	YTD Variance £m
Income	54.1	54.2	(0.1)
Pay	(44.5)	(44.8)	0.3
Non Pay	(11.0)	(10.6)	(0.4)
Surplus/(Deficit)	**(1.4)**	**(1.2)**	**(0.2)**

Control Totals

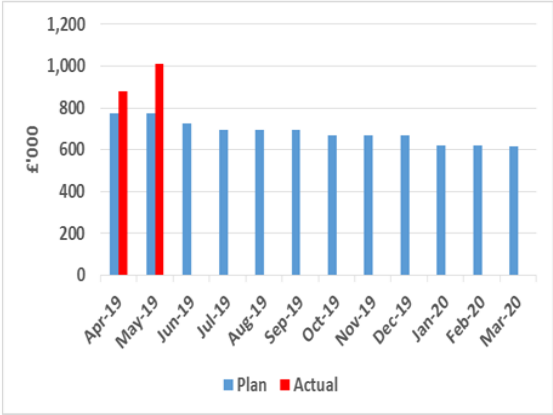
	YTD Plan £m	YTD Actual £m	YTD Variance £m
North	3.7	3.5	0.2
Central	3.0	3.2	(0.2)
South	4.7	5.0	(0.3)
Central	(12.8)	(12.9)	0.1
Surplus/(Deficit)	**(1.4)**	**(1.2)**	**(0.2)**

Key Indicators	Current	Plan Yr-End
Risk Rating	3	2
Agency Spend	£1.2m	£6.8m
FDP Delivery	£1.3m	£10.4m
Cash	£21.5m	£18.4m
Capital Spend	£1.2m	£12.4m

Agency Spend



Bank Spend



Key Issues/Risks

- Surplus/Deficit - £1.2m deficit at Mth2 which is £0.2m ahead of plan. The deficit is mainly due to the AfC Top of Scale payments in April for which income has not yet been received.
- Control Total – The Trust is forecasting delivery of its £2.6m Control Total.
- Risk Rating – The Use of Resources rating is a 3 at Mth2 & the forecast year-end rating is a 2.
- Pay costs are £0.3m above plan at Mth2. Monthly pay spend needs to reduce if the Trust is to meet its control total.
- Budgets have been re-set for 2019/20 based on normalised 18/19 out-turn.
- Agency Spend – Agency ceiling is £7.9m and Trust planned spend is £6.2m in 19/20. Spend at Mth2 is £1.2m which is £0.1m above plan and £0.1m below the ceiling trajectory. Forecast spend is £6.8m.
- Financial Delivery Plan - Savings of £1.3m have been achieved at Mth2 which is in line with plan.
- Cash – £21.5m at Mth2 which is £1.3m above plan.
- Capital Spend - £1.2m at Mth2 which is £1.2m below plan.

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

	06/05/2019		13/05/2019		20/05/2019		27/05/2019	
Medical	89	21	84	31	79	16	79	16
Qual Nursing	53	5	54	5	54	5	59	5
Unq Nursing	456		484		540		562	
A&C	51		49		82		56	
	649	**26**	**671**	**36**	**755**	**21**	**756**	**21**

In May the Trust reported an average of 26 price cap breaches (21 medical and 5 qualified nursing). In May 3 medics were paid over the price cap.

+

Northumberland, Tyne and Wear NHS Foundation Trust
Board of Directors

Meeting Date: 3 July 2019

Title and Author of Paper: **Review of Risk Management Strategy – Lindsay Hamberg, Risk Management Lead**

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

Paper for Debate, Decision or Information: Information

Key Points to Note:

1. The risk management strategy 2017 – 2022 was approved by Trust Board in May 2017. This review is to update Trust Board with regard to progress in meeting the Risk Management Ambitions outlined in the strategy.

2. There are five ambitions within the strategy:-

   - To support greater devolution of decision making and accountability for management of risk throughout the organisation from Trust Board to point of delivery (Board to Ward).

   - To promote a risk culture of monitoring and improvement, which ensures risks to the delivery of Trust's strategic ambitions are identified and addressed.

   - To refine processes, systems and policies throughout the Trust which are in place to support effective risk management and ensure these are integral to activities in the Trust.

   - To support service users, carers and stakeholders through reduction of risks to service delivery and improved service provision.

   - To support the Trust Board in being able to receive and provide assurance that the Trust is meeting all external compliance targets and legislation responsibilities, including standards of clinical quality, NHSI compliance requirements and Trust's licence.

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: To share with the Board progress in relation to the ambitions set out with the risk management strategy 2017 - 2022

Link to Policies and Strategies: Risk Management Strategy and Risk Management Policy

Risk Management Ambition One		
To support greater devolution of decision making and accountability for management of risk throughout the organisation from Trust Board to point of delivery (Board to Ward).		
Why is it important		
It is important to create a culture in which all staff are enabled to influence decisions, support process improvement and outcomes, to reduce risk and improve quality of services. Bringing decision making as close as possible to the Service Delivery.		
What do we want to do?		
To promote a risk culture whereby staff are able to make decisions and improvements to ensure risks to the delivery of the trusts ambitions are identified and addressed.		
How will we do it?	**Update**	**Status**
Review and implementation of a new risk management policy and strategy.	Risk Management Strategy and Policy implemented and embedded within the Trust. Risk Management Strategy was approved by Trust Board May 2017 and the Risk Management Policy was approved in September 2017 by Business Delivery Group.	Complete
Introduction of Risk Appetite to the decision-making framework ensuring risk appetite is linked to planning and decision making through the organisation.	To review the decision-making framework to ensure that the risk appetite is linked to planning and decision making through the Trust.	Ongoing
Embedding of Risk Appetite to aid decision making.	Completed the embedding of the Risk Management Policy. Delivery of bespoke training to support Corporate and CBU. Support Wards and Teams with their individual risks. Structured support to Risk Review Meetings.	Complete
Risk awareness sessions to support risk management culture change.	Risk awareness training has taken place across the Trust with sessions delivered to operational and corporate teams and individuals. Risk awareness training is included within the Trust induction programme.	Complete
The Risk Management Strategy Ambition One: There will be consideration taken to implement and embed the ambitions within North Cumbria.		

Risk Management Ambition Two		
To promote a risk culture of monitoring and improvement, which ensures risks to the delivery of the Trust's ambitions are identified and addressed.		
Why is it important		
It is important that we enable individual staff and groups to take a risk based approach in a consistent way with a common acceptance of the importance of the continuous management of risk.		
What do we want to do?		
To develop an effective risk culture which ensures individual staff and groups are able to take the right risks in an informed way.		
How will we do it?	Update	Status
Introduce nominated risk champions throughout the trust to champion risk management and help to inform and guide staff.	To change champions to a network approach. To implement a network with representatives from each area to offer support, improvements, lessons learned to grow the risk culture in the Trust.	Ongoing
Review and implementation of a new risk management policy and strategy.	Risk Management Strategy and Policy implemented and embedded within the Trust. Risk Management Strategy was approved by Trust Board May 2017 and the Risk Management Policy was approved in September 2017 by Business Delivery Group.	Complete
Risk Management Development sessions to support a change in risk culture.	BAF and CRR risks are reported to the Board and Sub Committees quarterly. Board Development sessions arranged to monitor the Risk Management Policy, Strategy and the Risk Appetite. Support is provided to wards and teams and an identified reporting structure is in place.	Complete
Review and ensure appropriate risk management governance is in place throughout the Trust.	This is done throughout the organisational structure from ward to Board. Wards and teams are aware of the risk process and if required to escalate. Within Corporate and CBU level any breaches in risk appetite are reported to the Sub Committees. Audit Committee and the national Risk Management training sessions.	Complete
The Risk Management Strategy Ambition Two: There will be consideration taken to implement and embed the ambitions within North Cumbria.		

Risk Management Ambition Three		
To define processes, systems and policies throughout the Trust which are in place to support effective risk management and ensure these are integral to activities in the Trust.		
Why is it important		
It is important that risk management has a process with a clear purpose, reliable inputs, well-designed activities and value-added outputs. A well-articulated systematic approach to risk management will allow us to provide a benchmark and ensure we are responsive to the Trust's risk management needs.		
What do we want to do?		
Define a Risk Management standard throughout the organisation ensuring a robust systematic approach to risk management.		
How will we do it?	Update	Status
Launch and roll out of a new Trust web-based platform for capturing risk and risk registers to support standardised recording and reporting.	Web based risk has been rolled out within the Trust to the Board Assurance Framework, Group/ Corporate and Corporate Business Unit/ Divisional/ Specialty level. Web Risk to be rolled out as phase two in February 2020.	Ongoing
Implementation of a Trust-wide risk management training package and information resource available to all staff.	Arrange to speak to the Head of Informatics to establish the appropriate team/person to develop an e-learning package. Currently organising Masterclass Risk Management Training to all staff in NTW.	Ongoing
Explore the introduction of risk management as part of the Trust-wide induction package for all new staff.	Induction risk training is now available in NTW and is part of the rolling induction package.	Complete
The Risk Management Strategy Ambition Three: There will be consideration taken to implement and embed the ambitions within North Cumbria.		

