# Board of Directors Meeting (PUBLIC)

*Wed 07 July 2021, 13:30 - 15:30*

**Microsoft Teams**

## Agenda

### Please note this meeting will be Recorded

### 1. Welcome and apologies for absence

*Ken Jarrold, Chairman*

### 2. Service User / Carer Story

### 3. Minutes of the meeting held 26 May 2021

*Ken Jarrold, Chairman*

- 3. Board PUBLIC minutes 26.05.2021 DRAFT final.pdf (11 pages)

### 4. Action Log and Matters Arising not included on the agenda

*Ken Jarrold, Chairman*

- 4. BoD Action Log PUBLIC as at 07.07.21.pdf (1 pages)

### 5. Chairman's Update

*Ken Jarrold, Chairman*

### 6. Chief Executive's Report

*John Lawlor, Chief Executive*

- 6b. Appendix A - CEO Report July.pdf (73 pages)
- 6c. Appendix B - CEO Report July.pdf (4 pages)
- 6a. CEO Report July.pdf (4 pages)

### Quality, Clinical and Patient Issues

### 7. Covid-19 Response Update

*Gary O'Hare, Chief Nurse*

- 7. COVID Board Report - July 2021 final.pdf (6 pages)

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## 8. Commissioning and Quality Assurance Update Month 2

*Lisa Quinn, Executive Director of Commissioning and Quality Assurance*

8. Monthly Commissioning Quality Assurance Report - Month 2.pdf (12 pages)

## 9. Non-Executive Director Service visits update

*Verbal* *Non-Executive Directors*

## Strategy and Partnerships

## 10. ICS Design Framework

*verbal update* *John Lawlor, Chief Executive*

## 11. CNTW Annual Plan 2021/22

*James Duncan, Deputy Chief Executive / Executive Director of Finance*

11. Annual Plan 21-22 Board Version v1.10 (002).pdf (11 pages)

## 12. CQC Strategy from 2021

*Lisa Quinn, Executive Director of Commissioning and Quality Assurance*

12. CQC strategy from 2021.pdf (4 pages)
12. CQC strategy from 2021 (Appendix 2).pdf (22 pages)

## Workforce Issues

## 13. NHS People Plan update

*Lynne Shaw, Executive Director of Workforce and Organisational Development*

13. NHS People Plan Action Plan - update June 2021 (002).pdf (5 pages)

## 14. Equality, Diversity and Inclusion Plan update

*Lynne Shaw, Executive Director of Workforce and Organisational Development*

14. EDI Annual Report Board Cover Sheet July 2021.pdf (5 pages)

## 15. Guardian of Safe Working Hours (Q4 and Annual Report)

*Rajesh Nadkarni, Medical Director / Lynne Shaw, Executive Director of Workforce and Organisational Development*

15. Safer Working Hours Quarter 4 Jan to Mar 21 QP Report Final.pdf (6 pages)

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## Regulatory

## 16. Board and Sub-Committee Terms of Reference Review

*Debbie Henderson, Director of Communications and Corporate Affairs and Company Secretary*

16. Board and Committee ToR Review 2021.pdf (41 pages)

## 17. Amendment of Scheme of Reservation and Delegation

*James Duncan, Deputy Chief Executive / Executive Finance Director*

17. Amendment to SORAD (003).pdf (3 pages)

## Minutes / Papers For Information and Items

## 18. Committee Updates

*Non-Executive Directors*

### 18.1. Quality and Performance Committee

*Alexis Cleveland, Chair*

### 18.2. Audit Committee

*David Arthur, Chair*

### 18.3. Resource Business and Assurance Committee

*Peter Studd, Chair*

### 18.4. Mental Health Legislation Committee

*Michael Robinson, Chair*

### 18.5. Provider Collaborative Committee

*Michael Robinson, Chair*

### 18.6. CEDAR Programme Board

*Peter Studd, Chair*

### 18.7. Charitable Funds Committee (as Corporate Trustees)

*Paula Breen, Chair*

## 19. Council of Governors' Issues

*Ken Jarrold, Chairman*

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## 20. Any Other Business

*Ken Jarrold, Chairman*

## 21. Questions from the Public

*Ken Jarrold, Chairman*

## 22. Date and Time of Next Meeting

*Wednesday 4th August 2021, 1.30pm – 3.30pm Via Microsoft Teams*

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**Minutes of the Board of Directors meeting held in Public**
**Held on 26 May 2020 1.30pm – 3.30pm**
**Via Microsoft Teams**

**Present:**
Ken Jarrold, Chairman
David Arthur, Non-Executive Director
Darren Best, Non-Executive Director
Les Boobis, Non-Executive Director
Paula Breen, Non-Executive Director
Alexis Cleveland, Non-Executive Director
Michael Robinson, Non-Executive Director
Peter Studd, Non-Executive Director

John Lawlor, Chief Executive
James Duncan, Deputy Chief Executive/Executive Finance Director
Ramona Duguid, Chief Operating Officer
Rajesh Nadkarni, Executive Medical Director
Gary O'Hare, Chief Nurse
Lisa Quinn, Executive Director of Commissioning and Quality Assurance
Lynne Shaw, Executive Director of Workforce and Organisational Development

**In attendance:**
Debbie Henderson, Director of Communications and Corporate Affairs / Company Secretary
Kirsty Allan, Acting Corporate Affairs Manager (Minute Taker)
Jayne Simpson, Corporate Affairs Officer
Fiona Grant, Lead Governor/Service User Governor for Adult Services
Anne Carlile, Carer Governor for Adult Services
Fiona Regan, Carer Governor for Learning Disabilities and Autism
Margaret Adams, Deputy Lead Governor/Public Governor for South Tyneside
Tom Bentley, Public Governor for Gateshead
Bob Waddell, Staff Governor – Non-clinical
Revell Cornell, Staff Governor – Non-clinical
Uma Geethanath, Staff Governor - Medical
Paul Richardson, Local Authority Governor, North Tyneside
Wilf Flynn, Local Authority Governor, South Tyneside Council
Tom Rebair, Service User Governor, Adult Services
Victoria Bullerwell, Staff Governor – Non-clinical
Raza Rahman, Staff Governor – Clinical
Damian Robinson, Group Medical Director, Safer Care *(Item 12 only)*
Sir Norman Lamb, Chairman, South London and Maudsley NHS FT
Charlotte Hudson, Corporate Affairs Director, South London and Maudsley NHS FT

## 1. Service User Story

Ken Jarrold extended a warm welcome and thanks to Emma Price who attended the Board to share her 'Never Ending Story' which highlighted Emma's personal journey, achievements, and challenges on her journey to recovery as well as explaining her goal to help others to realise their potential.

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2. **Welcome and apologies for absence**

Ken Jarrold welcomed everyone to the meeting including Sir Norman Lamb, Chairman and Charlotte Hudson, Corporate Affairs Director of South London and Maudsley NHS FT who joined the meeting as observers.

3. **Declarations of interest**

There were no new conflicts of interest declared for the meeting.

4. **Minutes of the meeting held 7 April 2021**

The minutes of the meeting held on 7th April 2021 were considered. John Lawlor referred to item 14, Budget Planning 2021/22 and requested for "Mental Health Support Hubs" to be removed from page 5, paragraph 3.

**Approved:**

- **The minutes of the meeting held 7 April 2021 were approved as an accurate record following amendment on page 5, paragraph 3 as noted above.**

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

Ramona Duguid provided an update on actions 06.11.19 (12) and 02.09.20 (5) and advised that audit work has been taken forward with IT and the Trust Innovations Team to review the Crisis Response answerphone system as well as follow-up calls in terms of responsiveness. Ramona stated that further work was required linked to the Community Transformation work and suggested a fuller update to be discussed at the September meeting of the Board.

Gary O'Hare referred to previous queries regarding automated messages and confirmed that answer machines were not in place as part of the Trust Crisis Team services. Automated messages are provided while people are queuing on calls and response times are measured through the Initial Response Service team.

Peter Studd referred to complaints received and feedback from service users in terms of messages not being returned via other means of contacting the Trust. With regard to automated messages, Peter asked if abandonment call rates were measured. Peter suggested that a wider review of access via telephone contact be undertaken in line with concerns raised at previous meetings.

**Action:**

- **To replace action 06.11.19 (12)/02.09.20 (5) with new action – as part of the Community Transformation work, undertake a review of telephonic access points into the Trust to incorporate issues identified in complaints/feedback from service users and to ensure easy access and prompt response.**

6. **Chairman's Remarks**

Ken Jarrold shared his thoughts regarding the challenges faced by the Trust including the response to COVID-19 and its wider impact. Ken referred to the lack of clarity regarding planning processes as well as the continuing uncertainties regarding the governance structures of Integrated Care Systems (ICSs)/Integrated Care Partnerships (ICPs). Ken noted that these challenges were reflected in many of the reports to the Board, particularly with regards to staffing pressures.

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Ken referred to a very good development session held earlier in the day focusing on two significant topics: Research and Innovation; and Liaison and Diversion services. Ken commended the work being undertaken by the teams and the work of the Liaison and Diversion Team who undertake extraordinary work in helping vulnerable people with mental health and learning disability issues within the Criminal Justice System.

Ken Jarrold referred to new appointments within the Board of Directors and confirmed the Board have agreed the appointment of Darren Best, Non-Executive Director as Vice Chair and David Arthur, Non-Executive Director as Senior Independent Director following appropriate consultation and agreement of the Council of Governors. Ken also advised that Paula Breen, Non-Executive Director would undertake the role as Chair of the Charitable Funds Committee following Les Boobis' decision to stand down from his role as Non-Executive Director on 30th June 2021.

**Approved:**

- **The Board noted the Chairman's verbal update and approved the appointment of David Arthur as Senior Independent Director, Darren Best as Vice-Chair and Paula Breen as Chair of the Charitable Funds Committee from 1 July 2021**

**7. Chief Executive's Report**

John Lawlor referred to Investors In People (IIP) and the receipt of formal confirmation that the reviewer was content that colleagues in North Cumbria have been fully integrated into the organisation following the transfer in October 2019 and made particular reference to the effectiveness of consultation and communication undertaken with staff during the transfer.

John referred to ongoing work to support staff noting the process of organising continuing support for staff and families working with the Indian High Commission in London in light of the pandemic crisis in India.

Over the past three months the Trust has considered several key areas of work in line with the Equality, Diversity and Inclusion agenda. Following engagement with Trust Staff Networks, Staff Side and Managers at all levels, three priority areas highlighted in the report have been agreed for 2021/22.

The Trust has formally launched the CNTW Climate Health Green Plan with a focus on creating a community of people helping and being involved in climate change issues.

John confirmed the ICS have submitted information required about how funding would be allocated in 2021/22 and referred to the Trust detailed organisational planning process. John noted that national requirements have largely been met although there are some areas with lower levels of investment then expected in some services.

Michael Robinson referred to the inclusive recruitment work undertaken and asked if there were any themes identified in the 100+ recommendations. John advised a working group had been established to look at theming the recommendations to take forward to implementation stage. Lynne Shaw stated that the group had met to lead a task and finish approach to reviewing the recommendations.

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**Resolved:**

- **The Board received the Chief Executive's update.**

**Quality, Clinical and Patient Issues**

**8. Commissioning and Quality Assurance Report update: Quarter 4**

Lisa Quinn referred to the Quarter 4 year-end report and noted a further seven Mental Health Act Reviewer visits had taken place during March, the key actions from which were detailed in the report. It was noted that the issue of locked doors was becoming a potential blanket restriction issue for the Trust. This has been taken forward within operational areas reminding staff of the importance to ensure patients have access to bedrooms when appropriate as well as from a risk-based approach.

Lisa referred to the issue of Acorn ward where service users with a learning disability and autism were currently residing within North Cumbria. Lisa explained Acorn ward was originally a ward designated for rehabilitation but due to damage of the existing learning disabilities facilities, alternative accommodation was sought.

Lisa confirmed to the Board in relation to Akenside ward there was now availability of wash facilities and maintenance issues around the shower had now been resolved.

In relation to Ferndene and issues relating to en-suite doors Lisa confirmed that this had been resolved and work continued to undertake a review across the wider organisation.

Regarding Yewdale ward, Lisa advised of a wider piece of work ongoing regarding review of services to West Cumbria.

Hadrian ward, Carlton Clinic had been highlighted as part of the Trust's due diligence process during the transfer of services from Cumbria Partnership NHS FT. Lisa confirmed that a Business Case had been developed to address the issues and capital allocations were now included in the capital plan.

Lisa reminded Board members that monitoring of quality and internal training standards had been reinstated following a decision not to performance managed the standards for a period due to the impact of the pandemic. Lisa confirmed that trajectories were now identified for both quality standards and training standards for 2021/22 with the expectation that achievement against trajectories would be met by March 2022.

James Duncan noted at Month 12 the Trust had delivered a financial performance position of break-even. The Trust planned £2.2m deficit was a result of a shortfall in income of £1.4m and an increase in the annual leave accrual £0.8m. James stated that the Trust had received funding to cover the income shortfall and the increase in the annual leave accrual.

James Duncan highlighted the Trust pay costs had been high this year due to the pandemic, including ongoing additional staff costs to cover sickness and ensure adequate resource into the delivery of vaccines to staff which had been offset by additional income. James mentioned the Trust had incurred £6.9m of operational COVID-19 costs up to Month 12 which included costs associated with additional services implemented to support the pandemic.

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Ken Jarrold expressed concern regarding waiting times within Children Services reflecting the national position and highlighted a recent report from NHS Providers outlining the challenges nationally. Lisa advised that the challenges were particularly evident within the Newcastle/Gateshead locality with waiting times within this locality. Lisa confirmed the Trust have commissioned third sector partners to help reduce waiting times predominately within the neurodevelopmental pathway.

John Lawlor referred to a recent meeting of the Children and Young People's national taskforce.

**Resolved:**
- **The Board received the Commissioning and Quality Assurance Report update: Quarter 4**

## 9. Service User and Carer Experience Report Quarter 4

Lisa Quinn presented the report and noted that the national Friends and Family Test was still paused. The report provided detail of feedback received by CNTW from service users and carers via internal and external mediums available during quarter 4. Lisa noted increased levels of feedback through Points of View following recommencement of the survey mail-out resulting in a 400%+ increase in responses in comparison to quarter 3.

Lisa stated that in terms of age analysis, the 18-24 age group was not well represented, and discussions were taking place to explore how best to engage with that population.

Ken Jarrold referred to page 8 of the report and his attendance at the National Understanding Patient and Carer Experience Data (NUPACED) collaborative meeting and found it helpful with other Trusts involved and confirmed he will be visiting Sunderland People's First.

**Resolved:**
- **The Board received the Service User and Carer Experience Report Quarter 4**

## 10. COVID-19 update Report

Gary O'Hare provided an updated COVID-19 response position confirming two COVID-19 positive patients within the organisation. Staff COVID-19 testing continues both with PCR testing and LFT with increased communications to staff in light of the new variant of concern. COVID-related sickness absence continues to decline.

There are currently no outbreaks identified in the Trust. 81% of staff have received a second dose of the COVID-19 vaccine and 88.6% of staff have received their first dose. Patient vaccinations continue as part of the rolling programme, with 75% of patients having received their first dose, and 50% receiving their second dose. In line with the national guidance the Trust have now reduced the gap between first and second dose of the vaccine to 8 weeks.

Gary confirmed that surge testing was currently taking place in the North Tyneside Locality due to an increase in cases associated with the variant of concern.

Gary referred to the development of the CNTW road map out of restrictions and a move to 'living with COVID' and the need for a cautious approach to reducing restrictions, particularly in terms of IPC and PPE compliance. With regard to the national lifting of travel restrictions

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Gary briefed the Board on the clear and robust guidance for staff with regard to any decisions to travel abroad and consideration of associated risks.

**Resolved:**
- **The Board received and noted the COVID-19 update Report**

**11. Safer Staffing Levels Quarter 4**

Gary O'Hare presented the report which identified the level of vacancies which are contributing to the current staffing pressures across the Trust. The report included the exception data against Trust agreed Safer Staffing levels for the period as well as detail of the impact of the pandemic. The report included an update on the process to look at the implementation of a new e-Rostering system, the aim of which will be to provide a wider range of reports to advise and support safe staffing levels.

David Arthur referred to the recruitment of the next cohort of apprentices and queried if the Trust were attracting the right quality and quantity of people. Gary advised that over 100 people were coming through the 3 and 4-year apprenticeship scheme and the 5-year apprenticeship scheme would attract people from local communities with the right values.

Gary stated that daily risk assessments take place in light of changing clinical need and levels of acuity supported by ward team safety huddles and sitrep meetings. Adjustments have been made as necessary to ensure patient safety is not compromised and any risks escalated.

Gary referred to the significant collaborative approach undertaken during the pandemic to ensure staffing levels have remained safe.

**Resolved:**
- **The Board received and noted the Safer Staffing Levels Quarter 4**

**12. Safer Care Report Quarter 4 Report**

Damian Robinson presented the report and highlighted an increasing number of deaths reported as serious incidents during Quarter 4. Damian noted the increase in numbers of local After-Action Reviews. Damian noted that the majority of cases have related to deaths of individuals associated with drug and alcohol services, a trend which is also evident at a national level.

Damian briefed the Board on a Never Event in North Cumbria relating to a failure of a collapsible shower rail. The serious incident review was escalated nationally and resulted in an Estates and Facilities national alert requesting all Trusts to review collapsible shower rails.

Rajesh Nadkarni made reference to concerns raised by the CQC in 2020 related to cases of long-term segregation and prolonged seclusion and advised that a new governance process has been implemented which included a review of all cases. The review panel includes representation from service users, subject matter experts and people with expertise in ethics.

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**Resolved:**

- **The Board received and noted Safer Care Report Quarter 4 Report**

**13. Infection, Prevention and Control Assurance Report**

Gary presented the report to ensure Board has oversight on managing the pandemic and highlighted that the CQC are interested in how the Board receives these reports.

Gary referred to an error within the report on item 1, paragraph two and confirmed where decline in Covid-19 infections is mentioned it should state 'increase' in infections and relayed apologies to the Board for this error and amendments to the report will be made.

Gary mentioned Trust compliance was demonstrated across all standards except for some gaps in staff compliance regarding cleaning, touchpoints, PPE, car sharing and exceeding Covid-19 secure environment numbers. He assured actions to resolve these have been taken in each area and lessons learnt have been shared across the organisation.

Gary referred to the Assurance Framework where all new standards have been highlighted in yellow and will continue to add new standards over the next 12 months.

**Resolved:**

- **The Board received and noted Infection, Prevention and Control Assurance Report**

**14. Service Visit Feedback**

Ken Jarrold invited Non-Executive Director members of the Board to share their feedback following virtual service visits undertaken during May. Peter Studd, Darren Best, Alexis Cleveland and Les Boobis shared the outcome of their visit to Roselodge. Peter noted that staff took an opportunity to discuss the discharge process and the potential development of the service in the future.

Peter Studd, Darren Best and Michael Robinson also visited Community CAMHS services in Cumbria. Peter made particular reference to the positivity of staff being part of CNTW following the transfer of services in 2019. The staff discussed ideas and suggestions about improvements to services.

David Arthur and Paula Breen visited the Cumbria Community Service Team in Carlisle. David noted a discussion with staff regarding the high level of sickness absence within the team and concerns regarding the premises. These have been escalated to the Executive Team. Staff were again complementary regarding their experiences of being part of the CNTW.

**Resolved:**

- **The Board received and noted the Service Visit Feedback**

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**Strategy and Partnerships**

**15. Refresh of CNTW Strategy**

James Duncan referred to a Board development session which took place to agree the process for the launch of a refresh to the Trust's strategy. James referred to the key elements of the programme which includes a focus on plans to look at the impact of the pandemic both in terms of recovery and improving services and delivering care and treatment in a different way. A focussed Annual Plan will be taken to the July meeting of the closed Board, highlighting risks to delivery of short-term objectives.

**Resolved:**

- **The Board received and noted the process to refresh the CNTW Strategy**

**16. Children and Adolescent Mental Health Services update**

Gary O'Hare presented the report and confirmed the opening of Lotus Ward to admissions took place 10th May 2021. Gary advised that challenges remain in terms of medical recruitment. Consequently, consultant cover has been provided from Ferndene with additional support from a specialist Community Consultant, with backfill arrangements for Ferndene in place.

The Board congratulated the team involved in developing the programme and ensuring the safe opening of services.

**Resolved:**

- **The Board received and noted the CAMHS update**

**Workforce Issues**

**17. Workforce Report Quarter 4**

Lynne Shaw referred to the introduction of Inclusive Mentoring which would be launched in June 2021.

As part of the Trust's commitment to support the Armed Forces, Lynne referred to the successful application for accreditation to be named a Veteran Aware Trust in recognition of the commitment to improving NHS care for veterans, reservists, members of the armed forces and their families.

Following the publication of the NHS People Plan in 2020, the roll out of wellbeing conversations will take place from May 2021.

Lynne referred to the implementation of the revised Appraisal Policy which introduced Career Conversations as part of the Trust approach to talent management.

Ken Jarrold commended the Equality, Inclusion and Diversity workshop.

**Resolved:**

- **The Board received and noted the Workforce Report Quarter 4.**

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**18. Staff Friends and Family Test Quarter 4**

Lynne Shaw presented the report which was taken as read.

**Resolved:**
- **The Board received and noted the Staff Friends and Family Test Quarter 4**

**19. Raising Concerns and Whistleblowing Report update**

Lynne Shaw reported that during the period October 2020 to March 2021, 40 issues had been raised either centrally or via the Freedom to Speak up Guardian representing a slight increase compared to the previous period. It was acknowledged that no concerns had been categorised as 'whistleblowing'.

Lynne took an opportunity to thank Les Boobis, Non-Executive Director Freedom to Speak Up Lead, who had been instrumental in effective close working with the Trust Freedom to Speak up Guardian.

**Resolved:**
- **The Board received and noted Raising Concerns and Whistleblowing Report update**

**Regulatory**

**20. Board Assurance Framework (BAF) & Corporate Risk Register Quarter 4**

Lisa Quinn referred to amendments to the BAF following previous Board discussion which had been detailed by risk area. There were no areas for escalation and no risks had been de-escalated during the quarter. Lisa confirmed all risks have been reviewed with actions in place.

**Resolved:**
- **Board received and noted the Assurance Framework & Corporate Risk Register Quarter 4**

**21. NHSE/I Single Oversight Framework Compliance Report Quarter 4**

Lisa Quinn asked the Board to note the report and confirmed there are no concerns to be escalated to the Board.

**Resolved:**
- **Board received and noted the NHSI/E Single Oversight Framework Compliance Report Quarter 4**

**22. CQC Must Do Action Plan update Quarter 4**

Lisa Quinn confirmed a review of all 'Must Do' actions took place and requested that as sufficient evidence was now in place to confirm completion of the action detailed in Appendix 1 of the report relating to Regulation 15 HSCA(RA) Regulations 2014 – Premises and Equipment that approval to close the action was granted.

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Lisa provided a quarter 4 update on the remaining actions and requested Board approval for an extension to timescales, the detail of which was provided in the report.

**Approved:**
- **The Board approved closure of the action relating to North Cumbria locality: Regulation 15 HSCA(RA) Regulations 2014 – Premises and Equipment as detailed in Appendix 1 of the report**
- **The Board approved the extension dates for completion of 'Must do' actions associated with quality and training standards**

### 23. Annual Review of Directors Declaration of Interest

Debbie Henderson confirmed the annual review of Board members' declaration of interest was a statutory requirement. The report provided detail of the recent review of interests in line with the Trust annual reporting process.

Ken Jarrold declared at the meeting that his son was an employee of the Trust and asked for this to be reflected in the final document. Ken had notified the Trust at the time of his son's employment but had forgotten to include it in the latest return. Board members agreed to the final report and acknowledged the requirement to make the report available to the public via the Trust website.

**Approved:**
- **The Board received the Annual Review of Directors Declaration of Interest and approved the report for publication on the Trust website**

### 24. Modern Slavery Act Statement

In line with the requirements of the Modern Slavery Act 2015, the Trust is required to provide a Modern Slavery Act Statement in relation to the organisation's commitment to tackling modern slavery. Debbie Henderson presented the statement for approval and subsequent publication on the Trust website.

**Approved:**
- **The Board received the Modern Slavery Statement for 2020/21 and approved the statement for publication on the Trust website**

**Minutes/papers for information and items**
**Committee updates**

### 24.1 Quality and Performance Committee

Alexis Cleveland referred to a presentation given by Anthony Deery from the South Locality which highlighted some challenges within the locality which were being addressed. The Committee also received a 'deep dive' on the Trust disciplinary and grievance procedures and steps taken to improve processes.

### 24.2 Audit Committee

David Arthur noted that a meeting of the Committee had been arranged to take place on 4th June 2021 to review the Annual Report and Accounts. David thanked the finance team for their work on the accounts in what had been a particularly challenging year.

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**24.3 Resource and Business Assurance Committee**
Peter Studd noted the Committee had reviewed the CNTW Green Plan and environmental and sustainability actions including the work to plant 1000 trees in three days across all sites.

**24.4 Mental Health Legislation Committee**
In the absence of Michael Robinson, Les Boobis chaired the meeting and noted the main item for discussion was the potential impact of the MM ruling. Michael also confirmed the Trust had submitted a formal response to the Mental Health Act White Paper.

**24.5 Provider Collaborative Committee and Terms of Reference**
Nothing to report.

**24.6 CEDAR Programme Board**
Nothing to report.

**24.7 Charitable Funds Committee**
Les Boobis referred to a good presentation provided by CAZENOVE on sustainable funds for investment. There was a recognition of an increase in expenditure given the demands on Charitable Funds during the pandemic with no increase in income seeing a net reduction in funds. Les referred to the work to appoint a Fundraiser and advised the job description was currently with the Agenda for Change panel for banding.

**25 Council of Governors issues**
Ken Jarrold confirmed Non-Executive Director recruitment was being taken forward and the posts would be advertised in June.

Ken referred to the Governors' Steering Group which organises the business of the Council and emphasised the importance of giving priority to Equality and Diversity issues.

Ken reflected on the close relationship between the Council of Governors, Service Users and Carers Reference Group, the Involvement Team, peer support colleagues and the contribution of Margaret Adams, Deputy Lead Governor.

**26 Any Other Business**
Ken Jarrold noted that this would be Les Boobis' final Board meeting following his decision to stand down from his role as Non-Executive Director. On behalf of the Board, Ken conveyed thanks to Les for all he had contributed to the Trust over the last six years including: membership of the Quality and Performance Committee and Mental Health Legislation Committee; attendance at, and support for, the Governors Quality Group; Chairmanship of the Charitable Funds Committee; contribution to the Research agenda; his role as Non-Executive Director Lead for the Freedom to Speak Up Programme and his participation in Consultant Interview Panels. The Board wished Les well for the future.

**27 Questions from the public**
None to note.

**Date and time of next meeting**
Wednesday, 7 July 2021, 1.30pm via Microsoft Teams

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**Board of Directors Meeting held in public**

**Action Log as at 7 July 2021**

| Item No. | Subject | Action | By Whom | By When | Update/Comments |
|---|---|---|---|---|---|
| **Actions outstanding** | | | | | |
| 05.08.20 (07) | Chief Executive's Report | Update on Trieste to be provided to a future Board development session | James Duncan | June 2021 | Complete – Board development topic for June meeting |
| 26.05.21 (5) | Access to support and services by telephone | As part of the Community Transformation work, undertake a review of telephonic access points into the Trust to incorporate issues identified in complaints/feedback from service users | Ramona Duguid | September 2021 | On track |
| **Completed Actions** | | | | | |
| 06.11.19 (12) 02.09.20 (5) | Staff Friends and Family Test | Agreed that actions to address potential impact of automated messages on people who contact services by telephone to be included in the Reset and Redesign of services work. | Gary O'Hare / Ramona Duguid | ~~May 2020~~ ~~August 2020~~ ~~December 2020~~ ~~February 2021~~ ~~March 2021~~ September 2021 | Update to be provided in line with the Reset and Redesign work and staff friends and family test.<br><br>Added to 26 May 2021 Board Agenda. |
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# COLLABORATING
# for better care

JUNE 2021

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# Foreword

Welcome to *Providers Deliver: Collaborating for better care*. This publication marks the start of an important and exciting work programme for NHS Providers, supporting greater provider collaboration. It has been developed in response to our member trusts' desire for us to help them adapt and evolve as leading players in the fast-changing health and care landscape.

In the coming months we will continue to highlight the benefits of these partnerships, showcasing the breadth of existing practice, and sharing learning to help forge new initiatives and deepen cooperation. We will also continue our work to influence national policy and guidance on provider collaboration, which offers great opportunities for trusts to broaden and develop their contribution as partners working at place, system and pan-system levels.

This is the fourth report in the publication series in which we celebrate and promote the work of NHS trusts and foundation trusts in improving care for patients and service users. Our first *Providers Deliver* report explored the way trusts have responded to feedback from Care Quality Commission, encouraging great ideas that have improved care. The next in the series, published last summer, looked at new roles for trusts in prevention. Our third report focused on the resilience and resourcefulness that characterised the response of trusts and their staff to the challenges posed by the pandemic.

This time we are focusing on ways in which providers are collaborating to address common challenges, provide more integrated care pathways and deliver more sustainable services. The case studies in this report show how trusts are at the forefront of work to recognise and respond to the opportunities of joint working. They demonstrate once again how, in a time of unprecedented challenge for the NHS, providers are delivering for patients, service users and the communities they serve.

**Saffron Cordery**
Deputy Chief Executive
NHS Providers

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# Introduction

## Understanding the national policy context

### The context

The health and care system is undergoing significant changes to the way it is structured, organised and delivered. In recent years, the national policy direction has shifted away from trusts and foundation trusts competing for contracts, as was envisaged in the Health and Social Care Act 2012, towards collaboration as the main driver of improvement. Integrated Care Systems (ICSs) have been established to plan and deliver better joined up care for patients and service users, and better health outcomes for local populations.

As part of these changes, providers have increasingly sought to work more closely together to address common challenges, provide more integrated care pathways, and deliver more sustainable services. This approach has been further accelerated during the COVID-19 pandemic, which saw providers, and wider system partners, supporting each other during an incredibly challenging time. Alongside this the scale and impact of provider collaboration is fundamental in tackling unwarranted variation in outcomes, access to services and experiences, as well as in tackling health inequalities.

The next year will be a key transition period for ICSs, with the government's legislative proposals aiming to place ICSs on a statutory footing by April 2022 (assuming the Health and Care Bill passes through the parliamentary process as planned). The associated policy frameworks will also change significantly, including the financial architecture, procurement model and regulatory frameworks, in response to this focus on system working and collaboration.

Trusts and the national NHS bodies have high aspirations for how provider collaboratives can operate and what they can achieve by working together. This report aims to identify key themes and share lessons learned from a wide range of provider collaborations spanning different functions, forms and geographic footprints, to support trusts to respond to national policy developments and embed collaborative arrangements within their local system(s).

### National policy developments

Recent national policy documents have placed provider collaboration as a key pillar in the development of ICSs. NHS England and NHS Improvement's *Integrating Care* paper, published in November 2020, renewed the vision for ICSs, setting an expectation for all trusts to be part of one or more provider collaborative, which will vary in scale and scope. The paper also reaffirmed the shift to strategic commissioning at ICS level, with other commissioning activities moving to provider organisations, provider collaboratives and place-based partnerships.

The Department of Health and Social Care's White Paper, ***Integration and innovation: working together to improve health and social care for all***, published in February 2021, confirmed that ICSs will be placed on a statutory footing from April 2022, but places and provider collaboratives will not have a statutory underpinning. However, there is an

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expectation that decision making will increasingly be delegated to provider collaboratives and place-based partnerships. The 2021/22 planning guidance (April 2021) also set the expectation that ICSs will firm up their governance and decision-making arrangements this year, with trusts working collaboratively to deliver the NHS' priorities, such as tackling waiting list backlogs.

The scale, scope and complexity of these proposed changes are significant, with trusts at different stages of developing their collaborative working arrangements. NHS England and NHS Improvement's new guidance on provider collaboratives will focus on supporting at-scale horizontal collaboration. It seems that NHS England and NHS Improvement intends to be flexible rather than directive, with the guidance expected to point to several potential models that are already working well in some areas, including: lead providers, shared leadership arrangements, and a provider leadership board.[1] However, it is important that the complexity, variety, and different levels of maturity of existing collaborative arrangements and functions are considered and built upon.

# What does provider collaboration mean?

## State of play in the provider sector

Many providers have already been working together, formally and informally, to deliver more joined up care in a complex network of collaborative arrangements. The level of formality can vary greatly depending on the local context, the size of the ICS(s) that providers are working within, the composition of providers within that footprint, and population needs. While some have been collaborating in this way for over a decade, others are building on new arrangements developed during the COVID-19 pandemic.

In this report we set out examples of a wide range of collaborations taking place across the country to show the complexity of arrangements, including:

- horizontal provider collaboratives at ICS (or multi-ICS) level, for example bringing together acute services, or community and primary care services, across a larger geographic footprint
- vertical integration in place-based partnerships across community services, mental health, primary care and local acute services, as well as other partners such as local authorities and the voluntary sector
- mental health provider collaboratives taking on responsibility for the budget and care pathway of a number of specialised services across an ICS or regional footprint
- group models bringing together several providers of the same type under the same leadership, sometimes (but not always) leading to mergers
- formal vertical integration, with trusts bringing together acute, mental health and community (and sometimes primary care) services into one provider.

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1 *NHS England to set three models for NHS provider groups*, Health Service Journal, 9 April 2021. https://www.hsj.co.uk/policy-and-regulation/nhs-england-to-set-three-models-for-nhs-provider-groups/7029864.article

The current myriad of provider collaboration arrangements in each ICS cannot be neatly defined. Some provider alliances or boards have different provider types represented on them and many of these arrangements will have been developed of providers' own volition. One type of provider collaboration does not preclude another, so there may be a group model or merger within a provider collaborative. Some providers are involved in place-based partnerships, at-scale provider collaboratives, regional networks and horizontal/vertical integration.

Sector-specific challenges will also need to be carefully thought through. For example, for providers working across several ICSs, places and neighbourhoods, such as ambulance services, collaboration becomes a complex task when it means contributing to a large array of different partnerships. Many mental health trusts have used the provider collaborative model for a number of years, so their previous experience, progress and challenges will vary to other sectors that have more recently set up collaborative arrangements. Additionally, there is a need to ensure that community providers have appropriate voice, input and opportunity to add value at all the different levels of the collaborative arrangements within local systems.

There are also complications for providers who deliver specialised services across much larger footprints than ICSs. NHS England and NHS Improvement's *Integrating Care* paper references an important role for clinical networks and provider collaborations in driving quality improvement, service change and transformation across specialised (and non-specialised) services. At the same time, there are plans to devolve strategic commissioning responsibilities for some specialised services to ICS or multi-ICS level, depending on patient flows. The interaction between providers of specialised services and ICSs needs careful thought. It is incumbent on everyone involved – including NHS England and NHS Improvement – to continue working through the detailed issues to understand and shape the implications of system working in this area.

## The case for change

The trust leaders we interviewed are clear that there is a key leadership opportunity for providers to be the engine room for transformation within ICSs and places. National policy on system working has evolved over time, from the original high-level strategic plans to the current recognition that providers are the key delivery vehicle within ICSs. The interviewees highlight several benefits of horizontal collaboration at scale, including tackling unwarranted variation, supporting sustainable services, and accelerating improvements in quality of care. Trust leaders also emphasise the advantages of vertical integration at place, with a much stronger focus on improving population health, tackling health inequalities and engaging with local communities.

Collaboration can also alleviate workforce pressures. Providers are able to create more attractive job opportunities, staff passports and portfolio careers for the health and care workforce when organisational barriers are removed. This creates the potential for providers to improve access and better manage demand and capacity across the ICS, which will be

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important for the recovery of elective care, meeting areas of under or unmet needs, and other services. It can also enable staff to focus more on delivering high quality care to the populations they serve.

However, the added responsibilities for trust leaders should not be overlooked, and support, time and investment will be needed to ensure there is capacity for them to service all these collaborations and continue leading their individual organisations.

## Enablers and barriers to collaboration

### Enablers

Our research has shown that there are several factors that enable effective collaboration. A common thread that runs throughout the case studies is the importance of developing strong relationships with partners. In many of these cases, COVID-19 has acted as a catalyst by providing a common purpose for providers and the wider system, bringing together senior leaders more regularly, and removing barriers to enable resources to be shared.

Buy in and alignment across senior leaders is also essential for successful collaboration. It requires leaders to take their organisations and staff with them. Senior leaders also need to have a strong commitment to modelling collaborative ways of working, which helps push forward proposals into action.

Having an unrelenting focus on patients, service users and local communities, including the NHS workforce, is also key, alongside a clear aim to address health inequalities. Trusts must ensure all voices are heard when developing collaborations, and the benefits for patients, staff, individual services and the wider care pathway are clear.

In systems where trusts have agreed to stop competing for contracts, this has opened up difficult conversations about who is best placed to deliver which services, with organisations prepared to "win some and lose some". Developing a memorandum of understanding between partners to provide clarity on the governance, responsibilities and risk-share of the collaboration can help, but it has to be underpinned by the right leadership, relationships and behaviours.

### Barriers

While relationships are a key enabler of collaboration, managing competing priorities can be a significant challenge. Equally a lack of clarity around the governance arrangements and accountabilities can also stifle effective collaboration, particularly at ICS level.

Another challenge is working through the commissioning, resource and capacity issues within the system. Some of the case studies highlight the cultural shift required when it comes to risk-sharing and open-book accounting, particularly where there is variation between the performance of organisations within a collaboration (for example, better performing organisations within a poorer performing system). Historically fragmented

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commissioning arrangements and funding inequities also create challenges, with provider collaboratives looking to address variation in service provision and historic underinvestment in particular providers and/or localities within the ICS. Working through these complexities will take time and will likely require partners within a collaboration to continuously develop and refine their approach. It will also be vital for the national bodies to provide necessary resources and support to ensure the ambitions for integrated care and collaboration have the intended impact.

## What are the next steps for provider collaboration?

Much of the collaborative work that providers have undertaken so far has been informal, innovative, and responsive to local needs. Formalising some of these arrangements under a national framework, in a way that is sufficiently permissive and enabling for the range and scale of collaborations already in existence, is a significant challenge, as well as an important opportunity. Several case studies in this report highlight the importance of the new policy and legislative framework being enabling and reducing bureaucracy, rather than further complicating the system architecture. This is the challenge for NHS England and NHS Improvement: to strike the right balance between providing sufficient guidance and best practice to support the development of collaboration, while enabling the appropriate level of local flexibility on the right issues.

There needs to be absolute clarity on how the roles and responsibilities of the ICS NHS body, the Health and Care Partnership, health and wellbeing boards, provider collaboratives, place-based partnerships and their constituent organisations will fit together, without overlap or confusion. There are also details to be worked through to ensure providers across different sectors have their interests fully and properly represented when the ICS NHS body is making decisions. Further questions remain around how multiple provider collaboratives, place-based partnerships and other collaborations will work efficiently together within an ICS, how funding will be allocated and delegated, and how this will be decided particularly within the context of strained resources. There are also examples of collaboration at scale taking place over multiple ICS boundaries, which adds further complexity.

We hope the report supports trusts and their partners – across ICSs, CCGs, primary care, social care, the voluntary sector and local authorities – to consider how they develop collaborative arrangements in 2021/22 and beyond.

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# The view from Bill McCarthy

North West regional director,
NHS England and NHS Improvement

This has been an extraordinary last 12 months. The courage and compassion shown by teams across the NHS in responding to the pandemic has been remarkable. Stretching all the way from the earliest days to the exceptional roll out of the vaccination programme.