Risk Management Ambition Four		
To support service users, carers and stakeholders through the reduction of risks to service delivery and improved service provision.		
Why is it important		
In an increasingly complex, competitive NHS environment NTW need to continually advance our risk management practices, building a strong foundation of protection and compliance and expand focus on risk factors that impact strategic decision-making and operational performance.		
Where do we want to do?		
Work collaboratively with other corporate departments and sub committees of the board to understand the world around us, triangulate data and information collaboratively to improve service provision and reduce risks to service delivery.		
How will we do it?	**Update**	**Status**
Implement network meetings with other services of risk interest to ensure we use all our resources available to minimise risk. Develop information sharing processes to ensure identification of emerging risks and triangulation.	To date there has been ongoing bespoke meetings and training sessions within 1:1 meets and team meetings. To implement a network with representatives from each area to offer support, improvements, lessons learned to grow the risk culture in the Trust. Arrange quarterly networking support meetings.	Ongoing
Design and implementation of a Risk Management Dashboard.	The risk management dashboard is currently under development with discussions taking place within relevant forums. Agreement and approval required for the design and content of the dashboard. This may require some changes to the safeguard system to allow pertinent information to be shown on the dashboard.	Ongoing
The Risk Management Strategy Ambition Four: There will be consideration taken to implement and embed the ambitions within North Cumbria.		

Risk Management Ambition Five		
To support the Trust Board in being able to receive and provide assurance that the Trust is meeting all external compliance targets and legislation responsibilities, including standards of clinical quality, NHSI compliance requirements and Trust's licence.		
Why is it important		
The systems of internal control within an organisation is an important component in the successful management of its risks. Internal controls are concerned with the methods, procedures and checks that are in place to ensure that the organisation is able to meet its ambitions.		
What do we want to do?		
Integrate risk management and ensure processes are in place to allow staff to identify, monitor and communicate risks that may affect the delivery of strategic ambitions.		
How will we do it?	Update	Status
All staff to have access to training, guidance and support in the delivery of effective risk management systems	Risk awareness training has now been introduced into the Trust induction programme and bespoke risk training, guidance and support is offered to Corporate and Operational services as required regarding risk management.	Complete
Develop internal partnerships to enhance risk management.	To implement a risk management network with representatives from each area to offer support, improvements, lessons learned to grow the risk culture in the Trust. Arrange quarterly support meetings.	Ongoing
Monitoring and review of assurance limitations of internal audits to ensure good governance is maintained.	The Risk Management Lead to receive audits and identify audit links to the NTW's Board Assurance Framework and Corporate Risk Register.	Complete
The Risk Management Strategy Ambition Five: There will be consideration taken to implement and embed the ambitions within North Cumbria.		

Northumberland, Tyne and Wear NHS Foundation Trust

Risk Management Strategy 2017-2022

Introduction

Northumberland, Tyne and Wear NHS Foundation Trust was established in 2006. We provide a wide range of mental health, learning disability and neuro-rehabilitation services to a population of 1.4 million people in the North East of England. We are one of the largest mental health and disability organisations in the country with an income of approximately £300 million. We employ over 6,000 staff, operate from over 60 sites and provide a range of comprehensive services including regional and national services.

In September 2016 the CQC rated our Trust as "Outstanding" and we became one of only two non-acute Trust's in England to be awarded an overall rating of outstanding.

The Risk Management Strategy will work alongside the Trust-wide Service Strategy and Trust-wide Supporting Strategies to achieve the Risk Management Ambitions for the next five years.

Risk Management is an integral part of the trust's quality, governance and performance management processes. All staff have a role in considering risk and helping to ensure it does not prevent the delivery of safe and high quality services.

The Board of Directors with the support of its committees have a key role in ensuring a robust risk management system is effectively maintained and to lead on a culture whereby risk management is embedded across the Trust through its policy, strategy and plans, setting out its strategic ambitions and priorities in respect of risk management when delivering a safe high quality service.

Effective Risk Management is the responsibility of every member of staff, either permanent, temporary or to those contracted working within, or for, the Trust.

Ambitions and implementation

This strategy is based on achieving the below 5 ambitions.
From April 2017 to March 2022 the Trust will aim to achieve the following Risk Management Ambitions:

1. To support greater devolution of decision making and accountability for management of risk throughout the organisation from Trust Board to point of delivery (Board to Ward).

2. To promote a risk culture of monitoring and improvement, which ensures risks to the delivery of Trust's strategic ambitions are identified and addressed.

3. To refine processes, systems and policies throughout the Trust which are in place to support effective risk management and ensure these are integral to activities in the Trust.

4. To support service users, carers and stakeholders through reduction of risks to service delivery and improved service provision.

5. To support the Trust Board in being able to receive and provide assurance that the Trust is meeting all external compliance targets and legislation responsibilities, including standards of clinical quality, NHSI compliance requirements and Trust's licence.

Risk Management Ambition One	
To support greater devolution of decision making and accountability for management of risk throughout the organisation from Trust Board to point of delivery (Board to Ward).	
Why is it important	
It is important to create a culture in which all staff are enabled to influence decisions, support process improvement and outcomes, to reduce risk and improve quality of services. Bringing decision making as close as possible to the Service Delivery.	
What do we want to do?	**How will we do it?**
To promote a risk culture whereby staff are able to make decisions and improvements to ensure risks to the delivery of the trusts ambitions are identified and addressed.	Review and implementation of a new risk management policy and strategy. Embedding of Risk Appetite to aid decision making. Introduction of Risk Appetite to the decision making framework ensuring risk appetite is linked to planning and decision making through the organisation. Risk awareness sessions to support risk management culture change.

Risk Management Ambition Two	
To promote a risk culture of monitoring and improvement, which ensures risks to the delivery of the Trust's ambitions are identified and addressed.	
Why is it important	
It is important that we enable individual staff and groups to take a risk based approach in a consistent way with a common acceptance of the importance of the continuous management of risk.	
What do we want to do?	**How will we do it?**
To develop an effective risk culture which ensures individual staff and groups are able to take the right risks in an informed way.	Introduce nominated risk champions throughout the trust to champion risk management and help to inform and guide staff. Review and implementation of a new risk management policy and strategy. Risk Management Development sessions to support a change in risk culture. Review and ensure appropriate risk management governance is in place throughout the trust.

Risk Management Ambition Three	
To define processes, systems and policies throughout the Trust which are in place to support effective risk management and ensure these are integral to activities in the Trust.	
Why is it important	
It is important that risk management has a process with a clear purpose, reliable inputs, well-designed activities and value-added outputs. A well-articulated systematic approach to risk management will allow us to provide a benchmark and ensure we are responsive to the Trust's risk management needs.	
What do we want to do?	**How will we do it?**
Define a Risk Management standard throughout the organisation ensuring a robust systematic approach to risk management.	Launch and roll out of a new Trust web based platform for capturing risk and risk registers to support standardised recording and reporting. Implementation of a Trust-wide risk management training package and information resource available to all staff. Explore the introduction of risk management as part of the Trust-wide induction package for all new staff.

Risk Management Ambition Four	
To support service users, carers and stakeholders through the reduction of risks to service delivery and improved service provision.	
Why is it important	
In an increasingly complex, competitive NHS environment NTW need to continually advance our risk management practices, building a strong foundation of protection and compliance and expand focus on risk factors that impact strategic decision-making and operational performance.	
Where do we want to do?	**How will we do it?**
Work collaboratively with other corporate departments and sub committees of the board to understand the world around us, triangulate data and information collaboratively to improve service provision and reduce risks to service delivery.	Implement network meetings with other services of risk interest to ensure we use all our resources available to minimise risk. Develop information sharing processes to ensure identification of emerging risks and triangulation. Design and implementation of a Risk Management Dashboard.

Risk Management Ambition Five	
To support the Trust Board in being able to receive and provide assurance that the Trust is meeting all external compliance targets and legislation responsibilities, including standards of clinical quality, NHSI compliance requirements and Trust's licence.	
Why is it important	
The systems of internal control within an organisation is an important component in the successful management of its risks. Internal controls are concerned with the methods, procedures and checks that are in place to ensure that the organisation is able to meet its ambitions.	
What do we want to do?	How will we do it?
Integrate risk management and ensure processes are in place to allow staff to identify, monitor and communicate risks that may affect the delivery of strategic ambitions.	All staff to have access to training, guidance and support in the delivery of effective risk management systems. Develop internal partnerships to enhance risk management. Monitoring and review of assurance limitations of Internal audits to ensure good governance is maintained.