Many characteristics have contributed to NHS achievements including resilience, innovation, decisiveness, agility in the face of adversity. This report is celebrating another, and one of the most significant. Collaboration between providers across many settings has been at the heart of the NHS response and core to serving our communities and patients effectively during the pandemic.

My own region, the North West, has had a particularly hard time with COVID prevalence and hospitalisations consistently higher than national levels. We understood very quickly that collaboration was not a polite aspiration but was the only practical response in real time to the challenges we faced. And this meant collaboration at many levels: in our local places where community, primary care and social care teams worked together to identify and support shielding people and care homes, in each of our three system level hospital collaboratives to provide daily mutual aid and support for critical care teams, and across the region where our mental health trusts have been working together on a strategy to enable our most complex patients to experience better lives. All of this has required leadership focused on and committed to the shared responsibility to serve patients and communities in the best way possible and putting this ahead of narrow organisational interest. I could not be prouder of the response from chief executives and their teams across the North West. I know from my fellow regional directors that level of collaboration and sense of pride in the response is replicated across the country.

The November 2020 publication, *Integrating care: Next steps to building strong and effective integrated care systems across England*, has baked this experience into the vision for the future. As much as collaboration across providers has been an essential response to COVID, so too will it be at the heart of recovery so that we can make the very best use of capacity while tackling inequality of access and build on our understanding of population health management techniques to coordinate effort for the most vulnerable groups. It will be important for us to use the planned establishment of ICSs on a statutory footing as an opportunity to build on the examples of good practice that we have seen across the country and to maintain our focus on collaboration to tackle these future challenges. It is great to see the progress that has already been made by so many, and a number of examples are included in this report.

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# Key to groupings

In this report we set out examples of a wide range of collaborations taking place across the country to show the complexity of arrangements. They are grouped as follows:

**Mental health provider collaboratives**

**Horizontal collaboration between acute providers at ICS level**

**Community and primary care collaboration at ICS level**

**Vertical integration at place level**

**The ambulance sector's role in provider collaboration**

**More formal vertical collaboration between trusts**

**More formal horizontal collaboration of trusts**

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CASE STUDY 1

# Provider collaboration within the South London Mental Health and Community Partnership

**Partners involved in this provider collaborative**

- Oxleas NHS Foundation Trust
- South London and Maudsley NHS Foundation Trust
- South West London and St George's Mental Health NHS Trust

## Background

The South London Mental Health and Community Partnership (SLP) is made up of three mental health trusts. They have around 12,000 staff between them working across a population of 3.6 million, spanning two ICSs and 12 London boroughs.

## Setting up the partnership

The three trusts collaborate in a variety of informal and formal ways, including through a lead provider collaborative model. They established a committee in common in 2020 with chief executive-led portfolio boards for each of the SLP's programmes and dedicated clinical directors for each provider collaborative programme.

One of the SLP's priority areas for collaboration is the delivery of services that are part of the national NHS-led mental health provider collaborative programme. The SLP also has locally developed collaborative programmes focused on nursing workforce development, complex care, acute care pathways, and corporate services. These programmes have their own programme and/or clinical directors from one of the trusts, and a chief executive lead from a different trust, to ensure a sense of balance across the partnership.

Matthew Trainer is the chief executive of Oxleas NHS Foundation Trust and the senior responsible officer for the partnership's forensic services provider collaborative programme.

There has always been a small central function that is dedicated to the running of the partnership. Matthew highlights that it was essential that this small team had enough capacity and seniority to push the partnership's work forward and to build relationships where needed. It now includes a commissioning hub in order to help the SLP best manage the £100m specialised care budget and £35m of CCG complex care budgets it has been delegated to manage to date.

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## The impact of the partnership so far

For Matthew, one of the most positive impacts of the SLP's work to date has been the improvements made in South London's children and young people's services. The trusts' use of children and young people's general adolescent beds has reduced by a third and the average distance of placements away from home has reduced on average from 73 miles to seven miles, thanks to the trusts working together.

They have also been able to reduce the number of forensic patients being sent out of area by a third and bring down the number of readmissions to forensic inpatient services by two thirds. More broadly, Matthew tells us the partnership has enabled the sharing of best practice between the three trusts and facilitated more joined up care for patients and service users across inpatient and community services in South London.

The SLP's work has also had a significant impact on workforce challenges facing the trusts. Its nursing development programme has resulted in a 5% increase in nurse retention rates. The partnership has also worked to develop shared career development pathways and a staff passport so that it is easier for staff to move between organisations and work more flexibly across South London.

All of this progress has meant the partnership has been able to reinvest £9m into the creation and delivery of new local care models to date – for example specialist community forensic services across South London and a new dialectical behaviour therapy service for children and young people at one of the trusts.

Matthew stresses the importance of providers being able to reinvest the savings made through collaborative working into genuinely new and improved services. This gives "real-life" examples trusts can show to staff, patients and the local population more broadly in order to demonstrate the tangible difference this way of working is making.

## Sharing lessons learned

Personal relationships between the chief executives of the three trusts, built on mutual trust and respect over several years, have inevitably been an important factor in the SLP's success to date. Strong leadership modelling from each of the three chief executives has also been vital, as they have made it clear to all staff that working collaboratively is important and needs to be prioritised.

The trusts' chief executives have also made a point of engaging with staff members' concerns about this new way of working – from the frontline right up to board level. For example, any rumours about mergers or politics stemming from new funding and commissioning responsibilities have been discussed openly and honestly. This approach has been equally important when it comes to engaging with key partners and stakeholders outside of the partnership. For example, the SLP had to work hard to allay concerns from some local authorities that the partnership's work might have undermined local NHS accountability and existing borough relationships.

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Matthew also highlights the importance of the partnership's strong investment in staff, genuine clinical leadership from across the three trusts, and use of simple governance that "doesn't make life difficult for individual providers" and involves non-executive directors.

Being transparent about finances and resource allocation has been particularly important. Matthew explains that the SLP has a simple mechanism for reinvesting the surpluses it generates – the funding is split three ways, with an emphasis on "levelling up" any areas where this is needed between the three trusts first and foremost.

He also stresses that the three trusts working together and communicating more informally as "providers who collaborate" has been just as important as the work they do as a formal provider collaborative.

## Challenges

The three trusts deliver services independently where that makes sense, and Matthew emphasises how important it has been for the SLP to focus only on "work that could be done better together than one trust could do alone". He also stresses the value of the partnership's work being guided by three simple principles: care closer to home, better patient experience and outcomes, and better value for the NHS.

Matthew reflects, in particular, on the SLP's attempt to use a collaborative model to deliver a single adult inpatient service across South London. They realised very quickly that it was the wrong scale and type of service for this collaborative model because it is less specialist and has more links at place level than a children and young people's eating disorder or forensic service for example. The trusts are therefore working together to standardise their adult crisis and home treatment service specifications and use a shared clinical model across their own services instead.

A key lesson learned by the SLP was that organisations and individual teams need to understand and work through any cultural differences and incompatibilities. Matthew shares an example of when the SLP had to "wind back" and spend time working on bringing the culture of certain teams from different organisations closer together in order to make the progress the partnership has been able to make to date.

Matthew also stresses the importance of each partner in a collaborative working arrangement being willing to compromise in order to make broader, strategic long-term progress that benefits the local population as a whole. For example, Oxleas has invested significant amounts of funding into an assessment area in one of their local acute hospital's emergency departments to reduce long waits for patients with mental health needs, which has improved collaborative working between frontline staff and also enabled other endeavours to progress.

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## Next steps

Looking to the future, Matthew tells us that working out how the two ICSs and multiple provider collaboratives and places within each will interact with the SLP and its three constituent trusts is a key area of focus and needs to be well thought through.

Discussions are also now taking place between the partnership and its ICSs about taking on more day-to-day commissioning. But Matthew is also keen to emphasise the importance of providers being given the time and support to consolidate the areas they have worked collaboratively on already, before expanding and taking on further opportunities.

## National policy to support provider collaboration

Matthew has some concern about the number of different collaborative arrangements trusts could be involved in and the risk of complicated governance arrangements. Whilst the SLP's governance has become more developed now that it holds formal contracts, Matthew stresses the importance of avoiding overly complex arrangements as much as possible, so as not to stifle innovation and the pace of delivery.

He was also keen to highlight that, whilst the SLP has worked well together when it comes to finances and resource allocation, their focus on targeting new investment to underfunded areas should not be a substitute for addressing any fundamental underfunding of services. Matthew tells us, "some services in South London have a threefold difference in per patient funding depending on the borough, and you can see the impact of this on the time people have to wait to access the care and support they need, and their outcomes."

More broadly, he is concerned about the risks of imposing a lead provider collaborative model onto areas as a "one size fits all model" where it may not make sense or have the right ingredients in place.

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CASE STUDY 2

# West Yorkshire Mental Health, Learning Disability and Autism Services Provider Collaborative

**Partners involved in this provider collaborative**

- Bradford District Care NHS Foundation Trust
- Leeds and York Partnership NHS Foundation Trust
- Leeds Community Healthcare NHS Trust
- South West Yorkshire Partnership NHS Foundation Trust

## Setting up the collaborative

The West Yorkshire Mental Health, Learning Disability and Autism Services (MHLDA) Collaborative was established in 2018 and is part of the West Yorkshire and Harrogate ICS. The boards of each trust involved in the collaborative approved the establishment of a committee in common that year, to help ensure that decisions are made together and in a streamlined way around a shared programme of work, such as service transformation.

The committee in common's membership is made up of the chief executives and chairs of the four trusts with delegated authority from their respective boards, operating together with an agreed memorandum of understanding and a rotational chair from each trust. The collaborative is currently chaired by Cathy Elliott, chair of Bradford District Care NHS Foundation Trust, and supported more broadly by Keir Shillaker, the ICS' programme director for mental health, learning disability and autism.

Cathy and Keir tell us the four providers decided to come together initially to improve the delivery of mental health services that were presenting the most significant challenges to all organisations within the collaborative. This includes those services that are part of the national NHS-led mental health provider collaboratives programme, as well as other areas where this made sense for West Yorkshire and Harrogate, for example: the delivery of complex rehabilitation services, services for people with a learning disability and autistic people, and psychiatric intensive care provision.

At the outset, the trusts worked together to understand their collective use of beds and capacity, workforce challenges and referral criteria across these different service areas. This information was used to assess the potential impact of improved, more collaborative working between the trusts – for example what benefits collaboration would have on reducing the number of people having to be sent out of area to receive the right level of care – as well as the extent to which West Yorkshire and Harrogate might also need additional capacity, and how and where this could be supported through commissioner commitments within the mental health investment standard.

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## The impact of the collaborative so far

Prior to the pandemic, the collaborative was able to demonstrate reductions in people's length of stay within tier four child and adolescent mental health services and adult eating disorder services, as well as the number of people in West Yorkshire and Harrogate having to be sent out of area to receive the right level of care.

They have improved working relationships across the system as a result of their work to date. However, the strength of relationships between the trusts really came to the fore during the COVID-19 pandemic, with the organisations able to share and learn from each others' approaches and responses to the new challenges COVID-19 posed for services and the patients in their care.

Keir and Cathy also feel working collaboratively has given more of a voice to the patient population that the trusts serve within their ICS more broadly, it has enabled partners to speak with one voice and help set ambitions for the whole ICS to reduce the gap in life expectancy for people with mental illness, learning disability and autism compared to the rest of the population by 2024.

Alongside service transformation, an example of successful attitudes to collaboration is the ongoing work to align the training that staff from each organisation receive in prevention and management of violence and aggression (PMVA). The co-production process undertaken has enabled the best examples of good practice from each trust to be shared, jointly reviewed and a more consistent way of working proposed across the collaborative for the benefit of patients and staff. This is now being stress-tested with teams and, if validated, will ultimately mean that staff can be more safely shared across the four trusts.

They are now building on their work to align PMVA training to develop a collaborative staff bank. A bank spanning the whole collaborative has already been put in place, in collaboration with West Yorkshire Association of Acute Trusts, for psychology staff to deliver the area's new staff mental health and wellbeing hub. Keir explains that "the wellbeing hub is a really good example of how, once you're in the mindset of collaborating, it's easier to choose to collaborate in order to tackle the next challenge".

The collaborative has also worked together to support all system partners to make best use of funding to transform the delivery of community mental health services. The MHLDA core team, working on behalf of the ICS, has brought together all place-based NHS, primary care and voluntary, community and social enterprise (VCSE) provision to agree how funds should be split amongst system and place. They have also worked together to agree a standard outcomes framework for the provision of community mental health services and which challenges – such as workforce and information governance – need tackling at scale. This has built upon the existing relationship of trust between collaborative partners and extended this ethos and way of working to others.

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## Sharing lessons learned

Keir and Cathy stress that the fundamental starting point for organisations coming together as a collaborative should be working on the relationships between them and building a willingness to collaborate through the creation of a sense of shared purpose, mutual respect and trust. Cathy reflects on the importance of these relationships and concludes that "what's particularly special about West Yorkshire and Harrogate ICS is that it's a coalition of the willing."

Cathy and Keir also stress the importance of recognising that collaboration is a journey and the organisations involved in other ICSs need to be prepared to redevelop and refine their approach as necessary over time. They have recently introduced a twice-yearly 'strategic session' as part of the cycle of collaborative meetings to give the trusts the opportunity to reflect, problem solve and reset where necessary in order to have foresight in their collective work.

Another key lesson Cathy and Keir highlight is the importance of 'taking everyone with you' and enabling the development of, and engagement with, 'critical friends' when it comes to delivering service transformations. One of the ways the collaborative does this is by holding a non-executive director, governor and lay member meeting twice a year to update and brief them on service transformations before they happen as well as take on board their feedback. Given the complexity of the work across numerous system partners – five CCGs, NHS England and NHS Improvement commissioners, four NHS providers of mental health, learning disability and autism services, five local authorities, multiple primary care organisations, and hundreds of possible VCSE organisations – there are still gaps in communication, understanding and agreement. Importantly though, the role of the collaborative is to learn and improve as it develops and as each piece of work comes to maturity, external communications is on their agenda for 2021/22.

Cathy and Keir also emphasise the importance of involving experts by experience and service users so that the transformation of services is truly co-designed and co-developed. As Cathy explains, "a provider collaborative can be quite hierarchical and it's made up of very senior leaders, but we have to keep bringing it back to what's the experience of service users to ensure person-centred care."

The collaborative has also recently introduced a template assurance report for each meeting of the committee in common, which goes to all four boards to ensure that they receive the same information about what the committee is assured on, alerted to and what further information it is seeking. Understanding the perspectives of different providers within the collaborative and respecting where their interests lie, which may mean not all need or want to be around the table for every particular agenda item, is also an important lesson learned.

Cathy and Keir also stress the importance of having a balance of formal and informal meetings taking place between leaders of each trust within the collaborative. For example, they have set up weekly meetings on a more informal basis between the chief operating officers of the trusts that provide adult mental health services, facilitated by the MHLDA

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core team, which have proved to be really effective. The chairs of each trust also meet informally, before each committee in common meeting at least, to exchange practice and updates.

Cathy and Keir also emphasise the importance of provider collaboratives being clear about the scale they are working at and adjusting what they focus on doing together accordingly. For example, those collaborating on a smaller scale may find it most valuable to focus their efforts on the sharing of good practice.

## Next steps for the collaborative

The collaborative is now evolving to look at how its members might be able to work together on broader areas, such as capital investment, workforce and recruitment, as well as equality, diversity and inclusion. Keir and Cathy highlight that working collectively should enable the trusts to give more opportunities to their staff to work in different ways and in more exciting roles in particular, such as roles with an element of focus on system transformation. They hope this will help overcome recruitment and retention challenges.

Cathy and Keir are also keen to build on the collaborative's work with experts by experience and service users, to ensure the voice of people living in West Yorkshire and Harrogate with mental health conditions is a regular part of everything it discusses and is truly embedded in its governance architecture going forward.

The collaborative is equally focused on the engagement and involvement of VCSE organisations in West Yorkshire and Harrogate at a system level. There are strong partnerships at a place level between the four trusts and the VCSE sector, and so they are now thinking about how they make sure that these partners are part of key conversations and discussions at a system level. Keir and Cathy highlight that this will be crucial to the delivery of the national programme to transform community mental health care at scale across West Yorkshire and Harrogate in particular.

The collaborative is also starting to think about how it gets the interface right between itself and the integration and collaboration happening at place level, as well as beyond the boundaries of their ICS.

## National policy to support provider collaboration

Keir and Cathy tell us they would welcome support at a national level to develop further system leadership capabilities and collaboration skills across all disciplines, given the different skill set required for this compared to those historically necessary to lead a trust or deliver a service within one organisation. Cathy would also welcome the development of peer learning on a more systematic and coordinated basis so that collaboratives can learn from colleagues across the country as they move along the process of services transformation.

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They stress that change management and transformation work requires genuine investment to deliver – that is investment in resources to enable trusts to dedicate existing staff time and energy to collaborate, as well as investment to create and sustain independent, strategic roles that act as a facilitator and 'an honest broker' for the collaborative. At the moment, the collaborative is reliant on a relatively small group of people, a number of whom are also service managers and clinical leaders delivering work locally at place level, alongside some ICS staff on fixed contracts, which does not feel wholly ideal and sustainable. The committee in common is currently considering more sustainable resource in future.

Keir also stresses the importance of ensuring their role as part of (not separate to) the ICS is not undermined as the policy around provider collaboratives develops at a national level. The ability for collaboratives to be able to focus on tackling the challenges that they decide are the right ones to focus on for their local populations is also crucial to maintain.

Cathy and Keir emphasise that the process of setting up, and the continuous development of, a provider collaborative needs to be driven by its constituent organisations based on what works best for their local communities, as opposed to a "one size fits all" model imposed nationally. However, Cathy and Keir are keen to stress that there are a number of "ingredients" that are key to provider collaboratives succeeding, as well as ICSs more broadly. Cathy shares that "it would be helpful for these common 'ingredients' of collaboratives to be set out for providers across the country so that local areas can 'pick and mix' from these fundamental elements based on what works for their local area specifically within their ICS."

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CASE STUDY 3

# Horizontal acute provider collaboration in the Greater Manchester ICS

## Partners involved in this provider collaborative

- Bolton NHS Foundation Trust
- Bridgewater Community Healthcare NHS Foundation Trust
- Manchester University NHS Foundation Trust
- Greater Manchester Mental Health NHS Foundation Trust
- North West Ambulance Service NHS Trust
- Pennine Acute Hospitals NHS Trust
- Pennine Care NHS Foundation Trust
- Salford Royal NHS Foundation Trust
- Stockport NHS Foundation Trust
- Tameside and Glossop Integrated Care NHS Foundation Trust
- The Christie NHS Foundation Trust
- Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust
- East Cheshire NHS Trust

## Background

In April 2016, the Greater Manchester Health and Social Care Partnership was formed. Serving a population of 2.8 million, the partnership is the first devolved health and care system, in charge of the £6bn health and social care budget for the 10 boroughs in which it operates.[2]

The Greater Manchester Health and Care Board brings together all statutory bodies in the partnership (trusts, CCGs and local authorities) and representatives from primary care and the voluntary, community and social enterprise sector. The Greater Manchester partnership executive board is constituted to be the operational decision-making body for the partnership and includes representation from across the health and social care system. Provider trusts are represented on the board by three chief executives nominated by the Provider Federation Board (PFB).

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2 The 2015 Memorandum of Understanding between the government, NHS and Greater Manchester NHS statutory organisations and local authorities delegated certain decision-making responsibilities of NHS England to GM. NHS organisations in GM remain part of the NHS and are subject to the same statutory duties and constitutional standards as those in the rest of the NHS.

CASE STUDY 3

## Setting up the collaborative

Providers in Greater Manchester have a long history of collaboration. Darren Banks, group director of strategy at Manchester University NHS Foundation Trust, tells us that acute provider chief executives originally began to meet on an informal, but regular, basis 20 years ago and that more recently, mental health and community providers, as well as the ambulance service, have joined the meetings. Darren explains, "that decision coincided with the initial discussions in Greater Manchester about devolution. As providers, we had already started talking about how we would move towards greater collaboration and system working and how we could formalise our collective decision-making approach". Providers were particularly keen to ensure their collective contribution to health improvement and delivery of high-quality care and constitutional standards was recognised in the new arrangements.

The PFB was set up as a membership organisation. In this equal share arrangement, each member pays a minimal subscription which covers the costs of a small secretariat, policy and programme support. "We already worked together in several different areas, but constructing PFB gave that collaboration a proper structure, a recognised voice for providers in the system and also ensured that our partners had a mechanism to engage with providers spanning community, acute and tertiary care across both physical and mental illness", Darren says. As such, the PFB has enabled both the system to benefit from provider expertise in those areas where it is needed, and providers to represent collective views to help shape policy and service delivery. This has facilitated more systematic co-design with partners, as well as greater clinical input, at a system level. The PFB member trusts also play a key role in place-based collaborations through the local care organisation approach across Greater Manchester.

## The case for change

As well as enabling providers to have a voice in the Greater Manchester Health and Social Care Partnership, the PFB was established to enable collective decision-making across trusts, provide a strategic approach to transformation and address provider quality and efficiency against the backdrop of the financial challenge. In particular, the core rationale for the PFB is to facilitate solutions which go beyond the remit and scope of the individual organisations in the membership, such as managing cancer pathways across Greater Manchester and dealing with urgent care pressures.

The emergence of the devolved system subsequently brought these objectives into sharp focus. Ryan Donaghey from the PFB secretariat, tells us, "Greater Manchester introduced a strategic plan for the first five years of the devolution experiment. Along with our core issues, that plan drove our agenda to a certain extent because we needed a collective position on many of the issues discussed with partners, particularly commissioners and local authorities."

To help it achieve its objectives, the PFB has an agreed approach to making formal, collective decisions in those areas which are both within providers' remit and likely to have a significant impact on PFB members. The approach seeks to define which

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member organisations need to be part of a specific decision (the eligible constituency) and then proceeds through stages from business case to decision. However, the overriding principle is for the PFB to work on a consensual basis and, importantly, the member trusts retain their statutory duties and accountabilities.

Having the full range of providers across physical health, mental health, ambulance providers, specialist services and community health services as members of the PFB has facilitated transformation conversations across a wide range of issues. Darren also points out that one type of provider collaboration does not exclude another, for example the mental health trusts are also part of the North West mental health provider collaborative and there are shared leadership teams and group models between some of the acute providers.

## The impact of COVID-19

Increasingly, the PFB has put more resource and organisation around its supporting infrastructure, including the director-led sub-groups which meet regularly to carry out work commissioned by the PFB. All of that has been fast-tracked since the start of the COVID-19 pandemic, "We quickly established a Gold Command within the PFB arrangements with key representatives from all trusts and the broader system meeting daily to manage the pandemic response." Gold Command, which continues to operate, drew heavily on the director and multi-professional subgroups to deal with issues like personal protective equipment (PPE) or escalation protocols around critical care.

Darren explains, "We moved a significant number of critical care patients and ventilators between our hospitals to even out the pressure, and moved thousands of items of PPE, so that not a single site fell over."

At the start of the pandemic, system-wide COVID-19 dashboards were quickly developed by Gold Command so they could see what the relative pressure was across the organisations and prioritise resources according to which organisation needed them most. "I think it worked incredibly well," Darren explains, "We were definitely building on the fact that we already had the PFB. We all knew each other well, which allowed us to operate as a hospital system and manage the pressure at a system level." Darren adds, "the common purpose allowed us to overcome any of the institutional barriers that may have arisen in the very early stages..."

The PFB now has clinical reference groups for the five most challenging specialties during recovery and are developing common approaches to the system's biggest challenges, for example orthopaedics. An example of collaborative transformation is the PFB's work with the primary care sector around endoscopy which enabled transformation of the entire pathway which has reduced demand and increased the productivity of the process itself for patients.

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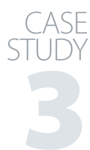


## Priorities for the collaborative

The key priorities for all the member organisations are to deliver high quality sustainable services, responsive to the needs of patients, and in line with statutory and constitutional standards. The PFB enables the sharing of best practice to help them all towards these goals.

In the immediate term, they want to restore services in a way that is fair and equitable for their population, while looking after staff who have just been through an extremely challenging time dealing with the pandemic.

They are also looking to develop their anchor roles within their localities, recognising that more could be done in this area to consistently capture the value added to the system, both in direct care provision and the economic contribution, and to seek further ways to support the Greater Manchester public service ambitions.

The PFB is also discussing its system leadership role, particularly in the areas of service transformation and improvement. These discussions are in the context of the collective approach with partners to the emerging Greater Manchester Health and Social Care Partnership and the opportunities set out in the recent White Paper, as well as the emerging guidance on collaboration. Darren says, "We consciously ask ourselves, is this something for us to do as a collaborative or as individual organisations? We've had a role to play in some service reconfiguration conversations, but this has been limited to clinical and operational advice because we're not the commissioner."

## Sharing lessons learned

One of the key enablers for provider collaboration in Greater Manchester has been the quality and stability of senior leadership relationships. But it takes time to build these. The provider chief executives spend a lot of time making sure that all organisations have the opportunity to participate and to have a leading role on specific projects.

Ryan says "even though we've been collaborating for as long as we have, we still face pitfalls, and it is sometimes challenging trying to get everyone on the same page. Those conversations take time and resources, so I would say to colleagues that they shouldn't underestimate the resources you need in terms of the infrastructure to make it happen." The PFB had relatively little resource over previous years but this was augmented through the management of the pandemic, which certainly helped them to facilitate increased collaborative working.

Looking to the future, Darren says, "Post COVID, we need to recover in a way which seeks to address some of the inequalities which existed across Greater Manchester and have been amplified. That is quite a challenge. But we've got more standardised approaches, we've got more transparency around equity of access to services, and a real drive to work with partners to re-engineer whole pathways working as a system, so we are starting to make progress."

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# Horizontal acute collaboration between acute trusts in the Bath and North East Somerset, Swindon and Wiltshire ICS

**Partners involved in this provider collaborative**

- Bath and North East Somerset, Swindon and Wiltshire (BSW) ICS
- Great Western Hospitals NHS Foundation Trust
- Salisbury NHS Foundation Trust
- Royal United Hospitals Bath NHS Foundation Trust

## Setting up the collaborative

The Acute Hospitals Alliance (AHA) was established in Spring 2018. This wasn't a pre-existing partnership, Kevin McNamara, chief executive of Great Western Hospitals NHS Foundation Trust tells us, saying "we didn't have a track record of working together on big, meaningful programmes". Historically, the trusts pointed in "three slightly different directions so it wasn't a natural geography" but this all changed when the trusts teamed up to provide community health services.

Cara Charles-Barks, chief executive at Royal United Hospitals Bath NHS Foundation Trust and chair of the AHA, agrees with this analysis, noting that the acute provider collaborative had evolved over several years before the chief executives were in their current posts. The starting point, Cara says, was "sharing the work that each organisation was doing, looking at whether there were opportunities for us to work together" for the benefit of staff and patients.

Reframing the AHA's priorities in April 2020 has been a gamechanger for the partnership, heralding a series of ambitious joint programmes that have been established over the past 12 months which focus on delivery and transformation across BSW ICS for the benefit of patients and staff alike. Cara recalls conversations in spring 2020 when all three chief executives sat down and had a "clear conversation about the things we felt we wanted to take forward over the next 12 months – that was the first time I think that we really sat down and committed to formal pieces of work together".

## Building personal relationships

Relationships across the three partner trusts have gone from strength to strength with a real focus by the leadership team on building trust and developing mutual understanding. Kevin tells us that the leadership team was now having, "three or four conversations each week on different things that previously would have been quite alien to the individual organisations".

There is a real commitment to strengthening the leadership team, Cara says, explaining that she, Stacey Hunter, chief executive of Salisbury NHS Foundation Trust, and Kevin recognise

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that, "the strength of what we want to deliver, the opportunities and our collective ambition will be strengthened by the way in which we work together". The three chief executives have, "proactively committed to having joint coaching together" to help take this collaborative way of working into the next phase.

Cara expresses her hope that the commitment of the three chief executives to work together in the AHA will enable them to "develop a framework so that we can have difficult conversations without it becoming personal or disrupting long-term relationships". Kevin adds that another key step forward has been the acute alliance conversations moving from just being a chair and chief executive level discussion to a wider executive-level conversation. This feels like a real gear shift when colleagues such as chief operating officers are engaging with this discussion.

## The case for change

Cara highlights the value in playing to the strengths of each individual organisation, which has benefited the development of the AHA. "Salisbury is really strong on procurement so they will lead that on behalf of the three organisations... we're also looking at some work from a finance perspective where this is a particular strength at Great Western for example". This sense of equity across the three trusts has been important in terms of influencing ways of working across the alliance and within its constituent organisations, with an executive member of each organisation leading a specific programme of work across all three. The AHA is also looking at replicating the Royal United Hospitals Bath NHS Foundation Trust's quality improvement programme in the other two trusts, to support a common approach to transformational change across the alliance.

By playing to each other's strengths and working at scale, the AHA is delivering tangible benefits, with Stacey highlighting improvements for patients, finance, safety and quality and the workforce from this collaborative way of working. She highlights an example of the work the AHA has been doing on children's oral surgery. Waiting lists for this service had increased significantly because of the COVID-19 pandemic. Clinicians across the three trusts worked together to pool staff expertise while also looking at how best to secure access to theatres and other infrastructure. By working together, the clinicians were on track to tackle that waiting list much more quickly than they would have been if working as standalone organisations.

Working as part of the AHA also meant that clinical teams were given the right kind of executive support to allow them to make decisions, Stacey says, which meant that clinicians could do "something really different within two or three months rather than two or three years". This also included reassuring some teams that existing relationships across different hospital sites or tertiary centres were not going to be unpicked.

The collaborative working arrangements in the AHA were particularly helpful at the height of the COVID-19 pandemic whereby providing mutual aid allowed the AHA to deal with serious site, system and organisational pressures. Kevin says, "We were trying to support one another." The experience of the COVID-19 pandemic also unlocked innovation in how some clinical specialities could be better configured across the three organisations,

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with Cara sharing the example of dermatology services which had long patient waiting lists and challenging workforce shortages. By working together and delivering some of this work virtually, the dermatology teams are now offering a much better service to patients, as well as a much stronger employment offer for staff with more opportunities for research and teaching.

Cara also highlights how being part of the AHA has enabled the trusts to quickly move towards setting up a collective elective recovery strategy and single waiting list. Doing so gives the AHA "visibility of the needs of all of our patients" Cara says, and helps the trusts "work out where we've got inequity of access" and what needs to be done to tackle that.

Cara also points out that collective working by the three acute trusts puts them in a stronger position to influence the ICS wide strategy, "We're then able to influence that into becoming a BSW-wide strategy that then creates a much better, collective and fair offer for patients but also importantly helps us start to address where we've got inequality because, particularly around elective pathways, the inequalities will be huge coming out of COVID".

All three trusts view the work through "both a horizontal and a vertical lens", Cara explains, which are both equally important in improving population health in their local communities and ensuring the sustainability of each individual organisation. There are many "layers of the onion", with each organisation focusing on neighbourhoods, place, the acute provider alliance and wider provider collaboration, and the ICS itself.

## Challenges

It hasn't all been plain sailing though. Working as part of an alliance comes with challenges for individual organisations. Stacey explains, "how do I try and influence and support my board through a conversation that on the face of it, is not great from a Salisbury Hospital point of view but is absolutely the best thing for the Salisbury and South Wiltshire population. This is a whole different conversation".

The AHA has sought to tackle this challenge head on, with Kevin saying, "We've also been a bit more explicit about various red lines". He added that the coaching the three chief executives have committed to having would "help those difficult conversations further down the road". The chief executives hope this coaching will also help them realise the art of the possible through their collective leadership.

There is a real commitment to openness, transparency, and accountability, with the AHA placing a strong emphasis on accountabilities within the provider alliance and ensuring there is clarity over who is accountable for which specific pieces of work. The AHA is also starting to have some of the more challenging conversations around contracts, governance, equity of access to services and funding. One of the key lessons learned from the AHA is to invest in relationships and have honest conversations, so that you can then discuss the "really tricky" issues and gain momentum on tackling tangible programmes which will demonstrate benefits to each provider board. The challenge will now be, as Kevin put it, to navigate what is best for local communities and what is in the White Paper and national guidance.

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## Next steps

Kevin highlights the impacts of the policy shift in recent years to system working and how this has changed how organisations who were previously in competition with each other, now work collaboratively. Leadership changes are a key driver in pushing forward system working, Kevin says, with Stacey having "joined from a system that is further down the line on this" and Cara having "gone to a new trust in the same ICS bringing a different perspective and approach there – that leadership change has helped pull that part of the system together a bit more". All three chief executives agree that this shift in mindset was deliberate and crucial to the development of the AHA, as trusts move away from being organisationally focused and a culture of competition towards doing what is best for the local population.

There is now a concerted effort to recruit individuals who could contribute to system leadership rather than just organisational leadership. Stacey agrees with this perspective, saying there was a "deliberate strategy to recruit people who were partnership and population orientated, not just people who could run hospitals". This has embedded the approach that the partnership serves the populations – not its three chief executives.

## Partnerships and population health

All three chief executives are mindful of the huge impact of COVID-19 on their patients and populations, particularly in exacerbating existing health inequalities. Stacey sees a role for the AHA in making sure "that our hospitals are organised around what our populations need rather than what we as individual hospitals determine needs to be done – there is a really big difference in those two things".

Having a "strong voice for acute hospitals in our broader ICS partnership" is also essential, Stacey says. There are also benefits for the ICS to not "always have three conversations" with each individual acute trust. All three chief executives agree that positioning within the ICS is key for the AHA, with a real focus, Stacey says, on "serving the partnership rather than trying to tell the partners what to do".

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CASE STUDY 5

# Cross-system provider collaboration across the Dorset ICS

**Partners involved in this cross-system collaboration**

- Bournemouth, Christchurch and Poole Council
- Dorset Council
- Dorset Clinical Commissioning Group
- Dorset County Hospital NHS Foundation Trust
- University Hospitals Dorset NHS Foundation Trust
- Dorset Healthcare University NHS Foundation Trust
- South Western Ambulance Service NHS Foundation Trust
- Dorset Primary Care Networks (PCNs)

## Background

Health and care organisations across Dorset had a history of working collaboratively long before the national ICS programme was established. Conversations about the shape of health services in the county started as early as 2013, with the launch of 'The Big Ask' public engagement process. This contributed to the formulation of the Dorset NHS System Collaborative Agreement in 2017/18 and 2018/19, which set out shared performance goals and financial controls for Dorset as well as plans to deliver the agreement.

The Dorset ICS has a population of over 800,000 people and includes two acute hospitals, approximately 80 GP practices, 18 primary care networks (PCNs), a community and mental health trust, a single CCG and an ambulance trust as well as two county councils.

We spoke to Stephen Slough, chief information officer for Dorset County Hospital NHS Foundation Trust and Dorset CCG, about his experiences of leading a programme of digital transformation across the ICS. He shared his thoughts about why integration of health and care services across Dorset has progressed so well.

## Setting up the collaborative

Stephen discusses the workstreams that have been set out in the ICS transformation programme and focuses on how this provider collaboration will come together. The ICS has identified two places of delivery, Bournemouth, Christchurch and Poole Council and University Hospitals Dorset in the east of the county and Dorset Council and Dorset County Hospital NHS Foundation Trust in the west. Community and mental health services and GP practices will span both.

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Stephen is keen to ensure the current digital technology portfolio and solutions, such as the Dorset intelligence and insight Service (DiiS), do not get "watered down" when the new system is put in place amid concerns that two teams delivering two lots of services may start to pull apart. Ideally, Stephen tells us, he would like to see a single back-office function for digital rather than two separate ones.

## Impact of COVID-19

Stephen says joint working between NHS organisations and local authorities in Dorset came into its own during the COVID-19 pandemic, and in particular with the roll out of the vaccination programme. He tells us more about DiiS, which was designed by clinicians and professionals – and the rapid speed with which they were able to use this to set up a COVID-19 dashboard.

The dashboard "has grown and expanded over the last 12 months" Stephen says, and now includes "everything from daily infection rates, COVID-19 test results, number of deaths, staff absences in both primary and secondary care settings, mortuary capacity, crematorium capacity, PPE stock... this single dashboard brings together all the information that trusts and primary care need to stay on top of what is happening across the ICS".

Stephen adds that the dashboard also includes "significant quantities of data from local authorities... including demographic data". This has been particularly important during the roll out of the COVID-19 vaccination programme, Stephen tells us, as the availability of local authority information on ethnicity and deprivation deciles allows the ICS to "map those factors against vaccine take up", alongside other information on areas which had high infection rates. Stephen adds that bringing this data together from across the system partners enabled them to address geographic pockets of the ICS and particular population groups where vaccine uptake was low. It also enabled them to address other factors and identify barriers, such as access to public transport and accessibility of vaccination centres. Recognising the impact the DiiS has on the population and to encourage others to realise the potential of following the example set in Dorset, Microsoft created a global case study to showcase the creative use of their products to power the DiiS.

Stephen tells us the pandemic has accelerated the use of data and digital platforms, which are "becoming central to everything now", and that this has led to local authorities and the local university getting involved as well. For example, joining data together has created "additional spin offs" including supporting population health management and discharge processes.

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## Sharing lessons learned

Stephen tells us about the importance of close relationships and collaborative working between NHS partners and colleagues in local authorities in both identifying and tackling deprivation and isolation. This collaboration has enabled measures to be put in place to address health inequalities and improve access to services. Stephen notes that they were able to build on the well-established relationships between primary and secondary care

in the Dorset ICS, which enabled patients to flow in and out of services without the usual barriers. He points out that while different organisations have their own culture and ways of working, it is vital that individuals can work together for the common good. "If you can't get on with each other, this will show up in the work you deliver and the results you achieve".

Stephen discusses how having a common foe, in this case COVID-19, acted as a catalyst for partners to put aside their organisational differences and focus on getting the job done. It was very much a case of "the NHS versus COVID" he says, which meant that any tensions, for example, in the provider-commissioner relationship, took a back seat while treating patients, re-allocating PPE via mutual aid and sharing staff across organisational boundaries took centre stage. The ICS is now "trying to work out how you keep the best elements of what we've gone through in the last 12 months and retain that as the way of working because it has made all our lives so much easier".

Thinking specifically about the ICS' digital journey, Stephen notes this is an uphill battle because it has been a back-office function for a long time and needs significant central investment to get it back onto a functioning, sustainable footing. However, as a first step, Stephen suggests finding advocates within individual organisations – such as chief clinical information officers, chief nursing information officers and digital midwives – to help build up and promote digital technology internally. Learning about the solutions they need to make their professional lives easier, and then fixing those things first, is key, Stephen says, because then these individuals will help "advocate for digital transformation and cultural change among their colleagues and teams".

## Challenges

Despite the significant progress that has been made towards integrated working across Dorset, Stephen notes "it's definitely not all plain sailing". Compromise seems to be key: colleagues get together and have open conversations and are able to make collective decisions to move forwards.

Stephen adds that a lot of work has gone into convincing leaders and health professionals that data and digital is the way forward. He says, "from a technology perspective, we have done a lot of work to persuade people that our digital aims and products are actually possible and to explain why they should trust us when we say this data stuff really is the future. We have worked hard to convince colleagues that we need to move into modelling and artificial intelligence as well". Stephen is keen to ensure that the DiiS and Dorset care record do not get watered down and re-fragmented by the focus on place. To avoid this, together with system partners he is developing plans with funding from the digital aspirant fund to have a single patient administration solution across the ICS.

Reflecting on the lack of central investment in IT over successive years, Stephen expresses concern about the risks this now poses to patient safety. He says, "we're now at a point where either very old, or poorly implemented technology risks negatively impacting the quality and safety of patient care. For example, if the WiFi is not working in the hospital and you can't get access to your drugs administration system, you can't prescribe to patients

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anywhere other than a fixed point in the pharmacy, this will slow down, or halt discharging the patient or disrupt the delivery of their continued care as an inpatient". Investment in this area will improve patient care both within the organisation and across the wider system.