Risk Appetite

Risk appetite is the level of risk the Trust Board deem acceptable or unacceptable based on the specific risk category and circumstances/situation facing the Trust. This allows the Trust to measure, monitor and adjust, as necessary, the actual risk positions against the agreed risk appetite.

Using the Good Governance Institute risk appetite matrix the Trust Board has adopted a risk appetite statement which is the amount of risk it is willing to accept in seeking to achieve its Strategic Ambitions. As well as the overall risk appetite statement, separate statements are provided for each risk category in the below table.

Risk Appetite Statement

Northumberland, Tyne and Wear NHS Foundation Trust recognises that its long term sustainability depends upon the delivery of its strategic ambitions and its relationships with its service users, carers, staff, public and partners. As such, Northumberland, Tyne and Wear NHS Foundation Trust will not accept risks that materially provide a negative impact on quality.

However NTW has a greater appetite to take considered risks in terms of their impact on organisational issues. NTW has a greatest appetite to pursue Commercial gain, partnerships, clinical innovation, Financial/Value for Money and reputational risk in terms of its willingness to take opportunities where positive gains can be anticipated, within the constraints of the regulatory environment.

Category	Risk Appetite	Risk Appetite Score
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.	**20-25**
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**

The below table shows risk appetite tolerance scores for each risk appetite. When a risk exceeds a risk appetite tolerance score this will be used as a framework for a risk to be communicated and reported upwards.

A suggested target risk is also added to help inform target risk scoring discussions. The target risk is provided as a guide and not an absolute expectation.

APPETITE	NONE	VERY LOW	LOW	MODERATE	HIGH
Risk tolerance Score	**N/A**	**1-5**	**6-10**	**12-16**	**20-25**
Target risk score	**N/A**	**0**	**4**	**9**	**15**

Risk Appetite and the Clinical Groups/Corporate Area

Risk appetite is linked to the Safeguard Risk Management System. The Safeguard system asks the user to choose a risk appetite category when recording a risk. The categories are linked to the risk appetite tolerance scores and where a risk breaches the Trust Risk Appetite the user will see the risk appetite rag rating change to red.

The Risk Management Lead will also have planned weekly audits in place to capture any risk appetite breaches that have not been reported/communicated as a control mechanism.

All risks which breach the Trust risk appetite will be reported through the Trust Governance Structures to the Board of Directors. This replaces the current system of all risks 15 and above being reported.

Risk Escalation

Risk appetite does not replace the escalation process defined within the risk management policy. Risks continue to be managed at the lowest and most appropriate level in the organisation and only escalated when action is required outside the control of the current risk owner.

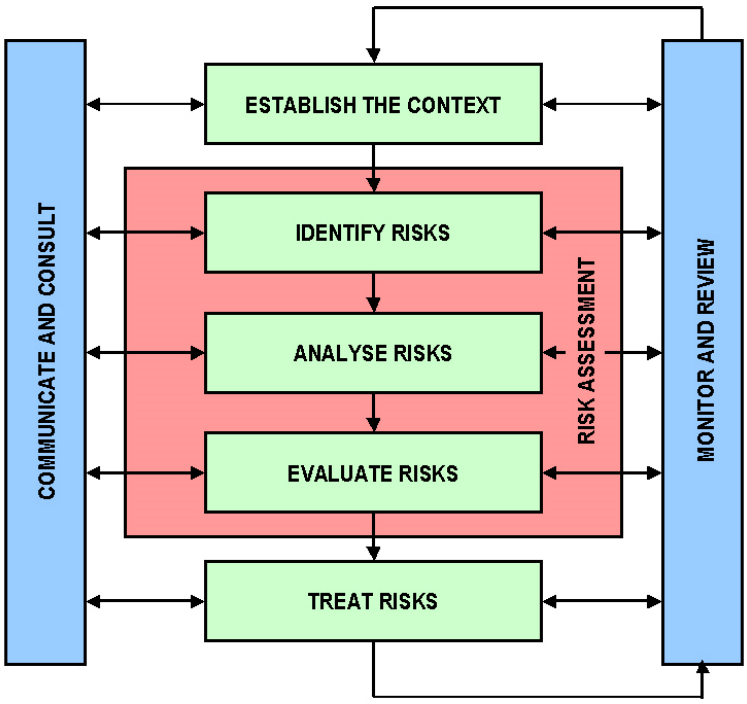
Risk Management System

Risk Management System

Definition
The Institute of Risk Management define Risk Management as:
"The process which aims to help organisations understand, evaluate and take action on all their risks with a view to increasing the probability of success and reducing the likelihood of failure"

Figure 1 below shows, risk management involves the identification, analysis, evaluation and treatment of risks or more specifically recognises which events may lead to harm and therefore minimising the likelihood (how often) and consequences (how bad) of these risks occurring.

Figure 1 – Risk Management Process.



* establish the context can also be described as establish the facts.

Identifying Risks

Risks facing the organisation will be identified from a number of sources, for example:

- Risk arise out of the delivery of day to day work related tasks or activities.
- The review of strategic or operational ambitions.
- As a result of an incident or the outcome of investigations.
- Following a complaint, claim or patient feedback.
- As a result of a health and safety inspection/assessment, external review or audit report.
- National requirements and guidance.

The identification, assessment, and control of risk is delegated to directors, managers, departments, wards and teams within NTW, together with the management and data entry onto a paper or electronic risk management system.

Analysing/Assessing Risks

The purpose of assessing and scoring a risk is to estimate the level of exposure to a particular risk, which will then help to inform where responses to reduce or better manage a risk can be taken.

Risk Evaluation and Scoring

Risks are scored using a risk scoring matrix. The Trust has adopted a 5x5 matrix with the risk scores taking into account the impact and likelihood of a risk occurring. Each risk is assessed by estimating the likelihood of a risk happening and multiplying it by the impact of the risk if it did happen. The risk evaluation and scoring guidance can be found in the risk management policy.

Each risk score is assigned 3 risk scores:

Initial Risk Score	Current Risk Score	Target Risk Score
The score on identification before any controls/mitigating actions are proposed.	The residual risk, the score with current controls/actions in place.	The risk score after improved actions have been achieved and improved controls are added.

Controls and Mitigation (action planning)

When considering the likelihood of a risk occurring, staff need to develop and consider the actions that can be put in place;

a. The avoidance of the risk – by not proceeding with an action which can produce the risk.

b. The reduction of the likelihood of a risk occurring or should it occur, the reduction of the potential impact of the risk occurring.

c. The Transfer of a risk to another party, either in part or in whole.

d. The retention of risk, after they have been reduced or transferred, there may be some residual risks which are retained (although plans to control and mitigate these risks will still be required)

e. The removal/elimination of risk.

These plans to avoid or reduce risk are more commonly referred to as the risk action plan.

Assurance

A key element of the Trust's risk management system is providing assurance that we manage risks effectively by ensuring the effectiveness of controls and actions being put in place to mitigate the impact of any risks.

Assurance Definition

Assurance	Definition
Provides:	Evidence/Certainty/Confidence
To:	Staff/Management/Directors/Organisation
That:	What we are currently doing is making an impact on risks.

Risk Escalation

The risk rating above can determine how a risk will be managed and escalated from ward/team to directorate or corporate area. Risks that exceed a risk appetite tolerance are regarded as significant risks and must be reported/communicated and discussed with the responsible senior member of staff.

Risks that exceed a risk appetite tolerance may still be managed at a lower level once communicated to the responsible senior member of staff. The Risk escalation and reporting process can be found in the risk management policy.

Risk Registers

A Trust-wide risk register is a log of risks of all kinds that threaten the delivery of ambitions and the delivery of services. It should be a live document which is populated through the risk assessment and evaluation process. Risk Registers operate at all levels in the trust – at local ward, department and service level, major projects and programmes, directorate, Group and Corporate level**.** Safeguard Risk Management System is the main system used to record risks although paper registers are currently still used in some areas.

Corporate Risk Register/Board Assurance Framework

The Corporate Risk Register and Board Assurance Framework are key documents used to record and report the Trust's key Strategic Ambitions, risks, controls and assurances to the board. The Corporate Risk Register and Board Assurance Framework ensures that the Trust have assurance that risks to the delivery of its Strategic Ambitions are successfully managed. The Corporate Risk Register and Board Assurance Framework takes into account the recommendations from Audit, Executive Leads and board sub-committees as to what should be included, amended or removed. The Framework is updated and approved by the Board of Directors.

Training and Support

Risk management training, guidance and advice is provided through the Risk Management Lead. An online risk management training package will be made available for existing staff and new members of staff.

Evaluation and Review

Progress on the delivery of this strategy will be undertaken on a day to day basis by the Risk Management Lead and progress will be continually reviewed by the CDT Risk Management Sub Group.

Duties, Accountabilities and Responsibility.

All staff in the trust have responsibilities relating to risk management. The key risk management responsibilities are documented below.

Role	Responsibility
Chief Executive Officer (CEO)	The chief executive as 'accountable officer' has overall accountability and responsibility for risk management within the trust, ensuring the implementation of an effective risk management system.
Executive Director of Commissioning and Quality Assurance	The Executive Director of Commissioning and Quality Assurance has a responsibility to ensure that the Trust has a robust Risk Management Strategy and policy in place, integrated with the Trust's Strategic business plan and the Trust's governance structure. This includes ensuring that there is a robust and effective Board Assurance Framework, Strategy and Policy.
Risk Management Lead	The Risk Management Lead supports the Executive Director of Commissioning and Quality Assurance in the day to day management of the Trust's Corporate Risk Register and Board Assurance Framework. The Risk Management Lead supports the review, development and embedding of the Risk Management Strategy and policy across the Trust to ensure that there is an effective Risk management System in place.
Executive Directors and Group Director Triumvirates	These staff are responsible for the implementation of this policy at corporate and service level including the establishment and continual management of Group and Directorate risk registers and project risks registers. They are responsible for managing risk within their Groups and Directorates.
All Staff	Management of risk is a fundamental duty of all staff. All staff must ensure that identified risks and incidents are reported in order to ensure appropriate actions are taken. These requirements also extend to agency staff.

Roles	Responsibilities
Partner Organisations and Contractors	Specific risks identified in the Trust will be shared with any other relevant organisation working in partnership with the Trust.
Board Of Directors	The board of directors are accountable and responsible for ensuring that the Trust has and effective process for identifying and managing risk of all types. The Board of Directors receive and consider reports from its Sub-Committees as necessary.
Sub Committees of the Board	Each sub-committee of the board has a role for risks pertaining to their area of focus. They have roles in reviewing and the management of the risks held on the Corporate risk register, board assurance framework and trust wide risks. They review the Board Assurance Framework and ensure that the board of directors receive assurance that effective controls are in place to manage corporate risk and report on any significant risk management and assurance issues.
Audit Committee	The Audit Committee is a sub-committee of the Board and is responsible for providing an independent and objective view of internal control.
Corporate Decisions Team	The Corporate Decisions Team ensure effective implementation of the risk management system, development of the board assurance framework and report to board sub committees on any significant matter relating to risk management.
Risk Management Sub Group	The Risk Management Sub Group is a Sub-committee of the Corporate Decisions Team. Risk Management Sub Group lead on the development of and ensure compliance with the organisation's risk assessment and management systems and processes and report to CDT.

Northumberland, Tyne and Wear NHS Foundation Trust

Board of Directors Meeting

Meeting Date: Wednesday 3rd July 2019

Title and Author of Paper: Interim NHS People Plan Claire Vesey – Head of Workforce Planning Developments

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

Paper for Debate, Decision or Information: Information and debate

Key Points to Note:

On 3rd June 2019 NHS Improvement, NHS England and HEE published the interim People Plan https://www.longtermplan.nhs.uk/wp-content/uploads/2019/05/Interim-NHS-People-Plan_June2019.pdf. (The full report from the link is available 'for information' on the AdminControl system).

It acknowledges that workforce supply is the biggest challenge facing the NHS but is clear that the quality of staff experience must be improved. A final people plan will be published late in 2019 following the spending review.

The Interim People Plan is structured into key themes:

1. Making the NHS the best place to work
2. Improving our Leadership Culture
3. Addressing urgent workforce shortages across nursing
4. Delivering 21st century care
5. A new operating model for workforce

The plan has been developed following engagement with various stakeholders to ensure wide input into the plan. It has been compiled under the direction of Baroness Dido Harding, NHS Improvement Chair and Senior Responsible Officer, Julian Hartley (Leeds Teaching Hospitals).

NHS organisations will be expected to undertake initial actions. Following the final People Plan publication there will be further actions to implement.

A summary of the plan has been compiled by NHS providers: https://nhsproviders.org/resource-library/briefings/on-the-day-briefing-nhs-interim-people-plan

Risks Highlighted to Board:

The CQC well-led framework and Oversight framework will be amended to reflect actions and deliverables within the People Plan.

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

Please state Yes or No

If Yes please outline

Equal Opportunities, Legal and Other Implications: n/a

Outcome Required / Recommendations:

Support in taking forward this work - workforce development and OD initiatives are interdependent and the need to ensure these are aligned is a priority area.

Link to Policies and Strategies:

NHS long Term Plan

Trust wide Workforce Strategy 2017 – 2022.

Five Year Forward View for Mental Health.

HEE Mental Health Workforce Plan: Stepping Forward to 2020/21

Developing Workforce Safeguards 2018 – NHSI

Trust wide Clinical Strategies

Interim NHS People Plan

1.0 Overview

The vision within the People Plan outlines a transformation of the workforce, moving towards a multidisciplinary approach with greater alignment to the wider system agenda. It acknowledges the cultural shift which will be needed to support different ways of working, skill mix changes and a move away from professional silos and outlines how leadership culture is critical to this change.

2.0 Themes within the interim People Plan

The Plan is themed into five key areas:

1. Making the NHS the best place to work

The plan aims to tackle high levels of sickness absence, growing work place pressure and frustration, rising levels of bullying and harassment and tackle the poor workplace experiences reported by BME staff.

NHS organisations will be asked to contribute ideas to the development of a new offer for staff setting out the support they can expect. This offer will recognise the generational differences across the workforce and their resulting expectations of a modern employer including flexible working, training, career development, freedom to speak up, health and wellbeing and robust equality and diversity practices. A balanced score card will be used to assess organisations in these areas via the Oversight Framework and CQC well-led inspection.

A national review of NHS terms and conditions is underway, including NHS pensions and the need to address the lifetime allowance issue which impacts upon the retention of senior clinical staff. A consultation is expected to take place which may lead to changes from April 2020.

2. Improving the Leadership Culture

The plan states that all NHS leaders should have a ‘compassionate and inclusive culture’ with a greater focus on system working, collaborative talent management and a range of measures to provide greater board assurance.

An agreed set of competencies for senior leaders will be developed by NHS England/NHSI and a new compact setting out the ‘gives and gets’ to support the development of senior leaders will be established.

Leadership priority areas are identified as:

- System leadership
- Quality improvement
- Talent management
- Inclusion and diversity

These apply equally to ALB’s in recognition of the role they have in fostering a new leadership culture.

3. Addressing urgent workforce shortages across nursing

Whilst the plan advocates a move away from separate professions, workforce supply across certain areas remains a concern. In acknowledgement of the rising number of nursing vacancies and the profession being a critical part of a multi professional skills based approach, a specific area of focus will be to address vacant nursing posts. This is set out across various routes including increased undergraduate courses, career pathways and entry routes, return to practice and a continued focus on safer staffing.

There will be an expansion of the retention Direct Support Programme (NTW were part of cohort 3) and the launch of a single campaign that reflects modern day nursing careers.

An increase in clinical placements by 25% will take place by September 2019 and improved coordination of international recruitment with a national procurement framework for lead agencies will be put in place.

It is envisaged the final People Plan will cover the development of a 'blended learning nursing degree' programme, a review of entry routes into the profession – building upon the nurse apprenticeship and nurse associate routes, and a greater focus on community and primary care nursing. CPD funding will be reviewed with the aim of achieving a phased restoration of CPD funding levels over 5 years.

4. Delivering 21st century care

Changing skill mix to support the emerging models of care across the wider ICS will be needed, including the scaling up of new roles via a multi-professional credentialing approach and utilising the apprentice levy more effectively. Ahead of the final People Plan there will be further planning work across all clinical professions, specifically:

- Nursing - the expansion of the Nursing Associate role.
- Medical – expansion of doctors in primary care, support for shortage areas and development of more generalist roles
- AHP and other roles – expansion of the multi-disciplinary team starting with primary care networks.

Clinical teams will be supported to take increasing ownership of how they plan and deploy the workforce and will be supported by the *Releasing Time to Care* programme which will focus on the use of technology to increase staff productivity. A review of clinical placement capacity and experience will take place to enable the move towards future workforce transformation.

5. A new operating model for workforce

There is acceptance that workforce planning needs to be part of a wider planning approach and the risk of this being done in isolation subsequently impacts upon workforce supply. It sets out an approach whereby workforce activities are

happening at the right level, whether that be in provider trusts, locally, regionally or nationally.

The plan advocates that over time ICSs will take on greater responsibility for regional people planning and transformation activities but this will not happen without the appropriate level of maturity.

Provider Trusts will need to ensure that a clear vision for the organisation is aligned to the overall ambition of the ICS. Recruiting, retaining, developing, inclusivity, diversity, well-being and health will be key priorities in a compassionate and improvement focused culture which supports the workforce.

3.0 Developing the final People Plan

Work on the final plan will be developed by the National People Board and an advisory board (chaired by Baroness Harding). A range of stakeholders will be invited to contribute resulting in a fully costed plan which will be published following the autumn spending review.