## Next steps

Looking to the future, Stephen is keen to expand the scope of the DiiS to help with demand and capacity management. The ICS is working with suppliers to explore whether it can turn historical information into a forward view which models demand and capacity. Linking this to smarter patient records could lead to more effective staff rostering and service preparedness ahead of major events, for example. Stephen tells us, "if you've got better intelligence, you can develop better plans, be better prepared, and afterwards you can review, evaluate and improve them".

Stephen also draws attention to the ICS' focus on its new 'Think Big' initiative, which aims to bring together "many of Dorset's outpatient services or procedures" in one place to help tackle elective care backlogs.

## National policy to support provider collaboratives

Stephen is clear that a key source of support from national NHS leaders and the government would be additional funding for digital. Stephen suggests it would be helpful for a "guaranteed percentage of an ICS' budget to be made available for digital improvement every year so that the ICS can plan strategically and consistently". He adds "There needs to be a commitment to revenue based, not capital funding", as services are increasingly moving to cloud-based models. Long term funding predictability is key, he says, adding that this needs to be accompanied by "financial leadership in our systems becoming more entrepreneurial".

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# Community provider and primary care collaboration across the Sussex ICS

**Partners involved in this provider collaborative**

- Sussex Community NHS Foundation Trust
- East Sussex Healthcare NHS Trust
- NHS Brighton and Hove CCG
- NHS East Sussex CCG
- NHS West Sussex CCG
- Brighton and Hove PCN
- East Sussex PCN
- West Sussex PCN

## Background

The Sussex Health and Care Partnership covers a population of over 1.7 million people across three local authorities including Brighton and Hove City Council, East Sussex County Council and West Sussex County Council.

There are currently three collaboratives operating at ICS level in Sussex, including the mental health collaborative, the acute collaborative network, and the most recently established primary and community care collaborative network. They all report into the ICS health and care partnership executive once a month.

Siobhan Melia, chief executive of Sussex Community NHS Foundation Trust, chairs the primary and community care collaborative network at ICS level, and her colleague Kate Pilcher, chief operating officer at the same trust, leads on work at place-level. The network was initially set up in summer 2020 and Siobhan says, "it's been difficult to think forward this year, but now is the right time for us to try and create some headspace".

The primary and community care collaborative network, as Siobhan tells us, has a number of different organisations around the table, including the chief executive at East Sussex Healthcare NHS Trust, executive managing directors from the three CCGs who are responsible for either community services or primary care, and clinical directors from the PCNs. The collaborative also has representation at ICS level, including the director of the ageing well programme and the director of long-term conditions programme. They are also looking to include representation from a director of public health.

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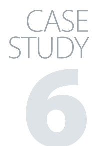


## Setting up the collaborative

Siobhan explains that the main purpose of the primary and community care collaborative is "to provide strategic leadership and a collaborative approach to the planning and delivery of primary and community care services across Sussex" in line with the ambitions of the NHS long term plan. They operate both at scale and at local level, as they are developing a high-level primary and community care strategy for Sussex, with a view to delivering integrated models of care at neighbourhood level.

## The impact of COVID-19

While they had several pieces of work exploring how they could tackle health inequalities before the pandemic, Siobhan says "COVID-19 has undoubtedly shone a spotlight on inequalities on so many levels". Sussex Community NHS Foundation Trust employed a public health consultant for the first time a year ago, and this has enabled them to think more comprehensively about population health, prevention and inequalities. "We are now in a good place to think over the coming year, 'how do we go further and faster with what we've got in place and what we've learned?'".

Siobhan and Kate both highlight a number of positive changes that have taken place during the COVID-19 response that enhanced collaboration, including accelerating digital services, which has transformed how they deliver care to patients in the community. Smaller peer groups across providers and commissioners have been set up to discuss and test potential workstreams before jointly presenting them to the wider network, integrating COVID-19 discharge hubs in line with the government's hospital discharge service guidance, and now thinking about what recovery looks like for the primary and community care sectors.

Siobhan tells us the collaborative's discussions about recovery have largely focused on restoring wider access to primary care services, and for community health services the priority is to tackle the most challenging waiting lists, such as diagnostic services for autism, access to speech and language therapy, pain treatment and musculoskeletal conditions. All the partners in the collaborative want to ensure they effectively restore access to services and address the backlog for these life-changing and long-term conditions, among others.

She also discusses the positive impact of the COVID-19 vaccinations programme on primary care engagement with the ICS. She says, "we now have a weekly ICS programme board meeting to discuss strategy, tactics and delivery of the vaccination programme across Sussex, with a strong focus on addressing vaccine inequality. Representation is from a wide primary and community setting, with a clinical director from every PCN, or the federation representing them, the directors of public health from the three local government organisations, Healthwatch, myself and the ICS system leader". She notes that this may not necessarily be the governance structure that is "here to stay" as the vaccine programme continues to evolve, but the conversations that have taken place have been really balanced and collegiate and highlight the value of coming together.

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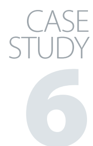

Siobhan reflects on the impact of COVID-19 over the past year and concludes , "I think there's potential to get to the point where we can engage on a better footing off the back of how we've had to come together in adversity".

## The case for change

Kate discusses work underway at place level in Brighton as an example of effective provider collaboration. They have developed a shared system discharge improvement plan, with a collective focus on delivering key success objectives in four domains, systems and processes, capacity modelling, ways of working and communication. The team is developing shared outcomes for patients rather than looking at organisational components as individual health and social care providers. Siobhan says they are in the early stages of looking at the metrics to determine the level of impact collaboration has had, such as on the referral pathways to a community bed or a patient's home. This will be something they will continue to monitor going forward and they will hopefully then be able to aggregate this work into West Sussex and then expand it to East Sussex as well.

Kate also notes that collaboration means they can share workforce more effectively in Brighton. She explains, "we've had memoranda of understanding in place to be able to share staff across providers throughout the pandemic". They have also looked at workforce in the context of business continuity for care home staff and how they can all support each other to deliver care to the population.

## Sharing lessons learned

Relationships built around a shared purpose have played a huge part in strengthening collaborative working. Siobhan points to the partnership they have with acute and adult social care colleagues, and how the collaborative approach of bringing everyone together under a common purpose has really changed things. She also touched on setting up peer groups, including a chief medical officers' group and a chief nursing officers' group across providers that functions as a forum to discuss ideas before they are proposed to the collaborative network.

Siobhan also reflects on the COVID-19 vaccination programme and how it brought providers across primary, secondary and adult social care together in a way that the incident management response hadn't. She says the vaccine programme enabled a common purpose for delivery, and the recent decision to have frontline GPs 'at the table' of the collaborative has gone down very well.

"I've been a strong advocate since we set up the primary and community care collaborative network to have the frontline GPs, who are very visible in the community here, involved in these important discussions".

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## Challenges

Siobhan is clear there are challenges around deciding what happens at place, provider collaborative, and ICS level. She says, reflecting on the recently published white paper, "it seems place is going to have a bigger role than we first thought". She also shares some of her thinking around what happens at system level and at place level for community services, explaining that it would be beneficial to agree a best practice standard and funding for community health services across the Sussex ICS, and for places to hold responsibility for delivery, which can then be nuanced to meet the needs of their populations. Kate adds that the thinking around community care in its broadest sense, such as discussions around the number of community beds across the system, needs to be decided at ICS level.

The relationship between the provider collaborative at ICS level and the place based executive partnerships is also an area Siobhan and Kate highlight as a current challenge. Siobhan says there's an ambition at ICS level to be more collaborative and enable decisions to be made in partnership, but notes that there still seems to be a disconnect at place. Kate says, "I think at place level there is still a degree of variation in decision making across Sussex which is possibly a result of still having three CCGs". They both agree that the strategic direction in the NHS White Paper will improve alignment, as there will be one ICS NHS body across Sussex accountable for the commissioning of services.

## Next steps

One of the core projects for the primary and community care collaborative network focuses on population health management, and Siobhan says, "I think we need to step into a space that says we can understand communities in ways that the acute providers can't" and show how we're making an impact to address health inequalities. She hopes to do this in partnership with primary care, the voluntary sector and local government partners.

Siobhan also highlights how it will be important to recognise pathways that interface with the acute collaborative network. She says "our provider chief executives acknowledge the need to remain close on some of the pathway developments within acute services as they will obviously pervade across acute, primary and community services. It is important that some of these pathways are starting to be articulated through the lens of primary and community care, and from the perspective of prevention, rather than just from the lens of hospital appointments, outpatient elective recovery, etc."

They are also looking to review their community bed model and think more creatively about the right place for patients to receive their total pathway of care. Siobhan says there is scope for them to think about the out of hospital model, which Kate agrees will be "absolutely critical for future investment in community services as the right thing for most people is to be at home rather than in a community bed". Siobhan welcomes the fact that collaboration at ICS level and the move to one commissioning organisation creates, for the first time, a Sussex-wide approach to community beds.

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## National policy to support provider collaboratives

Siobhan highlights that each ICS is very different from the rest, which means that provider collaboration also looks different within each system. She is concerned that the current national policy proposals focus narrowly and predominantly on inter-NHS collaboration, when non-NHS organisations, such as local government partners and a range of voluntary sector organisations including hospices, have a key role in the community sector.

She says, "I don't think all collaboratives need to be structural and to follow the same blueprint. One of my concerns about the white paper is that they will shoehorn structure and make it overly complex, which will get in the way of doing what is right for patients and populations, particularly for primary care". She adds that members of the primary and community care collaborative network have had really helpful discussions during the pandemic, for example planning the community long COVID service, and what this means for primary and community services in the context of projected demand, and she would like to continue in this spirit.

While Siobhan acknowledges that it might make sense for some smaller scale community providers to focus on place, there is a clear case in ICSs like Sussex to bring together primary and community care services at scale to have a strong voice at the ICS table where they can demonstrate their value and influence the overall ICS strategy.

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# Community provider and primary care collaboration across the North West London ICS

**Partners involved in this provider collaborative**

- Central London Community Healthcare NHS Trust
- Hounslow and Richmond Community Healthcare NHS Trust
- West London NHS Trust
- Central and North West London NHS Foundation Trust

## Background

North West London serves a population of 2.4 million people across eight boroughs including Brent, Ealing, Hammersmith and Fulham, Harrow, Hillingdon, Hounslow, Kensington and Chelsea and City of Westminster.

Four providers within the North West London ICS footprint have operated an out-of-hospital community provider collaborative on an informal basis for at least two years, and conversations within the system are now underway to formalise the existing arrangements.

Andrew Ridley, chief executive of Central London Community Healthcare NHS Trust, and the local care senior responsible officer for the ICS, is leading a programme of work to standardise the community services 'offer' across the North West London ICS as part of this collaborative.

While the North West London ICS functions as the lead ICS for Andrew's trust, the organisation runs services across three other ICSs including Hertfordshire and West Essex ICS, South West London ICS, and North Central London ICS, adding a layer of complexity to managing collaboration across different systems and places.

## Setting up the collaborative

Andrew explains that it all kicked off with a conversation between the provider chief executives within the ICS about the variation in non-elective admission rates across the eight boroughs. They began to discuss what they could do collaboratively to address this variation both within the acute trust setting and in the out-of-hospital space.

"It put a spotlight on the fact that there were different community based rapid response services in each of our eight boroughs, each commissioned by a different CCG". They operated to different specifications, and the fragmented commissioning model meant patients in one borough received different services to their neighbours.

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It was also particularly challenging for other providers, like the London Ambulance Service NHS Trust, which sit in the middle of the patch and look after patients from different boroughs, to refer a patient to the most appropriate community based rapid response service because the landscape was so complex. Similar challenges were faced in the commissioning of community beds, whereby patients could only access the beds in a trust if they lived in one of the boroughs that commissioned those beds.

"So it was that conversation that kicked off a piece of work that started to look at harmonising our rapid response services, their specification and our capability for core community services across the ICS."

## The impact of COVID-19

The COVID-19 pandemic accelerated work to harmonise rapid response services across the footprint – each borough now has consistent opening hours, referral pathways and clinical capability. The collaborative had been operating for about a year before the pandemic, but the COVID-19 response and emphasis on collaboration and mutual aid really catapulted community providers' joint working forwards. When the infection prevention control guidance was initially published, the community providers decided to take a unified approach to managing bed capacity across every borough during this period of operational intensity, rather than as individual trusts. Andrew says this has led them to now undertake a formal bed review across the system and to establish a pilot "community bed bureau" to ensure they have the right number of beds and there is consistency in length of stay across all units. "I think COVID has undoubtedly had an amazingly catalytic effect... it just put the finger on the fast forward button, so suddenly the theoretical conversations stopped being theoretical and the 'them and us' mentality ceased... It took away the friction that you normally get when you're trying to manage change."

## The case for change

Despite the complexity of provider collaborative arrangements, Andrew highlights that "if you take it to its core principles of collaboration and transparency rather than competition it is discernibly much better." Throughout the duration of the pandemic, it was clear that trusts were communicating as one system, and Andrew believes this will play a significant role in the elective care recovery going forward.

He also emphasises some of the benefits the shift from competition to collaboration has had for NHS staff. "I think the melting away of competition is quite significant for them because it allows them to focus on delivering services to their populations, and not have to worry about losing their contracts" to another service. They still relate mostly to their immediate team rather than the wider ICS, however Andrew has noticed that his staff do feel a strong association at place level. He also emphasises how important the shift to digital has been in the past year in enabling frontline staff to feel more connected to their wider organisation and senior leadership team.

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## Sharing lessons learned

Andrew says the work they undertake as a collaborative is very much provider-driven and supported by the wider system, with an ICS local care team that supports change and improvement. All provider chief executives sit on the ICS board and are really engaged in the work of the ICS, as well as the borough-based teams.

He does also stress that the context in London is quite different and complex to other parts of the country. He says, "In North West London there are many trusts operating within a densely populated area, and so fragmentation drives inefficiency and inequity in a way that it potentially doesn't if you were talking about Dorset or Devon." He says, "I would give careful thought if I was running a trust in a different area of the country", and would consider the differences in population utilisation flow, the number of trusts and their catchment size when thinking about provider collaborative arrangements.

He also contrasts the collaboration taking place in the North West London ICS to arrangements in Hertfordshire and West Essex ICS, where the Central London Community Healthcare NHS Trust is the main community provider in the South and West Hertfordshire Integrated Care Partnership (ICP), with a population of over 600,000. In this context the provider landscape is simpler, with a majority of people receiving treatment at one acute trust, the West Hertfordshire Hospitals NHS Trust, and service collaboration mostly occurring at place level with the ICP in London patient flow is more complicated and requires ICS level collaboration.

## Next steps

Discussions are under way to formalise the collaborative arrangements across the community providers in the North West London ICS, and questions have arisen around the scope of the collaborative: should it continue to include just community health services or should it extend to cover other local care services? How does it relate to the existing separate mental health collaborative? However, it is currently unclear how the community providers would have sufficient capacity and resource to deliver such a large scope.

Another challenge Andrew highlighted is around determining how the current at-scale community provider collaboration relates to the ICPs, and how duties and budgets are allocated, for example at place level or through the collaborative.

There may also be an opportunity to explore strategic commissioning functions and expand the collaborative's remit to address health and resource inequity across the ICS. Andrew pointed to the inequity across the eight boroughs, whereby the outer boroughs have significantly less service provision which is exacerbated by ongoing resource inequity, in comparison to the inner London boroughs.

Devolving budgets to ICPs could help address this inequity. The North West London ICS has eight 'place-based' boroughs, each with a quartet of directors covering primary care, mental health, community health, and the local authority to improve patient outcomes and service

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delivery. A key challenge is how to strategically move resources and make funding more equitable and needs-based across the whole ICS.

## National policy to support provider collaboratives

Andrew emphasises the need to keep national policy around provider collaboratives permissive and open to enable different ways of working collaboratively to take shape across different ICSs. He says the national thinking also needs to acknowledge the strategic role of community providers not just at place level but also within at-scale collaborative arrangements. He also says technical guidance could be helpful around governance and accountability, particularly as his collaborative could take on strategic commissioning functions in future and would need to be held accountable for delivering on this. Clarity on who they would be accountable to and for what will be needed if they do receive budget. Furthermore, there are questions around how a collaborative decides what work it would focus on and whether they would need to go through public engagement to prioritise work areas. Evidently, there are still very important questions that need to be answered by community providers and their partners, in a permissive, enabling environment.

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CASE STUDY 8

# Collaboration between at-scale primary care and secondary care: Modality Partnership

**Partners involved in this provider collaboration**

- Airedale, Wharfedale and Craven (10 GP practices)
- Sandwell and Birmingham (13 GP practices)
- East Surrey (3 GP practices)
- Lewisham (3 GP practices)
- Mid Sussex (4 GP practices)
- Walsall (10 GP practices)
- Wokingham (2 GP practices)

## Background

Modality Partnership brings together 49 GP practices that operate primary health care and community health services across the country. It started with two GP practices in West Birmingham merging to create Modality Partnership in 2009. Modality now serves more than 400,000 people and has been at the forefront of at-scale development in primary care since they began.

Naresh Rati, a founding partner of Modality Partnership, tells us about the partnership and how they collaborate with secondary care providers – mostly focusing on Sandwell and Birmingham, where Modality was initially founded.

## Setting up the partnership

Naresh says that "there was a like mindedness" among the two founding GP practices who began to see "there was something more to this than doing it on our own" back in 2009. It initially began with the intention to streamline processes and reduce duplication, for example they would share intelligence about meetings they attended to help manage their workloads and began to share back-office functions.

They started out by developing solutions to help struggling GP practices and over time, as their impact and benefits became more recognised, the partnership grew to what they have now. They became more innovative and proactive in their approach, which eventually led to them becoming one of the new care model vanguards in 2015. This enabled them to get further funding to build on their collaboration.

"So, progressively the partnership grew from two sites to five and then to six and so on. We started to be more innovative and eventually became a vanguard which propelled us to a whole different mindset."

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The partnership also started to think about sustainability and diversifying their business model. Naresh says "we started to think about what else we could do to add value to the system. And that's when the outpatient business was born". Exploring the role of GPs in an outpatient setting, as part of the *GP plus* programme also provides more diversity to GPs' roles and is "breaking down the walls between primary and secondary care". Both primary and secondary care clinicians enjoy working across different settings, and these kind of portfolio careers provide a more attractive employment offer.

Naresh says the goal of the partnership now is to become more resilient and shift the focus towards population health and address challenges facing the primary and secondary care workforce.

## The impact of COVID-19

Because they have been collaborating for a while, Modality practices were more prepared to manage the pressures and uncertainties brought about by the COVID-19 pandemic. The partnership was able to open specific practices up as COVID-19 hubs and produced uniform infection prevention and control guidance across all practices to streamline the process in a consistent approach. "Being an at-scale provider means we have a lot more Lego pieces to work with."

During the pandemic, they also modelled different scenarios to help them to forecast demand throughout its duration and beyond, and this prepared them to manage the second virus surge collaboratively. While waiting times have rapidly increased overall in the NHS, Naresh feels that collaboration has made this significantly more manageable and has made their services more "COVID proof". They continue to use modelling to predict future demand and account for potential new variants, future spikes and the potential increase in patients presenting with mental health issues.

He also notes that while they haven't been on the frontline dealing with the pandemic in the same way that hospitals have, the COVID-19 vaccination programme has helped them play an important part in the broader response.

## The case for change

Naresh uses a case study example of Modality's community-based specialist cardiology service in Sandwell and Birmingham to explain the benefits of collaborative working during the first wave of the pandemic.

The inner-city population is known to have a high burden of cardiovascular disease, so it was important that they set up a COVID-19 secure environment to give patients the confidence to attend their appointments, receive the care they needed and reduce the number of patients presenting late.

The integrated cardiology care model delivered by Sandwell and West Birmingham Hospitals NHS Trust and Modality enabled them to maintain low outpatient waiting times

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throughout the pandemic. While hospital consultants and other staff were redeployed to support the pandemic response, which meant backlogs were building up in outpatient services, they were able to increase capacity within community clinics so patients could continue to access the care they needed within four weeks of referral. Consultants, GPs with extended roles and other specialist staff such as echo technicians and cardiographers would run clinics, often at evenings and weekends to keep on top of the outpatient cardiology demand and prevent big backlogs from developing.

Naresh says, "there's no question that collaboration has eased the pressure, because we're on the same team, helping each other out". This partnership model has meant Sandwell and West Birmingham Hospitals NHS Trust has managed to maintain a low wait time throughout the pandemic as patients felt more confident attending a community-based clinic than going into the hospital environment during the pandemic, with 91% of patients saying they would recommend the service to their friends and family.

## Sharing lessons learned

Naresh says that relationships and trust between partners is so important for developing effective partnerships, but this all takes time and effort to build. Having these good relationships makes it easier for partners to feel they can be open and transparent about sharing issues and challenges and "removes some of the worry about losing a service to another provider".

Naresh also notes that because of the history of competition within the NHS, it is difficult to shift to a culture of collaboration. He says, the new care models vanguard programme helped build trust between partners and shift to a more collaborative culture. "Setting ourselves up as a vanguard really helped pave the path because it really did bring people together... it was this little piece that connected us". As a vanguard in 2015/16 they started piloting services with a local trust who sub-contracted work to them, and this really helped pull them together and benefits have been realised for both parties.

## Next steps and national policy to support provider collaboratives

Naresh touches on tensions that could arise as provider collaboration develops, particularly around collaborating at scale and having a seat at the table, so this will be something to work through. Naresh also hopes that the national policy changes to provider collaborative arrangements won't impact the successful collaboration already taking place within Modality Partnership and with their partners, as primary care's role at system, place and neighbourhood level is essential to achieving the ambitions of integrated care.

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# Vertical integration at place level in Bradford District and Craven ICP

**Partners involved in this vertical integration**

- Airedale NHS Foundation Trust
- Bradford Care Alliance Community Interest Company
- Bradford Care Association
- Bradford District Care NHS Foundation Trust
- Bradford District Voluntary and Community Sector Assembly
- Bradford Teaching Hospitals NHS Foundation Trust
- City of Bradford Metropolitan District Council
- NHS Bradford District and Craven CCG
- Primary care providers

## Background

The seeds of today's partnership were sewn back in 2011 when local health and care organisations came together to create an 'integrated care for adults' programme. The partnership brought together the providers, local authority and commissioners at the time to implement this piece of work following the Health and Social Care Act 2012. They collaborated in their own way in response to local population needs, which did not always fit into the mould of national policies and programmes, such as the new models of care vanguards.

Helen Hirst is the chief officer for Bradford District and Craven CCG and the senior responsible officer for the ICP development work in West Yorkshire and Harrogate ICS. She tells us how "in our context, the CCG is seen as the collaborator pulling the partnership together, which is a bit different to how some other systems operate." In 2015, the CCG made a commissioning policy decision to not use competitive procurement as a first option, and instead work with their provider market. This evolved into a unified approach to funding and commissioning services across the partnership and influences their ICP today.

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## Setting up the collaboration

Helen tells us one of the early projects was their transforming diabetes programme. She says, "the programme has had its challenges, but it brought the providers across acute, community, primary care and mental health together – and that was the key objective." She says it also "brought commissioning into a different space where we were facilitating and supporting providers and their services." While the transforming diabetes programme did not achieve all its intended outcomes, it did demonstrate that collaboration was part of how the system and system partners worked.

In 2017/18, a strategic partnering agreement was in place between the providers, local authority, voluntary and community sector and the three CCGs at the time. Helen says, "we decided to close our financial year in a collaborative way, and from then on we didn't have individual contractual discussions." Helen also tells us how the CCG decided to use the system wide surplus to support providers as well as investing in projects such as the 'Reducing inequalities in communities' programme. Interestingly, this did have a negative impact on the CCG's rating from NHS England and NHS Improvement, but "it was the right thing to do because it enabled us to think more about wider population health."

In terms of the governance arrangements, James Drury, the programme director for the ICP board, tells us how partners across the whole system are part of the decision making process. The board includes representation from the chief executives of trusts, the local authority, social care providers, primary care and the chair for the voluntary sector assembly. The voice of PCN clinical directors is brought in through a clinical advisory board.

Andrew Copley, the system finance director for the ICP, adds that they now have a system finance committee with representation from across the whole partnership. This means there's a focus on collaboratively managing the total resource allocation for the place.

## The impact of COVID-19

Helen tells us how the relationships they have developed over the years made it easier to respond to the COVID-19 pandemic. Out of this partnership approach a new *Act as one* programme was developed during COVID-19 to help them plan the recovery and restoration of services as well as preparing the ground for the future health and care landscape.

Kim Shutler, chair of the Bradford District Voluntary and Community Sector Assembly, tells us how partners from the ICP came together as part of the COVID-19 response in a different way to elsewhere in the country. There was a seat at the decision making table for voluntary and community sector representatives. She participated in the NHS Gold Command cell leading the operational response and tells us how "the role that voluntary organisations play in the health and care system is recognised here." This has now evolved into a strategic coordination group which has enabled them to mobilise interventions within their communities more effectively, such as thinking about "how we can get health messaging into neighbourhoods, schools and other local community settings."

Mel Pickup, the chief executive of Bradford Teaching Hospitals NHS Foundation Trust who started her role in early 2020, also highlights how "COVID-19 really short-circuited the normal period of time it would have taken to build relationships because we saw much more of each other virtually than we would have in normal times." She discusses how some of the lessons learned from the COVID-19 response around improving remote access to services is being used in the development of new programmes with primary care to keep people out of hospital as much as possible.

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## The case for change

The *Act as one* programme has enabled the development of a shared set of workforce principles and policies to allow staff to work together across organisational boundaries to deliver better joined up care, share population health data across partners, and set priorities based on shared data. For example, this enabled the ICP to collectively decide to increase resources to autism services and reduce the backlog in this area, as this was identified as a priority within their system.

Mel tells us how the shift to think more collegiately about population health has enabled them, as an acute trust, to think more about keeping people out of hospital. She uses an example of maternity services to explain the vertical integration with primary care, whereby "our obstetricians and our maternity staff now have a responsibility across the continuum of care to intervene earlier and reduce poor outcomes in maternity services."

Mel also discusses the horizontal integration between six acute trusts across West Yorkshire and Harrogate ICS, and how collaboration at this scale alongside place level enables them to explore areas, such as workforce and specialised equipment, and "to consolidate investments and make their services more resilient, cost effective and improve operational efficiency."

Andrew adds, "it's been an eye opener in terms of how much, as an acute provider, you were focused on your silo mentality rather than wider health inequalities. Now we're thinking more about our total resource and responsibility and looking at how resources can be moved across the system to address wider issues. This is the right thing to do and simultaneously supports our work as an ICP."

## Sharing lessons learned

Everyone we spoke to in the ICP discussed the importance of relationships on a personal level, with an emphasis on building trust and having a shared purpose. James adds, "when you start with governance you end up working together within a set of rules rather than a shared purpose and that's why investing in relationships and unifying our purpose is so important."

However, relationships are not without their challenges. Helen tells us how in the early stages of their transforming diabetes programme, "it was easy to see how collaboration might work in theory, but in practice it was difficult for partners to let go of their money to support the development of this programme." These relationships take time and effort before gaining traction.

Mel adds, "the delegation of money will always bring with it the challenges of how we distribute it in a fair and equitable way. The hope is that we have done enough of the groundwork to enable us to work through these challenges in a mature way."

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Strong leadership is vital and Kim says, "there are some leaders who will understand the important contribution that voluntary organisations bring to the table, and create a space and opportunity to be inclusive, and this is being filtered down." She adds, "if you really want to address health inequalities and look at making sustainable change, you need voluntary and community sector organisations around the table."

Brendan Brown, chief executive for Airedale NHS Foundation Trust and partnership lead for Airedale, Wharfedale and Craven Partnership, said "We are an incredibly diverse area not just in terms of our population but also our geography and the communities we serve. This means we have to consider the needs of all our people stretching from Airedale and Craven through to Wharfedale and into Bradford. For example, we work across more than one local authority area, so this can be challenging but also offers us a real opportunity to develop those relationships across our place and learn from each other."

## Next steps

One way the ICP utilises its leaders to enable collaboration is by taking a distributed leadership approach across its programmes. Mel explains, "we take responsibility to lead a programme focused on specific population needs and addressing unwarranted variation. We cover areas that aren't necessarily within the scope of our day job and we identify touchpoints along the continuum of the programme where working together with our partners across the ICP enables us to be more impactful."

Brendan and Kim discuss some of the key priorities for the ICP going forward, including tackling health inequalities, COVID-19 recovery, and a strong focus on the workforce. From the perspective of voluntary and community sector organisations, Kim mentions that "one of the big challenges for the sector when participating in an ICP to address these priorities is the resource, capacity and time it takes to realistically mobilise quite a diverse spectrum of organisations." She also highlights how the sector is vulnerable in terms of financial sustainability which makes participation in ICPs and ICSs more challenging.

## National policy to support provider collaborations

The senior leaders in the Bradford District and Craven ICP are keen to make sure that they continue to build on what they have developed, strengthen the partnership, and deliver benefits for patients and the wider populations they serve. As a mature partnership, they all highlight their concerns around having to change their approach or pause development in areas if it does not align with national policy changes.

Mel notes, "we're quite a mature system and there's a risk that national policy will result in us being shoehorned into a different structure and we will have to reframe the way we work, even though our current arrangements are working well for us and our communities." Andrew adds, "I think we've got momentum to get on with it, and what's stifling our collaboration is some of the national policy changes taking place."

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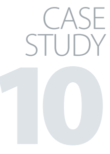


# Vertical integration at place level within the Surrey Downs ICP

**Partners involved in this vertical integration**

- Surrey Heartlands Health and Care Partnership
- Surrey County Council
- Epsom and St Helier University Hospitals NHS Trust
- GP Health Partners Limited
- Dorking Healthcare Limited
- Surrey Medical Network in the East Elmbridge area
- Central Surrey Health
- Surrey Medical Network Limited
- Princess Alice Hospice

## Background

The Surrey Downs ICP is one of four place level partnerships within the Surrey Heartlands ICS and covers a population size of approximately 300,000. It brings together the acute trust, community providers, GP federations, the county council, districts and boroughs and the local voluntary sector to tackle health inequalities, empower the local population to lead healthy lives, and support their physical and mental wellbeing.

## Setting up the partnership

The origins of Surrey Downs ICP stretch back to 2016 when providers started coming together to address shared challenges. The biggest concern across providers was that local hospitals were admitting an increasing number of older people who would have better outcomes receiving treatment closer to home.

Under the leadership of Daniel Elkeles, chief executive of Epsom and St Helier University Hospitals NHS Trust and Surrey Downs ICP leader, the *@home* project was set up. The partnership started on this relatively small-scale project, with the dual aim of admitting fewer people into hospital and discharging those who had been admitted more swiftly into the care of partners in the community. The *@home* service has been a great success and now provides joined up care to people at risk of admission, resulting in an 8% reduction in overnight stays at Epsom General Hospital for over 65s.

The partnership took another step forward in 2018 when it was awarded an integrated secondary, community and primary care contract. All three GP federations were included within the scope of the arrangement and Surrey Downs Health and Care was established soon afterwards as a joint venture to help deliver the contract. The scope of the partnership has expanded in recent years to include integrated stroke and acute frailty services.

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Progress has been made rapidly since then, with the ICP board being established in 2019 with a shared vision and objectives agreed by all partners. This was closely followed by a delegated local commissioning model being developed with the CCG, alongside the first joint financial recovery plan.

Individual integrated services have developed rapidly too – a good example of that is Chirag Patel, general manager for 'Home First' (the service which supports patients' discharge home from hospital sooner by facilitating their on-going social and therapy assessments at home) and integrated stroke services across Sutton and Surrey Downs. When he joined the partnership four years ago he had six people in his team – now he has 400. This illustrates how the ICP is shifting resources away from hospitals into community settings to provide more proactive, preventative care.

Over the past year, the focus of the partnership has increasingly turned to population health, with radical service changes being introduced in response to the COVID-19 pandemic. The ICP has established a series of committees in common with local partners, which form the alliance at the ICP board.

## The case for change

Thirza Sawtell, executive director of integrated care at Epsom and St Helier University Hospitals NHS Trust identifies the partnership's focus on delivery and commitment to achieving change for patients and service users as its unique selling point. She says, "We're really proud of the fact that we have the person and their care at the centre of what we do.

"When people see us working, it is not possible to tell who works for what organisation in our teams, indeed it is irrelevant. What people see is a large group of professionals whose passion is delivering outstanding care to their patients. This ethos applies across our Home First services, our frailty units, our integrated stroke services and our PCNs."

Dr Robin Gupta, the PCN clinical director in Dorking, highlights the value of multi-disciplinary team (MDT) working, and closer collaboration between primary and community care. The community medical team has grown significantly in recent years, with GPs working alongside district nurses, community matrons, physiotherapists, and occupational therapists to support patients with complex needs in the community. He reflects on how this directly benefits patients and tells us, "The MDT is a fully integrated service across the community health teams, the council, volunteers, and the mental health team, so it's a huge wraparound service that Surrey Downs Health and Care have been able to implement. It's better for patients, better for primary care, and better for community care".

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Dr Russell Hills, GP and clinical chair of Surrey Downs ICP, agrees with this assessment and tells us, "We're trying to think about what's it like to be a resident of Surrey, and what we can do to make sure they can access the best health and social care."

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This steady shift of focus has changed the configuration of health services locally. Daniel Elkeles reflects on how this shift towards community care has impacted on his trust, "There's been this huge shift of pressure away from our acute hospitals – I'm really proud we have the fewest number of acute beds we've ever had, even with COVID-19, because these guys are looking after so many people in community hospital beds, and community settings."

Great effort has also been put into improving communication between organisations for the benefit of patients in Surrey Downs. Emma Alderman, operations manager at Surrey Downs Health and Care, notes that the roll out of SystmOne and EMIS Web to community services has been pivotal in this respect. Additional funding has also meant the ICP has been able to invest in laptops for local care homes, improving communication and supporting MDT working with GPs.

All this collaboration and partnership working has ensured that the ICP has seen a 6% reduction in emergency admissions into Epsom Hospital for over 80s for three years in a row.

## Impact of COVID-19

"Throughout the last year our COVID-19 response has demonstrated at pace what you can do around the integration agenda," says Dr Hills. Weekly co-ordination meetings were put in place for community and GP partners to allow the teams to respond rapidly to COVID-19, with care homes being brought into the fold as the pressures on the sector became increasingly apparent. Staff worked incredibly flexibly, with school nurses working on wards, podiatrists working in district nursing teams – working outside the traditional boundaries of their roles to ensure patients were provided with the best service.

Susan Sharkey, senior manager of adult social care for Surrey County Council, also reflects on COVID-19 and the significant challenges this brought about for the ICP, "As soon as COVID-19 came in, the world kind of flipped on its axis and we had to match our teams to what was happening."

Susan notes that the "collegiate approach" of the teams working in the partnership was key in shaping the ICP's approach and shares her pride that "they rallied around, rose to the challenges and just got on with it."

Simon Littlefield, director of nursing and quality for Sutton Health and Care and Surrey Health and Care, also praises the way colleagues came together during the pandemic, sharing an example of how teams across community services and hospices worked to support end of life care and to share information on infection prevention and control. He praises the willingness and commitment of all partners to share knowledge and to "really deliver the best care" for patients during an incredibly challenging time.

Nicki Shaw, chief executive of Princess Alice Hospice, reflects on how the demand for end of life care increased significantly at the start of the pandemic. She recalls receiving a call

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from Daniel Elkeles when he was looking into creating a Nightingale-type hospital in the local area. Nikki says the ICP was able to mobilise provision for end of life care relatively quickly because "the relationships are there, the trust is there, but also because we know where each other's strengths are, and so we know we can contribute that added value, which has been really important". Nicki's hospice also provided education and psycho-social support to care home staff.

Dr Hilary Floyd, the medical director for a GP federation of 20 practices across the Epsom locality, discusses the establishment of the NHS Seacole Centre which provided rehabilitation for COVID-19 patients after discharge from hospital. In just 35 days, with teams across the ICP and the local resilience forum working together, the centre was transformed from a disused and derelict military hospital (which had been empty for years) to a working rehabilitation centre. This meant that those recovering from COVID-19 and in need of rehabilitation could be moved out of local hospitals to give them more capacity for the sickest patients. Dr Floyd welcomes the collaborative spirit within the ICP saying "it's really nice to be part of a team, a team that supports each other".

For Dr Floyd the ICP's realisation that processes didn't need to be perfect, was important. There was value in "learning and working together, delivering programmes of work quite quickly and constantly changing."

As the pandemic progressed, new challenges arose for the ICP, but these were also overcome by the ICP's willingness to put aside organisational and professional roles and work collaboratively.

Dr Gupta shares how cross team working across the ICP meant that they were able to roll out the vaccination programme to vulnerable housebound patients, "The rollout of the COVID-19 vaccination programme has worked really well because we decided as GP practices that we could deliver the vaccines for housebound patients more efficiently in Dorking because of the huge geography and this would enable our district nurses to keep working in the community medical team rather than taking out that capacity".

## Challenges

The challenges facing the ICP have changed as the partnership has evolved. Thirza Sawtell tells us about the effort that went into building relationships locally. She says, "We started quite small, but small wasn't easy, it involved all of the partners, including Surrey County Council, community services, primary care services, mental health services and acute services working together.

"Where we are as an ICP hasn't just come about because we put a structure in place. We have those good relationships and that's taken real leadership and disagreements, as well as agreements, about how things work... there wasn't always agreement, but partners always came from the place of trying to get it right for patients."

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Dr Hills agrees with this assessment and tells us, "While we haven't always necessarily agreed on everything, that's usually just because we're trying to work out a new way of doing something and we're all coming at it from a different perspective".

As partnership working has matured, Thirza tells us about the ongoing challenges around developing the right governance within the ICP "that is safe, appropriate and works effectively, but also delivers what the right thing to do is". Thirza notes Daniel's 'mantra' of "we need to make the right thing to do the easiest thing to do" and adds, "it's impossible to understand how often the system prevents that happening, so our governance from the beginning has always been about shared decision making".

## Next steps

Looking to the future, Daniel Elkeles sees a "huge opportunity in planned care. There's a massive opportunity to join up our pathways so that there are a lot fewer outpatient referrals, by sharing the expertise from within the hospital with the PCNs. And there is a lot of scope to deliver joined up care at an MDT level within the PCN. This is particularly successful across chronic conditions, with the MDT focused on looking after a whole person". Each PCN already has a lead GP, lead manager and lead nurse or therapist working as a leadership trio.

The ICP also plans to implement its health inequalities reduction plan this year, as well as pressing ahead with proposals to roll out its population health management approach to all localities. For Daniel, the focus is on "how you turn the NHS into a proactive care system." He reflects on the need to tackle health inequalities in each locality, a concern which Dr Hills also shares. He says, "The health inequalities space is really important and we've decided to think about population health in the context of place."

## National policy to support provider collaboration

Daniel outlines the ICP's hope that a "bigger share of the health budget" will be "delegated from the ICS to our place" through contractual mechanisms. He acknowledges that this will bring new challenges such as "how we allocate resources between ourselves and our partners who are part of the ICP." Potential issues around fairness and transparency would have to be addressed.

Dr Hills agrees with this and discusses the preparations that have been put in place to ensure the ICP would be ready to manage a delegated budget. The ICP is actively working through the governance issues, Dr Hills says, but he is confident that the collaborative approach which underpins the partnership would mean that any issues could be worked through.