The final plan will include:

- More detail on changes to professional education and CPD investment
- More detail on the additional staff needed to support the changes which lie ahead
- Measures to develop leadership capability and the subsequent culture change which must be embedded.

4.0 Taking forward the interim People Plan actions in NTW

Work is already underway across a number of areas. Recognition of workforce independencies and the need to align resulting priorities is ongoing and includes:

- Workforce Planning
- Equality and Diversity
- Talent Management
- Retention and Reward
- Health and Wellbeing
- Career Development and Pathways

<u>Workforce Planning</u>

The Trust has developed its approach to workforce planning over the last 24 months, adopting the principles of collective leadership and placing the planning decisions at a local level. In June 2019, the Trust will have clinical workforce plans which future forecast over a 5 year period and from these, analysis will further enable the discussion and challenge around workforce decisions and identify emerging workforce risks and mitigate against these via a collaborative and solution focused approach. The clinical workforce plans represent an alignment between workforce, finance and service planning at a CBU, Locality and Trust wide level.

The workforce plans will be refreshed annually (or in line with service developments) as part of the annual planning process and demonstrate a joined up approach to planning.

Equality and Diversity

The Trust Equality and Diversity strategy has recently been refreshed and actions resulting from this continue to be embedded. This work is complemented by the development of a Trust quality priority which seeks to improve clinical effectiveness by removal of barriers people with protected characteristics face in accessing our services. Ongoing work to take forward actions in relation to the WRES and WDES continue, as does the establishment of further equality and diversity networks to support those members of the workforce who have protected characteristics.

Talent Management

Programmes aligned to the talent management agenda are emerging at both a regional and national level. A trust wide approach to talent management is currently being developed which will align to national and regional developments, whilst supporting internal priority talent areas in response to future workforce planning needs.

Retention and Reward

Actions have been developed and embedded as part of the Trust participation in cohort 3 of the Direct Support Programme for Retention. Feedback from NHSI has been positive and work remains ongoing in this area. A recent revision to the exit process has seen an increase in exit survey response rates from 16% to 40%. The information obtained from these responses continues to support and inform the development of future retention work.

Health and Wellbeing

Campaigns are underway at both locality and trust level. The Trust will soon be assessed for IIP status and has a ‘Maintaining Excellence’ standard with the Better Health at Work Award. A Regional Streamlining group is being established with a focus on health and wellbeing of which NTW will have representation. Ongoing work continues in relation to the management of sickness absence and review of occupational health services via the tender route.

Career Development and Pathways

The NTW Academy has established a ‘Grow your own’ programme for degree level registered nursing apprenticeships and in 2019 the Trust began an Advanced Clinical Practitioner Programme with the University of Sunderland. Work is currently in progress to develop the Advanced Practice across professions. The internal Talent Management approach will advocate a career pathway across all professions and feature a specific management pathway. The use of the apprentice levy, stretch roles and practical placements will support the development of such pathways.

5.0 Conclusion

Trust Board is asked to note the content of this paper. Further updates will be given as work progresses and the final People Plan is published.

Claire Vesey

Head of Workforce Developments

Northumberland, Tyne and Wear NHS Foundation Trust

Board of Directors Meeting

Meeting Date: 3 July 2019
Title and Author of Paper: NTW ACADEMY - Board Briefing June 2019 Gail Bayes, Deputy Director, NTW Academy Development
Executive Lead: Gary O'Hare, Executive Director of Nursing/Chief Operating Officer
Paper for Debate, Decision or Information: For information
Key Points to Note: • Progression across all areas of the Academy development work plan • Sustainable expansion of the wider apprenticeship programme to meet organisational needs, deliver efficiency, enhance staff opportunities and meet national targets • The successful launch of the Degree Level Nursing Apprenticeships in January 2019 • Expansion of development into Cumbria • Apprenticeship Business Plan attached as an appendix for detail
Risks Highlighted to Board : Risk is managed via the Academy Board There is nothing of significance to report to Trust Board
Does this affect any Board Assurance Framework/Corporate Risks? Please state **Yes** or **No: No** If Yes please outline
Equal Opportunities, Legal and Other Implications: None
Outcome Required: Note for information
Link to Policies and Strategies: NTW Nursing Strategy 2019-24 NTW Workforce Strategy

Northumberland, Tyne and Wear NHS Foundation Trust

NTW ACADEMY

Board Briefing June 2019

Created in 2017, the NTW Academy has implemented substantial change across the organisation, bringing a range of positive benefits

It originally had seven main components

1. Continue good practice and models which already exist and work well

2. Review and enhance delivery of current models using technology

   Both of these work-streams have progressed significantly. The modernisation of existing good practice models and the use of technology has contributed significantly to the 'Creating Capacity to Care' (CC2C) aim of the organisation, with an estimated saving of 29,000 hours of clinical time in 2018/19 by switching to an improved on-line learning system for specific topics. The slow but steady increase of Skype models of delivery is adding to the efficiencies. The Academy continues to develop new methods and applications as they arise.

3. Identify and deliver new models to best meet service need and maximise use of the new national apprenticeship opportunities at all levels and for all disciplines, clinical and non-clinical.

   NTW has an Apprenticeship Business Plan (attached). It aims to use apprenticeships across our workforce to meet organisational work-force planning needs, maximise the use of the Apprenticeship Levy and meet the required national targets for public sector organisations. NTW has a mixed model of apprenticeships – employing entry level apprentices and enrolling existing staff onto apprenticeship programmes at a range of levels.
   In 2018/19 NTW were 1 of only 2 Trusts in the region to achieve the public sector target of 2.3%, with 3.34% of the workforce being enrolled onto an Apprenticeship Programme – that's over 200 staff, the bulk across admin and healthcare with the rest across IT, finance, engineering and management. This is a sustainable amount which has been managed in a planned way to ensure capacity for learning within teams, in line with work-force plans.
   For new entrants to the organisation as apprentices, NTW has an 80% conversion rate of retaining that knowledge in the organisation following completion of qualification.

   NTW is on track to break even with its use of the Apprenticeship Levy by mid-2020/21. There will be an additional amount of Levy to transfer to NTW later in 2019 from CPFT along with a small number of staff currently enrolled on apprenticeships. The Academy is confident it can adapt and expand the existing Cumbria apprenticeships to the NTW model of need and sustainability.

4. Create a cohesive framework with previously 'un-joined' parts of the organisation to maximise efficiencies and close gaps in service delivery

   This work-stream has changed direction a number of times since it was originally planned to fit in with changing organisational need. Rather than duplicate work, the focus of this is now aligned to the CC2C project, managed via Business Delivery Group (BDG). NTW Academy's role is to be responsive to the needs of the CC2C projects around the organisation

5. Nursing Academy.

   The NTW Nursing Strategy 2014 – 19 articulated a career development route for individuals across the nursing work-force, from support worker, to registered nurse, to nurse consultant. Work was well underway by 2017 to develop support staff using vocational qualifications but the main route to Registered Nurse (RN) was via Universities and a three year fee of circa £27,000. The introduction of the Apprenticeship Levy opened the door to an array of possibilities. Whilst some Universities offered apprenticeship programmes to RN level, they simply offered it as an alternative to the traditional route, with applicants needing to be released full time for three years minimum. For NTW, this was neither affordable nor desirable. The University of Sunderland was prepared to listen and together with NTW and key NE Trusts, developed a different approach whereby apprentices could study to become RNs across a three or four year programme BUT, would only need to be released from the workplace for approximately 50% of this time. Following an intensive period of work to have the framework co-produced, this genuine employer-led programme was validated in 2018.

   NTW saw its first cohort of 39 apprentices enrol onto the programme in January 2019 and a further 19 will begin in July 2019.
   A January 2020 cohort is being planned which will include the Cumbria locality.

   Concurrently, the development of the Nursing Associate apprenticeship standard, the conversion opportunity for Assistant Practitioner to Nursing Associate and the introduction of the Masters Level MSc for Advanced Clinical Practice have all contributed the a holistic framework from career progression. It is now possible for nursing staff to follow a career progression pathway from band 2 Support Worker to band 8 Nurse Consultant whilst in NTW employment, a key aim of the Nursing Strategy 2019-24.

   The Nursing Academy Business Case for investment (approved in March 2018) indicated an NTW break even position of supply of RNs meeting demand by 2021/22. It is too early to make accurate predictions, particularly with the inclusion of the Cumbria locality, but the Academy is working to expand opportunity to Cumbria and is confident this breakeven position will be met.

   NTW Nursing Academy, a collaboration of skills and determination between the Academy and the Nursing Directorate, continues to go from strength to strength to meet the work-force needs of the organisation through opportunity and support to enhance retention.

6. Leadership (Phase I – medical; Phase II – multi-disciplinary); this aim changed to multi-disciplinary Leadership and Management development during 2018 based on emergent workforce planning information

   NTW has identified a key gap at senior level development across disciplines, namely those at bands 7 and 8 who wish to develop into Associate Director level posts.

   Whilst Leadership development has been available and desirable for a number of years, at various levels, on its own it does not prepare individuals for the role of senior leader ***and*** manager, to successfully take on the role of Associate Director or higher.

   The emergent Talent Management model in NTW (to be named differently as the term is not well received) proposes a model of a governed approach to identifying individuals, alongside an array or managed and pragmatic learning opportunities in NTW, supported by an academic framework (apprenticeship based) leading to a formal qualification. CDT – W recently saw a presentation to this effect. The model will be applicable across all professions and staff disciplines to offer an inclusive opportunity.

   This is particularly important in succession planning to support NTWs future, and the future aspirations of Integrated Care System Leadership models

7. National and International Developments
   There are overlaps with Trust Innovations work where the Academy can and does assist and support.

An additional work-stream has been added to the Academy development plan – Cumbria

8. NTW Academy@Cumbria now forms the 8th work-stream on the plan

   Work is in progress to establish the following

- The first cohort of Degree Level Nursing Apprentices (with University of Sunderland) starting in January 2020
- Working with University of Cumbria to develop diploma to degree level top up pathways
- Development of Advanced Practice across professions to include non-medical prescribing, non-medical AC and the Advanced Clinical Practitioner at masters' level which includes NMP and AC roles where appropriate.
- Availability and readiness of the locality for Trainee Nursing Associates
- Opportunities for band 2 and 3 staff to develop relevant skills for career progression in the future
- Introduction of the Collective Leadership sessions (as delivered in NTW in 2016, focussed on devolution, responsibility and accountability) in autumn 2019

A number of events have taken place to explore and progress these issues and the work plan articulates further developments happening in 2019 and beyond.

GB June 2019

Apprenticeship Business Plan 2018-2021

Update May 2019 (blue text)

Summary

The Northumberland Tyne and Wear NHS Trust Strategy, "Caring, Discovering, Growing: Together" outlines our vision as underpinned by our core values "to be a leader in the delivery of high quality care and a champion for those we serve".

Our future workforce is key to meeting the future demands of the NHS and this is reflected in a multitude of national strategies and guidance documents.

- The NTW Apprenticeship Business Plan will support NTW to meet its strategic aims and those of the NTW Workforce Strategy.
- The NTW Apprenticeship Business Plan outlines what we want to achieve over the next four years in line with the public sector targets for apprenticeships starts and NTW's workforce plans.

The national and local apprenticeship context

The Apprenticeship Levy was introduced in April 2017

- It directs all organisations of a certain size to pay an Apprenticeship Levy to fund apprenticeship opportunities.
- NTW's Levy is circa £1m per annum. This will increase when the Cumbria locality is added in October 2019 (figure tbc)

Via the Enterprise Bill the government introduced statutory targets for the public sector's contribution to its commitment to three million apprenticeship starts.

- *All NHS Trusts must ensure that 2.3% of its overall workforce be registered on an apprenticeship programme*; which includes both those employed as apprentices and those in a substantive role enrolled onto an apprenticeship.
- This 2.3% figure equates to 147 members of staff for NTW.
- In 2018/19 NTW were 1 of only 2 Trusts in the region to achieve our public sector target of 2.3% with 3.34% of the workforce being enrolled onto an Apprenticeship programme

How an apprentice may help your CBU/Department

There are two main types of Apprenticeship route

1. Staff members are ***employed as an apprentice*** to follow a specific apprenticeship programme, usually for a set duration, leading to an opportunity to progress
2. Staff members ***already employed in a variety of roles*** where the organisation supports them to follow an Apprenticeship programme to gain a specific skill

The training and assessment costs of the apprenticeship programme are funded by organisations drawing on their Levy contribution. The apprentice's salary cannot be met from this Levy.

There is a minimum apprenticeship wage, but there is no maximum.

Areas and levels of apprenticeship development

Apprenticeships are now available at various levels

- Intermediate (L2)
- Advanced (L3)
- Higher (4/5)
- Degree level (L6)

- Masters and PHD Level 7 & 8 apprenticeships have been approved for delivery in selected areas with further courses being developed. Some apprenticeships provide a route to support senior leadership development, for example the Senior Leader Master's Degree Apprenticeship (MBA), whilst another is the Advanced Clinical Practitioner Standard for experienced clinicians who demonstrate expertise in their scope of practice.

See appendix 1 for more detail. Please note, the range of apprenticeships is expanding all the time. Please check for the most recent information https://haso.skillsforhealth.org.uk/standards/

How to progress with employing an apprentice/supporting staff on apprenticeship programmes

Appendix 2 outlines a flowchart process

There are several points which require careful thought before the process is started

Workforce plans are the starting point and constant reference point – think innovatively, do not assume like for like replacement, think ahead, consider 'invest to save', embrace new roles and opportunity

- Does your workforce plan identify the needs for more staff and/or additional skills?
- Can you fund the post/secondment costs
- Can you support the 20% 'off the job' training
- What is the timescale of the apprenticeship
- Can your team commit to supporting the apprentice in their learning and development to successfully achieve the outcomes – remember, the Apprenticeship Team in the Academy will support the **apprenticeship system**, the individual team/department must commit to supporting the apprentice with the learning outcomes to be achieved to gain the qualification

Finally – can you afford NOT to embrace apprenticeships and new roles?

The NTW 3-5 year plan & priorities around apprenticeships

The Academy has a well-established small team who will support you every step of the way with any apprenticeship programme. September 2018 saw the launch of the ***Apprenticeship and Career Development Team*** (formerly the vocational team) as the key resource for information and support about apprenticeships across the Trust.

NTW is committed to

- The continued expansion and development of its apprenticeship programmes in line with work force plans.
- Increasing apprenticeship opportunities in both numbers and breadth of opportunity – working with managers to understand the business benefits of the apprenticeship offer across the organisation.
- Increase higher level apprenticeships across all subject areas, with a particular focus on skills shortage areas in the early phase of this strategy.
- Supporting potential apprentices – to ensure they understand the benefits of apprenticeships and that they are of the required calibre for business and are supported into work.
- Ensuring quality provision – ensuring provision meets current and future business need
- Widen participation in the Trust's apprenticeship programme in line with the pledge made as part of the Apprenticeship Diversity Champions Network ADCN).
- Continue to work closely with schools and partners to promote apprenticeships as a quality learning/training route and to raise the profile of NHS apprenticeships
- Meet the Public Sector 2.3 % Apprenticeship Target equivalent to 144 enrolments P/A within NTW In 2018/19 NTW were 1 of only 2 Trusts in the region to achieve our public sector target of 2.3% with 3.34% of the workforce being enrolled onto an Apprenticeship programme,
- Achieve best value for money by making best cost-effective use of the Apprenticeship Levy
- Develop an Academy prospectus to publicise these opportunities.
- Develop our Information Advice and Guidance (IAG) service to maximise efficiencies and close gaps in service delivery. The Academy would be 'a careers advice hub'.
- Meet the aims of ADCN and Apprenticeship Ambassador Roles to add value and support the prosperity of the social, economic and physical area the Trust serves.

Measuring success

The Academy Board will receive progress reports against deliverables, and updates will be given to appropriate groups such as CDT-W, BDG as required.

We have identified a range of success measures which will allow us to understand the impact of the business plan and inform the progress reports and updates.

- The number of level 2 and level 3 health apprenticeships available to support staff will be 75 per annum over three years. We currently have 77 enrolled onto the programmes with a further 40 due to be signed up before November 2019
- The Degree Level Nurse Apprenticeships will start with a cohort of 30 in 2019 and an additional cohort of ten per annum – We started a cohort of 39 in January 2019 and expect to start an additional cohort of 19 in July 2019
- We will recruit a cohort of ten to be the first to be employed as health apprentices within the Trust, This is currently on hold until future workforce needs are better understood.
- We will ensure we implement data collection measures to record enrolment figures and can demonstrate we meet the 2.3% Public Sector target In 2018/19 NTW were 1 of only 2 Trusts in the region to achieve the public sector target of 2.3%with 3.34% of the workforce being enrolled onto an Apprenticeship programme,
- A range of pathways with sustained job outcomes will have been developed and these will be monitored along with the qualification output. This will ensure that every broad service area in the Trust offers Apprenticeships by 2020
- We will implement a quality assurance model & a quality improvement plan to measure the quality and impact of learning and skills. This has commenced and quarterly updates will be provided from Q1 of 19/20
- Our Contract manager will hold regular contractual monitoring reviews. This will include an audit of learner reviews which will monitor progress, the welfare of the apprentice, monitoring her or his health and safety and equality of opportunity.
- The conversion of vacant Band 2 jobs into potential apprenticeship opportunities will have begun with an anticipated 10 recruits per annum in health and ten in business administration roles. This has not yet progressed across the Trust
- Apprentices successfully completing their studies will be an asset to NTW to retain where possible. A system now exists to 'match' apprentices to substantive band 2 posts rather than using Central Recruitment. Since 2018, over 60% of business admin apprentices have been employed in this manner with over 80% of them being employed all together (including the Central Recruitment route before the new matching process was in place)