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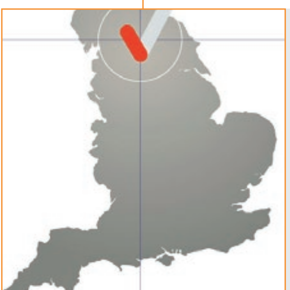
CASE STUDY 11

# Collaboration from the perspective of Yorkshire Ambulance Service NHS Trust



**Partners involved in this provider collaboration**

- West Yorkshire and Harrogate ICS
- Humber Coast and Vale ICS
- South Yorkshire and Bassetlaw ICS
- Yorkshire Ambulance Service NHS Trust

## Background

Yorkshire Ambulance Service NHS Trust provides urgent and emergency care services to 5.5 million people across three ICSs: West Yorkshire and Harrogate ICS, Humber Coast and Vale ICS, and South Yorkshire and Bassetlaw ICS. The trust also works at a sub-system level, in each ICS' place-based partnerships and neighbourhood level arrangements, as well as being part of the Northern Ambulance Alliance (NAA), formed in 2016, which brings together four ambulance providers to address common challenges through collaboration, and share best practice.

## Setting up the collaborative

The trust has a strong track record of collaboration with other ambulance services and wider partners. The work with the NAA provides an invaluable opportunity to support innovations that need to take place across a wider footprint than ICSs, but below national level. The chief executive of Yorkshire Ambulance Service NHS Trust, Rod Barnes, says it has been particularly helpful in developing the digital agenda. One example here is a joint computer aided dispatch system for emergency and non-emergency ambulances.

The NAA is pushing ahead with its digital agenda, which has led to the implementation of a common fleet management system, including ambulance maintenance schedules and collaborative procurement. This investment in digital is having positive knock on effects across the wider system through facilitating greater collaboration between regional ambulance services, reducing unwarranted variation between different services while also building "better resilience across the different services".

Recent changes to the commissioning landscape are also significant. There is now an integrated strategic partnership across the three ICSs to plan priorities for the urgent and emergency care sector. This includes a clinical forum of lead clinicians from primary care, secondary care, and the ambulance sector, which considers access to a range of services including mental health crisis response, frailty, and respiratory pathways.

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At a system level, the trust is looking to embed integrated leadership teams within all three ICSs to ensure there is equal knowledge about 999, 111 integrated urgent care and non-emergency patient transport. When these teams are in place, anyone in the ICS who needs information about urgent and emergency care services should find "there'll be one individual that they'll be able to contact" who understands all these areas.

## Challenges

Rod tells us that one of the key challenges facing Yorkshire Ambulance Service NHS Trust is the number of different 'places' within each ICS that they need to engage with, and the likelihood that each of these will identify an independent set of local priorities. While recognising the importance of tailoring care to local patient and population needs, Rod says, there is a risk that the ambulance service is "going to get pulled in too many different directions".

To remedy this, the trust is working hard to reach a "balance" between a common agenda across the three ICS footprints and "responding to priorities at an ICS level as well as to local priorities at place level" and is looking to create advanced clinical roles that align with the new place-based decision making structures, so that ambulance teams can play into strategic conversations.

## The impact of COVID-19

The COVID-19 pandemic was a catalyst for "far closer collaboration within the ICSs... and broke down some of the barriers that previously existed". Partners within the ICSs came together to resolve shortages of PPE and to support each other through mutual aid. For the ambulance sector, significant challenges around social distancing rules have meant reducing capacity in non-emergency patient transport services, so ambulances can only carry one patient as opposed to the usual three or four. The pace at which these can be relaxed will be heavily dependent upon how the virus evolves.

Rod also tells us that while there was a reduction in patients going into hospital for planned care, "hospitals had an increased requirement to discharge patients on the day or move patients between facilities according to whether they were treating COVID patients or not". Transfers between hospitals or for other services are going to carry on being a "real challenge" for the foreseeable future because of social distancing and other issues, Rod says, adding that the ambulance service has increased its surge capacity within patient transport to cope with these additional demands.

He welcomes the increased collaboration brought about by the pandemic with acute colleagues working with the ambulance sector on activity planning and managing demand, as well as closer working between non-emergency patient transport providers to coordinate capacity, share PPE and understanding of infection prevention and control guidance.

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## Sharing lessons learned

Rod describes a shift in mindset over the past couple of years from colleagues who are now recognising the role of the ambulance service in proactively tackling health inequalities as an integrated system partner, rather than just seeing it as an emergency response service. This has largely come about through partnership working in ICSs and a clear focus and commitment amongst those involved to develop strategic priorities, including tackling the inequalities agenda. He shares an example of specific recruitment campaigns and community engagement activities to give people in disadvantaged areas opportunities through volunteering to get into the job market. Rod says there are more conversations now about which interventions have the best impact and welcomes "partnership leadership arrangements involving the voluntary sector and local authorities".

Collaborating with West Yorkshire Police and West Yorkshire Fire has led to innovative policies to tackle knife crime and violence reduction in Leeds and Huddersfield. He says, "the best partnerships are those that are developed in local communities... collaborating with local community groups and local schools".

## Next steps

In terms of next steps, Rod highlights several key priorities for the ambulance service over the next few years. The first is the need to build on the 111 first initiative with local partners to mobilise pathways and services that avoid patients going into the emergency department if they do not need to be there.

The second is making sure that the new roles in PCNs, which go live later this year, do not exacerbate workforce shortages for the wider health and care system. This is a "real risk" to the ambulance paramedic workforce, Rod tells us, identifying a "massive workforce challenge, bigger than anything we've seen in the last decade". Rod's trust is looking at whether it will be possible to rotate specialist paramedics across both the ambulance trust and primary care, given the significant mismatch between the number of experienced trained staff currently available and the demand from PCNs. He adds it is vital there is an "agreed rollout timetable": failure to do so could lead to a "massive bidding war for trained paramedics or potentially the ambulance service could be destabilised both on a regional and national level."

Rod says that, "we are still finding our feet" in terms of what facilitates greater collaboration, but he highlights a focus on empowering local teams and clinicians, having the right culture and mechanisms in place to support decision-making and resourcing teams at ICS and/or place level to carry out the transformation work.

Rod is clear about the value and pivotal role the ambulance service brings to ICSs and the health and care system more broadly. He says, "our teams have a huge impact on patient care and the wider system... we see well over three million patients a year. That's an awful lot of the patient contacts that go on within any one ICS, and we influence where those patients go in the system".

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## National policy to support provider collaboratives

Rod highlights how the planned changes to procurement rules will encourage further integration across urgent and emergency care services both within and across providers. Historically, both 111 and patient transport services were subject to competitive tendering every three to five years. Rod says the uncertainty this created led to variation in service delivery and hindered greater integration of patient transport service, 111 and 999 services. He explains, "if you think you will soon be going through the huge turmoil of unpicked systems and leadership teams, you're more inclined to leave them as separate services operating with a degree of independence". Rod is convinced that a more collaborative approach will improve the care the service is able to offer patients, and will encourage better information sharing between system partners to better meet health needs of local populations.

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CASE STUDY 12

# Collaboration from the perspective of West Midlands Ambulance Service University NHS Foundation Trust

**Partners involved in this provider collaboration**

- Birmingham and Solihull ICS
- Black Country and West Birmingham ICS
- Coventry and Warwickshire ICS
- Herefordshire and Worcestershire ICS
- Shropshire, Telford and Wrekin ICS
- Staffordshire and Stoke-on-Trent ICS
- West Midlands Ambulance Service University NHS Foundation Trust

## Background

The West Midlands Ambulance Service University NHS Foundation Trust serves a population of 5.6 million people covering an area of more than 5,000 square miles and work across six systems. While they are a regional ambulance service, they currently have a lead ICS, Black Country and West Birmingham ICS, that works on behalf of the 22 CCGs within the six ICS regions.

The trust employs approximately 7,000 staff and operates from 15 new fleet preparation hubs across the region through a programme called *Make Ready* – an approach that led to improved efficiency and productivity and less variation in care and infrastructure. The trust took over provision of the NHS 111 service in the West Midlands (except Staffordshire) in November 2019 and provides non-emergency patient transport services across some parts of the region for patients who are unable to travel unaided because of their medical condition or clinical need.

Vivek Khashu, director of strategy and engagement at West Midlands Ambulance Service University NHS Foundation Trust, tells us that one of the key challenges for ambulance trusts is getting the partnership engagement piece right, particularly at place level. This includes managing the benefits of being a regional service with no borders but making sure they are also plugged in at a local level so that they can better connect with people and communities. He emphasises some of the complexities that exist around being an ambulance service across a particularly wide geographic footprint.

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## The impact of COVID-19

Vivek tells us the COVID-19 pandemic has brought provider leadership at system level to the fore and made partners much more aware of the NHS' role in tackling health inequalities and improving public health services, particularly as public health responsibilities sit with local authorities.

Restoration of elective care and other services is an important conversation taking place at the moment across all six ICSs. While recovering services isn't necessarily applicable to ambulance services as they never stopped, they have been plugged into the wider system recovery and transformation planning, which is focused around waiting times. However, Vivek highlights that there are important related issues for the ambulance sector particularly around managing handover performance and eliminating long delays outside hospitals.

He also discusses what financial recovery will look like given changes to contracting. "I think capital will be an interesting issue for ambulance services, and this is where system working may start to collide with organisational interest... there may be a need for some arbitration or independent review to mitigate any tensions".

## The context for ambulance services

Vivek highlights how all ten ambulance trusts work within different contexts, so for example while the West Midlands Ambulance Service University NHS Foundation Trust operates across six ICSs, the North East Ambulance Service NHS Foundation Trust works within one ICS. Vivek says having a 'forum' in the form of the Association of Ambulance Chief Executives and its subgroups to share learning and discuss challenges is useful and will continue to be as collaborative working arrangements evolve.

Ambulance services work within a slightly different hybrid context of emergency services, including fire and rescue and the police, so they don't see their function as "purely NHS". This makes the world of system working quite complex for ambulance services, although there are opportunities to drive further integration across the system.

## The case for change

In terms of integrated care, he stresses that most of the work they do as an ambulance service is supporting people with exacerbations of long-term conditions, frailty, or chronic diseases, and so from an integrated care perspective they have an opportunity "to integrate patients into a continuum of care".

Vivek says he feels that working in collaboration also provides more opportunities for better population health management and reducing health inequalities. He says the ambulance service has some valuable population health data about the people who call them and integrating this across the system could help address some wider health issues in their

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patch. "Ambulance services can act as a real integrator of care because, like primary care, we are often the first port of call, and it's about how we plug people into the right parts of the health and social care system. I think we have a big responsibility as we move closer towards integrated care, not just from a public health perspective but also with regards to addressing health inequalities".

He also notes the importance of strengthening the delivery of local people plans, equality, diversity and inclusion, and the important role ambulance services have in addressing some of these challenges. He says, "we have thousands of contacts, many in person with our clinicians every day". That is a lot of contact where we can influence health and well-being within the communities we serve and ask things like 'Have you had your flu jab?' You can start to see how we could make a difference". The trust will be refreshing its organisational strategy to consider strategic priorities in these areas. He also notes, for example, how "ambulance services could potentially work alongside and virtually with integrated care teams to assess the needs of our patients and deliver the right outcomes first time".

Vivek also illustrates some of the shared benefits that could be realised by sharing the population health data they have with local trusts to help prevent patients needing to be admitted into hospital. So, for example, they could provide an individual, who would otherwise call the ambulance service on a regular basis, with necessary equipment and adaptations to their property so that they are not as vulnerable as they previously were. Vivek says, "we're going to increasingly have be more involved in helping people live independently, live longer with more dignity and contribute to reducing demand on the healthcare system".

Over the next year, the trust will also be thinking about the potential dividend for integrating care in this way. They will be thinking about opportunities to support greater productivity and efficiencies in healthcare across the region and the need to adapt commissioning arrangements to achieve this. He says, ultimately "the principle of ICS working is to remove boundaries and barriers and to support each other to achieve a collective goal".

While there are opportunities with regards to population health management there are also some associated risks. Vivek questions, "How will we be commissioned? How will we have a seat at every ICS table? How will we have a say, and a voice?".

## Sharing lessons learned

One thing that has worked well for the West Midlands Ambulance Service and its patients is having a lead commissioner who works on behalf of the 22 CCGs that exist within the six ICS boundaries. They are also hosted by one ICS on behalf of the six, and this simplifies the planning and commissioning arrangements. Vivek has some concerns about how this will change as the national policy around ICSs develops, preferring a regional commissioning board model with a lead ICS, or potentially a specialised commissioning approach.

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Another challenge they've had to navigate is balancing at-scale collaboration with place. "One of the biggest challenges, I don't think is at system level, but actually at place level, particularly as a regional ambulance service trying to make sure we're still plugged in locally". He says one way they've been building relationships at this local level is by getting the collaborative's senior operational managers involved in projects, such as rebuilding emergency departments at place within their patch.

He also discusses the role PCNs will have in employing paramedics in primary care, which has been particularly challenging as there are 110 PCNs within the six ICSs. He explains how the ICSs have had an important role in bringing together voices from appropriate partners to streamline this process. "ICS workforce leads set up a forum with us to exchange views and are now working on our behalf with PCNs within their patch, which has been very helpful."

## Next steps

Regarding his concerns about the future role of ICSs in terms of resources and planning for the ambulance sector, Vivek sees value in maintaining a single lead commissioner role in some form or shape.

Vivek also touches on some of the challenges associated with moving towards shared accountability, particularly for systems where performance at an organisation level is variable. "At the moment we're achieving all of our objectives as we're measured as a standalone trust, and that gives us a lot of pride, but we don't know how it will play out as we move closer towards collaborative working arrangements and collective accountability...". There is a need to ensure everybody has the necessary influence over decisions at system level, including ambulance trusts.

However, the benefit of "a collective accountability arrangement means we are of course bound together with the obvious requirement to support one another" to address system wide challenges. Vivek says the trust is now thinking about how they can re-orientate themselves and continue delivering an outstanding service with a shared responsibility on a much greater level across their partners.

## National policy to support provider collaboratives

Vivek agrees that putting ICSs on a statutory footing is absolutely the right thing to do when it comes to clear accountability and decisions about resources. But this is not without its challenges, as his trust recently had to work through, when it wanted to use its own capital to replace some aging fleet vehicles reaching the end of their five-year lifespan, when the ICS itself was resolving a challenging financial position. Working with partners the matter was resolved, however previously the trust wouldn't have had to go outside of the organisation to even discuss the matter. "There may always be this issue of organisational interest versus collective good, and with organisations still being held accountable for the care and welfare of their patients and staff, there will inherently continue to be tension".

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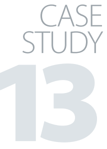


# Vertical collaboration between trusts in the Somerset ICS

**Partners involved in this vertical collaboration**

- Somerset Clinical Commissioning Group
- Somerset County Council
- Somerset NHS Foundation Trust
- Yeovil District Hospital NHS Foundation Trust

## Background

Somerset NHS Foundation Trust is one of the first trusts in England to provide community, mental health, learning disability services and acute hospital services. The trust was formed in April 2020 when Somerset Partnership NHS Foundation Trust and Taunton and Somerset NHS Foundation Trust merged.

Before they merged, they established a joint executive team in 2017 that oversaw all aspects of both trusts' operations and worked to a single set of strategic objectives covering hospital, community and mental health services. They decided to merge to remove the barriers that added unnecessary delay and cost to the care they provide, and to better integrate community, mental health and hospital services. The merger was built on the trusts' clinical strategy that was formulated as a result of significant engagement with staff in a wide variety of different services, who saw the improvements that could be made if services worked differently together.

They are now working towards a merger between Somerset NHS Foundation Trust and Yeovil District Hospital NHS Foundation Trust to bring together services across the system. Yeovil also has a history of developing integrated care models as a result of its work as one of the primary and acute care vanguard sites. This resulted in an innovative partnership with primary care and the development of an 'at-scale' primary care subsidiary, Symphony Healthcare Services. Jonathan Higman, the chief executive of Yeovil District Hospital NHS Foundation Trust, says, "we are about to submit our strategic case for a merger between the two foundation trusts to NHS England and NHS Improvement, and this would bring together the two acute sites with all mental health and community health services in Somerset. Between the two trusts we have integrated 20 GP practices as well".

Jonathan also reflects on the simplicity of the provider landscape in the Somerset ICS that has enabled this more formal collaboration to take place. He says, "we're a relatively simple system. We have one CCG, two foundation trusts, around 65 primary care practices, and one local authority." Commenting on the context in Somerset, he adds that their 'place' footprint is also defined as Somerset, "but actually within that there are four distinct localities and 13 neighbourhoods".

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## Setting up the collaboration

Peter Lewis, chief executive of Somerset NHS Foundation Trust, tells us that the partnership between the legacy organisations in the original merger, Somerset Partnership NHS Foundation Trust and Taunton and Somerset NHS Foundation Trust, was initiated by conversations about how they could work more closely together as two trusts.

He explains that they did not initially intend to merge the trusts, but that "once we had set up the alliance, it quickly became apparent that there was a great opportunity here. We had people solving problems together rather than blaming the other party. We realised that if we really wanted to integrate our services, we probably needed to be one organisation".

There were conversations at the time to merge with Yeovil District Hospital NHS Foundation Trust as well, but they were focused on their work as one of the new care model vanguards. Jonathan says, "when Somerset NHS Foundation Trust was formed it felt like the natural next step to bring the learning that we have at Yeovil between hospital and primary care together with the work they have been doing between acute, mental health and community services."

## The impact of COVID-19

Peter and Jonathan both discuss how COVID-19 has enabled them to deliver changes at pace in a way they hadn't previously been able to, using an example of their intermediate care service. Peter says, "our work on intermediate care really took off during the COVID-19 response because we urgently needed to create capacity in hospital and improve patient flow".

He also notes that, "when the system bureaucracy stopped, it enabled providers to collaborate better. It really helped that the commissioner gave providers permission to act and empowered them to get on and do things. We mustn't lose this."

## The case for change

Peter discusses how moving towards greater collaboration will have benefits for patients in Somerset and the staff who serve them. He feels there is a real opportunity to improve the interface between the two trusts and standardise the quality of, and access to, services.

Jonathan also discusses the one organisation approach and says, "we can see the benefit to having a population budget with clear outcomes and being able to plan and move resources across boundaries into prevention and early intervention services".

Peter adds, "it really does give us an opportunity to focus more on addressing inequalities, prevention, and population health because now the incentives are aligned in a way where we can be proactive in our care. I think now we've got the scale and reach at our disposal to really put that at the centre of what we do."

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Jonathan also highlights that, "having a 'one Somerset' service is actually much more attractive for staff, which has helped with workforce sustainability. We have already seen that having a single urology or stroke service, for example, gives staff more opportunity for research and pursuing specialist interests".

## Sharing lessons learned

Peter and Jonathan both tell us that relationships and culture are key to collaboration, but it takes time to develop and get this right. Jonathan says, "I think culture is the bit that you can't just change overnight and, actually, it might not be about changing it but instead embracing and supporting the evolution over time, as both organisations have strong and distinct cultures".

Peter and Jonathan both highlight that while a formal merger was the right model for the people of Somerset, it may not work everywhere. Jonathan says, "this is only one way of doing things, it's not necessarily right for every system". Peter adds, "other systems are more complex, which highlights the need to make sure there is flexibility in national policy and guidance. We need a permissive approach to ICSs rather than a rules-driven approach".

Peter also discusses the importance of bringing everyone on the journey. He says, "people were concerned that mental health would get lost in the new integrated organisation and the acute services would take all the money. So, we set out some very clear objectives, one of which was to prevent that and invest more in mental health than in the acute services. That got people in mental health services on board". He notes that there has been some "fantastic transformation" in their mental health services as a result.

Jonathan also notes the importance of bringing people with you and says, "we need to engage with primary care across the whole county and build on the work we have already done with Somerset County Council who are also going through a change process to move to a unitary authority model".

## Next steps

Peter notes that during the pandemic, there was a positive change in the provider-commissioner relationship. He says the question is now, "how do we ensure the ICS enables the level of collaboration that took place during the pandemic?" Jonathan highlights, "it's a difficult time to engage with staff about this level of change, as many people are just focused on coming out of the pandemic".

Jonathan also discusses next steps for the operating model within Somerset and engaging with different localities. He says, "We're thinking about how we make sure that we take the best county-wide approach, recognising that there are distinct geographies within Somerset, to address population health needs and health inequalities. We are also thinking about how we engage with the voluntary sector, who can potentially provide resource in a different way. So, it's about both the horizontal and the vertical integration, and bringing all organisations together within our provider collaborative".

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## National policy to support provider collaboratives

Peter and Jonathan both highlight the need for legislation and guidance to be permissive and flexible enough so that they can continue to build on their simple model for collaboration. Jonathan says, "our focus is on how we can maintain simplicity, within the minimum standards set by national guidance".

Peter also notes that, "there is a danger that if you try and force change in a certain way without getting the important principles right, like aligned leadership and objectives, then you won't achieve the right outcomes. What we've done at Somerset NHS Foundation Trust to integrate community, mental health and acute hospital services has involved colleagues from services spread across the county and was possible because we developed a shared vision about what we could achieve together and had flexibility to do that." He adds, "we don't want there to be unnecessary layers of bureaucracy, especially as we've got a relatively simple health and care system. I understand that with the bigger ICSs, there will be a need for something different to coordinate across a wider geography and population, with more partners, but we aren't in this position".

Jonathan concludes, "I think collaboration is about bringing people together to make the services better for the population and recognising there's a mutual benefit in doing it".

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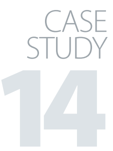

# Horizontal collaboration of trusts across Herefordshire and Worcestershire ICS and Coventry and Warwickshire ICS

**Partners involved in this provider collaborative**

- South Warwickshire NHS Foundation Trust
- Wye Valley NHS Trust and
- George Eliot Hospital NHS Trust

## Setting up the collaborative

The Foundation Group was set up as a partnership in 2017 initially between South Warwickshire NHS Foundation Trust and Wye Valley NHS Trust. George Eliot Hospital NHS Trust joined the Foundation Group a year later in 2018.

Glen Burley had been chief executive at South Warwickshire since 2006 and successfully helped turn around Wye Valley in 2016, which had been placed in quality special measures. Wye Valley then appointed Glen as their chief executive and the two trusts moved to a shared leadership model. Faced with similar sustainability challenges, George Eliot Hospital – which was also in special measures – asked to join the Foundation Group under Glen's leadership. Each individual organisation has a managing director in post, reporting directly to the chief executive.

The Foundation Group originally aimed to be a sustainability model for three small to medium-sized trusts. Over time, each organisation has become the leader of integrated care in their 'place' within the two ICSs covered by the trusts in the group. Reflecting on the progress of the group and how this has aligned with national objectives in recent months, Glen tells us, "the national strategy is very consistent with the strategy of the group. Our strategy has been around a little longer".

Each year, all three trusts set their organisational level objectives, as well as collectively setting some group objectives. The Foundation Group has a committee in common governance arrangement which binds the interests of all three organisations together. The group strategy committee drives the collective activity. For example, all three trusts see staff wellbeing as a top priority, so they tackle this together and share their learning to help each other improve.

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## The case for change

Working within the Foundation Group offers a range of benefits for its members that they wouldn't necessarily be able to achieve on their own. Glen shares an example of how the combined turnover of £750m between the three trusts enabled them to invest in key leadership roles including a group financial advisor, a group digital advisor and a group improvement lead. By sharing data, the Foundation Group is also seeking to improve productivity and performance across the three trusts.

Crucially, group working has delivered significant benefits for both patients and the workforce. Glen welcomes the significant progress that had been made in completely changing urgent care at both Wye Valley and George Eliot by adopting the patient flow models used by South Warwickshire.

Glen was delighted about Wye Valley's recently received 'Good' rating from CQC for urgent care alongside it being the trust with the most significant improvement in mortality rates in 2019. This was driven by the trust's work to ensure people got the right care at the right time across the system. Similarly, improvements in George Eliot Hospital's urgent care has had a positive impact on recruitment, with the A&E team recently expanding from two to eight consultants. All three trusts within the Foundation Group are among the best in the region in terms of meeting the four hour A&E standard and they recently received plaudits from the West Midlands Ambulance Service University NHS Foundation Trust for their turnaround times during winter, which was a major safety benefit for patients.

Glen values the staff survey results and there have been significant improvements across the Foundation Group. He says, "the big one for me will be the staff survey, which drives all the quality that patients experienced. Focusing on empowering the frontline and giving people opportunities to improve the way that services function for patients". This evidence, combined with improvements in recruitment and retention, bottom line finances and the quality of services, all indicate the benefits of working in the group structure.

On staffing at a more senior level, Glen also highlights how having managing directors in post at each of the three trusts creates an excellent leadership pipeline for future chief executives.

## Challenges

It hasn't all been plain sailing though. The Foundation Group spans two ICSs (Herefordshire and Worcester ICS and Coventry and Warwickshire ICS) and Glen is mindful that there is a "challenge about the number of layers in which we have to operate these days".

The Foundation Group is also grappling with different local government arrangements across the two ICSs. Glen says he welcomed the 'one Herefordshire' approach which meant that significant progress was being made on integration. However, other areas like Warwickshire, which has a series of district councils and a county council, are more complicated. Glen highlights the joint posts the Foundation Group has set up with

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Warwickshire County Council. One particularly successful example has been the public health doctor who is now part of the Foundation Group's leadership team. This role, Glen says, is "helping us look at things differently".

## The impact of COVID-19

Glen is clear that the existence of the Foundation Group and system working has been a key factor in shaping their response to the COVID-19 pandemic over the past year. The pandemic has been a "single unifying purpose" Glen says, sharing his pride at the way different parts of the health and care system have come together to manage the impacts and challenges of the COVID-19 pandemic. In particular, he singles out the local response to support care homes saying, "we wrapped ourselves around them and helped them to function during that period". He also reflects positively on the integrated trust model, which really came into its own in the discharge to assess process.

## Working with partners to improve population health

Significant work is being done by the Foundation Group to collaborate with primary care. Glen acknowledges the, "very real risk that we could disengage primary care" in the current conversations about the ICS structure and lead provider models at place, but highlights primary care's pivotal role in supporting population health. He says, "I will always say the building blocks of population health should be the PCNs. So rather than looking at what the priorities are from an ICS, or even a place, we should look at those neighbourhood arrangements and say what are the big public health issues?"

Glen particularly welcomes the "significant progress" that had been made on embedding out of hospital care. He notes that when he first joined Wye Valley, the trust was on the verge of letting their community service contracts go. He made sure the trust continued to provide these community health services because of the long term need to invest in population health and focus on the wider determinants of health. He also ensured that resources that were in the trust's contract for acute services were redirected to expand primary and community services.

Glen highlights the group's commitment to "involving primary care in leadership" as well as the group's willingness to take on the system's financial risk and consulting their primary care colleagues every step of the way. To make the lead provider model work, he reflects that you need to show partners that you will invest in the system priorities to demonstrate the true nature of the partnership.

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## Sharing lessons learned

Glen offers this advice for those looking to move to more collaborative ways of working, "Don't try and design an end game situation... because everything keeps changing. The key enabler is to focus on incremental improvements." The group model has enabled Glen and colleagues to move forward quickly and realise benefits for patients sooner, without needing to go down the more formal route of mergers or acquisitions.

Glen notes that he personally didn't want to get distracted by a "huge load of governance and reorganisation. It was about connecting three organisations as simply as we could and supporting the frontline to get on and do things". In particular, he highlights the need to maintain the individual identities of the organisations involved, and the importance of co-producing strategic and operational plans tailored to each organisation, which were key to keeping staff on board.

## National policy to support collaboration across providers and their partners

Glen expresses his hope that budgets and decision making will be delegated down to place. He saw this role evolving over time, with a narrow range of decisions being taken by the place-based partnership initially, with the scope to take on more as they demonstrated their credentials. This shouldn't be a one-way, irreversible process though, Glen warns, "ICSs should have the ability to reverse it if goes wrong as well as ensure that those place-based leads do a good job".

He also highlights the difficulties the two NHS trusts in the Foundation Group faced in accessing capital, compared to the process for the foundation trust. He hopes that being part of a high-performing group will allow non-foundation trusts greater autonomy in accessing capital investment. This would be a great way of incentivising more trusts to join a group.

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# Conclusion

The long quest for closer health and care integration has taken on a new momentum. As this report shows, NHS trusts and foundation trusts are at the heart of this process. They are harnessing a spirit of collaboration, propelled by the pandemic, to find better ways of working. They are joining forces with partners to plan and provide for the needs of their communities, improving care for patients and service users. There is growing awareness and recognition at the centre – from government and national bodies – that providers are the 'engine room' for transformation, with a key role to play as leaders and co-leaders in this fast-changing landscape, and as the point of delivery for services. While important questions remain around the statutory role and remit of ICSs, how they're comprised, and what their governance, accountability and funding will look like, the collaborative arrangements developing within and across ICSs have shown they can operate in a range of functions, forms and footprints that deliver success.

It is because of this variety of approaches – and the different purposes they serve – that we have focused on provider collaboration in its broadest sense: exploring the characteristics of acute 'horizontal' provider collaboratives in the Greater Manchester ICS alongside 'vertical' integration at place in the local partnerships in Bradford and Craven, and Surrey Downs, highlighting perspectives from an ICS level community and primary care collaborative in Sussex, and the increasingly important partnerships between at-scale primary care providers and secondary care – exemplified by the work of the Modality Partnership, showcasing the mental health provider collaboratives such as in South London, and considering the role of ambulance services in Yorkshire and the West Midlands.

A key lesson from these case studies is the importance of leadership in driving the transition from competitive to collaborative ways of working, and the way relationships based on trust and shared objectives can transcend institutional barriers of governance, form or structure. The Acute Hospitals Alliance within the Bath and North East Somerset, Swindon and Wiltshire ICS highlights the shared commitment of three chief executives to deliver benefits for patients and staff by developing mutual understanding and playing to the strengths of each organisation. The importance of building trust across leadership teams is also a key theme of the South London Mental Health and Community Partnership in resolving new funding and commissioning responsibilities, and in the Dorset ICS where close working between NHS partners and colleagues in local authorities has been important in identifying and tackling deprivation and isolation.

While some of the relationships behind provider collaboration go back many years, there is no question that the imperatives presented by the pandemic provided a powerful catalyst to develop these partnerships. The effect was neatly summarised by Andrew Ridley, speaking as the local care senior responsible officer for the North West London ICS, who said, "it put the finger on the fast forward button, so suddenly the theoretical questions stopped being theoretical and the 'them and us' mentality ceased."

Pandemic pressures forged closer collaboration over workforce, PPE and other equipment, it spurred progress on digital and clinical partnerships, and work to address inequalities. In the community provider collaborative across the Sussex ICS, work on the vaccination programme consolidated relationships across primary, secondary and social care, fostering a common purpose for delivery. And in the West Yorkshire and Harrogate Mental Health,

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Learning Disability and Autism Services Collaborative, the pandemic provided a powerful stimulus for organisations to share and learn from each others' approaches to improve services for patients in their care.

Another key ingredient for successful provider collaboration is an unrelenting focus on a shared vision, with organisations working in a way that is right for their local patients and populations. Provider collaboration leaders in the Somerset ICS describe how coming together has allowed them to plan and move resources into prevention and early intervention services. And in the Bradford and Craven ICP, the *Act as One* programme has delivered better joined up care, with a more collegiate approach to population health exemplified by work "across the continuum of care" to improve outcomes in maternity services.

One of the features of provider collaboration is the way in which it has brought together different parts of the provider sector: hospitals, mental health, community and ambulance trusts, along with other partners to deliver better care, closer to home, for patients and populations. They bring their own pressures, priorities and expertise to these collaborations, as evidenced by these case studies. The ambulance perspectives – as seen here from West Midlands and Yorkshire – highlight the challenges of working across multiple footprints, including at region, ICS, place and neighbourhood levels. The West Midlands example highlights the opportunities for population health management and reducing health inequalities, acting as an integrator across the system. The Yorkshire case study also points to the way collaboration has helped to focus attention on the inequalities agenda.

Provider collaboration – in its many manifestations – is driving integration and delivering benefits for patients. But as we have seen, it requires commitment, strong leadership and a clear shared vision. It takes time and patience to build the right relationships, to develop and embed collaborative ways of working, and deliver improvements. Glen Burley, chief executive of the Foundation Group of South Warwickshire NHS Foundation Trust, Wye Valley NHS Trust and George Eliot Hospital NHS Trust, has this advice for those looking to move to more collaborative ways of working, "Don't try and design an end game situation, because everything keeps changing. The key enabler is to focus on incremental improvements."

So what needs to happen now? It is clear that providers want a flexible and enabling national policy and legislative framework that will build on, rather than disrupt, existing arrangements, while providing clarity on how accountabilities will sit alongside those of the statutory ICS, and trusts and foundation trusts. The recent White Paper indicated that decision-making would be devolved increasingly to provider collaboratives and place-based partnerships, but the timing and nature of this needs to be worked out locally. For providers to come together as collaboratives and partnerships, acting as the engine room of transformation within ICSs in the way envisaged, they will need to be appropriately resourced.

They will also require ongoing support to share best practice and learning from peers. For this they can count on NHS Providers to play its full part as its provider collaboratives support programme takes shape in the coming months.

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## Suggested citation

NHS Providers (June 2021), *Providers Deliver: Collaborating for better care.*

## Interactive version

This report is also available in a digitally interactive format at:
www.nhsproviders.org/providers-deliver-collaborating-for-better-care

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**NHS Providers** is the membership organisation for the NHS hospital, mental health, community and ambulance services that treat patients and service users in the NHS. We help those NHS foundation trusts and trusts to deliver high-quality, patient-focused care by enabling them to learn from each other, acting as their public voice and helping shape the system in which they operate.

NHS Providers has all trusts in voluntary membership, collectively accounting for £92bn of annual expenditure and employing more than one million staff.

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Registered Office
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# Westminster Hall debate - Children and young people's mental health

## Wednesday 16 June 2021

NHS Providers is the membership organisation for the NHS hospital, mental health, community and ambulance services that treat patients and service users in the NHS. We help those NHS trusts and foundation trusts to deliver high-quality, patient-focused care by enabling them to learn from each other, acting as their public voice and helping shape the system in which they operate.

NHS Providers has all trusts in voluntary membership, collectively accounting for £92bn of annual expenditure and employing more than one million staff.

## Key messages

- In recent years, welcome progress has been made to improve the access and quality of mental health services, supported by significant investment and support alongside the dedication of those leading and working in the sector.
- The pandemic has brought into sharp focus the impact of rising demand and chronic underinvestment in beds, workforce and capital funding for the sector. There remains significant unmet need, despite services reaching more individuals than ever before.
- A recent survey of mental health trust leaders by NHS Providers focused on children and young people's mental health services, and found that demand for treatment had increased in the last six months, with 84% of respondents saying that waiting times have got worse. The top three reasons noted for the increasing pressures were:
  - Children's symptoms becoming more severe and complex
  - Additional demand due to the pandemic
  - Lack of suitable social care provision.
- As highlighted in NHS Providers written and oral evidence to the Health and Social Care Select Committee's inquiry into children and young people's mental health services, NHS trusts are doing all they can to make improvements with the staff and resources available.
- The way mental health services are resourced, commissioned, funded and paid for needs to be addressed to improve the current quality and system of care for children and young people. National policy must not only focus on increased support for children and young people's mental health, but public health and social care too.
- While we have seen some progress, the shortfalls both in the number and skill-mix of staff in the mental health sector remain the most pressing challenge to the sustainability and accessibility of

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services for children and young people, and one which will take the longest to resolve. We need to see a long term, fully funded workforce plan that builds on the steps already being taken to grow the mental health workforce.

## Current pressures in children and young people's mental health services

Recent NHS statistics showed the number of children and young people (CYP) in contact with mental health services has risen considerably, with the average number of individuals in contact each month 80.6% higher in 2020 than in 2017. Similarly, our recent survey of mental health trust leaders found mental health services for CYP are under growing pressure and increasingly overstretched, despite significant support and investment. Of the respondents to the survey, 100% said demand for CYP mental health services is increasing compared to six months ago.

The survey findings also showed that a high proportion of children and young people not previously known to services are coming forward, and they are more unwell, with more complex problems than in the past. Only a third of respondents said they are able to meet the current demand for children's care and most of them are concerned about their ability to meet anticipated demand within the next 12-18 months. In particular, a large majority said they couldn't meet demand for eating disorder services (85%), and for child and adolescent community (66%) and inpatient care (65%).

There are a number of factors that have resulted in increased pressure on CYP mental health services. Trust leaders noted the top three reasons why pressures are increasing:

- Children's symptoms becoming more severe and complex
- Additional demand due to the pandemic
- Lack of suitable social care provision

Trust leaders also reported worrying staff and bed shortages, and concerns over workforce stress and burnout. In the survey, 83% of trust leaders were extremely (37%) or moderately (47%) concerned about staff wellbeing and current levels of stress and burnout across their CYP services workforce.

## Improving access to mental health services

There has been progress made on improving access to mental health services, including early achievement of the national children and young people's access ambition as set out in The Five Year Forward View for Mental Health 2016. This reflects the welcome focus, investment and effort nationally and locally over recent years to improve access to these services.

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Contact: Kerry Racher, external affairs adviser, kerry.racher@nhsproviders.org

However, despite services reaching more individuals than ever before, there remains a substantial treatment gap and barriers to accessing help. Prior to the pandemic, services were at full stretch and access thresholds in many places were too high, creating long waits and contributing to deteriorating mental health for many individuals.

There are longstanding barriers to trusts being able to deliver the right level of mental health care for all who need it. These include:

- the stigma of seeking or receiving mental health care
- historical under-provision
- a scarcity of inpatient beds in some areas close to home for those who are most unwell
- a lack of suitable social care provision
- the need for more training in evidence-based interventions, and
- a shortage of specialist staff across health and care services.

It is clear a more joined up, proactive approach between education, health and social care is needed in all areas of the country, with a greater focus on prevention and earlier intervention.

## Funding

In order to address these issues, the needs of mental health services must be adequately prioritised. This means fully and promptly funding, on a sustainable basis, the rapid expansion of services needed to meet the extra demand for mental health care and support. This includes a commitment to expand services in the community to avoid inpatient admissions where possible, and a rapid increase in beds in areas where they are needed so that out of area placements can be avoided.

It is also important that when the government considers its plans for social care reform, the needs of children and young people are not overlooked. We need funding for services to be focused on filling the current gaps in support available for children and their families – for example when someone first starts to ask for help, or after they receive a diagnosis. Trusts have expressed frustration that having carried out autism assessments – the waits for which can span years – there may be no services available in the local area to provide care and support for those they diagnose. Adequate capital funding is also needed to ensure trusts can provide patients with a safe and therapeutic environment.

## Workforce

Workforce shortages have been a key, longstanding reason why mental health trusts have struggled to meet local demand. While we have seen some progress, the shortfalls both in the number and skill-mix of staff in the mental health sector remains the most pressing challenge to the sustainability and accessibility of services for children and young people.

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Contact: Kerry Racher, external affairs adviser, kerry.racher@nhsproviders.org

Mental health trust leaders are deeply concerned about existing staff wellbeing, stress and burnout, following the pandemic. One mental health trust leader told us its staff are already extremely stressed from overwork, and increased demand stemming from the outbreak will make that worse. They added they will need “well over 100% (of capacity) to keep pace” moving forwards, but staff are tired and “in chronically short supply”, especially the highly trained staff they need for the more complex cases they are now seeing.

We need to see a fully funded, long term plan to help address the impact of workforce issues on the broader health and care agenda. This needs to include adequate investment at a national level to maintain and build on the steps being taken to grow the mental health workforce, which was already identified as fundamental to meeting the ambitions set out in the NHS Long Term Plan. Trust leaders also need resources and support to give staff the time they need to rest and recover from the pandemic, and trusts need the autonomy to move at their own pace, given the variable impact of the outbreak across the country.

## What are NHS trusts doing?

Despite the challenges, trusts have been working hard with local partners to meet the needs of children and young people in their local areas. The steps they have taken include:

- setting up day services to provide an alternative to admission to hospital
- using digital solutions to expand access to care where appropriate
- working with schools, GPs, local authorities and the voluntary sector to deliver services that meet individuals' needs at an earlier stage.

Trusts have also been working hard over the years to meet the workforce gaps they face, by using new roles, changing skills-mixes, and pursuing a range of recruitment and retention initiatives. However, the impact of the steps trusts are currently taking are limited without greater national progress on growing and funding the domestic workforce pipeline.

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Contact: Kerry Racher, external affairs adviser, kerry.racher@nhsproviders.org

**Board of Directors Meeting**
**7 July 2021**

| **Title of report** | **Chief Executive' Report** |
|---|---|
| **Report author(s)** | **John Lawlor, Chief Executive** |
| **Executive Lead** | **John Lawlor, Chief Executive** |

| **Strategic ambitions this paper supports (please check the appropriate box)** | | | |
|---|---|---|---|
| Work with service users and carers to provide excellent care and health and wellbeing | X | Work together to promote prevention, early intervention and resilience | X |
| To achieve "no health without mental health" and "joined up" services | X | Sustainable mental health and disability services delivering real value | X |
| To be a centre of excellence for mental health and disability | X | The Trust to be regarded as a great place to work | X |

| **Board Sub-committee meetings where this item has been considered (specify date)** | |
|---|---|
| Quality and Performance | N/A |
| Audit | N/A |
| Mental Health Legislation | N/A |
| Remuneration Committee | N/A |
| Resource and Business Assurance | N/A |
| Charitable Funds Committee | N/A |
| CEDAR Programme Board | N/A |
| Other/external (please specify) | N/A |

| **Management Group meetings where this item has been considered (specify date)** | |
|---|---|
| Executive Team | N/A |
| Corporate Decisions Team (CDT) | N/A |
| CDT – Quality | N/A |
| CDT – Business | N/A |
| CDT – Workforce | N/A |
| CDT – Climate | N/A |
| CDT – Risk | N/A |
| Business Delivery Group (BDG) | N/A |

| **Does the report impact on any of the following areas *(please check the box and provide detail in the body of the report)*** | | | |
|---|---|---|---|
| Equality, diversity and or disability | | Reputational | |
| Workforce | | Environmental | |
| Financial/value for money | | Estates and facilities | |
| Commercial | | Compliance/Regulatory | |
| Quality, safety, experience and effectiveness | | Service user, carer and stakeholder involvement | |

| **Board Assurance Framework/Corporate Risk Register risks this paper relates to** |
|---|
| N/A |

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## Trust updates

- **Annual Staff Excellence Awards**

The events of the last year have shown us all that we have a great deal to be proud of. Each year we hold our annual staff awards to celebrate the achievements of our staff. In May, Nominations opened for our 12th annual Staff Excellence Awards and we have received the largest number of nominations to date with 868 submissions.

Our Staff Excellence Awards celebrate the dedication, hard work and achievements of CNTW and NTW Solutions staff members who've made a real difference to service users, carers or work colleagues. We are hoping that our Awards ceremony will be held face to face on 3rd September however, if this is not possible, we will hold a virtual ceremony, as we did last year, enabling staff, their family and friends to join us the celebrations.

- **Annual Plan and Priorities 2021/22**

Work has commenced on setting out our annual plan for the year, recognising the context within which we have started 2021/22. In order to ensure our priorities are focussed on the key issues affecting our patients and staff, we have reviewed these considerably during June with the senior leadership team. The importance of recognising the stability and focus in relation to the COVID19 pandemic, including the learning we have gained in new ways of working will remain a constant feature in how we deliver services safely from a COVID19 perspective.

The priorities we have set focus on the front-line service delivery issues this year whilst also recognising the continued focus we need as the development of the integrated care system and placed based partnerships progress across the North East and North Cumbria continue to take shape and evolve.

- **Quarterly Staff Report**

A Quarterly Staff Survey (as outlined in the NHS People Plan) is to be rolled out across the NHS from July 2021. It will be carried out in April, July and January each year with the NHS Staff Survey held in Quarter 3. All staff will be given the opportunity to take part in each of the quarters and will be asked the nine engagement themed questions from the annual NHS Staff Survey which will be held online due to the time constraints and requirements around date submission.

The method of data collection is flexible and the Trust has decided to use the national People Pulse as the method of delivery initially with ongoing review. A communications plan is currently being developed to support the survey.

Nationally, the results will be available one month after submitting the data to allow for the data to be validated, quality assured and published nationally. The Quarterly Staff Survey will run alongside the annual NHS staff survey, providing a more regular insight into the working experience of our NHS people at a high level.

Results will be overseen by Corporate Decisions Team – Workforce Sub-Group and used alongside other data to support ongoing work across the Trust.

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- **Armed Forces Network**

An Armed Forces Staff Network has recently been launched across the Trust. The Network aims to ensure the Trust provides sufficient support to staff who are connected with the armed forces. It will meet quarterly and be open to staff who are part of the reserves or cadets, who have served within any branch of the armed forces, and those with family or partners who are currently serving or veterans. Staff with responsibilities for the Trust's specialist services for veterans will also be involved.

The Network is co-chaired by Richard Lloyd and Dave Goldsmith (both ex armed forces) and is meeting quarterly. The first meeting on 7 June 2021 was well supported with representation from all three services, reservists, cadets and families of forces personnel. Feedback from Facebook communications and local news outlets (Cumbria Crack) has been really positive.

The Network will also be key to helping the organisation fulfil its duties under the Armed Forces Covenant and the requirements of being a Veterans Aware organisation. The Trust signed the Armed Forces Covenant in February this year and was accredited as a Veteran Aware Trust by the Veterans Covenant Healthcare Alliance (VCHA) in April. Currently a Bronze Award is held under the Defence Employer Recognition Scheme (ERS), and work has commenced to achieve a Silver Award.

**Regional updates**

- **Mental Health Medical Leadership post**

Following agreement between Medical Directors of CNTW and NUTH, a position has been created within Medical Leadership of Newcastle Acute Trust for a CNTW employed psychiatrist to lead on mental and physical health interface issues. This position will be directly answerable to the Medical Director within NUTH to improve services in the acute hospital trust from a mental health perspective. It is the first initiative of its kind nationally and will lead to further improvements in this area.

**National update**

- **Collaborating for Better Care**

Attached as 'Appendix A' is a publication from Providers Deliver: Collaborating for better care which focuses on ways in which providers are collaborating to address common challenges, provide more integrated care pathways and deliver more sustainable services.

- **ICS Design Framework**

NHS England and NHS Improvement has published a new integrated care system (ICS) design framework, to support progression and development. It sets out some of the ways NHS leaders and organisations will operate with their partners in ICSs from April 2022. It is subject to legislation, which is expected to begin passage through Parliament before the end of summer. Key elements that the framework seeks to describe are set out below:

- the functions of the ICS Partnership, involving all stakeholders including Local Authorities, to align the ambitions, purpose and strategies of partners across each system
- the functions of the ICS NHS body, including planning to meet population health needs, allocating resources, ensuring that services are in place to deliver against ambitions, facilitating the transformation of services, co-ordinating and improving people and culture development, and overseeing delivery of improved outcomes for their population
- the governance and management arrangements that each ICS NHS body will need to establish to carry out those functions including the flexibility to operate in a way that reflects the local context through place-based partnerships and provider collaboratives

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- the opportunity for partner organisations to work together as part of ICSs to agree and jointly deliver shared ambitions
- key elements of good practice that will be essential to the success of ICSs, including strong clinical and professional leadership, deep and embedded engagement with people and communities, and streamlined arrangements for maintaining accountability and oversight
- the key features of the financial framework that will underpin the future ambitions of systems, including the freedom and mechanisms to use resource flexibly to better meet identified needs and to manage financial resources at system level
- the roadmap to implement new arrangements for ICS NHS bodies by April 2022 to establish new organisations, appoint leadership teams to new statutory organisations and to ensure that people affected by change are offered a smooth transition that allows them to maintain focus on their critical role in supporting recovery from the pandemic.

This is an ambitious and significant change for the NHS, and one which will be challenging to deliver, given that the necessary legislation has not yet passed through Parliament and we have a new Secretary of State. The Framework sets out a high degree of flexibility in design and implementation of the ICS and this is subject to significant discussion and debate across the North East and North Cumbria.

The Trust continues to advocate for primacy of place, allocation of resources to meet population needs, an inclusive governance structure and a federal rather than centralised ICS approach.

- **Disparity Ratios**

The National Workforce Race Equality Standard (WRES) programme has developed ‘disparity ratios’ which highlight how staff with minority ethnic backgrounds are represented at different levels in each Trust in a bid to tackle ‘racist practice’ in the NHS.

The data, which has been submitted by organisations as part of the WRES 2020 survey has been used to calculate the disparity ratio and has been created to indicate the differences in progression between white people and those from an ethnic minority background through the ranks of each organisation. The data is presented at three tiers:

- bands 5 and below (‘lower’)
- bands 6 and 7 (‘middle’)
- bands 8a and above (‘upper’)

Initial information has now been received by each organisation with additional analysis/interpretation expected through webinars and regional meetings. A further update will be provided for a future Board meeting.

- **Westminster Hall debate – Children and young people’s mental health**

Attached as ‘Appendix B’ the NHS Providers June 2021 briefing which provides an update on current pressures in children and young people’s mental health services as well as improving access to mental health services and highlights what Trusts are doing despite the challenges faced.

John Lawlor
**Chief Executive**
**July 2021**

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**Report to the Board of Directors**
**7th July 2021**

| **Title of report** | COVID-19 update |
|---|---|
| **Report author(s)** | Anne Moore, Group Nurse Director Safer Care, Director of Infection Prevention Control (DIPC) |
| **Executive Lead (if different from above)** | Gary O'Hare, Chief Nurse / Accountable Executive Officer |

| **Strategic ambitions this paper supports (please check the appropriate box)** | | | |
|---|---|---|---|
| Work with service users and carers to provide excellent care and health and wellbeing | X | Work together to promote prevention, early intervention, and resilience | X |
| To achieve "no health without mental health" and "joined up" services | | Sustainable mental health and disability services delivering real value | |
| To be a centre of excellence for mental health and disability | | The Trust to be regarded as a great place to work | |

| **Board Sub-committee meetings where this item has been considered (specify date)** | | **Management Group meetings where this item has been considered (specify date)** | |
|---|---|---|---|
| Quality and Performance | N/A | Executive Team | N/A |
| Audit | N/A | Corporate Decisions Team (CDT) | N/A |
| Mental Health Legislation | N/A | CDT – Quality | N/A |
| Remuneration Committee | N/A | CDT – Business | N/A |
| Resource and Business Assurance | N/A | CDT – Workforce | N/A |
| Charitable Funds Committee | N/A | CDT – Climate | N/A |
| CEDAR Programme Board | N/A | CDT – Risk | N/A |
| Other/external (please specify) | N/A | Business Delivery Group (BDG) | N/A |

| **Does the report impact on any of the following areas *(please check the box and provide detail in the body of the report)*** | | | |
|---|---|---|---|
| Equality, diversity and or disability | | Reputational | X |
| Workforce | X | Environmental | |
| Financial/value for money | | Estates and facilities | |
| Commercial | | Compliance/Regulatory | X |
| Quality, safety, experience and effectiveness | X | Service user, carer and stakeholder involvement | X |

| **Board Assurance Framework/Corporate Risk Register risks this paper relates to** |
|---|
| N/A |

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**Coronavirus (COVID-19)**
**Report for the Board of Directors meeting**
**7th July 2021**

## 1. Executive Summary

This report provides an exception report in response to the COVID-19 pandemic since the last Trust Board. For this month the report includes four areas:

- COVID-19 Prevalence and Nosocomial and Outbreak Management
- Patient and Staff Testing and Vaccinations
- Working Safely and Living with COVID
- Road Map – Easing of Restrictions

## 2. Trust COVID-19 Prevalence, Nosocomial Infections and Outbreak Management

Since the last report to Board, there has been a significant surge in the number of confirmed Covid Delta Variant cases, the variant of concern previously known as the Indian variant. We have seen a rapidly changing position nationally and the North East and Cumbria, have seen sharp increase in cases over the last four weeks. The North East appears to be two weeks behind the North West and has seen higher than national average cases doubling week by week 150 - 300 per 100,000, rising to previous rates seen in April 2021. The age profile indicates that 70% of positive cases are in the 20-50 year age range and unvaccinated.

Following easing of lockdown restrictions there is evidence of household and community transmission. The main cause has been social gatherings, little attention to social distancing or Infection Prevention Control (IPC) measures such as handwashing, ventilation and increases in those who remain unvaccinated

Whilst locally there has been an increase in COVID-19 admissions to acute hospital, these are not at the rates seen previously. Admissions are in the younger age group and a smaller number in the over 60 age group. It is noted that most admissions are those who haven't been vaccinated or have had only one dose.

Since the last report, North Tyneside and Cumbria local authorities commenced PCR Surge testing during June to target and prevent further spread. Newcastle is an area of concern and the potential for surge testing in this locality is likely.

Vaccination rates in all areas are also being targeted to reduce further risks. Newcastle Health Protection Board has requested support from external partners to help with the vaccination programme to meet the trajectory by 19th July 2021. This date has been brought forward by the government from 31st July 2021. The Trust has liaised with Newcastle GP Services and staff have volunteered to work overtime shifts for a time limited period to support the vaccine bus, pop up clinics in the town centre and the clinic at the Eagles Arena.

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## 2.1 Nosocomial infection (Hospital Acquired) cases in Patients

At the time of reporting, the Trust continues to have zero patient cases and on the date of the report submission we have not had an outbreak for 84 days. Standard Infection Precaution measures appear to be effective, and patients continue to be screened and isolated on admission.

## 2.2 Rise in Staff cases

However, the number of staff currently isolating due to a positive PCR test result increased rapidly in the last two weeks of June and the biggest impact has been on rising numbers of staff needing to self-isolate as a result of being a close contact or waiting for a PCR result. School closures and positive class bubbles has resulted in many children needing to be sent home and staff required to arrange childcare at short notice. Therefore, there are business continuity pressures in some service areas because of staff isolating, especially where large numbers are from the same team.

Daily sitreps have recommenced to monitor staff absence and impact on business continuity. The position is reviewed daily and via twice weekly Executive meetings and weekly BDG. The IMG for Covid is on standby and will be reinstated in response to staffing pressures

As a result of the increase the Central Absence Line, Senior Nurse Test and Trace Team, and IPC activity has been high, seeing volumes of calls and close contact risk assessments at a level similar to December 2020 and January 2021 when we were at the height of outbreak activity. Additional staffing is being mobilised to support

# 3. Patient and Staff Testing & Vaccinations

## 3.1 Patient Testing

Our testing strategy continues to swab inpatients on days one, three, five and seven for new admissions and every seven days thereafter. This enables early indication of positive PCR and isolation and care plans reflecting IPC management to avoid transmission to other patients. There remains a risk that some patients may not test positive until day 3 or 5 of admission. Staff have been reminded to support patients to social distance, use IPC measures whilst in inpatient settings and strict adherence whilst supporting ground and external leave.

## 3.2 Asymptomatic Staff Testing

Staff have been reminded to use LFT kits regularly and report their results twice a week. It is disappointing to report that the use of LFT kits and logging results has decreased and we continue to highlight the importance of lateral flow testing as this is a proven way of early identification of the COVID virus. Action has included briefings at managers meeting and Business Delivery Group (BDG) plus production of a range of Communications i.e. LFT animation, infographics, and a Talking Heads video to promote messaging.

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Managers are encouraged to use the dashboards to review staff use of LFTs and speak to staff directly where results are not logged regularly.

### 3.3 COVID-19 Vaccination Staff, Patients and Clinical Partners

COVID vaccination is now regarded as the most important factor in preventing serious illness and transmission. Since the last report the government has accelerated its programme. On the advice of the Joint Committee on Vaccines and Immunisations (JCVI) COVID vaccinations are now available to anyone 18 years and over.

Ward staff and community staff are reminded to 'make every contact count' for patients and discuss and offer vaccinations. We continue to vaccinate those aged 40 plus patients with Astra Zeneca and have good supplies. For those who are aged 40 and under it is recommended that alternatives to the Astra Zeneca vaccine are offered. Patients within the high risk JCVI groups are being supported to access Pfizer

The Trust continued with its staff vaccination programme, which has been a successful programme using a three-site model from St Nicholas Hospital, St George's Park and Hopewood Park. However, there are still some staff who have not come forward for their first or second dose. Managers are reminded to discuss vaccinations with staff who haven't had their first or second dose. The last Trust clinic for second dose vaccinations was on 30th June 2021 and thereafter staff will need to book a vaccination via the National booking system.

A Trust COVID Vaccination Learning Review took place in June and identified learning which will be embedded in the planning for any further booster programmes likely to commence in the Autumn alongside the Annual Flu plan.

Outcome of Consultation on Mandatory Vaccination for Care Home staff
From 18th October 2021 all Care Home staff will need to have had a COVID vaccination unless exempt. This also applies to visiting health and social care professionals. This will have implications for Trust staff visiting Older Peoples Care Homes and LD/ MH Care Homes & supported living. A wider consultation on health care worker mandatory vaccination is set to commence shortly.

## 4. Working Safely and Living with COVID

The Trustwide Working Safely Group has been meeting fortnightly. Four workstreams have been established to develop 'new ways of working' models for Corporate and Operational / Clinical services. The group are exploring key enablers such as homeworking and Microsoft Teams to optimise benefits, including reduced travel and changes to accommodation requirements. It is acknowledged that an incremental approach is required as COVID measures still need to be adhered to currently and principles followed in relation to COVID Secure Environmental Risk Assessments.

It is anticipated that a mixed model of office and home working will be an outcome for some service areas. Community services need to ensure face to face contacts continue to be a feature of clinical assessment / interventions and clinical effectiveness and safety are not compromised.

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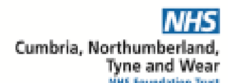
## Working Safely Group




### New Ways of Working
### 4 Workstreams

| Estates Strategy | Corporate Model(s) | Operational/ Clinical Model(s) | Vaccination & Testing |
| --- | --- | --- | --- |
| What office / workplace accommodation do we need going forward based on the learning from Teams and home working? | • Office / Home Working<br>• Microsoft Teams<br>• Staff Wellbeing<br>• Pilots? | • Office / Home Working<br>• Microsoft Teams<br>• Principles re: use of Teams in clinical practice<br>• Staff wellbeing<br>• Patient Carer Experience of Teams | • Absence Line<br>• Vaccination Programme for Autumn – Flu & Covid Booster (?)<br>• Longer Term Plan for Testing Team |

Workforce – Informatics – Transformation – Health & Wellbeing

Caring | Discovering | Growing | **Together**

## 5. Road Map Step 3 – Easing of Restrictions and Living with COVID

### 5.1 Road Map – Easing of Restrictions

On 21st June 2021 the Government decided not to lift all restrictions and have put the date back to 19th July 2021. This was essentially due to the increase in cases of the Delta variant, the vaccination programme is seen as a key enabler to restrictions lifting. The trajectory for all adults to receive their first dose of the vaccine has been brought forward from 31st July 2021 to 19th July 2021.

Health Care Settings are advised by PHE and NHSE/I to continue to adhere to social distancing and wearing masks in the workplace and wear appropriate PPE for close contact clinical interventions. Staff do not need to wear a mask outdoors if they are alone or can maintain a two metre distance from others.

### 5.2 Travel

The government continues to review travel restrictions and staff are expected to self-isolate on return from overseas travel to an Amber country and quarantine in government approved hotels if returning from a Red country.

From 30th June 2021 Malta, Madeira, the Balearic Islands, several UK overseas territories and Caribbean islands (including Barbados) were added to the government's green list, having met the necessary criteria to be reclassified. All additions to the green list apart from Malta will also join the 'green watch list', signalling that these countries are at risk of moving from green to amber. Whilst we would discourage travel outside the UK, all staff have been informed that they must discuss travel plans with line managers and agree the appropriate quarantine and testing arrangements, working from home or special leave if required.

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## 6. Recommendation

The Board are asked to receive this report, noting the increase in covid related activity and assurance on the measures taken to date.

**Anne Moore**
**Group Nurse Director Safer Care, Director of Infection Prevention and Control**

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07/02/2021 12:10:00

**Report to the Board of Directors**
**7th July 2021**

| **Title of report** | **CNTW Integrated Commissioning & Quality Assurance Report** |
|---|---|
| **Report author(s)** | **Allan Fairlamb, Deputy Director of Commissioning & Quality Assurance** |
| **Executive Lead (if different from above)** | **Lisa Quinn, Executive Director of Commissioning & Quality Assurance** |

| **Strategic ambitions this paper supports (please check the appropriate box)** | | | |
|---|---|---|---|
| Work with service users and carers to provide excellent care and health and wellbeing | X | Work together to promote prevention, early intervention and resilience | |
| To achieve "no health without mental health" and "joined up" services | | Sustainable mental health and disability services delivering real value | |
| To be a centre of excellence for mental health and disability | X | The Trust to be regarded as a great place to work | X |

| **Board Sub-committee meetings where this item has been considered (specify date)** | |
|---|---|
| Quality and Performance | 23.06.21 |
| Audit | |
| Mental Health Legislation | |
| Remuneration Committee | |
| Resource and Business Assurance | |
| Charitable Funds Committee | |
| CEDAR Programme Board | |
| Other/external (please specify) | |

| **Management Group meetings where this item has been considered (specify date)** | |
|---|---|
| Executive Team | 21.06.21 |
| Corporate Decisions Team (CDT) | |
| CDT – Quality | 28.06.21 |
| CDT – Business | |
| CDT – Workforce | |
| CDT – Climate | |
| CDT – Risk | |
| Business Delivery Group (BDG) | |

| **Does the report impact on any of the following areas *(please check the box and provide detail in the body of the report)*** | | | |
|---|---|---|---|
| Equality, diversity and or disability | | Reputational | X |
| Workforce | X | Environmental | |
| Financial/value for money | X | Estates and facilities | |
| Commercial | | Compliance/Regulatory | X |
| Quality, safety, experience and effectiveness | X | Service user, carer and stakeholder involvement | X |

| **Board Assurance Framework/Corporate Risk Register risks this paper relates to** |
|---|
| |

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# CNTW Integrated Commissioning & Quality Assurance Report
# 2021-22 Month 2 (May 2021)

## Executive Summary

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

2. There have been three remote Mental Health Act Reviewer visits – Wards 1 & 2, Walkergate Park and Aldervale ward. The themes from the visits that have taken place in the last month include; restricted access to outside space, recording regarding medication or CTO consideration in relation to leave, a room that was open but should have been locked, IMHA support and carer contact from ward and a meeting request was outstanding between the carer and staff.

   The action plans relating to these visits are owned by the relevant service and the Associate Director is responsible for following up on actions until the action plan is complete through their CMT/CBU. The CQC Compliance Officer routinely receives updates on all outstanding action plans and these are collated and shared with the Mental Health Legislation Steering Group and Mental Health Legislation Committee on a quarterly basis. The Associate Director/CBU must provide evidence to the CQC Compliance Officer to support the closure of any action contained in the action plan. The CQC Reviewer Group considers all action plans and adds in any additional overarching information where relevant prior to sign off by the Group Director/Group Nurse Director for the relevant locality group.

   The themes from these visits are taken to BDG on a monthly basis and Mental Health Legislation Steering Group and Mental Health Legislation Committee on a quarterly basis.

3. The Trust met all local CCG's contract requirements for month 2 with the exception of:

   - CPA metrics for all CCG's with the exception of South Tyneside and Sunderland.
   - Numbers entering treatment within Sunderland IAPT service (601 patients entered treatment against a target of 810) and North Cumbria (375 patients entered treatment against a target of 605).
   - Delayed Transfers of Care within Durham, Darlington and Tees and North Cumbria.

4. The Trust met all the requirements for month 2 within the NHS England contract with the exception of the percentage of patients with a completed outcome plan (98.4% against a 100% target).

5. All CQUIN schemes for 2021/22 have been suspended until Quarter 3 2021-22 due to the COVID-19 pandemic.

6. There are 30 people waiting more than 18 weeks to access services this month in non-specialised adult services (47 reported last month). Within children's community services there are currently 704 children and young people waiting more than 18 weeks to treatment (693 reported last month).

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7 Training topics below the required trust trajectory as at month 2 are listed below:

| Training Topic | Month 2 position | Quarter 1 trajectory | Quarter 1 standard |
|---|---|---|---|
| Medicines Management | 84.5% | 85% | |
| Information Governance | 87.5% | 95% | |
| PMVA Breakaway training | 72.7% | 80% | |
| Mental Health Act combined | 62.2% | 79% | |
| Clinical Risk and Suicide Prevention training | 81.3% | 85% | |
| Clinical Supervision | 78.7% | 83% | |
| Seclusion training | 68.8% | 83% | |
| Rapid Tranquilisation | 80.3% | 85% | |
| Safeguarding Children Level 3 | 73.0% | 82% | |
| PMVA Basic training | 34.9% | Under review | |
| MHCT Clustering | 59.1% | | 85% |

8 Appraisal rates are reported at 77.5% in May 2021 (77.5% last month), therefore on track to achieve the recovery trajectory for Quarter 1 of 77% Trust.

9 The percentage of staff with a completed clinical supervision record is reported at 52.8% as at 9th June 2021. At 31st May 2021 the proportion of staff with a management supervision recorded in the last 3 months is reported at 53.5% against a recovery trajectory of 71% for Quarter 1 2021.

10 The confirmed April 2021 sickness figure is 4.9%. This was provisionally reported as 4.95% in last month's report. The provisional May 2021 sickness figure is 5.35% which is above the 5% standard. The 12 month rolling average sickness rate has increased to 5.39% in the month.

11 At Month 2, the Trust has a surplus of £0.6m which is in line with the plan. Agency spend at month 2 is £2.8m of which £1.6m (59%) relates to nursing support staff.

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Other issues to note:

- There are currently 18 notifications showing within the NHS Model Hospital site for the Trust.
- The number of follow up contacts conducted within 72 hours of discharge has decreased in the month and is reported trust wide at 91.4% which is above the 80% standard. (was 95.2% last month).
- There were no inappropriate adult out of area bed days reported in May 2021 which meets the trajectory from March 2021.
- During May 2021 the Trust received 269 Points of You survey returns, of which 64% were from service users, 12% from carers, 21% were completed on behalf of a service user and 3% did not state the person type. Of the 269 responses 261 answered the FFT question with 85% of service users and carers stating their overall experience with CNTW services was either good or very good.

2021-22 Reporting of Quality Standards, Training & Appraisals during pandemic

During April, each of the locality groups and corporate services have been setting out their recovery trajectories for none compliance against standards. These trajectories show how the groups will progress towards meeting and maintaining each of the standards which will be monitored on a quarterly basis through the Accountability Framework and through to the Board in this report.

Training trajectories have been set whilst taking a number of considerations into account such as

- Availability of face to face training e.g. PMVA
- Ability for teams to release staff to take part in or deliver training e.g. PMVA
- Staff leave – taking carried forward annual leave as covid restrictions ease
- Trainee rotations – drop in LET doctor and doctors in training training standards when new rotations are taken on

Please see Appendix 1 for Training and Quality Trajectories for 2021 – 2022.

From Month 01 the Board report will monitor against the agreed trajectories rather than the overall standard.

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| 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: | 2 |
| | CQC | | | | |
| | Overall Rating | Number of "Must Dos" | There have been three Mental Health Act reviewer visit reports received since the last report. The visits continue virtually with the process including interviews with Ward Managers/Clinical Leads, service users and carers and IMHA representatives. | | |
| | Outstanding | 45 | | | |

| 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 | North Cumbria CCG |
| | 94% | 80% | 80% | 90% | 100% | 93% | 62% | 62% |

| | CQUIN - Suspended | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Cirrhosis & fibrosis tests for alcohol dependant patients | Staff Flu Vaccinations | Use of specific Anxiety Disorder measures within IAPT | Routine outcome monitoring in CYPS & Perinatal MH Services | Routine outcome monitoring in Community Mental Health Services | Biopsychosocial assessment by Mental Health Liaison Services | Healthy Weight in Adult Secure Services | Achieving high quality 'formulations' for CAMHS inpatients | Mental Health for Deaf | Routine outcome monitoring in perinatal inpatient services |
| | All CQUIN schemes are currently suspended for 2021/22 until Quarter 3 | | | | | | | | | |

| Internal | Accountability Framework | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | North Locality Care Group Score: May 2021 | | Central Locality Care Group Score: May 2021 | | South Locality Care Group Score: May 2021 | | North Cumbria Locality Care Group Score: May 2021 | |
| | 4 | The group is below standard in relation to CPP metrics and training requirements | 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 | 4 | The group is below standard in relation to a number of internal requirements |
| | Quality Priorities: Quarter 1 internal assessment RAG rating | | | | | | | |
| | No update May 2021 | | | | | | | |



Cumbria, Northumberland Tyne and Wear NHS Foundation Trust # 549848
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**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 increased in month 2. 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 Trajectory Achieved Trustwide: | Number of courses <5% below trajectory Trustwide: | Number of courses trajectory not achieved (>5% below standard): |
|---|---|---|
| 8 | 4 | 7 |

Clinical Risk training (81.3%), Clinical Supervision training (78.7%), Rapid Tranquilisation training (80.3%) and Medicines Management training (84.5%), are within 5% of the Quarter 1 trajectory. Information Governance (87.5%), PMVA basic training (34.9%), PMVA Breakaway training (72.7%), MHA combined training (62.2%), MHCT Clustering Training (59.1%), Seclusion training (68.8%), Safeguarding Children Level 3 (73.0%), are reported at more than 5% below the Quarter 1 trajectory.

**Appraisals:**

Appraisal rates have remained the same at 77.5% in May 2021 (was 77.5% last month).

**Sickness Absence:**

CNTW Sickness (Rolling 12 months) April 2018 to date

The provisional "in month" sickness absence rate is above the 5% target at 5.35% for May 2021

The rolling 12 month sickness average has increased to 5.39% in the month

CNTW Sickness (in month) 2018/19 to 2021/22

## Finance

At Month 2, the Trust has a surplus of £0.6m which is in line with plan. Agency spend at Month 2 is £2.8m of which £1.6m (59%) relates to nursing support staff.

Cumbria, Northumberland Tyne and Wear NHS Foundation Trust #549848
07/02/2021 12:10:00

## Financial Performance Dashboard

### Income & Expenditure

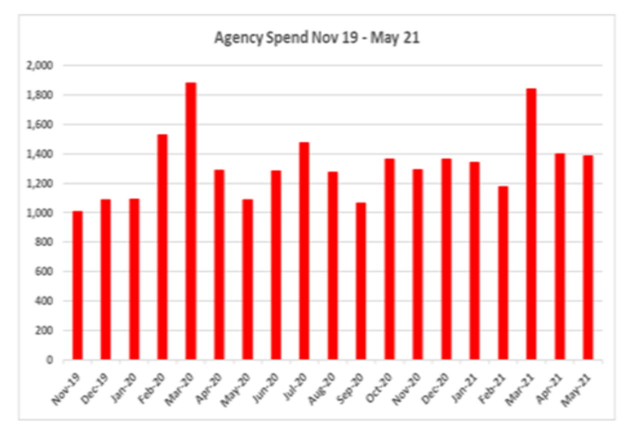
| | Plan £m | Actual £m | Variance (£) |
|---|---|---|---|
| Income | 81.2 | 80.8 | (0.4) |
| Pay | (57.5) | (57.8) | (0.3) |
| Non Pay | (23.1) | (22.4) | 0.7 |
| | **0.6** | **0.6** | **(0.0)** |

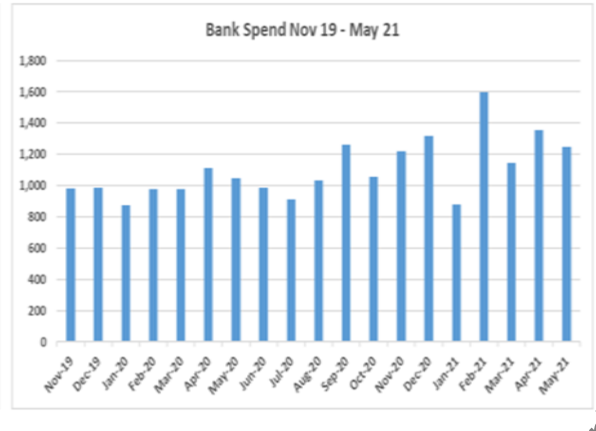
### Key Indicators

| Key Indicators | Year To Date |
|---|---|
| Surplus/ (Deficit) | £0.6m |
| Agency Spend | £2.8m |
| Cash | £57.9m |
| Capital Spend | £3.7m |

### Key Issues/Risks.

- At month 2 the Trust has a delivered a £0.6m surplus.
- Income arrangements are a continuation of the block contracts implemented in 2020/21 in response to COVID. These arrangements will continue for at least the first 6 months of the year (H1).
- The Trust has agreed to deliver break-even at the end of H1 as part of the North ICP/ICS financial plan.
- The Trust has agreed the MHIS funding for 2020/21 and 2021/22 together with investment from the Service Development Fund and Spending Review funding provided for Mental Health.
- The Trust is the Provider Collaborative lead for the North East & Cumbria for Specialist CYPs services and Adult Secure services. As a result the Trust will manage an additional £53m income and expenditure in 2021/22.
- Cash – £57.9m at month 2 which is more than historical cash levels (pre-COVID) due to improved working balances, capital spend being less than plan in 2020/21 and increases in provisions.
- Capital Spend - £3.7m at month 2 which is £2.8m less than plan.




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

| | 03/05/2021 | | 10/05/2021 | | 17/05/2021 | | 24/05/2021 | |
|---|---|---|---|---|---|---|---|---|
| Medical | 96 | 36 | 101 | 46 | 106 | 57 | 106 | 57 |
| Qual Nursing | 132 | 118 | 186 | 184 | 192 | 192 | 198 | 191 |
| Unq Nursing | 1,315 | 67 | 1,401 | 27 | 1,539 | 41 | 1,473 | 97 |
| A&C | 36 | | 55 | | 60 | | 53 | |
| | **1,579** | **221** | **1,743** | **257** | **1,897** | **290** | **1,830** | **345** |

In May the Trust reported an average of 278 price cap breaches (49 medical, 171 qualified nursing and 58 nursing support). At the end of May 8 medics were paid over the price cap.

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**Risks and Mitigations associated with the report**

- There is a risk of non-compliance with CQC essential standards and the NHS Improvement Oversight Framework.
- The Trust did not meet all the commissioning standards across all local CCG's and NHS England at month 2.
- There continues to be over 18 week waiters across services. Work continues to monitor and improve access to services across all localities.
- Please note the change in requirement and reporting due to COVID-19 are not reflected in this report.
- Quality and training standards have been impacted as a consequence of responding to COVID-19.

**Recommendations**

The Board of Directors are asked to note the information included within this report

Allan Fairlamb

Deputy Director of Commissioning & Quality Assurance

Lisa Quinn

Executive Director of Commissioning & Quality Assurance

18th June 2021

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# Training Trajectories 2021-2022 – Appendix 1

| Metric ID - Training Name | Standard | Q1 North | Q1 Central | Q1 South | Q1 N.Cumbria | Q1 Corporate | Q1 Trust Trajectory | Q2 North | Q2 Central | Q2 South | Q2 N.Cumbria | Q2 Corporate | Q2 Trust Trajectory |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 3001 - Clinical Risk and Suicide Prevention Training | 85% | 85% | 85% | 85% | 85% | 70% | 85% | 85% | 85% | 85% | 85% | 75% | 85% |
| 3002 - Clinical Supervision | 85% | 85% | 80% | 85% | 75% | 80% | 83% | 85% | 82% | 85% | 77% | 85% | 84% |
| 3004 - Equality & Diversity Introduction | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% |
| 3006 - Fire | 85% | 85% | 85% | 85% | 85% | 80% | 85% | 85% | 85% | 85% | 85% | 85% | 85% |
| 3008 - Health & Safety | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% |
| 3015 - Infection Prevention & Control - Inoculation Incidents – Hand Hygiene | 85% | 85% | 85% | 85% | 85% | 83% | 85% | 85% | 85% | 85% | 85% | 84% | 85% |
| 3018 - Medicines Management Training | 85% | 85% | 85% | 85% | 83% | 70% | 85% | 85% | 85% | 85% | 84% | 75% | 85% |
| 3019 - Moving & Handling Awareness Training | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% |
| 3022 - PMVA Basic | 85% | ~~50%~~ | ~~28%~~ | ~~35%~~ | ~~50%~~ | ~~50%~~ | ~~43%~~ | ~~60%~~ | ~~38%~~ | ~~50%~~ | ~~65%~~ | ~~65%~~ | ~~56%~~ |
| 3023 - Rapid Tranquilisation Training | 85% | 85% | 85% | 85% | 85% | 80% | 85% | 85% | 85% | 85% | 85% | 85% | 85% |
| 3026 - Safeguarding Adults Level 1 | 85% | 85% | 85% | 85% | 85% | 83% | 85% | 85% | 85% | 85% | 85% | 85% | 85% |
| 3027 - Safeguarding Children Level 1 | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% |
| 3030 - Information Governance (Data Security Awareness) | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% |
| 3042 - Seclusion Training | 85% | 85% | 85% | 85% | 80% | 75% | 83% | 85% | 85% | 85% | 82% | 85% | 85% |
| 3043 - PMVA Breakaway | 85% | 85% | 71% | 85% | 75% | 65% | 80% | 85% | 78% | 85% | 77% | 75% | 82% |
| 3046 - Safeguarding Children Level 3 | 85% | 85% | 80% | 85% | 80% | 75% | 82% | 85% | 85% | 85% | 82% | 85% | 84% |
| 3047 - Safeguarding Children Level 2 | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% |
| 3075 - MHA MCA DoLS Combined | 85% | 80% | 75% | 80% | 65% | 60% | 79% | 85% | 78% | 85% | 75% | 63% | 83% |
| 3501 - Complete JDR's | 85% | 85% | 71% | 80% | 76% | 73% | 77% | 85% | 75% | 85% | 80% | 77% | 80% |
| 3514 - Proportion of staff with management supervision recorded in the past 3 months | 85% | 70% | 65% | 70% | 85% | 65% | 71% | 80% | 85% | 80% | 85% | 75% | 81% |

Shaded trajectories are where standard is already met or exceeded.
PMVA Basic trajectories are currently under review and will be updated as soon as possible.