NTW Academy

NHS Northumberland, Tyne and Wear NHS Foundation Trust

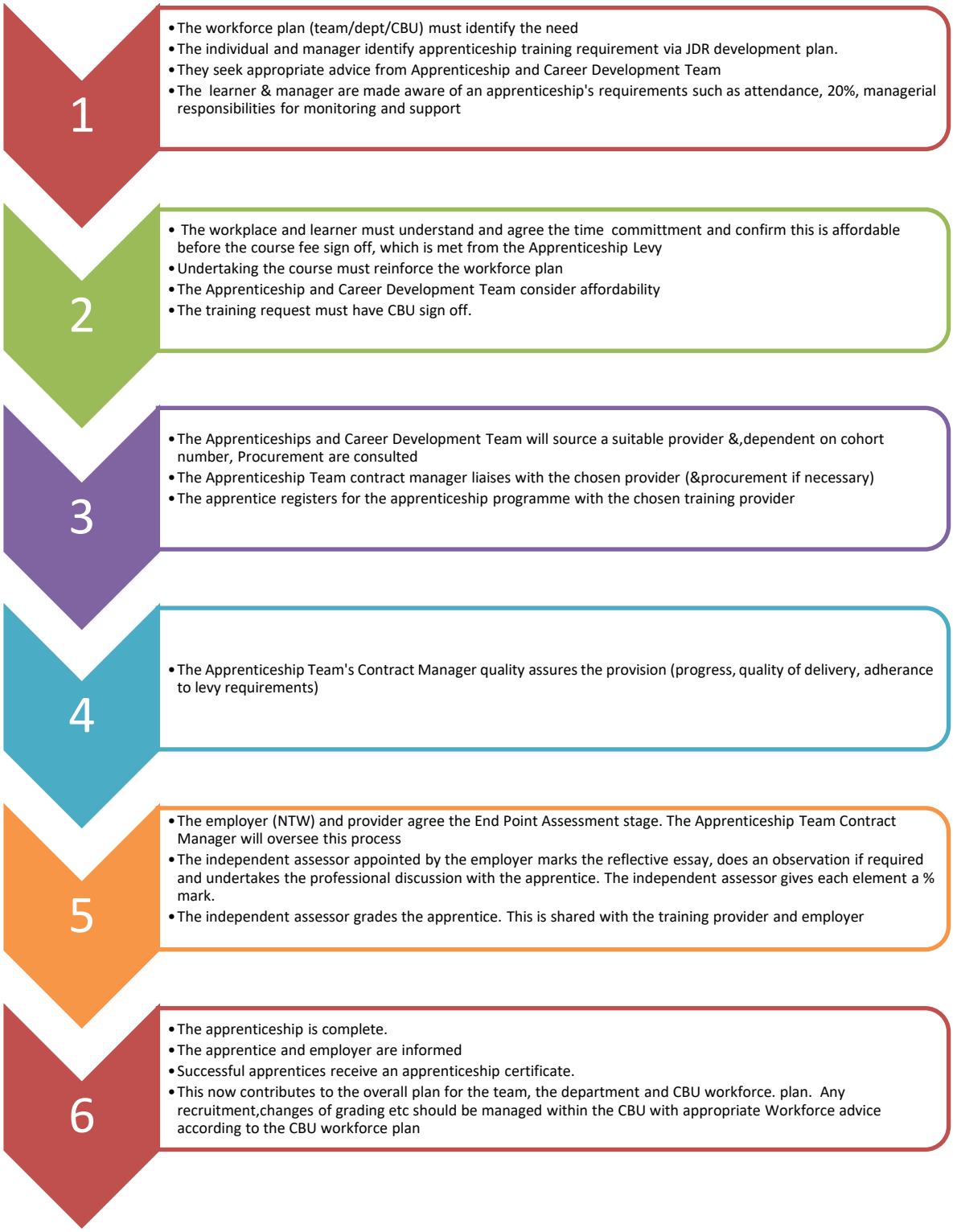
Appendix 1 – NTW apprenticeships currently available

Approved Standards ready for delivery			
Sector	**Apprenticeship standard**	**Apprenticeship Level (not related to AfC bandings)**	**Duration**
Admin, Management and Leadership			
Business and Adminstration	https://www.instituteforapprenticeships.org/apprenticeship-standards/business-administrator/	3	18 months
Associate Project Manager	https://www.instituteforapprenticeships.org/apprenticeship-standards/associate-project-manager/	4	24 months
Leadership & Management	https://www.instituteforapprenticeships.org/apprenticeship-standards/chartered-manager-degree/	6	48 months
Chartered Manager Degree Apprenticeship	https://www.instituteforapprenticeships.org/apprenticeship-standards/chartered-manager-degree/	6	48 months
Senior Leader Master's Degree Apprenticeship (Degree)	https://www.instituteforapprenticeships.org/apprenticeship-standards/senior-leader-masters-degree-apprenticeship-degree/	7	24 months
Customer Service			
Customer Service Practitioner	https://www.instituteforapprenticeships.org/apprenticeship-standards/customer-service-practitioner/	2	12 months
Information Technology			
Information Systems- Business Analyst	https://www.instituteforapprenticeships.org/apprenticeship-standards/is-business-analyst/	4	18 months
Digital Industries - Data Analyst	https://www.instituteforapprenticeships.org/apprenticeship-standards/data-analyst/	4	24 months
Digital -Digital and Technolgy Solutions Degree	https://www.instituteforapprenticeships.org/apprenticeship-standards/digital-and-technology-solutions-professional-degree/	6	36 months
Estates and Facilities			
Horticulture and Landscape - Horticulture Operative	https://www.instituteforapprenticeships.org/apprenticeship-standards/horticulture-and-landscape-operative/	2	24 months
Food and Drink - Process Operator	https://www.instituteforapprenticeships.org/apprenticeship-standards/food-and-drink-process-operator/	2	30 months
Electrotechnical - Installation Electrician	https://www.instituteforapprenticeships.org/apprenticeship-standards/installation-electrician-maintenance-electrician/	3	42 months
Energy & Utilities Utilities Engineering Technician	https://www.instituteforapprenticeships.org/apprenticeship-standards/utilities-engineering-technician/	3	48 months
Finance			
Financial Services Credit Controller	https://www.instituteforapprenticeships.org/apprenticeship-standards/credit-controller-collector/	2	12-18 months
Financial Services Customer Advisor	https://www.instituteforapprenticeships.org/apprenticeship-standards/financial-services-customer-adviser/	2	12 months
Financial Services - Adminstrator	https://www.instituteforapprenticeships.org/apprenticeship-standards/financial-services-administrator/	3	12 months
Healthcare			
Healthcare - Healthcare Support Worker	https://www.instituteforapprenticeships.org/apprenticeship-standards/healthcare-support-worker/	2	12 months
Healthcare - Senior Healthcare Support Worker	https://www.instituteforapprenticeships.org/apprenticeship-standards/senior-healthcare-support-worker/	3	18 months
Healthcare - Assistant practitioner	https://www.instituteforapprenticeships.org/apprenticeship-standards/healthcare-assistant-practitioner/	5	18 months
Healthcare - Nursing Associate	https://www.instituteforapprenticeships.org/apprenticeship-standards/nursing-associate/	5	24 months
Healthcare - Nurse Degree	https://www.instituteforapprenticeships.org/apprenticeship-standards/registered-nurse-degree/	6	48 months
Human Resources			
HR - HR Support	https://www.instituteforapprenticeships.org/apprenticeship-standards/hr-support/	3	18 months
HR - HR Consultant	https://www.instituteforapprenticeships.org/apprenticeship-standards/hr-consultant-partner/	5	36 months
Please contact the Apprenticeship and Career Development Team to discuss the Apprenticeship Levy funding process			

Appendix 2 – Flowcharts and considerations

1. Apprenticeship Flow Chart –**New Employee**

2. Apprenticeship Flow Chart - **Existing Employee**



Northumberland, Tyne and Wear NHS Foundation Trust

Board of Directors Meeting

Meeting Date: 3 July 2019
Title and Author of Paper: NTW ACADEMY – Opportunities for Development of Managers and Leaders Board Briefing June 2019 Gail Bayes, Deputy Director, NTW Academy Development
Executive Lead: Gary O'Hare, Executive Director of Nursing/Chief Operating Officer
Paper for Debate, Decision or Information: For information
Key Points to Note: • Workforce planning has identified 2 particular 'difficult to fill' levels of staff • This proposal outlines 2 pilot cohorts of staff to develop • The overall emergent Talent Management model is key to future developments
Risks Highlighted to Board : Risk is managed via the Academy Board
Does this affect any Board Assurance Framework/Corporate Risks? Please state **Yes** or **No:** No If Yes please outline
Equal Opportunities, Legal and Other Implications: None. Talent Management Board would govern future developments
Outcome Required: For information, debate and support of a pilot phase
Link to Policies and Strategies: NTW Workforce Strategy

NTW ACADEMY – Opportunities for Development of Managers and Leaders

Board Briefing June 2019

Background

NTW has facilitated a number of Leadership opportunities for many years using external resources (e.g. North East Leadership Academy, Kings Fund) and developing internal NTW programmes of Collective Leadership at various levels.