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| Metric ID - Training Name | Q3 | | | | | | Q4 | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | North | Central | South | N.Cumbria | Corporate | Trust Trajectory | North | Central | South | N.Cumbria | Corporate | Trust Trajectory |
| 3001 - Clinical Risk and Suicide Prevention Training | 85% | 85% | 85% | 85% | 80% | 85% | 85% | 85% | 85% | 85% | 85% | 85% |
| 3002 - Clinical Supervision | 85% | 83% | 85% | 82% | 85% | 85% | 85% | 85% | 85% | 85% | 90% | 85% |
| 3004 - Equality & Diversity Introduction | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% |
| 3006 - Fire | 85% | 85% | 85% | 85% | 90% | 85% | 85% | 85% | 85% | 85% | 90% | 85% |
| 3008 - Health & Safety | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% |
| 3015 - Infection Prevention & Control - Inoculation Incidents – Hand Hygiene | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 88% | 85% |
| 3018 - Medicines Management Training | 85% | 85% | 85% | 84% | 80% | 85% | 85% | 85% | 85% | 85% | 85% | 85% |
| 3019 - Moving & Handling Awareness Training | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% |
| 3022 - PMVA Basic | ~~70%~~ | ~~50%~~ | ~~65%~~ | ~~75%~~ | ~~65%~~ | ~~66%~~ | ~~85%~~ | ~~60%~~ | ~~85%~~ | ~~80%~~ | ~~75%~~ | ~~78%~~ |
| 3023 - Rapid Tranquilisation Training | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% |
| 3026 - Safeguarding Adults Level 1 | 85% | 85% | 85% | 85% | 90% | 85% | 85% | 85% | 85% | 85% | 90% | 85% |
| 3027 - Safeguarding Children Level 1 | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% |
| 3030 - Information Governance (Data Security Awareness) | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% |
| 3042 - Seclusion Training | 85% | 85% | 85% | 84% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% |
| 3043 - PMVA Breakaway | 85% | 85% | 85% | 82% | 75% | 85% | 85% | 85% | 85% | 85% | 85% | 85% |
| 3046 - Safeguarding Children Level 3 | 85% | 85% | 85% | 84% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% |
| 3047 - Safeguarding Children Level 2 | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% |
| 3075 - MHA MCA DoLS Combined | 85% | 82% | 85% | 85% | 70% | 85% | 85% | 85% | 85% | 85% | 85% | 85% |
| 3501 - Complete JDR's | 85% | 78% | 85% | 85% | 80% | 83% | 85% | 80% | 85% | 85% | 85% | 85% |
| 3514 - Proportion of staff with management supervision recorded in the past 3 months | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% |

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## Quality Trajectories 2021-2022

| | | Q1 | | | | | Q2 | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Metric ID - Quality** | **Standard** | **North** | **Central** | **South** | **N.Cumbria** | **Aggregate** | **North** | **Central** | **South** | **N.Cumbria** | **Aggregate** |
| **155 Care Plans Discussed** | 95% | 95% | 93% | 92% | 84% | 91% | 95% | 95% | 95% | 85% | 93% |
| **156 Current Service users clustered within threshold (previous 2 reviews)** | 85% | 80% | 85% | 80% | 58% | 76% | 83% | 85% | 83% | 65% | 79% |
| **157 Current service users clustered within review threshold** | 85% | 80% | 84% | 80% | 71% | 79% | 83% | 85% | 83% | 73% | 81% |
| **11 % of service users with a record of CPA/non CPA status** | 95% | 85% | 94% | 85% | 68% | 83% | 90% | 95% | 90% | 75% | 88% |
| **34 Current service users on CPA reviewed in last 12 months** | 95% | 97% | 95% | 97% | 95% | 96% | 97% | 95% | 97% | 95% | 96% |
| **401 CPA reviews where cluster performed +3/-3 days either side of CPA review** | 85% | 80% | 79% | 80% | 68% | 77% | 83% | 81% | 83% | 75% | 81% |
| **984 Current service users with valid ethnicity** | 90% | 90% | 90% | 90% | 90% | 90% | 90% | 90% | 90% | 90% | 90% |
| **1427 Number of Service Users on the EIP caseload Screen Using the LESTER tool** | 90% | 90% | 90% | 90% | 68% | 85% | 90% | 90% | 90% | 75% | 86% |
| **298 DTOC** | <7.5% | | | | 13% | 13% | | | | 13% | 13% |
| **101 Risk Assessments** | 95% | 95% | 95% | 95% | 65% | 88% | 95% | 95% | 95% | 75% | 90% |

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| Metric ID - Quality | Standard | Q3 | | | | | Q4 | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | North | Central | South | N.Cumbria | Aggregate | North | Central | South | N.Cumbria | Aggregate |
| 155 Care Plans Discussed | 95% | 95% | 95% | 95% | 90% | 94% | 95% | 95% | 95% | 95% | 95% |
| 156 Current Service users clustered within threshold (previous 2 reviews) | 85% | 85% | 85% | 85% | 75% | 83% | 85% | 85% | 85% | 85% | 85% |
| 157 Current service users clustered within review threshold | 85% | 85% | 85% | 85% | 75% | 83% | 85% | 85% | 85% | 85% | 85% |
| 11 % of service users with a record of CPA/non CPA status | 95% | 95% | 95% | 95% | 85% | 93% | 95% | 95% | 95% | 95% | 95% |
| 34 Current service users on CPA reviewed in last 12 months | 95% | 97% | 95% | 97% | 95% | 96% | 97% | 95% | 97% | 95% | 96% |
| 401 CPA reviews where cluster performed +3/-3 days either side of CPA review | 85% | 85% | 83% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% |
| 984 Current service users with valid ethnicity | 90% | 90% | 90% | 90% | 90% | 90% | 90% | 90% | 90% | 90% | 90% |
| 1427 Number of Service Users on the EIP caseload Screen Using the LESTER tool | 90% | 90% | 90% | 90% | 85% | 89% | 90% | 90% | 90% | 90% | 90% |
| 298 DTOC | <7.5% | | | | 13% | 13% | | | | 13% | 13% |
| 101 Risk Assessments | 95% | 95% | 95% | 95% | 85% | 93% | 95% | 95% | 95% | 95% | 95% |

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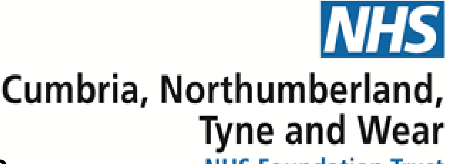

**Report to the Board of Directors**
**7 July 2021**

| **Title of report** | **Annual Plan 2021-22** |
|---|---|
| **Report author(s)** | **Anna Foster**<br>**Trust Lead for Strategy and Sustainability** |
| **Executive Lead (if different from above)** | **James Duncan, Deputy Chief Executive and Executive Director of Finance, Ramona Duguid, Chief Operating Officer** |

| **Strategic ambitions this paper supports (please check the appropriate box)** | | | |
|---|---|---|---|
| Work with service users and carers to provide excellent care and health and wellbeing | x | Work together to promote prevention, early intervention and resilience | x |
| To achieve "no health without mental health" and "joined up" services | x | Sustainable mental health and disability services delivering real value | x |
| To be a centre of excellence for mental health and disability | x | The Trust to be regarded as a great place to work | x |

| **Board Sub-committee meetings where this item has been considered (specify date)** | |
|---|---|
| Quality and Performance | |
| Audit | |
| Mental Health Legislation | |
| Remuneration Committee | |
| Resource and Business Assurance | |
| Charitable Funds Committee | |
| CEDAR Programme Board | |
| Other/external (please specify) | |

| **Management Group meetings where this item has been considered (specify date)** | |
|---|---|
| Executive Team | x |
| Corporate Decisions Team (CDT) | x |
| CDT – Quality | |
| CDT – Business | x |
| CDT – Workforce | |
| CDT – Climate | |
| CDT – Risk | |
| Business Delivery Group (BDG) | x |

| **Does the report impact on any of the following areas *(please check the box and provide detail in the body of the report)*** | | | |
|---|---|---|---|
| Equality, diversity and or disability | x | Reputational | x |
| Workforce | x | Environmental | x |
| Financial/value for money | x | Estates and facilities | x |
| Commercial | x | Compliance/Regulatory | x |
| Quality, safety, experience and effectiveness | x | Service user, carer and stakeholder involvement | x |

| **Board Assurance Framework/Corporate Risk Register risks this paper relates to** |
|---|
| All |

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# Annual Plan 2021-22

## Introduction:

1. This paper introduces the CNTW 2021-22 Annual Plan to the Board for approval, ensuring quality care is provided to service users and highlighting known risks and mitigations.
2. There has been increased investment this year in some CNTW services to expand the workforce and achieve Long Term Plan deliverables agreed with commissioners, who are required to meet the Mental Health Investment Standard (MHIS) by increasing their spend on mental health services by at least 2021-22 published allocation growth, plus Service Development Funding linked to specific programmes of work.
3. Successful delivery of this plan will require difficult decisions, as our workforce need to recuperate from pandemic pressures yet we must also progress service development to deliver Long Term Plan ambitions amid capacity, demand, financial and pandemic uncertainty.
4. The CNTW 2021-22 Annual Plan sets out **three Trustwide Priorities** for the remainder of the financial year:
   - **Our people** – we will focus on the health and wellbeing of our staff, including taking action to ensure we have safe staffing models in place across our front line services, in order to provide high quality care for our service users.
   - **Quality standards & safety** – we will focus on improving access and waiting times, improving the inpatient experience, and prioritising time to ensure the safety of care we deliver is our main priority.
   - **Service demand and delivery** – we recognise that the NHS long term plan sets out several priorities for us to deliver during the remainder of this year. However in addition to this it is important we focus on improving access to services across our inpatient and crisis pathways as well as changing how we work across community services with our partners.
5. It is important to recognise that running across all our three priorities will be embedding and working with COVID19 as a constant feature whilst also identifying how we address service demand and delivery that supports robust resource planning. The emerging development of the Integrated Care System will also be a constant feature during the year in terms of how we engage with our partners at place and influence the system to ensure mental health, learning disabilities and autism have a strong voice and priority across the system.
6. **This transitional plan sets out how the organisation is intending to develop from a position of sustained COVID19 crisis management, learning from the pandemic and restabilising our core services, prioritising our workforce, quality standards and service delivery during 2021-22 via a collective leadership approach. We also recognise the importance of looking beyond this year with the development of a refreshed strategy from 2022.**

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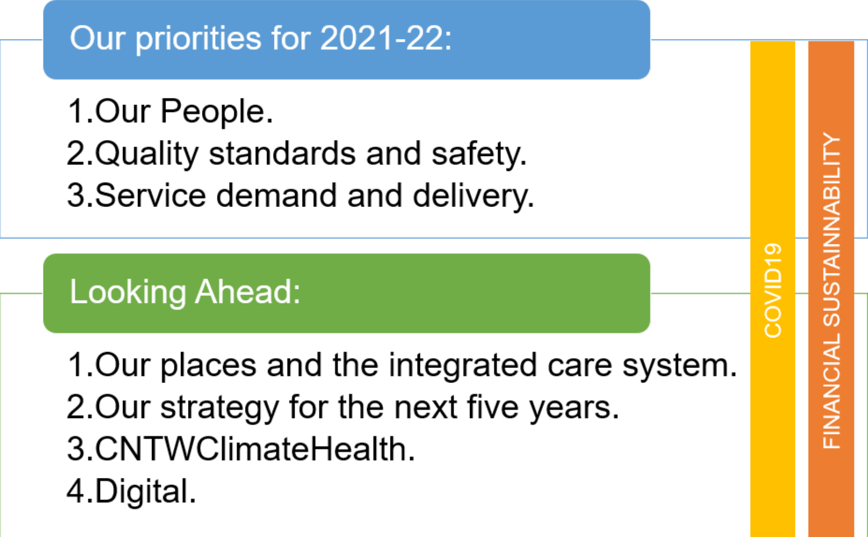


## Context:

7. The events of the last 18 months have brought into sharp focus the health impact of societal inequalities, as well as the positive impact we can have when we work together to respond to shared challenges. CNTW staff have responded to the pandemic with the dedication and compassion that are at the core of who we are as an organisation, with clarity, agility and flexibility, to ensure continued delivery of services.

8. It is important that we identify and incorporate lessons learned from the pandemic into our planning for the rest of this financial year as we progress towards a “Business as Usual plus COVID19” scenario while managing the uncertainty of future waves.

9. Staff continue to work differently to meet infection safety measures such as the wearing of PPE, testing, social distancing, changing use of technology and home working. In addition to the general physical and/or mental impact of working in the NHS during Coronavirus, some colleagues are also coping with the health impact of long COVID and with our workforce reflecting wider society, many colleagues are affected by the social and financial impact of the pandemic in their personal lives.

10. Other ongoing challenges across the organisation include a tired workforce, levels of violence and aggression in some inpatient wards, high occupancy and observation levels, long waiting times to access some community services, recruitment to new roles and meeting the deliverables attached to Long Term Plan investment. Externally, of note are the implementation of Provider Collaboratives, proposed legislative changes to support integrated care and place-based decision-making, the financial framework to support COVID19 and the independent public inquiry into the handling of the pandemic scheduled for spring 2022. The delay in bringing this Annual Plan to the Board for consideration reflects the ongoing uncertainty within the system.

11. **The biggest risks to delivery of this plan are potential further COVID19 waves of varying impact and the capacity of our workforce. Should the level of infection once again rise to the point where the NHS is impacted, the Gold Command structure will be reinstated at a pace and scale proportionate to the situation.**

12. We have identified priorities for 2021-22 on the areas requiring collective focus to support our workforce and continued emphasis on delivering quality services whilst recognising the need to create time to look ahead and engage in the development of the broader system and our places.

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## 2021-22 Trust-wide Priorities:

13. The three proposed Trust-wide priorities to be delivered in 2021-22 are:

| Our People | Quality Standards and Safety | Service Demand and Delivery |
|---|---|---|

14. These priorities take into consideration:

- ✓ the NHS 2021-22 Operational Planning Guidance,
- ✓ local agreement of Long-Term Plan deliverables
- ✓ other local developments and issues not included in the Long-Term Plan
- ✓ NHS Mental Health Implementation Plan 2019-20 to 2023-24
- ✓ NHS Advancing Mental Health Equalities Strategy
- ✓ Transforming Care
- ✓ NHS People Plan and People Promise
- ✓ Feedback on Quality Priorities from CNTW stakeholders

15. The priorities will be underpinned by the expectation of continuing COVID19 measures and achieving financial balance, while working towards tackling health inequalities, system working within local communities, promoting rights-based approaches and fulfilling our responsibility as an anchor institution.

**COVID19 measures**

16. The Infection, Prevention and Control Board Assurance Framework provides assurance that any relevant areas of risk are identified, and corrective actions implemented. Working safely during the pandemic, regardless of infection levels, continues to significantly impact upon the organisation and at present there are no plans to reduce current practice in relation to:

- PPE, IPC and social distancing (personal protective behaviours)
- Patient and staff testing
- Working from home / working safely

17. If further waves of the pandemic do threaten to overwhelm the Trust, the Gold Command function, currently operating at minimum level, will be reinstated along with robust outbreak management processes.

18. There is also uncertainty around plans and timing of any COVID19 staff and patient booster vaccination programme.

19. There will also be a requirement to prepare in advance for the independent national inquiry into the handling of the pandemic, due to commence in March 2022.

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## Priority One: Our People

20. The first priority is to help our workforce continue to deliver or support quality care to service users by protecting and improving the wellbeing of our workforce, aligning with the 21-22 Operating Guidance and with progress monitored via the Quality & Performance Committee.

Our People

- Wellbeing
- Equality, Diversity and Inclusion
- Safer staffing
- Working safely with covid

21. Our staff are recovering from the intense pressures of working in the NHS during the pandemic, adapting to significant change, meeting increasing demand and continuing to work in a COVID safe approach, and sadly, some staff are experiencing long COVID.

22. The regional NHS staff wellbeing hub, provided by CNTW, remains in place to support staff alongside other wellbeing measures such as Schwartz rounds. The Health and Wellbeing strategy has been refreshed to include career, financial, psychological, social, physical and social wellbeing.

23. Retaining existing staff, ensuring a sense of belonging in CNTW, and attracting new staff to the organisation are key to providing or supporting the delivery of compassionate, quality healthcare and without protecting the wellbeing of staff, none of our remaining priorities will be achieved. Careful consideration of workforce capacity has been considered while determining the 21-22 priorities.

24. The Appraisal Policy was recently updated to support the newly launched, inclusive Talent Management Framework, improving retention by enhancing career development.

25. The Talk First violence reduction initiative continues, as many staff continue to experience unacceptable levels of violence and aggression at work.

26. As demonstrated by the 2020 Staff Survey results, BAME colleagues continue to experience discrimination at work, and actions to support the Workforce Race Equality Standard and improve equality, diversity and inclusion include the Collective Leadership and Management Development Programme, the ongoing development of staff networks and a planned RESPECT campaign. Other actions to respond to issues raised by staff via the Staff Survey are being taken forward via the Trust Improvement Collaborative (TIC).

27. As highlighted in Safer Staffing reports to Board, the majority of inpatient wards are experiencing shortages of registered nurses, mitigated by the use of non-registered and temporary staff. Locality groups are closely managing these issues.

28. There is also an 8% vacancy rate in medical staffing across the Trust, particularly in North Cumbria community services (all ages) and across inpatient services for people with a learning disability and/or autism at Northgate. This situation is being mitigated by overtime, agency staff and international recruitment.

29. **A key workforce risk to note is the high risk of newly funded roles linked to the delivery of Long Term plan objectives being filled by internal candidates, depleting capacity and affecting services elsewhere in the organisation.**

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## Priority Two: Quality Standards and Safety

30. The 2020-21 CNTW Quality Account, details four agreed 21-22 Trust-wide Quality Priorities to support the long-term Quality Goals set out in the Trust Strategy.

**Quality Standards and Safety**

- Improving the Inpatient Experience
- Improving Waiting Times*
- Equality, Diversity, Inclusion and Human Rights
- Increasing time spent with service users and carers
- Meeting other quality and regulatory standards
- Continue to improve safety
- Continue to embed learning to improve safety
- Delivering care safely with COVID19

31. Other quality and regulatory standards include quality measures agreed with commissioners, including new requirements linked to the Long Term Plan.

32. See **Appendix 1** for new metrics related to investment in services with Long Term Plan commitments to be monitored in-year. Work is ongoing to establish the baseline position and scale of gap between existing position and agreed standards, which will be brought to Trust Board in September 2021.

33. As reported in the Quality & Commissioning Report updates to Board, performance against quality standards are closely monitored and improvement trajectories are agreed with Locality Groups via the Accountability Framework. All locality groups currently have improvement trajectories in place to meet all quality and workforce standards by the end of the financial year.

34. Monitoring of services against CQC and other regulatory standards continues, along with preparations for future comprehensive inspection activity.

35. *The waiting times measured through the 'Improving Waiting Times' Quality Priority include Adult and Older Adult mental health provision, services for Children and Young People, Adult Gender Dysphoria, Adult Autism Spectrum Disorder Diagnosis and Adult Attention Deficit Hyperactivity Disorder Diagnosis.

36. Risks and assumptions relating to the agreed 21-22 Long Term Plan Deliverables:

- There is some disconnect to be overcome between 1) the national vision for future community mental health services for adults and older people and 2) the specific investments made by CCGs this year to support specialised elements of community services.
- The increased investment is currently non-recurrent and assumed to become recurrent in 2022-23.
- There is a risk of non-recruitment into new posts or the appointment of staff from elsewhere in the organisation, exacerbating existing workforce challenges in some areas.

There is ongoing dialogue with some CCGs, delaying the release of funds. This is being mitigated by early commencement of recruitment processes for key new roles.

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## Priority Three – Service Demand and Delivery

37. The priority areas of focus to manage demand, maintain and improve services will support the delivery of the long-term plan requirements while taking a realistic approach to the service delivery challenges we face now.

**Service Demand and Delivery**

- Managing demand for inpatient beds & improving the emergency admission process
- Maximising the effectiveness of the crisis pathway
- Supporting place-based working to develop and improve community services
- Review the complex learning disabilities and/or autism assessment and treatment pathway
- Reduce long waits for access to services for children and young people and continue our work on transitions
- Adapting services to support Long Term Plan deliverables
- Achieving Financial Sustainability (see below)

38. The demand for inpatient beds continues to be a challenge across all localities, which requires the admission, treatment, and discharge processes to be reviewed across our key pathways.

39. Linked to the increase in acute inpatient admissions is the need to ensure we maximise the effectiveness of our crisis services.

40. The national commitment to transform community mental health services will be a short, medium and long-term priority for the Trust. However, there are key deliverables for this year including how we continue to evolve and support working at place across social, primary, community care with all partners.

41. The relationship between adult community and inpatient mental health services is now reported through the Long Term Plan metrics (Appendix 1) monitoring access to community services (numbers), number of people admitted to inpatient services who have no previous contact with community services, and average length of stay on inpatient wards.

42. Other 21-22 Long Term Plan requirements are centred around improving the numbers of people accessing services, and/or improving waiting times to services.

43. We will also increase our focus on interdependencies between adult community mental health services and substance misuse services.

44. We will continue to support the Transforming Care priorities in terms of learning disabilities and autism with a focus on our complex assessment and treatment pathways.

45. We will continue to improve the Neurodisability pathways of care.

46. Ensuring we develop responsive services for children and young people will remain a core part of our longer-term strategy with a focus on reducing long waits for access to services and continuing our work on managing transitions effectively.

47. Supporting the resource planning and allocation across the Trust in the context of service delivery will also play a key feature in meeting current and future demand for services.

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## Financial Sustainability and Financial Plan 21-22

48. As reported previously to Board, the Trust is in receipt of temporary system funding related to COVID19 and current expenditure remains higher than previous income levels. Work is continuing to analyse this difference, taking into account agreed Long Term Plan System Development Funding investment priorities.

49. Operational services will be supported where necessary to review and realign resources to deliver financially sustainable services in line with delivery of the Long Term Planning ambitions, continuing a piece of work paused during the height of the pandemic to integrate planning around quality, activity, workforce and financial management

50. The Organisation Finance Plan – H1 2021/22 previously presented to the Board showed the Trust plans to deliver financial breakeven at Sept 2021 as part of the North ICP plan to deliver a £2.2m surplus. To breakeven, the Trust is being supported by £9.5m of temporary system funding. The Trust submitted a capital programme to NHSEI in April and the planned spend for 21/22 is £47.2m. A process to prioritise the use of the uncommitted element of the programme is being undertaken and a proposed programme will be brought to the Board for approval when this is completed.

51. Work on the underlying financial position regarding spending rates across the Trust, compared to reconciling income back to the commissioned position pre-Covid reveals a financial gap of £24.9m. While there is no certainty on funding going forward, it is essential that we plan on the basis of fully understanding and resolving that gap as we run into 2022/23. However, there has also been a significant investment into the Trust of approximately £19.2m, with significant risks associated with recruitment and delivery. Work is ongoing to quantify those risks to enable further discussions with commissioners. While this may support the financial position in year, it would clearly put at risk delivery of Long-Term Plan commitments.

52. There is no formal guidance available at this stage regarding the financial arrangements for H2. The expectation is that current arrangements will continue with temporary funding made available to support delivery of breakeven in H2, with the addition of an efficiency requirement applied to H2. Our current understanding is that this efficiency be around 3% on H2 turnover, and that this will be tapered in some way through the second half of the year. This leaves a maximum risk of reduced income of £7m in the second part of the year. The Trust is currently looking at options and opportunities to manage this risk. To enable operational certainty, resource envelopes for H2 will be maintained at current levels to ensure that we focus on long term sustainability, while maintaining quality of services.

53. Also of note is the short-term financial risk from timing issues relating to the planned bed reduction trajectories in Learning Disability and/or Autism inpatient services.

54. It is recommended that this report is read in conjunction with the separate, detailed Board report articulating the 2021-22 financial position.

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## Looking to the future:

55. While the organisation recovers and restabilises this year, we will also be looking to support longer-term objectives by looking to the future in terms of:

**Our Places and Integrated Care System**

56. We continue to work collaboratively with the North East and North Cumbria Integrated Care System and partners to deliver the regional strategy, in particular, the mental health system priorities.

57. Locality Groups work closely with all partners and sectors at place to develop services that meet the needs of local populations.

58. Place-based systems are leading on work to develop community-based services in line with the vision set out in The Community Mental Health Framework for Adults and Older Adults.

**Five Year Strategy**

59. The existing NTW strategy, "Caring, Discovering, Growing: Together" (2017-2022) is nearing the end of its lifecycle and in May 2021 the Trust Board approved a project and timetable to refresh the strategy for the five-year period 2022-2027.

60. A stakeholder engagement/listening campaign will take place, intended to build trust and hear the quietest voices

61. The final strategy document will include a clear, patient-focussed "vision" for the Trust, a statement of purpose and intended outcomes which can be used as a basis for future planning and decision-making. Future annual plans will be aligned to the strategy, along with Accountability Framework arrangements.

**CNTW ClimateHealth**

62. The CNTW Green Plan 2021-2026 includes in year deliverables to support the seven aims of the plan.

63. The plan is based around the principles of sustainable healthcare, ie prevention, empowerment, value, carbon.

64. The CNTWClimateHealth staff engagement programme continues and the Trust is part of the ICS Sustainability Group.

**Digital**

65. The use of digital technology accelerated as a result of the pandemic and will continue to increase over time.

66. To ensure that the future digital needs of clinical and support services are met, taking into account new technologies, the Trust Digital Strategy is to be reviewed.

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## Annual Plan Monitoring and Reporting

67. Progress against the plan will be monitored via the Accountability Framework 2021-22 which will be refreshed to align with the 2021-22 Annual Plan.
68. The Trust Board will receive Annual Plan updates in 2021-22 as follows:
    - September 2021 – 2021-22 funding update, agreed deliverables update and results of performance gap analysis
    - December 2021 – progress against plan deliverables

## Recommendations

69. That the Board consider this paper alongside the supporting 2021-22 Finance paper.
70. That the Board approve the 21-22 Annual Plan, noting Trust wide priorities, risks and mitigations.

**James Duncan**
**Deputy Chief Executive &**
**Executive Director of Finance**

**Ramona Duguid**
**Chief Operating Officer**

**June 2021**

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Appendix 1

## Long Term Plan Activity and Performance Metrics

*new or adjusted metrics for 21-22

1. IAPT Roll-Out*
2. IAPT recovery rate
3. IAPT waiting times
4. IAPT in-treatment pathway waits
5. Implementation of IAPT - Long Term Condition pathways
6. Estimated diagnosis rate for people with dementia
7. Improve access to Children and Young People's Mental Health Services*
8. Waiting times for Routine Referrals to Children and Young People Eating Disorder Services
9. Waiting times for Urgent Referrals to Children and Young People Eating Disorder Services
10. People with severe mental illness receiving a full annual physical health check and follow up interventions
11. Number of people accessing Individual Placement and Support
12. Access to community mental health services for adults and older adults with severe mental illnesses*
13. Inappropriate adult acute mental health Out of Area Placement (OAP) bed days
14. Inpatient admissions for people who have had no previous contact with community mental health services*
15. Adult mental health inpatients receiving a follow up within 72hrs of discharge
16. Reducing long length of stay for adults and older adults in acute inpatient services*
17. Number of women accessing specialist community perinatal mental health services
18. Mental Health Services Dataset - Data Quality Maturity Index Score

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**Report to the Board of Directors**
***7th July 2021***

| | |
|---|---|
| **Title of report** | **Care Quality Commission Five Year Strategy from 2021** |
| **Report author(s)** | **Vicky Grieves, CQC Compliance Officer** |
| **Executive Lead (if different from above)** | **Lisa Quinn, Executive Director of Commissioning & Quality Assurance** |

| **Strategic ambitions this paper supports (please check the appropriate box)** | | | |
|---|---|---|---|
| Work with service users and carers to provide excellent care and health and wellbeing | X | Work together to promote prevention, early intervention and resilience | X |
| To achieve "no health without mental health" and "joined up" services | X | Sustainable mental health and disability services delivering real value | X |
| To be a centre of excellence for mental health and disability | X | The Trust to be regarded as a great place to work | X |

| **Board Sub-committee meetings where this item has been considered (specify date)** | |
|---|---|
| Quality and Performance | |
| Audit | |
| Mental Health Legislation | |
| Remuneration Committee | |
| Resource and Business Assurance | |
| Charitable Funds Committee | |
| CEDAR Programme Board | |
| Other/external (please specify) | |

| **Management Group meetings where this item has been considered (specify date)** | |
|---|---|
| Executive Team | |
| Corporate Decisions Team (CDT) | |
| CDT – Quality | |
| CDT – Business | |
| CDT – Workforce | |
| CDT – Climate | |
| CDT – Risk | |
| Business Delivery Group (BDG) | |

| **Does the report impact on any of the following areas *(please check the box and provide detail in the body of the report)*** | | | |
|---|---|---|---|
| Equality, diversity and or disability | X | Reputational | X |
| Workforce | X | Environmental | X |
| Financial/value for money | | Estates and facilities | |
| Commercial | | Compliance/Regulatory | X |
| Quality, safety, experience and effectiveness | X | Service user, carer and stakeholder involvement | X |

| **Board Assurance Framework/Corporate Risk Register risks this paper relates to** |
|---|
| SA5: The Trust will be the centre of excellence for mental health and disability.<br>Risk 1688 Due to the compliance standards set from NHSI, CQC and legislation there is a risk that we do not meet and maintain standards which could compromise the Trust's statutory duties and regulatory requirements.<br>Risk 1691: As a result of not meeting statutory and legal requirements regarding mental health legislation this may compromise the Trust's compliance with statutory duties and regulatory requirements. |

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**Care Quality Commission Five Year Strategy from 2021**

**Board of Directors**

**7th July 2021**

## 1. Executive Summary

At the February 2021 Board of Directors meeting the Board received details of the Care Quality Commission's (CQC) consultation on their strategy for 2021 and beyond. In this document the CQC set out how it planned to develop its approach in line with a changing health and care landscape taking into account the context and learning from COVID-19, the development of system working and greater use of digital technologies to ensure its regulatory model is relevant and fit for purpose in an evolving system.

The CQC have now published their new strategy which lays out their intentions to take a more proportionate and risk-based approach to regulation and minimise burden where possible by using a more flexible and 'real time' approach.

## 2. Findings

The strategy sets out their ambitions under four themes:

- **People and communities**
  To be an advocate for change, with regulation driven by people's needs and their experiences of health and care services, rather than how providers want to deliver them.

  This means focusing on what matters to the public, and to local communities, when they access, use and move between services. Working in partnership with people who use services, to help build care around the person.

- **Smarter regulation**
  To be smarter in how it regulates, to keep pace with changes in health and care, providing up-to-date, high-quality information and ratings for the public, providers and all our partners.

  Regulation will be more dynamic and flexible in order to adapt to the future changes that it can anticipate – as well as those it cannot. Smarter use of data means resources can be targeted, focusing on risk and where care is poor.

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- **Safety through learning**
  To have stronger safety and learning cultures. Health and care staff work hard every day to make sure people's care is safe. Despite this, safety is still a key concern as it's consistently the poorest area of performance in assessments.

  Safety is to be prioritised creating stronger safety cultures, focusing on learning, improving expertise, listening and acting on people's experiences, and taking clear and proactive action when safety does not improve.

- **Accelerating improvement**
  To do more to drive improvements across individual services and systems of care. To use their position to spotlight the priority areas that need to improve and enable access to support where it's needed most.

  To empower services to help themselves, while retaining a strong regulatory role. The key to this is by collaborating and strengthening relationships with services, the people who use them, and our partners across health and care.

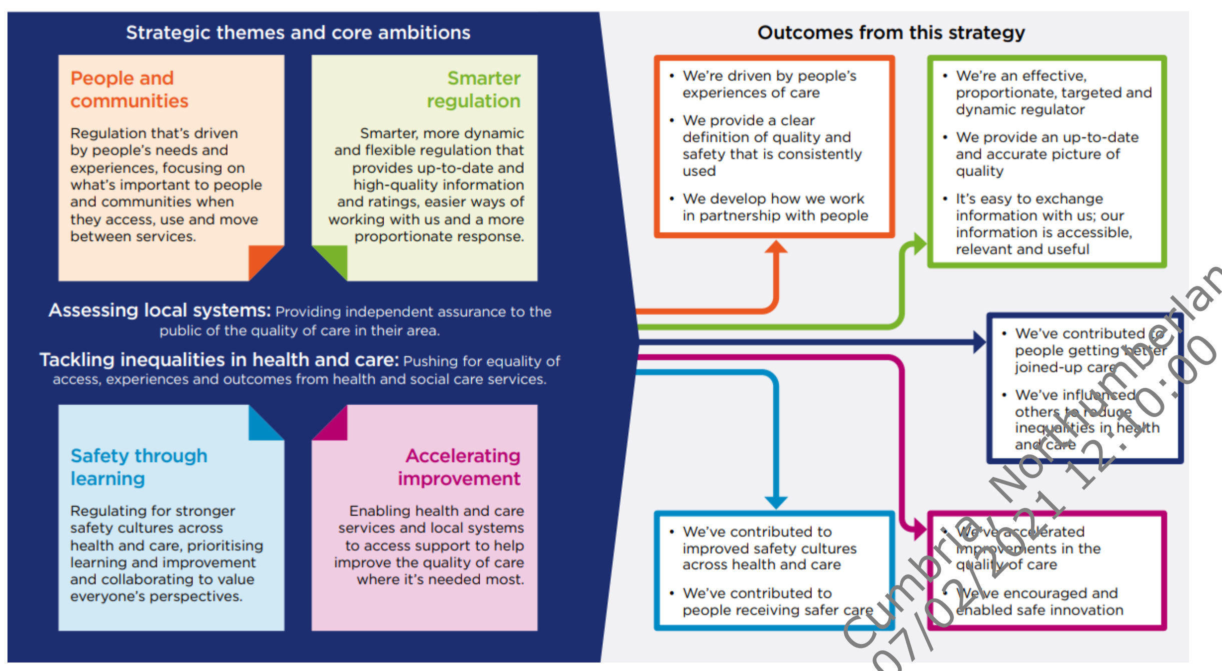
Running through each theme are two core ambitions:

- Assessing local systems: Providing independent assurance to the public of the quality of care in their area
- Tackling inequalities in health and care: Pushing for equality of access, experiences and outcomes from health and social care services

The full strategy document has been attached as Appendix 2 and below is a diagram of the strategic themes, ambitions and outcomes from the strategy.

## Our purpose

**We make sure health and social care services provide people with safe, effective, compassionate, high-quality care and we encourage care services to improve.**

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## 3. Recommendations

The Board are asked to note the strategy document.

**Name of author:**
Vicky Grieves, CQC Compliance Officer

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

3 June 2021

Cumbria, Northumberland Tyne a
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# A new strategy for the changing world of health and social care

## Our strategy from 2021

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# Introduction

## We're changing how we regulate to improve care for everyone.

What we've learned from the past five years puts us in a better position for the future. Our new strategy combines this learning and experience and we've developed it with valuable contributions from the public, service providers and all our partners. It means our regulation will be more relevant to the way care is now delivered, more flexible to manage risk and uncertainty, and will enable us to respond in a quicker and more proportionate way as the health and care environment continues to evolve.

This new strategy strengthens our commitment to deliver our purpose: to ensure health and care services provide people with safe, effective, compassionate, high-quality care and to encourage those services to improve. Our strategy is purposefully ambitious, and to implement it we will need to work closely with others to make it a reality. We'll review this strategy regularly so we can adapt to changes and be prepared for what the future holds.

Our purpose and our role as a regulator won't change – but how we work will be different. We set out our ambitions under four themes:

- **People and communities**

  Regulation that's driven by people's needs and experiences, focusing on what's important to people and communities when they access, use and move between services

- **Smarter regulation**

  Smarter, more dynamic and flexible regulation that provides up-to-date and high-quality information and ratings, easier ways of working with us and a more proportionate response

- **Safety through learning**

  Regulating for stronger safety cultures across health and care, prioritising learning and improvement and collaborating to value everyone's perspectives

- **Accelerating improvement**

  Enabling health and care services and local systems to access support to help improve the quality of care where it's needed most

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Running through each theme are two core ambitions:

- **Assessing local systems**

  Providing independent assurance to the public of the quality of care in their area

- **Tackling inequalities in health and care**

  Pushing for equality of access, experiences and outcomes from health and social care services

We'll look at how the care provided in a local system is improving outcomes for people and reducing inequalities in their care. This means looking at how services are working together within an integrated system, as well as how systems are performing as a whole.

We're committed to our ambition of regulating to advance equality and protect people's Human Rights. Everyone in health and social care has a role to play in tackling the inequalities in health and care for some people. This strategy sets out our ambition for how we can help influence change.

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## People and communities

We want to be an advocate for change, with our regulation driven by people's needs and their experiences of health and care services, rather than how providers want to deliver them.

This means focusing on what matters to the public, and to local communities, when they access, use and move between services. Working in partnership with people who use services, we have an opportunity to help build care around the person: we want to regulate to make that happen.

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## Listening and acting

People need to see how their voice can make a difference to the safety and quality of the services they use and how we reflect their experience in our work. We want to hear both positive and negative experiences when people access, use and move between services.

- We'll make it **easier for people, their families and advocates to give feedback** in the most convenient and suitable ways for them whenever they want. We'll also enable those who act as trusted intermediaries to share feedback with us. Working with local communities, we'll make the most of existing sources of feedback so people don't have to repeat themselves.
- **We'll identify more and better ways to gather experiences from a wider range of people** and develop the skills and tools that we need to do this. We'll reach out to people whose voices and experiences we don't often hear: people who are the most disadvantaged in our society, have had distressing or traumatic experiences, and those who are more likely to experience poor outcomes and inequalities. This includes people with a learning disability, people with communication needs, people living in poverty, those whose voices are not often heard, those who are detained under the Mental Health Act, and people who are at risk of abuse or other human rights breaches.
- A priority will be improving our capacity and capability to get the most out of feedback. **We'll change the way we record and analyse people's feedback** so it's easier for us to quickly identify changes in the quality of care – both good and bad. We'll be clear about the value and weight we give to quantitative and qualitative information when using it with other evidence.

People's feedback is vitally important. It's important to build trust with the public and motivate people to share their experiences.

- When we publish information about quality, **we'll be clearer about how we've used what people have told us** – both good and bad. We'll explain what action we and others have taken as a result.
- When people take the time to share their experiences with us **we'll provide a response in the way people need it** and explain how their feedback has informed our view of quality.

People are often afraid to speak up. We want to help build a new culture among the public, health and care providers, and all our partners, that welcomes, values and acts on feedback.

- **We'll improve the way we assess how services and local systems encourage and enable people to speak up**, and how they act on this feedback. It will be unacceptable if they are not doing this – where they are not, we will make sure they take action to address it. We'll also focus on this when we look at how local systems are listening to their communities. This is so they can improve access to services that meet people's needs, in particular people who are most likely to have a poorer experience of care or who are less able to speak up.

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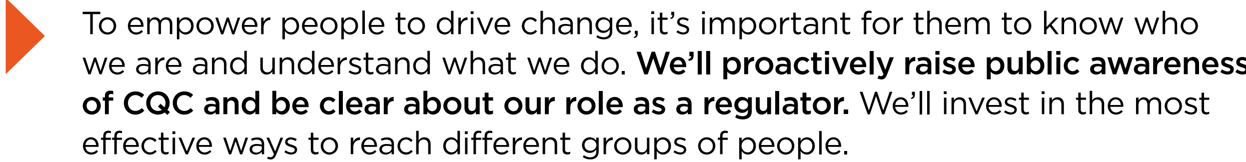
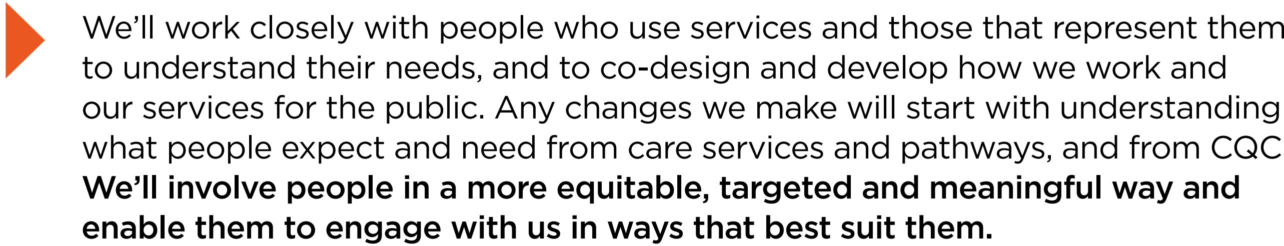
## People are empowered

We know care is better when it's developed through the eyes of people who use services and delivered in partnership with them. We think the same of regulation. When we talk about the quality of care in our work we will have people at the centre.



- To empower people to drive change, it's important for them to know who we are and understand what we do. **We'll proactively raise public awareness of CQC and be clear about our role as a regulator.** We'll invest in the most effective ways to reach different groups of people.



- We'll work closely with people who use services and those that represent them to understand their needs, and to co-design and develop how we work and our services for the public. Any changes we make will start with understanding what people expect and need from care services and pathways, and from CQC. **We'll involve people in a more equitable, targeted and meaningful way and enable them to engage with us in ways that best suit them.**

- We'll work with all our partners and people who use services to develop an agreed and shared view of quality that makes clear what standards people can expect from their health and care services. **We'll provide a clearer definition of what good and outstanding care looks like for everybody, based on people's lived experience of care and what matters to them.** Everybody will be able to easily access, understand, and use these definitions. We'll use them as the basis for assessing services and the information that we collect as evidence.

  This shared view of quality will enable a joined-up approach that's applied to individual services, corporate providers, and across system boundaries in health and social care.

Providing independent, trusted and high-quality information about the quality of care is a fundamental part of our work.

- We'll change how we provide information so that it's more relevant, up to date, and meaningful for people who use services, and reflects their experiences. **We'll ensure people have easy access to information in the way they need it**, and use clear and accessible language.

- **We'll encourage people to use our information in ways that are relevant to them.** Our up-to-date view of the quality of care in a service will help people and their families make informed decisions, where they can, about where to go for their care. It will also give people confidence that our information reflects the quality of care that they can expect.

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## Prioritising people and communities

- **We'll look at how effectively a service works with others, and in partnership with local communities, to involve people in designing and improving services.** This includes how services embed equality, diversity and inclusion, and corporate social responsibility in everything they do, such as improving local health and wellbeing, and environmental sustainability.

Working collaboratively as a local system is essential to improving the quality and safety of care. Health and care services and commissioners need to understand the diverse needs of their local populations and where there are inequalities in how people access and experience care, and in their outcomes.

- When assessing individual health and care services, we'll look at how they work together in an area, as one system, to deliver better and more coordinated care. **We'll focus on how well local systems perform against the important things that matter to people in that community** – such as being able to move easily between services. We'll work to build our understanding of the needs of a local population so we can hold services to account effectively.

  Our work in this area will be through legislation in the Health and Social Care Bill and we'll align with other regulators to encourage a shift towards more integrated services.

- **Our assessments of local systems will provide independent assurance to the public of how they are working together to deliver high-quality care.** We'll ensure our people have the right skills and capability to assess at both a service provider and a system level.

- We'll publish what we find about the performance of a system. **If we see good practice, we'll highlight this and share examples so that others can learn from it and adapt it to their own area.** We'll also make recommendations to improve where we find issues or concerns.

We will identify and call out unwarranted variation and inequalities in how people experience health and care services. But we also know that a person's health and wellbeing is significantly affected by factors outside health and care.

- **We'll assess how local systems understand the needs of their local populations**, especially people who face the most barriers to accessing good care and those with the poorest outcomes, enabling them to proactively address inequalities.

- We'll work with other appropriate agencies, voluntary and community organisations, and other regulators to develop a **shared understanding of the factors that contribute to inequalities in people's access and experiences and how this affects their outcomes** from using care services. Together, we'll identify the levers that we can all use to tackle these inequalities.

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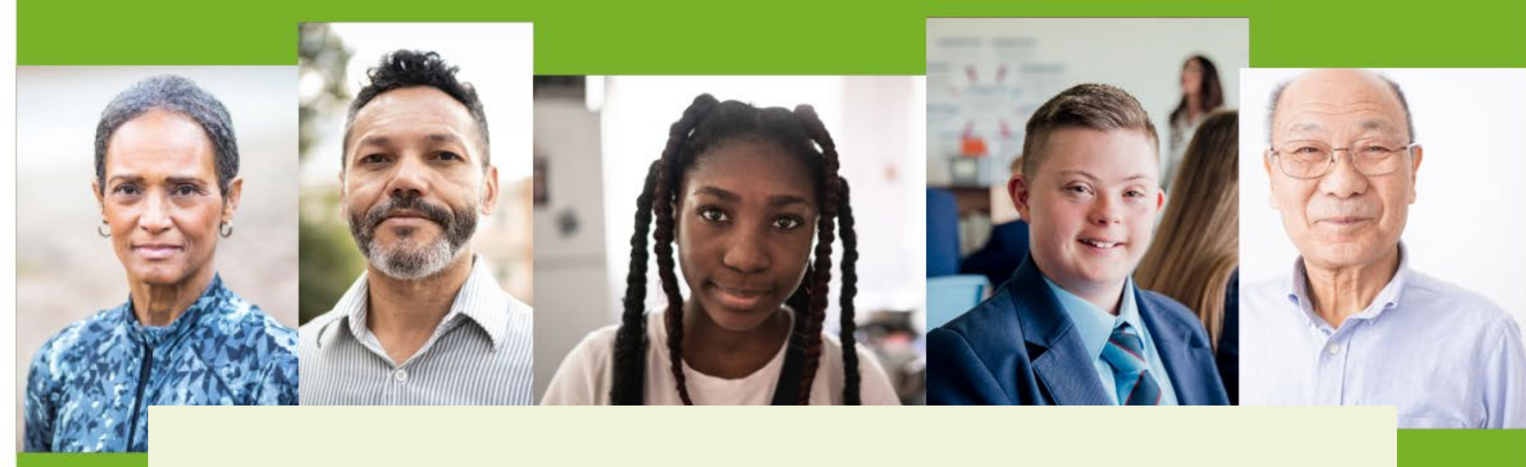

## Smarter regulation

We will be smarter in how we regulate. We'll keep pace with changes in health and care, providing up-to-date, high-quality information and ratings for the public, providers and all our partners.

We'll regulate in a more dynamic and flexible way so that we can adapt to the future changes that we can anticipate – as well as those we can't. Smarter use of data means we'll target our resources where we can have the greatest impact, focusing on risk and where care is poor, to ensure we're an effective, proportionate and efficient regulator.

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## Taking the right action at the right time

We have a baseline understanding of quality across health and social care. But we know that the quality of care can vary from day to day. We'll use our regulatory powers in a smarter, more proportionate and consistent way to make the right decisions and take the right action.

- Our assessments of quality will be different. **On-site inspections are a vital part of our performance assessments and essential to observe the care people receive.** But they are not the only way to assess quality: we want to move away from relying on a set schedule of inspections to a more flexible, targeted approach. To do this, we'll use all our regulatory methods, tools and techniques to assess quality.

- **We'll build stronger relationships with services and with local systems.** This includes having ongoing conversations about quality, which will give us a better insight and enable us to tailor our approach to be more proportionate.

- **We'll visit when there's a clear need to do so.** For example, this could be when we're responding to risk, where we only have limited data or we need specific information, where we need to speak to people using the service face-to-face, or to ensure that our view of quality is reliable. For some types of service, we'll need to visit more often to observe care.

  Our continuous insight and monitoring activity mean that rather than spending time looking at paperwork when we're on site, we'll be able to make the most of our time – **we'll have better conversations with people who live in or use the service, and their families and advocates, and more time to talk with staff.**

- We'll build digital platforms that will better integrate the data we hold, which will enable us to interpret data in a more consistent way. **We'll use innovative analysis, artificial intelligence and data science techniques proactively to support robust and proportionate decision-making, based on the best information available.**

  Combined with the experience, knowledge, and professional judgement of our inspectors, this means we'll be alert and ready to act quickly in a more targeted way and tailor our regulation to individual circumstances.

## More meaningful ratings

Our ratings will be more dynamic – we'll update them when there is evidence that shows a change in quality. We won't always need to carry out an inspection to do this.

- **Ratings will evolve to reflect how people experience care so they're more meaningful and focus on things that matter to them.** We'll be clear about what information we use and how we use it in our judgements and decisions about ratings.

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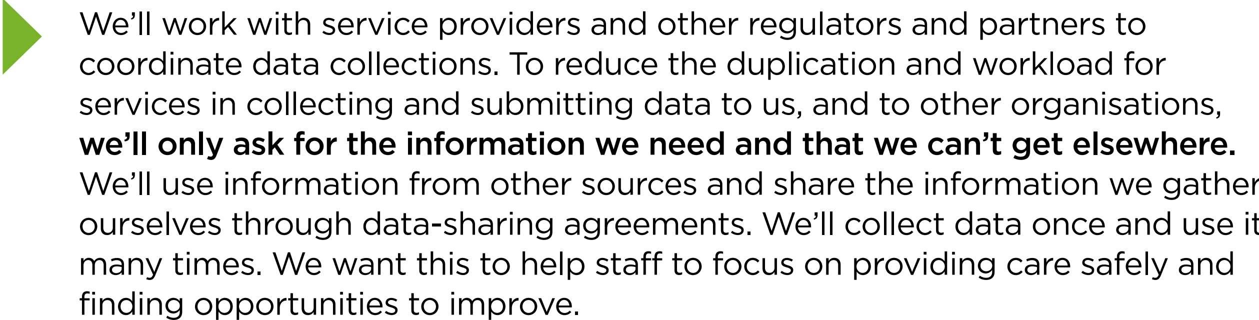
## Making it easier to work with us

We all have a common drive to improve people's care. From the point of registration, we'll develop ongoing, collaborative relationships with services, built on openness and trust. We want this to enable effective and proportionate regulation so we can focus our work where quality needs to improve and minimise any unnecessary workload.



We'll work with service providers and other regulators and partners to coordinate data collections. To reduce the duplication and workload for services in collecting and submitting data to us, and to other organisations, **we'll only ask for the information we need and that we can't get elsewhere.** We'll use information from other sources and share the information we gather ourselves through data-sharing agreements. We'll collect data once and use it many times. We want this to help staff to focus on providing care safely and finding opportunities to improve.

We'll improve the way we connect with services digitally. Starting from the point of registration, where we do need to collect information directly **we will make it easier for services to give us the information we need and simpler to update what they've already told us.** We'll also make it easier for services to access more of the information we hold about them by having it in one place.

We want everyone we work with to benefit from our regulation. The way we regulate will become more constructive and supportive – using what we know to help services to tackle problems early and providing up-to-date, high-quality information and ratings.

**We'll share the data and information we hold on services** with organisations that represent or act on behalf of people who use services, and with our partners and others where it will help them in their own work to improve people's care.

## Adapting to changes

Like the services we regulate, we're evolving and adapting to changing models of care, such as integrated care systems and digitally-enabled care. The move to looking at how services work together in a local system is a change in our approach that better reflects how people experience care – we think this is a smarter way to regulate.

We'll work with service providers, partners and other regulators to align our activity, understand how care is changing and **ensure that our regulatory model keeps pace with changes.**

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- By improving the way we register services, **we'll be better able to hold organisations to account for people's care.** We'll expand our definition of what we consider to be a provider of care and what it means to carry on a regulated activity. This will make sure that we register all the parts of an organisation that are responsible for directing or controlling care; and importantly, this will make sure they can be held accountable.
- Our assessments will always **focus on what matters to people as they access, use, and move between services.** We'll also look more closely at aspects that we know have a positive effect on quality such as the culture of a service, how it works with other services in a local system, and how it drives improvement.
- We'll focus our assessments on how services and local systems are working to ensure equal and appropriate access to good health and care services for everyone. The information we gather will enable us to **better understand the risks of inequalities in people's experiences of their pathway through care and their outcomes.** We'll take action where we see a need for improvement.

## Relevant for all

We want our ratings and information to help people to make informed choices about their care, and to give services an assessment of their quality to encourage them to improve.

- **We'll use our clearer definition of quality as a reference for what good and poor care looks like.** We'll explain clearly how we use this to assess the quality of services and how we decide what information to collect as evidence. This definition will be at the heart of our regulatory processes and will help us improve consistency in what we do – so people can be confident that good means good wherever they are in the country and whichever service they are using.
- We'll move away from long reports written after inspections, and instead provide information and data to better meet the needs of all audiences, including people who use services. **Information will be easier to understand and more accessible.** We want people to be able to get information in ways that suit them.

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# Safety through learning

We want all services to have stronger safety and learning cultures. Health and care staff work hard every day to make sure people's care is safe. Despite this, safety is still a key concern for us as it's consistently the poorest area of performance in our assessments.

It's time to prioritise safety: creating stronger safety cultures, focusing on learning, improving expertise, listening and acting on people's experiences, and taking clear and proactive action when safety doesn't improve.

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## The importance of culture

Having the right organisational culture is crucial to improving safety. This means safety must be a top priority for all – regardless of seniority or role. A strong safety culture needs everyone working in health and care, as well as people who use services, to play their part. In a strong safety culture, risks aren't overlooked, ignored, or hidden – and staff can report concerns openly and honestly, confident that they won't be blamed.

- **We'll work with others to agree and establish a definition and language about safety** and how this could apply in different health and care services. This will create a better understanding of risk across all health and care – so that we all know what's not acceptable – and therefore help to reduce avoidable harm, neglect, abuse and breaches of human rights. When we talk about safety we'll make sure it reflects what's most important to people when they use services. More clarity will enable services to prioritise the essentials and have clearer expectations when we assess them.
- We'll be looking for cultures that have learning and improvement at their core. In a good safety culture, it's accepted that all incidents – positive, negative, or wholly avoidable – provide opportunities to learn and improve. It's important that **we also embody a learning culture and demonstrate this in our relationships with providers and all our work.**
- Our assessments of safety will have a sharper focus on checking for open and honest cultures. We'll encourage health and care staff to speak up about safety issues where they work, including where there may be safeguarding issues. We'll expect all services to have stronger safety and learning cultures and that learning and improvement should be the primary response when anyone speaks up. **We want staff to feel confident that we'll also listen and act when they raise concerns with us, and we'll intervene quickly where appropriate.**
- We can do more to help services improve safety by sharing the insights, learning, and exemplary practices that we've identified. **We'll use our independent voice to highlight the changes and improvement that services have made to improve safety as a direct result of our regulatory actions.**

## Building expertise

Knowledge is crucial to having the right safety cultures, but there are different levels of knowledge and expertise in different types of service and sectors.

- **We'll look at how services and systems assure themselves that they have the right knowledge and expertise,** and how they are investing in improving safety.
- **We'll improve and increase our own safety expertise in CQC** to ensure our approach is in line with the latest safety thinking. Together with our unique data and insight, this will enable us to challenge and highlight failures in services and in systems.

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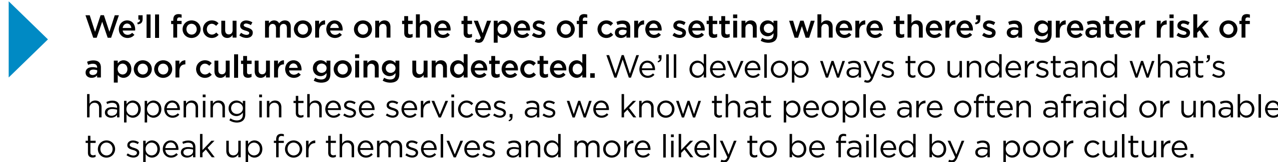
## Involving everybody

People should be able to influence the planning and prioritisation of safe care and be truly involved as equal partners in their care at all levels. This collaborative approach has the potential to transform safety and to ensure that people's human rights are upheld.

In our assessments we'll look for processes to show that leaders and staff are committed to involving people in their own safety throughout their health and care journey, and the impact this has on their outcomes. **We'll check that services actively take into account people's rights and their unique perspectives on what matters to them in the way they choose to live their lives and manage risk.** This includes having the information they need to help them be equal partners in their care and play a part in their own safety.

## Regulating safety

We know that some of the greatest safety risks – both physical and psychological – happen when people struggle to access the right care, when they're transferred between services or after they're discharged. We also know that some services are more likely to have greater safety risks than others.



**We'll focus more on the types of care setting where there's a greater risk of a poor culture going undetected.** We'll develop ways to understand what's happening in these services, as we know that people are often afraid or unable to speak up for themselves and more likely to be failed by a poor culture.

We'll review how effectively we are assessing and monitoring safety – from registration through to enforcement. We'll use our improved safety expertise to make sure we're taking the right approach. As part of this, **we'll review how we gather data to ensure greater consistency across sectors regardless of who it is reported to.**

Learning and improvement must be the primary response to all safety concerns in all types of service and local systems. **Where we have concerns, we will direct services and systems to respond and show us – and people who use the services – what action they'll take to learn and improve.** We'll share this information with the public as part of our up-to-date view of quality.

Services that are not open to learning can't be safe. **We'll use our powers and act quickly where improvement takes too long, or where the changes won't be sustainable.** We'll take action where services are unable to identify systemic issues in their own organisational culture or fail to learn lessons from widely publicised failures happening across health and care.

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- **We'll change how we regulate safety in all services to reflect new ways of delivering care and as more services work as part of a local system.** We'll check how well services work together – those that are truly focused on safety will be determined to ensure a safe journey of care for people moving on to a different service, or when being transferred between services for ongoing care.

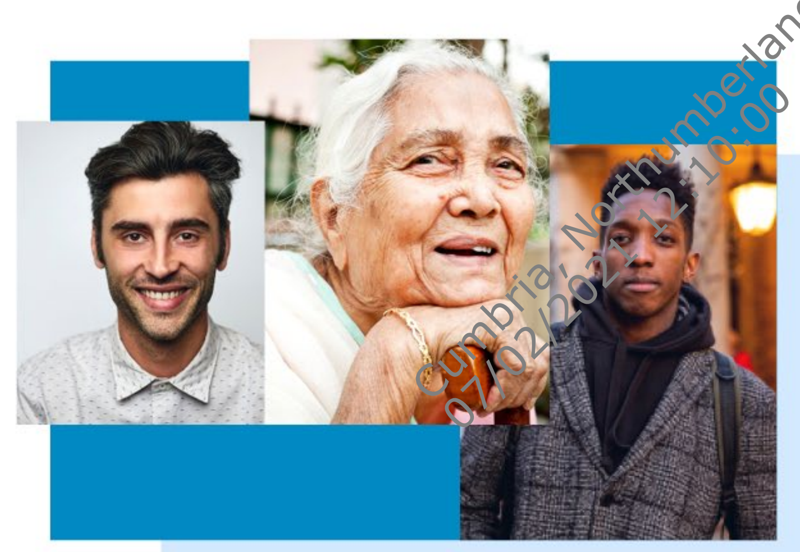
- Where we see systemic safety issues in a local area, we'll speak out to encourage meaningful change. **We'll share the learning from our insight on themes, trends, and best practice to help services and local systems improve their safety.** We'll also share with regional organisations our data and information about safety in local systems, to support their oversight of safety in their area.

## Consistent oversight and support

To improve safety, service providers may need support and guidance. In some sectors, there's a national team of experts who provide guidance and alerts about safety. But this type of national support and oversight doesn't exist in all sectors.

- It's crucial that all health and care services have consistent access to the right support and insight to help them build strong safety cultures, learn from safety and safeguarding incidents, and improve their practice. **We'll work with others to develop solutions to ensure that all services have support and leadership** during difficult times, and that they have the right tools to always provide safe care. We'll need to understand where this oversight is best placed and develop the right frameworks as needed.

- **We'll use our insight and independent voice to promote a national conversation on safety across health and care sectors and systems.** We can use this to drive improvements in safety cultures and reduce harm.



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## Accelerating improvement

We will do more with what we know to drive improvements across individual services and systems of care. We'll use our unique position to spotlight the priority areas that need to improve and enable access to support where it's needed most.

We'll empower services to help themselves, while retaining our strong regulatory role. The key to this is by collaborating and strengthening our relationships with services, the people who use them, and our partners across health and care.

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## Collaborating for improvement

The support that's available to improve the quality of care varies between and within health and care sectors and across England. We'll work collaboratively to support all parts of a local system to focus on improvement.

- Where there are gaps in improvement support, **we will facilitate national improvement coalitions with a broad spectrum of partners within both health and adult social care**, including those representing people who use services. These coalitions will work collaboratively to improve the availability of support, both nationally and at a local system level. This will **build on existing partnerships and programmes around improvement** rather than duplicate efforts. We'll champion consistent access to direct, tailored, hands-on support for all services who need it.
- Local systems need to drive improvement in their areas. We will support these efforts and assess how well they are doing this, including how well they are ensuring everybody has fair and equal access to care, an equally good experience and good outcomes. **We'll strengthen our ongoing relationships at a local level to promote collaboration on improvement** across areas, working with local and national partners from the relevant improvement coalitions.

## Making improvement happen

We want to see improvements that benefit people. We'll play an active part in this by setting clear expectations and empowering services and local systems. But we're clear that while enabling access to support, we will retain our core regulatory role, which means using our powers to act where we see poor care.

- **We'll encourage continuous improvement in quality by being clearer on the standards that we, and people who use health and care services, expect.** Services and local systems will need to demonstrate a culture of improvement and contribute to improvement in their local area. As part of this, we'll expect them to address inequalities in access, experiences and outcomes.
- We'll develop collaborative relationships with services, helping them to find their own route to improvement. This will involve facilitating access to improvement support and pointing services to sources of guidance, best practice, and other providers and organisations that can offer advice and support. **We'll hold improvement conversations with services and offer a range of resources to support them to decide for themselves the best way forward** rather than telling them what to do. We will develop our skills, capability, and culture to enable this shift.

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- In collaboration with others **we'll identify the areas that need to improve as a priority – both at a local and national level.** Using our independent voice, we'll deliver a programme of activity to drive change in these areas, based on evidence of what works. We'll share good practice and examples of the factors that drive improvement, and the findings from our in-depth reviews. We'll prompt action through events and workshops, and by publishing guidance, tools, and frameworks that support improvement.

- **We'll empower services and local systems to improve themselves by offering analysis and benchmarking data.** This will enable them to self-assess how they're performing against similar services and areas. Our benchmarking information will also show us where we need to focus our work to drive improvement.

## Encouraging innovation and research

Innovative practice and technological change present an opportunity for rapid improvement in health and care. We have a role in creating a culture where innovation and research can flourish.

- **We'll encourage and champion innovation and technology-enabled services where they benefit people and where the innovation results in more effective and efficient services.** We know the path to innovation can be difficult; we want to use what we know as a regulator to create an environment where services can try new ways to deliver safe, high-quality care. We'll aim to support their efforts to innovate through clear advice and guidance.

- We'll understand and keep pace with changes, both in new technology and new ways to deliver care. **We'll work in partnership with services and other stakeholders to develop a coordinated, effective, and proportionate approach to regulating new innovations and technology.** When we do this, we'll consider where the use of new technology to deliver care might not suit some people, and what services need to do to make sure that nobody is disadvantaged.

- Research can help improve the quality of care, and people often value the opportunity to participate in research, whether clinical trials or other studies. **We'll encourage services to play an active part in research to improve care for all, foster innovation and enhance people's experiences of care.**

## An approach based on evidence

We have valuable knowledge and insight about improvement – we'll use this to inform our regulatory approach.

- We want to promote an improvement culture across health and social care. Through our assessments of services and local systems, and across all our work, **we'll identify and investigate the things that are most important to ensuring good quality care.** We'll use the evidence we collect to support improvement.

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- **We'll invest in research and make better use of external evidence to have a better understanding of the conditions that drive quality improvement,** including evidence and best practice from other industries. We will also strengthen our evidence on the extent and nature of inequality in people's experiences of care, and the good practice to help reduce this.
- We'll use the best available evidence to inform our approach to regulation. We'll develop and extend our own internal improvement activity and capability. As part of this **we will embed a culture of learning and evaluation in CQC to maximise our impact on the quality and outcomes of care for people.**

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# Outcomes from this strategy

By delivering this strategy, we will achieve 12 outcomes:

## People and communities

1. Our activity is driven by people's experiences of care.
2. We clearly define quality and safety in line with people's changing needs and expectations. This definition is used consistently by all people, and at all levels of the health and social care system.
3. Our ways of working meet people's needs because they are developed in partnership with them.

## Smarter regulation

4. We are an effective, proportionate, targeted, and dynamic regulator.
5. We provide an up-to-date and accurate picture of quality.
6. It is easy for health and care services, the people who use them and stakeholders to exchange relevant information with us, and the information we provide is accessible, relevant, and useful.

## Safety through learning

7. There is improvement in safety cultures across health and care services and local systems that benefit people because of our contribution.
8. People receive safer care when using and moving between health and social care services because of our contribution.

## Accelerating improvement

9. We have accelerated improvements in the quality of care.
10. We have encouraged and enabled safe innovation that benefits people or results in more effective and efficient services.

## Core ambitions

11. We have contributed to an improvement in people receiving joined-up care.
12. We have influenced others to reduce inequalities in people's access, experiences and outcomes when using health and social care services.

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# How to contact us

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**Follow us on Twitter** @CareQualityComm

**Download this document in other formats at**
www.cqc.org.uk/Strategy2021

Please contact us if you would like this document in another language or format.

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**Board of Directors**
**Wednesday 7 July 2020**

| **Title of report** | **NHS People Plan Update 2020/21**<br>**Building on 2020/21 Priorities in 2021/22** |
|---|---|
| **Report author(s)** | **Lynne Shaw, Executive Director of Workforce and OD** |
| **Executive Lead (if different from above)** | **As above** |

| **Strategic ambitions this paper supports (please check the appropriate box)** | | | |
|---|---|---|---|
| Work with service users and carers to provide excellent care and health and wellbeing | | Work together to promote prevention, early intervention and resilience | |
| To achieve “no health without mental health” and “joined up” services | | Sustainable mental health and disability services delivering real value | |
| To be a centre of excellence for mental health and disability | | The Trust to be regarded as a great place to work | x |

| **Board Sub-committee meetings where this item has been considered (specify date)** | |
|---|---|
| Quality and Performance | 23.6.21 |
| Audit | |
| Mental Health Legislation | |
| Remuneration Committee | |
| Resource and Business Assurance | |
| Charitable Funds Committee | |
| CEDAR Programme Board | |
| Other/external (please specify) | |

| **Management Group meetings where this item has been considered (specify date)** | |
|---|---|
| Executive Team | 14.6.21 |
| Corporate Decisions Team (CDT) | |
| CDT – Quality | |
| CDT – Business | |
| CDT – Workforce | 21.6.21 |
| CDT – Climate | |
| CDT – Risk | |
| Business Delivery Group (BDG) | |

| **Does the report impact on any of the following areas *(please check the box and provide detail in the body of the report)*** | | | |
|---|---|---|---|
| Equality, diversity and or disability | X | Reputational | |
| Workforce | X | Environmental | |
| Financial/value for money | | Estates and facilities | |
| Commercial | | Compliance/Regulatory | |
| Quality, safety, experience and effectiveness | | Service user, carer and stakeholder involvement | |

| **Board Assurance Framework/Corporate Risk Register risks this paper relates to** |
|---|
| |

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## NHS People Plan Update 2020/21

## Building on 2020/21 Priorities in 2021/22

### 1. Executive Summary

On 30 July 2020 the NHS People Plan was published.

**We are the NHS: action for us all** from NHS England and NHS Improvement (NHSEI) and Health Education England (HEE) set out what our NHS people can expect from their leaders and each other.

The document focused on how we must look after each other and foster a culture of inclusion and belonging, as well as action to grow and train our workforce, and work together differently to deliver patient care. The plan focused primarily on the immediate term (2020/21) with an intention for the principles to create longer lasting change.

This paper outlines the progress made to date on the 2020/21 action plan at a Trust level. Due to the pandemic the actions have been rolled over nationally as described below. The majority of the Trust actions have been completed, some with ongoing review and monitoring. (See Appendix 1 for full list of actions)

People priorities for 2021/2022, as set out in the national planning guidance, build on the People Plan 2020/2021: action for us all and are informed by learning during the pandemic. They aim to embed more preventative health and wellbeing approaches, tackle inequalities, lock in beneficial changes and new ways of working, and boost efforts to attract and retain more people. (See Appendix 2)

### 2. Current Position

There were over 100 actions outlined in the NHS People Plan. This included Trust level actions and those to be carried out by systems, Health Education England, NHSE/I and the Care Quality Commission. Many of the Trust actions were already completed or ongoing at the time of the publication of the report.

There are seven actions which are yet to be fully completed by the Trust. These are outlined below.

The full action plan (Appendix 1) and People Priorities for 2021/22 (Appendix 2) can be found **here**

### 3. Next Steps

The outstanding actions for 2020/21 will continue to be a priority for the remainder of this year. In addition, work will be undertaken to further embed, monitor and evaluate the actions already completed alongside the employer priorities for recovery 2021/22 as set out in the Planning Guidance.

Monitoring will continue through Corporate Decision Team – Workforce.

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## 4. Risks/Mitigations

There are no specific risks identified in respect of the action plan.

## 5. Recommendations

The Trust Board of Directors is asked to review the content of the document and support the delivery of the actions.

Lynne Shaw
Executive Director of Workforce and OD

24 June 2021

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**Health and Wellbeing**

| | | | |
|---|---|---|---|
| 7 | Prevent and tackle bullying, harassment and abuse against staff, and create a culture of civility and respect. | Quarter 4 | Included in the Collective Leadership Development Programme – completed.<br><br>Management Skills Training updated – shift from policy focused to behaviours.<br><br>To be included as part of the RESPECT Campaign which will commence in June 2021.<br><br>To be monitored through Staff Survey, People Pulse, Exit Questionnaire, Disciplinary and Grievance statistics. |
| 20 | All new starters should have a health and wellbeing induction. | Quarter 3 | Local Induction process and paperwork to be reviewed. |

**Flexible Working**

| | | | |
|---|---|---|---|
| 4 | Cover flexible working in standard induction conversations for new starters and in annual appraisals. | Quarter 3 | Induction policy and paperwork to be updated.<br>Local Induction to be reviewed.<br><br>Included in the Management Skills and Collective Leadership Development Programmes. |

**Equality and Diversity**

| | | | |
|---|---|---|---|
| 1 | Overhaul recruitment and promotion practices to make sure that staffing reflects the diversity of the community, and regional and national labour markets. | Quarter 3 | Four day recruitment workshop took place in January/February 2021. Feedback from the session 31 March 2021.<br><br>Task and Finish Group set up to implement recommendations.<br><br>Trust involved in NHSEI Inclusive recruitment pilot |



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| 4 | 51 per cent of organisations to have eliminated the ethnicity gap when entering into a formal disciplinary processes. | Evaluate following Q4 | New Disciplinary Triage process in place.<br>Introduction of Cultural Ambassadors.<br>Training for further Cultural Ambassadors took place in February 2021. A further cohort being arranged.<br>On-going awareness raising of the role.<br>Included in relevant training. |
|---|---|---|---|

**Culture and Leadership**

| 8 | Review governance arrangements to ensure that staff networks are able to contribute to and inform decision-making processes. | Quarter 3 | Executive sponsors in place.<br>Network of Network Event took place in March 2021 with follow up June 2021<br>Governance arrangements to be reviewed with Network Chairs.<br>Network members involved in Inclusive Recruitment work. |
|---|---|---|---|

**New Ways of Delivering Care**

| 2 | Continued focus on developing skills and expanding capabilities to create more flexibility, boost morale and support career progression. | Quarter 4 | CNTW Academy to support development.<br>Implementation of Talent Management Framework. |
|---|---|---|---|

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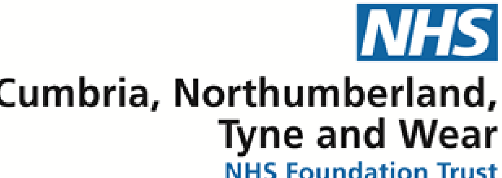

**Report to the Board of Directors**
**Wednesday 7 July 2021**

| **Title of report** | **Equality, Diversity and Human Rights Report (to end April 2021)** |
|---|---|
| **Report author(s)** | **Christopher Rowlands, Trust EDI Lead** |
| **Executive Lead (if different from above)** | **Lynne Shaw, Executive Director of Workforce & OD** |

| **Strategic ambitions this paper supports (please check the appropriate box)** | | | |
|---|---|---|---|
| Work with service users and carers to provide excellent care and health and wellbeing | | Work together to promote prevention, early intervention and resilience | |
| To achieve "no health without mental health" and "joined up" services | | Sustainable mental health and disability services delivering real value | |
| To be a centre of excellence for mental health and disability | | The Trust to be regarded as a great place to work | ✓ |

| **Board Sub-committee meetings where this item has been considered (specify date)** | |
|---|---|
| Quality and Performance | 23.06.21 |
| Audit | |
| Mental Health Legislation | |
| Remuneration Committee | |
| Resource and Business Assurance | |
| Charitable Funds Committee | |
| CEDAR Programme Board | |
| Other/external (please specify) | |

| **Management Group meetings where this item has been considered (specify date)** | |
|---|---|
| Executive Team | 14.06.21 |
| Corporate Decisions Team (CDT) | |
| CDT – Quality | |
| CDT – Business | |
| CDT – Workforce | 21.06.21 |
| CDT – Climate | |
| CDT – Risk | |
| Business Delivery Group (BDG) | |

| **Does the report impact on any of the following areas *(please check the box and provide detail in the body of the report)*** | | | |
|---|---|---|---|
| Equality, diversity and or disability | ✓ | Reputational | |
| Workforce | ✓ | Environmental | |
| Financial/value for money | | Estates and facilities | |
| Commercial | | Compliance/Regulatory | |
| Quality, safety, experience and effectiveness | | Service user, carer and stakeholder involvement | |

| **Board Assurance Framework/Corporate Risk Register risks this paper relates to** |
|---|
| |

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**Equality, Diversity and Human Rights (to April 2021)**
**Board of Directors**
**Wednesday 7 July 2021**

## 1. Executive Summary

The report highlights the work undertaken by the Trust during the second year of the Equality, Diversity and Inclusion Strategy.

Due to the pressures of the pandemic no report was produced in 2020 therefore this report covers the period November 2019 to April 2021.

The report summarises the work undertaken around the following areas:

- Equality, Diversity and Inclusion Speak Easy Events
- Staff Networks
- History Months
- Covid-19 Response
- Workforce Race Equality Standard and Workforce Disability Equality Standard
- Key Actions Approved by the Board
- Objectives for 2021/22
- Data relating to EDI including the EDS2 Summary Report

## 2. Risks and mitigations associated with the report

There are no specific risks highlighted in the report.

## 3. Recommendation/summary

The Board of Directors is asked to approve for publication the content of this report, so that we meet our statutory obligations under the Public Sector Equality Duties of the Equality Act 2010.

Chris Rowlands
Equality, Diversity and Inclusion Lead

Lynne Shaw
Executive Director of Workforce & OD

June 2021

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**Purpose**

The general equality duty requires organisations to consider how they could positively contribute to the advancement of equality and good relations within their workforce and the communities which they serve. Compliance with the duty is a legal obligation and one of the ways in which we are required to demonstrate this is through the publication of an annual report that details our progress towards meeting equality, diversity and inclusion objectives.

Normally this report is compiled and published on an annual basis – usually presented at the November Board in line with the anniversary of our Equality, Diversity and Inclusion Strategy. However, during 2020 reporting requirements were suspended to allow efforts to be concentrated on the response to the pandemic. Therefore this report covers the actions that have taken place during the period from November 2019 through to the end of April 2021.

The appended report has been presented to Executive Directors, The Trust-wide Equality Diversity and Inclusion Steering Group, CDT – Workforce and Quality and Performance Committee. The Board is asked to approve the report for publication, so that we meet our statutory requirements under the Public Sector Equality Duty of the Equality Act 2010. The key points are summarised below.

**Equality and Diversity Strategy**

The strategy has passed the mid-way point in its progress. In addition to Trust-wide objectives our operational localities and corporate departments have begun to use NHS England's Equality Delivery System 2 (EDS2) to set local objectives towards improving equality, diversity and inclusion for those we serve and to make the Trust a great place to work. Some of the progress we had hoped to report on this year has been halted due to the impact of Covid-19, however this work is being picked up as part of our recovery and our 2021/22 actions have been influenced by the impact of the pandemic. We have recognised that the impact of the pandemic has hastened the need to refresh our Equality, Diversity and Inclusion Strategy earlier than anticipated. Work will commence on this in 2021, rather than the planned date of 2022.

**Equality, Diversity and Inclusion Speak Easy Events**

These semi-structured conversations held across all localities addressed the following issue: How can we ensure we have a representative and supported workforce and inclusive leadership at all levels?

The feedback from the events has informed our Equality, Diversity and Inclusion action planning through to 2022 and feeds into the work plans for WRES, WDES and post Covid-19 organisational development work.

**Staff Networks**

Support for networks has grown during this reporting period. Running virtual meetings has improved attendance and allowed for the flexibility to hold meetings more frequently and at different times. All of the networks have developed action plans and have been supported by budgets for activities, release time for network chairs and administrative support. Network chairs met regularly with the Equality and Diversity Lead to talk about cross cutting issues and to plan and deliver joint activities. During Black History and LGBT History Months there were events that recognised the intersectionality of race and sexuality. We have also seen

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the release of a central fund for equality and diversity which the networks can submit bids to for initiatives that will support key work that will help address Trust-wide actions. A detailed account of staff network activities is given in the appended annual report. Here however are the highlights from across the networks.

- Prerana Issar NHS England's Chief People Officer attended our BAME Staff Network and spoke about the importance of staff network contributions during the Pandemic.
- For the first time the Trust has had series of events to celebrate Black History Month during October. The BAME Staff Network were instrumental in delivering a varied programme of activities and resources that celebrate the lives of Black People in the UK and raise levels of awareness about issues that affect the lives of these communities in the UK. This culminated with the delivery of a BAME Conference at the end of the month at which a number of national speakers, including Roger Kline presented.
- We celebrated Disability History Month in December and launched our Disabled Staff Passport. As the name passport implies, if a disabled member of staff changes jobs the passport will help facilitate the provision of reasonable adjustments, without the need to start a conversation with the new manager. The provision should allow reasonable adjustments to be in place from the commencement of a new job.
- Our Mental Health and Wellbeing Network was the first to embrace virtual meetings and provides a safe space for people to come and talk about how our wellbeing is affected by work and how our wellbeing affects us at work too. The network has run during the pandemic regular meetings and 'cafes' where activities have included meditation and mindfulness sessions.
- Our LGBT+ Staff Network with the support of the Trust's Chaplaincy Team conducted a virtual service to commemorate Trans Day of Remembrance in November. In February the network delivered an online event to celebrate LGBT History Month. The event included discussions on conversion therapy, faith and sexuality, addictions and recovery, race and sexuality and Transwomen in sport.

**Addressing Covid-19 Inequalities**

The E&D lead worked with colleagues to develop the first iteration of the risk assessment toolkit to assess the risk of Covid-19 for Trust Staff. The Guidance documentation for enabling conversations with BAME staff has been highlighted by both NHS Employers and NHS England as an example of good practice that has been shared nationally. The E&D Lead has been part of the Covid Risk Assessment Group (CRAG) that has developed the risk assessment decision aid that has been used to complete the assessments to comply with the NHS England targets for risk assessment. Key work on this was the development of a set of frequently asked questions to help inform and guide staff and managers in the process. This work has also been linked into that taking place in the staff networks – particularly the BAME and Disabled Staff networks, where the risk has been deemed to be greater. The networks have helped to influence the development of the decision aid and frequently asked questions.

**Stonewall Diversity Champions**

At the start of 2019 we signed a three year agreement to be Diversity Champions with Stonewall. The Diversity Champions programme is the leading employers' programme for ensuring all LGBT staff are accepted without exception in the workplace. As part of this we took part in their Workplace Equality Index for the first time. We ranked 357th out of 750 organisations that completed the exercise. We have followed feedback from the index findings and anticipate an improvement in our ranking when we submit again later this year.