More recently, Integrated Care Systems in the region are taking their own approaches to developing leaders of the future through Systems Leadership approaches.

NTW has supported the National Graduate Trainee Programme in small numbers but rarely retained those individuals in the organisation

The focus overall has been on 'Leadership' rather than 'Leadership and Management'

In the past 12 months, NTW's work-force planning has identified in more detail that it has two significant risk areas for recruitment and retention which require urgent attention

- Preparation for and appointment to band 7 ward manager/team leader/department manager**
- Preparation for and appointment to Associate Director/Group Director posts

The main reasons behind this are

- the apparent reluctance of band 5/6 staff to pursue a management career as they see the skills required being very different to clinical skills
- the reluctance of more senior band 7/8a and above staff aspiring to become ADs and GDs as they do not have the skills necessary to manage at that level yet are reluctant or unable to gain the skills due to a variety of reasons – move away from clinical skills/subject expertise, time available to pursue skills and lack of appropriate mentors and obvious career pathway are just some of the factors fed back in a recent focus group. Additionally, a 'management' role does not always carry the kudos of a senior clinical role.

The Trust-wide approach to work-force development

The Trust as a whole is developing a Talent Management (TM) approach to career progression as part of a portfolio of work-force planning tools. The TM Board will

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govern selection and monitoring of individuals to meet work-force needs and it will ultimately oversee a wide range of opportunity (The phrase 'Talent Management' may well be replaced with a more acceptable terminology).

What is our immediate concern?

In the short term, a pragmatic pilot model proposal was presented to BDG in May 2019 to progress a management skills model to address the two main identified gaps.

A proposal

Two cohorts would run, one from band 5/6 level (cohort 1), one from band 7/8a level (cohort 2)

- **Cohort 1** would be for up to 10 individuals and would follow an accredited apprenticeship programme, up to degree level, alongside an NTW support model which will offer workplace mentors, readily available managerial experiences and on-the-job support – much in the same way our student clinical colleagues experience placements and mentoring in the workplace as they learn
- As apprentices, the learning is mainly done in the workplace, with the 20% 'off the job' requirement being facilitated by the supportive infrastructure outlined above
- The programme would take 3 years but the expectation is that individuals would be ready to take on the management roles earlier than that and complete their qualifications in the more senior role.
- NTW Academy would manage and facilitate the processes in line with the University framework for learning and in line with developments of the Talent Management Board.
- **Cohort 2** would be similar but different. This cohort size could be up to 10 individuals but would be at masters' level.
- The emphasis academically at this level is on strategic leadership and, recognising some staff at this level may be ready for this, but lacking in pragmatic, operational management experience, the same opportunities can be made available to this cohort to gain the skills they may be lacking, or improve those they already have.
- Mentors for this cohort can be the same or different to cohort 1 depending on need. This can be personalised to suit individual need
- The programme would take 2 years but the expectation is that individuals would be ready to take on the AD/GD roles earlier than that and complete their qualifications in the more senior role.

This is an opportunity for the organisation to state what it wants its future managers and leaders to experience and be skilled in, ***and be in a position to offer those***

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skills and appraise learning and competence via an internal system of mentorship, backed up by appropriate academic accreditation

Some random examples of practical managerial experiences might include:-

Conducting investigations/complaints management, chairing of disciplinary panels, exposure to commissioning forums, negotiating content of contracts, procurement processes, understanding income and expenditure streams, relationship management (internal and external), having difficult conversations, managing conflicting demands, time management, exploring work-life balance challenges, on-cell experiences, local/regional/national representation of the Trust at various forums, chairing meetings, understanding corporate functions, living 'a day in the life of (another department or profession)' experience, corporate governance, statutory responsibilities etc.

This list is illustrative and cannot possibly identify the entire range of opportunities that NTW can make available to support management skills' development.

- Additionally, there is a third cohort option available whereby prospective managers/leaders could avail themselves of the practical learning opportunities without pursuing an apprenticeship qualification to degree or masters level. For example, this may be suitable where someone already has a management qualification or equivalent but not necessarily the right NHS experience for that person to feel confident or competent. This can be explored as required.

BDG was broadly supportive of the proposal.

We have the skills within the Academy to set up a Trust-wide, managed mentorship network to provide practical support. Alongside the appropriate HEI framework providing the accreditation, NTW could use this proposal to see its own 'Graduate Management Trainee Programme' in place within the next 6 months.

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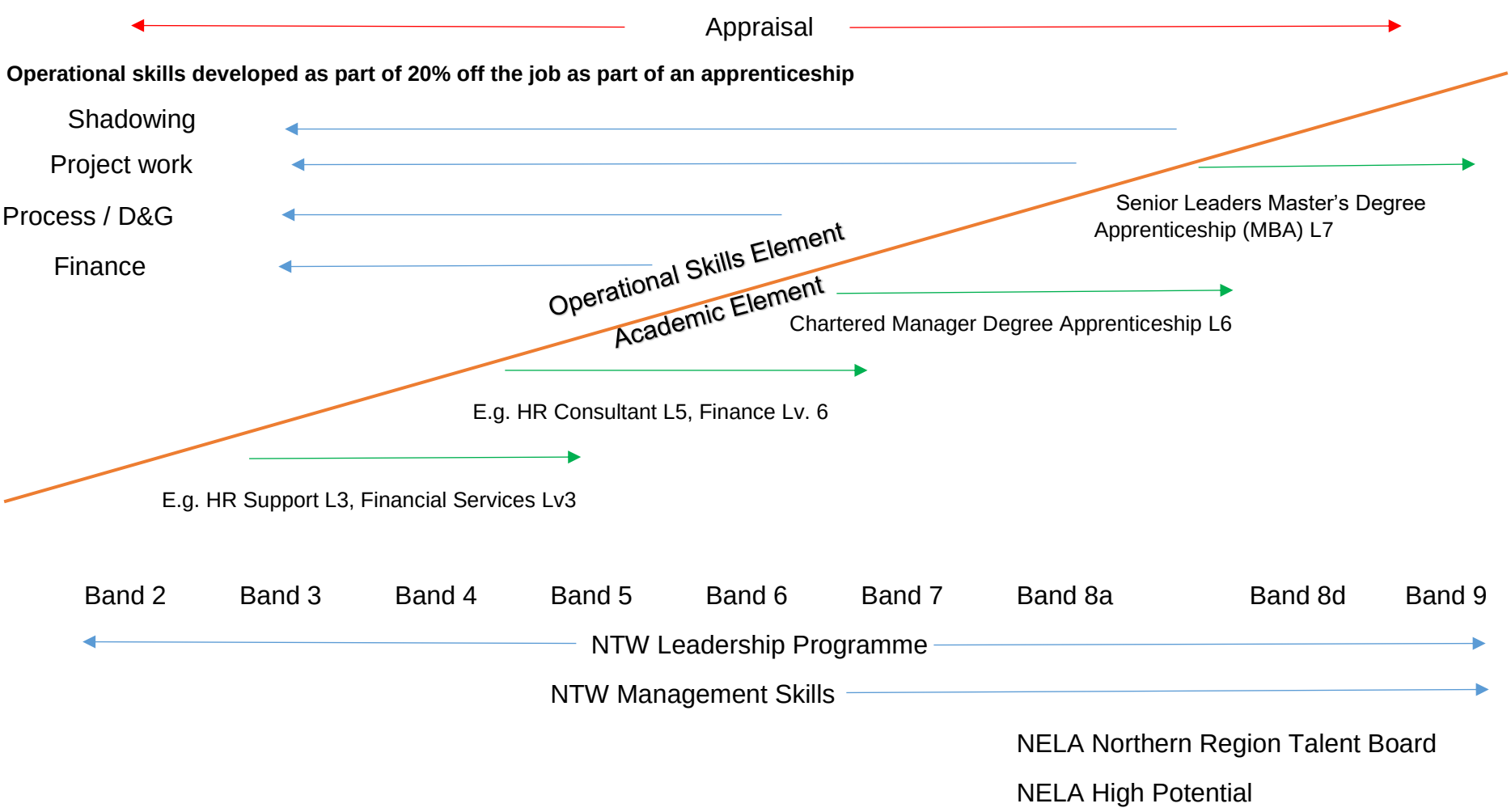
Management Career Pathway



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