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**Workforce Race and Disability Equality Standards**

The findings from these have previously been discussed and their associated actions approved by the Board. The approved actions associated with these standards are

- Overhaul of recruitment and promotion practices for all levels of post to ensure that staffing reflects the diversity of the community and regional and national labour markets.
- Introduction of a campaign to tackle inappropriate values and behaviours in relation to, amongst other things, racism and other forms of discrimination. This is going under the banner of Respect.
- Reviewing disciplinary processes to eliminate the ethnicity gap when entering formal disciplinary processes.

Work has commenced on all of these actions and we look forward to reporting on their progress to Trust Board in due course.

The full report can be accessed here.

**Chris Rowlands**
**Equality and Diversity Lead**
**June 2021**

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**Report to Board of Directors Meeting**
**Wednesday 7 July 2021**

| **Title of report** | **Quarterly Report on Safe Working Hours: Doctors in Training – Quarter 4** |
|---|---|
| **Report author(s)** | **Becky Dioh, Head of Medical Recruitment and Education in the absence of Dr Clare McLeod, Guardian of Safe Working Hours** |
| **Executive Lead** | **Dr Rajesh Nadkarni, Executive Medical Director** |

| **Strategic ambitions this paper supports (please check the appropriate box)** | | | |
|---|---|---|---|
| Work with service users and carers to provide excellent care and health and wellbeing | | Work together to promote prevention, early intervention and resilience | |
| To achieve "no health without mental health" and "joined up" services | | Sustainable mental health and disability services delivering real value | |
| To be a centre of excellence for mental health and disability | | The Trust to be regarded as a great place to work | X |

| **Board Sub-committee meetings where this item has been considered (specify date)** | |
|---|---|
| Quality and Performance | 12/05/2021 |
| Audit | |
| Mental Health Legislation | |
| Remuneration Committee | |
| Resource and Business Assurance | |
| Charitable Funds Committee | |
| CEDAR Programme Board | |
| Other/external (please specify) | |

| **Management Group meetings where this item has been considered (specify date)** | |
|---|---|
| Executive Team | |
| Corporate Decisions Team (CDT) | |
| CDT – Quality | 19/04/2021 |
| CDT – Business | |
| CDT – Workforce | |
| CDT – Climate | |
| CDT – Risk | |
| Business Delivery Group (BDG) | |

| **Does the report impact on any of the following areas *(please check the box and provide detail in the body of the report)*** | | | |
|---|---|---|---|
| Equality, diversity and or disability | | Reputational | X |
| Workforce | X | Environmental | |
| Financial/value for money | X | Estates and facilities | |
| Commercial | | Compliance/Regulatory | X |
| Quality, safety, experience and effectiveness | X | Service user, carer and stakeholder involvement | |

| **Board Assurance Framework/Corporate Risk Register risks this paper relates to** |
|---|
| No |

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**Quarterly Report on Safe Working Hours:**
**Doctors in Training – Quarter 4**

## 1. Executive summary

This is the Quarterly Board report for the period Jan to Mar 2021 on Safe Working Hours which focuses on Junior Doctors. The process of reporting has been built into the new junior doctor contract and aims to allow trusts to have an overview of working practices of junior doctors as well as training delivered.

The new contract is being offered to new trainees' as they take up training posts, in effect this will mean for a number of years we will have trainees employed on two different contracts. It is also of note that although we host over 160 trainee posts, we do not directly employ the majority of these trainees, also due to current recruitment challenges a number of the senior posts are vacant.

All new Psychiatry Trainees and GP Trainees rotating into a Psychiatry placement from 2nd August 2017 are on the New 2016 Terms and Conditions of Service. There are currently 150 trainees working into CNTW with 150 on the new Terms and Conditions of Service via the accredited training scheme via Health Education England. There are an additional 10 trainees employed directly by CNTW working as Trust Grade Doctors or Teaching/Research/Clinical Fellows.

**High level data**

Number of doctors in training (total): 150 Trainees (as at March 2021)

Number of doctors in training on 2016 TCS (total): 150 Trainees (as at March 2021)

Amount of time available in job plan for guardian to do the role: This is being remunerated through payment of 1 Additional Programmed Activity

Admin support provided to the guardian (if any): Ad Hoc by Med Education Team

Amount of job-planned time for educational supervisors: 0.5 PAs per trainee

Trust Guardian of Safeworking Hours: Dr Clare McLeod

## 2. Risks and mitigations associated with the report

- 20 Exception Reports raised during the period January to March due to hours and rest with TOIL being granted for 14 and payment for 5 and 1 still open for decision.
- 3 Agency Locums booked during the period covering vacant posts
- 142 shifts lasting between 4hrs and 12hrs were covered by internal doctors
- On 19 occasions during the period the Emergency Rotas were implemented (either by rota collapse or training rota covering a shift)
- 27 IR1s submitted due to insufficient handover of patient information
- 0 Fines received during the quarter due to minimum rest requirements between shifts not being met

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**Exception reports (with regard to working hours)**

| | | Exception Reports Received January to March 2021 | | | | |
|---|---|---|---|---|---|---|
| Grade | Rota | Jan | Feb | Mar | Total Hours & Rest | Total Education |
| CT1-3 | St Nicholas | | | | | |
| CT1-3 | Hopewood Park | 2 | | | 2 | |
| CT1-3 | RVI/CAMHS | | | | | |
| CT1-3 | NGH/CAV | | | | | |
| CT 1-3 | St George's Park | | | | | |
| CT 1-3 | GHD/MWM | | | 8 | 8 | |
| CT 1-3 | Cumbria | 5 | | | 5 | |
| ST4+ | North of Tyne | 2 | | 3 (*1) | 5 | |
| ST4+ | South of Tyne | | | | | |
| Total | | 9 | | 11 | 20 | 0 |

*1 including still pending decision. Awaiting update from the supervisor. Process includes a meeting between the trainee and supervisor to identify issues and any actions.

**Work schedule reviews**

During the period January to March 2021 there have been 20 Exception Reports submitted from Trainees all for hours and rest; the outcome of which was that TOIL was granted for all 14 cases, payment made for 5* cases and 1 case is outstanding.

*There is an agreement to pay travel for trainees when starting early/finishing late for travel between Whitehaven & Carleton Clinic for Teaching & Out of Hours work.

Emergency Rota cover is arranged when no cover can be found from either Agency or current Trainees. The Rota's are covered by 2 trainees rather than 3 and payment is made to the 2 trainees providing cover at half rate.

**a) Locum bookings - Agency**

| Locum bookings (agency) by department | | | |
|---|---|---|---|
| Specialty | Jan | Feb | Mar |
| Hopewood Park | | | |
| Gateshead | | | |
| NGH | | | |
| RVI | | | |
| SNH | | | 1 |
| CAMHS | | | |
| LD | | | |
| SGP | 2 | 2 | 2 |
| Cumbria | | | |
| South of Tyne | | | |
| North of Tyne | | | |
| **Total** | **2** | **2** | **3** |

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| Locum bookings (agency) by grade | | | |
|---|---|---|---|
| | Jan | Feb | Mar |
| F2 | | | |
| CT1-3 | 2 | 2 | 3 |
| ST4+ | | | |
| Total | 2 | 2 | 3 |
| **Locum bookings (agency) by reason** | | | |
| | Jan | Feb | Mar |
| Vacancy | 2 | 2 | 3 |
| Sickness/other | | | |
| Total | 2 | 2 | 3 |

**b) Locum work carried out by trainees**

| Area | Number of shifts worked | Number of hours worked | Number of hours to cover sickness | Number of hours to cover OH Adjustments | Number of hours to cover special leave | Number of hours to cover a vacant post |
|---|---|---|---|---|---|---|
| SNH | 23 | 209.75 | 110.75 | 41.5 | 0 | 57.5 |
| SGP | 16 | 149 | 58 | 91 | 0 | 0 |
| Gateshead | 7 | 45.75 | 8.5 | 37.25 | 0 | 0 |
| Hopewood Park | 6 | 33.5 | 29.25 | 4.25 | 0 | 0 |
| RVI | 42 | 378.5 | 0 | 181 | 111.25 | 86.25 |
| NGH | 4 | 33 | 33 | 0 | 0 | 0 |
| Cumbria | 25 | 282.25 | 114.5 | 167.75 | 0 | 0 |
| North of Tyne | 8 | 66 | 0 | 33 | 0 | 33 |
| South of Tyne | 11 | 102.75 | 4.25 | 61.25 | 37.25 | 0 |
| CAMHS | 0 | 0 | 0 | 0 | 0 | 0 |
| **Total** | **142** | **1300.5** | **358.25** | **617** | **148.5** | **176.75** |

**c) Vacancies**

| Vacancies by month | | | | | |
|---|---|---|---|---|---|
| Area | Grade | Jan | Feb | Mar | |
| NGH/CAV | CT<br>GP<br>F2 | 2 | | | |
| SNH | CT<br>GP<br>F2 | 2 | | | |
| SGP | CT<br>GP<br>F2 | | | | |
| RVI | CT<br>GP<br>F2 | | | | |
| Cumbria | CT<br>GP<br>F2 | | <br>2 | <br>2 | |

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| Hopewood Park | CT<br>GP<br>F2 | | | | |
|---|---|---|---|---|---|
| **TOTAL** | CT<br>GP<br>F2 | 4 | <br>2 | <br>2 | |

There are currently 0 posts unfilled. Majority of these training gaps have been filled by Teaching/Research & Clinical Fellows & LAS appointments.

**d) Emergency Rota Cover**

| Emergency Rota Cover by Trainees | | | | |
|---|---|---|---|---|
| | Rota | Jan | Feb | Mar |
| Sickness/Other | NOT<br>SOT<br>SGP<br>SNH<br>RVI<br>GHD/MWM<br>Cumbria<br>HWP<br>NGH | 0<br>0<br>4<br>5<br>1<br>3<br>2<br>1<br>1 | <br><br><br><br>2 | |
| Total | | 17 | 2 | |

An Emergency Rota cover is arranged when no cover can be found from either Agency or current Trainees. If cover identified and filled in a timely manner, there is no need for a Rota collapse.

**e) Fines**

There were no fines issued during this quarter.

**Issues Arising**

There has been an increase in the number of shifts covered by internal locums due to absences due to sickness, adjustments or rota gaps, as compared to same quarter in 2020. With Covid it has become extremely challenging to cover shifts due to length of sickness, isolation etc. Same quarter last year Covid absences were not as challenging. Discussions around sickness cover happen in different forums. Shifts are put out well in advance (depending on when we are made aware of the gap) to enable doctors' book additional shifts to cover vacancies.

There have been 20 exception reports submitted in the three months Jan to March 2021. This is a slight increase from the same period in 2020 when 12 exception reports were submitted. This is due to increased workload, pressures of Covid on staff / workforce.

There have been 27 IR1s submitted for inadequate medical handover this quarter, a slight increase from last quarter. This continues to be collated by Medical Education staff and the Director of Medical Education (DME) and reviewed through the GoSW forum.

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The Trust was awarded a total of £84,166.33 to be spent to improve the working lives of junior doctors following the adoption of the Fatigue and Facilities charter. This has been sorted including Cumbria however we are still waiting a permanent site for the On Call Room in Cumbria. In the meantime, the On-call room is a temporary location with all equipment bought in it.

The GoSW forum continued to take place throughout the COVID restrictions, but as with other meetings took place via TEAMS. Attendance has been maintained and increased with this and may need to consider a combination of face to face and teams' sessions once restrictions are eased. Dr Owen (DME) and Dr Rao AMD have jointly supported the role of Guardians since Dr McLeod's absence.

**Summary of actions in place**

An additional temporary rota is in place to support trainees and manage the increased workload over weekend and bank holiday days. This is now gradually being phased out but will continue at SGP due to intensity of workload.

Work continues to increase the completeness of Exception Reporting and change the culture of under-reporting. Trainees are encouraged to complete an exception report as necessary.

We will continue to encourage trainees to report episodes of Insufficient Medical Handover and promote good practice and feedback progress to clinicians throughout the Trust.

## 3. Recommendation

Receive the paper for information only.

| | |
|---|---|
| Author: | Becky Dioh, Head of Medical Recruitment and Education in the absence of Dr Clare McLeod, Guardian of Safe Working for CNTW |
| Executive Lead: | Dr Rajesh Nadkarni, Executive Medical Director |

April 2021

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**Report to the Board of Directors**
**7th July 2021**

| **Title of report** | **Board of Directors and Board Sub-Committee Terms of Reference Annual Review** |
|---|---|
| **Report author(s)** | **Vicky Grieves, CQC Compliance Officer** |
| **Lead (if different from above)** | **Debbie Henderson, Director of Communications and Corporate Affairs/Company Secretary** |

| **Strategic ambitions this paper supports (please check the appropriate box)** | | | |
|---|---|---|---|
| Work with service users and carers to provide excellent care and health and wellbeing | X | Work together to promote prevention, early intervention and resilience | X |
| To achieve "no health without mental health" and "joined up" services | X | Sustainable mental health and disability services delivering real value | X |
| To be a centre of excellence for mental health and disability | X | The Trust to be regarded as a great place to work | X |

| **Board Sub-committee meetings where this item has been considered (specify date)** | |
|---|---|
| Quality and Performance | X |
| Audit | X |
| Mental Health Legislation | X |
| Remuneration Committee | X |
| Resource and Business Assurance | X |
| Charitable Funds Committee | X |
| CEDAR Programme Board | X |
| Provider Collaborative, Lead Provider Committee | X |
| Other/external (please specify) | |

| **Management Group meetings where this item has been considered (specify date)** | |
|---|---|
| Executive Team | |
| Corporate Decisions Team (CDT) | X |
| CDT – Quality | |
| CDT – Business | |
| CDT – Workforce | |
| CDT – Climate | |
| CDT – Risk | |
| CDT – Digital | |
| Business Delivery Group (BDG) | |

| **Does the report impact on any of the following areas *(please check the box and provide detail in the body of the report)*** | | | |
|---|---|---|---|
| Equality, diversity and or disability | | Reputational | |
| Workforce | | Environmental | |
| Financial/value for money | | Estates and facilities | |
| Commercial | | Compliance/Regulatory | X |
| Quality, safety, experience and effectiveness | X | Service user, carer and stakeholder involvement | |

| **Board Assurance Framework/Corporate Risk Register risks this paper relates to** |
|---|
| N/A – Statutory and Regulatory requirement in line with the Trust Constitution and Standing Orders |

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# Board of Directors and Sub Committees Terms of Reference Annual Review June 2021

## 1. Executive Summary

In line with the requirements of the Trust Constitution and Standing Orders and to ensure the continuation of good governance, the Board of Directors and Sub-Committees of the Board are required to undertake an annual review of their Terms of Reference.

- The Board of Directors Terms of Reference was last reviewed at the April 2019 Board meeting.
- The Sub Committee Terms of Reference were last reviewed at the May 2019 and September 2019 Board meetings.
- The Terms of Reference for the Charitable Funds Committee were last reviewed in March 2020.
- The Terms of Reference for the newly established Provider Collaborative and Lead Provider Committee was approved at the April meeting of the Board.
- All Sub Committees have completed a self-assessment against their Terms of Reference which is available if requested.
- All Terms of Reference have been reviewed by the respective committee or chair and are attached for approval.

| | Committee | Change Since last approval |
|---|---|---|
| 1 | Board of Directors | Inclusion of Charitable Funds Committee and Provider Collaborative Committee as sub-committees of the Board. |
| 2 | Resource and Business Assurance Committee | Minor amendments made to membership: inclusion of North Cumbria Locality Group, incorporated recent changes to the structure of the Executive Team. |
| 3 | Quality and Performance Committee | Minor amendments made to membership: inclusion of North Cumbria Locality Group, incorporated recent changes to the structure of the Executive Team and the number of Non-Executive Directors has increased to five. The frequency of meeting increased to eight times a year to incorporate twice yearly Quality and Performance Updates from Locality Groups. |
| 4 | Mental Health Legislation Committee | Minor amendments made to membership: inclusion of North Cumbria Locality Group, incorporated recent changes to the structure of the Executive Team. The number of Non-Executive Directors increased to three and the Clinical Information Officer added to membership. |
| 5 | Audit Committee | Quorum for the meeting revised from two members to three, to include a minimum of one Non-Executive Director and one Executive Director to ensure effective decision making. |

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| 6 | Provider Collaborative and Lead Provider Committee | No changes proposed. |
|---|---|---|
| 7 | Remuneration Committee | No changes proposed. |
| 8 | CEDAR Programme Board | Minor amendments made to membership and scope of programme board expanded upon. |
| 9 | Charitable Funds Committee | One minor amendment to clarify the ability for decisions on Charitable Fund expenditure to be made via e-mail out-with formal meetings, with all decisions being ratified at the next formal meeting.<br>Also inclusion of 'guidance' to bullet point 3 in scope of duties. |
| 10 | Corporate Decisions Team | Minor amendments made to membership: inclusion of North Cumbria Locality Group and incorporated recent changes to the structure of the Executive Team. |

## 2. Recommendation

The Board are asked to:

- Approve the attached Terms of Reference for the Board of Directors and Board Sub-Committees outlined above.

**Debbie Henderson**
**Director of Communications and Corporate Affairs/Company Secretary**
**July 2021**

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# Board of Directors
# Terms of Reference

| Committee Name: | Board of Directors |
|---|---|
| **Committee Type:** | N/A |
| **Timing & Frequency:** | Board meetings will be held monthly in public. Closed Board meetings will be held monthly to discuss matters to be excluded from discussion in public in line with the Trusts Constitution. |
| **Committee Secretary:** | Director of Corporate Affairs and Communications |
| **Reporting Arrangements:** | N/A |

| **Membership** | |
|---|---|
| **Chair:** | Chairman |
| **Deputy Chair:** | Vice-Chair |
| **Members:** | Chief Executive<br>All other Non-Executive Directors<br>All Executive Directors of the Board |
| **In Attendance:** | Director of Corporate Affairs and Communications and Company Secretary<br>***NB:** Other Trust representatives may attend meetings of the Board by invitation.* |
| **Quorum:** | Five members to include a minimum of two Executive Directors and a minimum of three Non-Executive Directors |
| **Deputies:** | The Trust Vice-Chair to deputise for Trust Chair.<br>Deputies are permitted to deputise for Executive Directors for discussion only. Deputies have no voting rights.<br>No deputies are permitted for Non-Executive Directors. |

| **Purpose** |
|---|
| The Board of Directors is collectively responsible for the exercise of powers and the performance of the NHS Foundation Trust *(the Trust)* and for the effective discharge of the Board's statutory duties. The general duty of the Board and of each director individually, is to act with a view to promoting the success of the organisation so as to maximise the benefits for members of the Trust as a whole and for the public.<br><br>Its role is to provide entrepreneurial leadership of the Trust within a framework of prudent and effective controls, which enables risk to be assessed and managed. |

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| **Governance, rules and behaviours** |
| --- |
| Collective responsibility/decision making, arbitrated by the Chairman i.e. all members of the Board have joint responsibility for every decision of the Board regardless of their individual skills or status. This does not impact on the particular responsibilities of the Chief Executive Officer as the Accounting Officer. In addition all directors must take decisions objectively and in the best interests of the Trust and avoid conflicts of interest.<br><br>• As part of their role as members of a unitary Board, all directors have a responsibility to constructively challenge during Board discussions and help develop proposals on priorities, risk, mitigation, values, standards and strategy. In particular NEDS should scrutinise (i.e. assess and assure themselves of) the performance of the Executive Management Team in meeting agreed goals and objects, receive adequate information and monitor the reporting performance, satisfying themselves as to the integrity of financial, clinical and other information, and make sure the financial and clinical quality controls, and systems of risk management and governance are robust and implemented.<br>• Compliance with the Trusts Standing Orders and Monitor's Code of Governance will be maintained.<br>• Agenda timings may be prioritised to accommodate outside speakers and non-members.<br>• All members are expected to attend-absenteeism is an exception.<br>• All members will support the Chair to ensure meetings will start and end on time.<br>• Members should refrain from using mobiles phones during the meeting. |
| **Scope** |
| The Board of Directors is responsible for:<br><br>• Ensuring the quality and safety of healthcare services, education, training and research delivered by the Foundation Trust and applying the principles and standards of clinical governance set out by the Department of Health, NHS Improvement/NHS England, the Care Quality Commission and other relevant NHS bodies.<br>• Setting the Trust's strategy, vision, values and standards of conduct and ensure that its obligations to its members, patients and other stakeholders are understood, clearly communicated and met. In developing and articulating a clear vision for the Trust, it should be a formally agreed statement of the Trust's purpose and intended outcome which can be used as a basis for the Trust's overall strategy, planning and other decisions.<br>• Ensuring compliance by the Trust with its licence, its constitution, mandatory guidance by Monitor, relevant statutory requirements and contractual obligations.<br>• Setting the Trusts strategic aims at least annually, taking into consideration the views of the Council of Governors, ensuring that the necessary financial and human resources are in place for the Trust to meet its priorities and objectives and then periodically reviewing progress and management performance.<br>• Ensuring that the Trust exercises its functions effectively, efficiently and economically. |

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**Authority**

Decision making in line with the authority outlined in these terms of reference and the Trusts' Standing Financial Instructions and Standing Orders.

**Deliverables**

<u>Leadership</u>

- Clear vision and strategy (implement and communicate)
- Excellent employer (Workforce Strategy, implementation and operation)
- Effective Board and Committee structures, clear lines of reporting and accountability (implement)

<u>Culture, Ethics and Integrity</u>

- Set values (including widely communicating and adherence)
- Promote a patient centred culture of openness, transparency and candour
- Maintain high standards of corporate governance and personal integrity in the conduct of business
- Application of appropriate ethical standards
- Establish appeals panel as required by employment policies
- Adherence of directors and staff to codes of conduct

<u>Strategy</u>

- Set and ensure delivery of the Trust's strategic vision, aims and objectives
- Ensure an approach to partnership working across the wider ICS system
- Monitor and review management performance to ensure objectives are met
- Oversee the delivery of planned services and achievement of objectives
- Develop, maintain and ensure delivery of the Trust's Annual Business Plan, having due regard to the views of the Council of Governors
- Have regard to, and implement where necessary, national policies and strategies

<u>Quality</u>

- Responsibilities for ensuring internal controls are in place for clinical effectiveness, patient safety and experience
- Intolerance of poor standards and foster a culture which puts the patients first
- Engage with stakeholders, including staff and service users, on quality issues and ensure appropriate escalation and dealing with issues
- Responsible for the publication of the Trust's Annual Quality Account

<u>Finance</u>

- Ensure the Trust operates effectively, efficiently, economically
- Ensure continuing financial viability
- Ensure resources are properly managed and financial responsibilities are delivered
- Review performance identifying opportunities for improvement
- Responsible for the publication of the Trust's Annual Accounts

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Governance and Compliance

- Ensuring comprehensive governance arrangements are in place by complying with principles, standards and systems of corporate governance having regard to NHS Regulatory guidance and codes of conduct, accountability and openness
- Ensure compliance with all requirements of the Trust's Provider Licence conditions
- Ensure compliance with the Trust's Constitution, and review the Constitution on a regular basis
- Formulate, implement and review the Trust's Standing Orders, Standing Financial Instructions, and Schedule of Matters Reserved for Decision by the Board
- Ensure compliance with the requirements of the NHS Act, Health and Social Care Act, Mental Health Act and other legislative requirements
- Required returns and disclosures made to the regulators
- Ensure effective systems are in place for the appropriate appointment and evaluation arrangements for senior positions
- Responsible for the publication of the Trust's Annual Accounts

Risk Management

- Ensure an effective system of integrated governance, risk management and internal control across all clinical and corporate activities
- Determine and agree the Trust's Risk Appetite and review on a regular basis
- Develop, monitor and review the Trusts Board Assurance Framework and manage the risks to the achievement of the Trusts strategic objectives
- Oversee and monitor the implementation of the Trusts Risk Management Policy

Communication and Involvement

- Responsible for developing and maintaining effective communication channels between the Board, Trust Governors, Trust members, members of staff and the local community based on openness and transparency
- Responsible for ensuring effective communication with key stakeholders
- Ensure the Council of Governors are equipped with skills and knowledge needed to undertake their role
- Ensure effective dissemination of information on service strategies and plans
- Ensure effective strategies, systems and processes are in place for staff, service users and carer and stakeholder involvement in development of care plans, review of quality of services and development of new services

**Sub Groups**

The following Committees will report to the Board via submission of minutes of meetings supported by verbal updates from the Chair:

- Audit Committee (statutory committee)
- Remuneration Committee (statutory committee)
- Quality and Performance Committee (standing committee)
- Mental Health Legislation Committee (standing committee)
- Resource and Business Assurance Committee (standing committee)
- Provider Collaborative Committee (standing committee)

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- CEDAR Programme Board (standing committee)
- Charitable Funds Committee (standing committee)
- Corporate Decisions Team (standing committee)

Due to the confidential and sensitive nature of information concerning members of the Board of Directors, the Board shall receive a verbal summary of the Remuneration Committee meeting rather than committee minutes.

**Current review date: June 2021**
**Date of Board approval: July 2021**
**Date of previous review: April 2019**

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# Resource and Business Assurance Committee
# Terms of Reference

| | |
|---|---|
| **Committee Name**: | Resource and Business Assurance Committee |
| **Committee Type**: | Standing sub-committee of Trust Board |
| **Timing & Frequency**: | Quarterly, Wednesday of week prior to Board of Directors meeting. |
| **Personal Assistant to Committee:** | PA to Director of Finance/Deputy Chief Executive |
| **Reporting Arrangements**: | Minutes and Report from Chair to Board of Directors |

| **Membership** | |
|---|---|
| **Chair:** | Non-Executive |
| **Deputy Chair:** | Non-Executive |
| **Other members:** | Deputy Chief Executive/Director of Finance<br>Chief Nurse<br>Chief Operating Officer<br>Executive Director of Workforce and Organisational Development<br>Executive Director Commissioning and Quality Assurance<br>The Executive Medical Director will attend as required |
| **In Attendance:** | Group Triumvirate Director Representation (4)<br>Deputy Director of Finance and Business Development<br>Managing Director, NTW Solutions Ltd<br>Director of Informatics<br>Head of Income and Contracted Services<br>1 Governor<br>PA to Committee |
| **Quorum:** | Chair or Deputy Chair<br>2 Executive Directors |
| **Deputies:** | Deputies required for all members and those in attendance |

**Purpose**:
Provide assurance to the Board that:

- The Trust has effective systems and processes in place to secure economy, efficiency and effectiveness in respect of all resources, supporting the delivery of the Trust's Strategy and Operational Plans.
- There is a clear understanding of current and emerging risk to that delivery and that strategic risk in relation to the effective and efficient use of resources and the long-term sustainability of the Trust and its services are being managed.

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**Scope:**

- Review of arrangements for the development of the Trust Annual Resource Plan, ensuring that resources are adequately identified to meet quality and performance standards, or to highlight appropriate risks to the board
- Oversee the assurance delivery against the Trust's annual resource plan and the impact of in year delivery on key financial strategic risk.
- Oversee arrangements for financial reporting, cash management, internal control and business planning to ensure that they comply with statutory, legal and compliance requirements and that they are developing towards best practice. Ensure that that there is a clear understanding of current and emerging risks and that actions are in place to maintain and continually improve the organisation's position as a high performing Trust for the use of resources.
- Oversee and assure the Trust's delivery of the Capital Programme in the light of service development plans, risk and quality issues, and in line with the Trust's Strategy and Operational Plans and the management of strategic risks.
- Oversee and assure arrangements for managing contractual relationships with Commissioners of services and ensure that there is a clear understanding of current and emerging risks.
- To oversee the development of significant investment and development proposals on behalf of the Board of Directors, including major projects, business case development, and tenders. Also, to receive assurance on effective financial modelling for major tenders, effective project implementation and post project evaluation.
- Oversee and assure arrangements relating to the review the Trust's Commercial Investment Policy and Innovations Strategy.
- To receive assurance that proper arrangements are in place for the procurement of goods and services and that there is a clear understanding of current and emerging risks.
- To receive assurance that proper arrangements are in place for the management of the Trust's estate and that the infrastructure, maintenance and developmental programme supports the Trust's Strategy, Operational Plans and legal and statutory obligations. Ensure that there is a clear understanding of current and emerging risks.
- To receive assurance on the Trust delivery against its Green Plan and its overall response to the Climate and Ecological Emergency
- To receive assurance that proper arrangements are in place for the management of the Trust's Information Technology and Infrastructure, maintenance and development programme ensuring it supports the Trust's Strategy and Operational Plans, including delivery of improvement and efficiency objectives, and the fulfilment of legal and statutory obligations. Ensure that there is a clear understanding of current and emerging risks.
- To receive assurance that proper arrangements are in place to ensure delivery of sustainable healthcare, with a focus on productivity, benchmarking and the shift to early intervention and prevention
- To receive assurance that cash investment decisions are made in line with the Treasury Management Policy, and to review changes to this Policy, where appropriate.
- To receive assurance that appropriate arrangements are in place for insurance against loss across all Trust activities.
- Receive for assurance purposes routine reports from all standing subgroups and any other relevant reports/action plans in relation to current issues.

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- Contribute to the maintenance of the Trust's Corporate Risk Register and Board Assurance Framework by ensuring that the risks that the Resource and Business Assurance Committee are responsible for are appropriately identified and effective controls are in place and that strategic risk in relation to the effective and efficient resources, and the long-term sustainability of the Trust and its services are being managed.
- Each Subcommittee of the Board of Directors takes on the following role for Risks pertaining to their area of focus:
  - Review the management of the Corporate Risk Register and the Groups top risks.
  - Review the Board Assurance Framework to ensure that the Board of Directors receive assurances that effective controls are in place to manage corporate risks.
  - Report to the Board of Directors on any significant risk management and assurance issues.

**Authority:**
To act on behalf of the Board to receive assurances that effective arrangements are in place to manage those areas within the Committee's scope across the organisation.

**Deliverables:**
Assurance to the Board that:
- Effective systems and processes are in place to deliver the Trust's Financial Strategy and targets (including the Trust's capital resources) and that there is a clear understanding of current and emerging risk to that delivery.
- Effective systems are in place to deliver against the Trusts Green Plan.
- Effective systems and processes are in place to ensure the Trust's delivery against specific aspects of the Trust's Workforce Strategy/performance standards ensuring that the Trust has the workforce resources and capacity to deliver the Trust's Strategy and Operational Plans and that there is a clear understanding of current and emerging risk to that delivery.
- Effective systems and processes are in place to ensure that legislative, mandated (e.g. CQC, CQUIN) and best practice workforce, organisational development, education, training and equality and diversity related outcomes are being delivered.
- Effective services are delivered by key workforce strategic partners i.e., Capsticks and Team Prevent.
- Effective systems and processes are in place to manage commercial activity and business development, in line with the Trust's Strategy, Operational Plans, Trust policies and Monitor requirements, including major projects, business case development, tendering and post project evaluation arrangements and that there is a clear understanding of current and emerging risks.
- Effective systems and processes are in place for managing contractual relationships with Commissioners of services and that there is a clear understanding of current and emerging risks.
- Effective systems and processes are in place for the procurement of goods and services and that there is a clear understanding of current and emerging risks.
- That Estates and Information Technology infrastructure, systems and processes are designed, delivered and maintained to support the delivery of the Trust's Strategy and Operational Plans and that there is a clear understanding of current and emerging risks.

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| |
|---|
| • The risks, that the Resource and Business Assurance Committee are responsible for, are appropriately identified and effective controls are in place and that strategic risk in relation to the effective and efficient resources, and the long term sustainability of the Trust and its services are being managed. |
| **Sub Groups:**<br>Project Boards Links to CDT, Operational Groups and Integrated Business Development Group |
| **Current review date: May/June 2021**<br>**Board approval date: July 2021**<br>**Date of previous review: April 2019** |

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# Quality and Performance Committee
# Terms of Reference

**Committee Name: Quality and Performance Committee (Q&P)**

**Committee Type:** Standing sub-committee of Board of Directors

**Timing & Frequency:** Eight times a year, Wednesday of week prior to Board of Directors meeting

**Personal Assistant to Committee:** CQC Compliance Officer

**Reporting Arrangements:** Minutes and Report from Chair to Board of Directors

| **Membership:** | |
|---|---|
| **Chair:**<br>**Deputy Chair:** | Non-Executive<br>Non-Executive |
| **Members:** | Chief Operating Officer<br>Chief Nurse<br>Executive Medical Director<br>Executive Director Commissioning and Quality Assurance<br>Executive Director of Workforce and Organisational Development<br>Other Non-Executive Directors (including Chair and Vice-Chair) |
| **In Attendance:** | Group Triumvirate Director Representation (4)<br>Group Nurse Director, Safer Care<br>2 named Officers:<br>Deputy Director of Commissioning and Quality Assurance<br>Chief Pharmacist/Controlled Drugs Accountable Officer<br>Director of Research, Innovation and Clinical Effectiveness<br>Two Governor representatives<br>PA to Committee |
| **Quorum:** | Chair or Deputy Chair<br>2 Executive Directors |
| **Deputies:** | Deputies Required for all members |

**Purpose:**
Provide assurance to the Board that:

- The Trust has effective systems and processes in place for the management of risks pertaining to their area of focus, safety quality and performance across the Trust.
- The Trust has an effective Assurance/Performance Framework.
- The Trust complies with the law, best practice, governance and regulatory standards which are within the Committee's scope.

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**Scope:**

- Oversee and assure the successful implementation of key quality and performance strategies, programmes of work and systems.
- Each Subcommittee of the Board of Directors takes on the following role for Risks pertaining to their area of focus:
  - Review the management of the Corporate Risk Register and the Groups top risks;
  - Review the Board Assurance Framework to ensure that the Board of Directors receive assurances that effective controls are in place to manage corporate risks;
  - Report to the Board of Directors on any significant risk management and assurance issues.
- Gain assurance that the Trust's action plans in relation to compliance and legislative frameworks, which are within the scope of the Committee, are robust, completed and signed off.
- Oversee and assure the implementation of NICE Guidance and other nationally agreed guidance as the main basis for prioritising Clinical Effectiveness.
- Monitor through its various sub groups the Trust's continued compliance with the CQC's Fundamental Standards.
- Monitor compliance against the Coroners Amended Rules 2008, in particular to the amendment to Regulation 28, whereby the Trust will respond within 56 days.
- Gain assurance from each of the Operational Groups that they have effective systems and processes in place to ensure standards of care, compliance with relevant standards, quality, risk and assurance arrangements.
- Monitor through a review of periodic thematic reports, themes and trends relating to quality issues including Serious Incidents, Incidents, Near Misses and Complaints gaining assurance regarding lessons learnt and changes in practice/service improvement.
- Gain assurance that information from patient and carer experience is informing service improvement.
- Gain assurance that information from staff experience is informing service improvement.
- Gain assurance through periodic exception reports from the Committee's Sub Groups, as to their effectiveness in delivering their Terms of Reference.
- Gain assurance through annual reports on specific areas, which are within the scope of the Committee, on compliance with best practice, national standards and legislative frameworks e.g. Controlled Drugs report from the Accountable Officer, Information Governance, Caldicott etc.
- Gain assurance regarding the effectiveness of the systems and processes relating to Clinical Audit and Board Assurance Framework audits.
- Receive routine updates from the Council of Governors Quality Group to ensure the Committee has links to relevant service user/carer and Governor forums.

**Authority:**

To act on behalf of the Board to receive assurances that effective arrangements are in place to manage those areas within the Committee's scope across the organisation.

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**Deliverables:**
Assurance to the Board re:

- The successful implementation of key quality and performance strategies, programmes of work and systems.
- That there is an effective risk management system operating across the Trust including Group Risk Registers, a Corporate Risk Register and Board Assurance Framework which provides assurances to the Board that effective controls are in place to manage corporate risks.
- The Trust's action plans in relation to compliance and legislative frameworks are robust and completed/signed off, with the exception of areas covered by the Resource and Business Advisory Committee and Mental Health Legislation Committee.
- The implementation of NICE Guidance and other nationally agreed guidance are the main basis for prioritising Clinical Effectiveness.
- The Trust's continued compliance with the CQC's Fundamental Standards.
- Compliance against the Coroners Amended Rules 2008.
- Standards of care, compliance with relevant standards and quality and risk arrangements in each Operational Group.
- That information from patient and carer experience, including themes and trends, is informing service improvement.
- That information from staff experience, including themes and trends, is informing service improvement.
- The operation of all standing sub groups and delivery of any relevant reports/action plans in relation to current issues.
- The management and use of Controlled Drugs within the Trust and across the local prescribing interface with the statutory Local Intelligence Network.
- The Committee has links to relevant service user/carer and Governor Forums.
- Effective systems and processes are in place with regard to clinical audits and Board Assurance Framework audits including robust processes to ensure recommendations and action plans are completed.
- The risks, that the Quality and Performance Committee are responsible for, are appropriately identified and effective controls are in place.

**Sub Groups:**
Health, Safety and Security
Positive and Safe
Emergency Preparedness, Resilience and Response
Caldicott Information Governance
Medicines Optimisation
Clinical Effectiveness
Research and Development
Safeguarding and Public Protection
Physical Health and Wellbeing
Infection, Prevention and Control
Patient and Carer Experience
Group Quality Standards.

Also links with:
Council of Governors' Quality Group
CQC Quality Compliance Group
CDT-Quality

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| CDT-Workforce<br>CDT-Risk |
| --- |
| **Current review date: March/April 2021**<br>**Date of Board approval: June 2021**<br>**Date of previous review: May 2020** |

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# Mental Health Legislation Committee
# Terms of Reference

**Committee Name: Mental Health Legislation Committee**

**Committee Type:** Standing sub-committee of Board of Directors

**Timing & Frequency:** Quarterly, Wednesday of week prior to Board of Directors meeting

**Personal Assistant to Committee:** PA Directorate

**Reporting Arrangements:** Minutes and Report from Chair to Board of Directors

**Review of Terms of Reference:** The Terms of Reference will be reviewed annually by the Committee prior to approval by the Trust Board

| **Membership:** | |
|---|---|
| **Chair:**<br>**Deputy Chair:** | Non-Executive Director<br>Non-Executive Director<br>Non-Executive Director |
| **Members:** | Executive Medical Director<br>Chief Nurse<br>Chief Operating Officer<br>Executive Director Commissioning and Quality Assurance<br><br>4 Locality Care Group Director Representatives:<br>- 1 from North |
| **In Attendance:** | - 1 from Central<br>- 1 from South<br>- 1 from North Cumbria<br>Group Medical Director (Chair of the Mental Health Legislation Steering Group)<br>Chief Clinical Information Officer<br>Representatives of Mental Health Legislation Team<br>Mental Health Legislation Development Lead<br>Two Governor Representatives<br>Training Academy Representative<br>PA to Committee |
| **Quorum:** | Chair or Deputy Chair and 2 Executive Directors<br>(Named deputies for Executive Directors will be accepted) |
| **Deputies:** | Deputies required for all members and attendees |

**Purpose:**
Provide assurance to the Board that:

- There are systems, structures and processes in place to support the operation of Mental Health Legislation within inpatient and community settings, and to ensure compliance with associated code of practice and recognised best practice.

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- The Trust has in place and uses appropriate policies and procedures in relation to Mental Health Legislation and to facilitate the publication and guidance of the legislation to all relevant staff, service users, carers and managers.
- Hospital Managers and appropriate staff groups receive guidance, education and training in order to understand and be aware of the impact and implications of all new relevant mental health and associated legislation.

**Scope:**

- Ensure the formulation of Mental Health Act Legislation Steering Group and receive quarterly assurance reports on the Mental Health Legislation Steering Group's activities in relation to activities.
- Keep under review annually the Trusts "Delegation of Statutory Functions under the Mental Health Act 1983" policy including the Schedule of Delegation appended to that policy.
- Receive and review the Mental Health Act Activity Report.
- Receive assurance from the Mental Health Legislation Steering Group that the Trust is compliant with legislative frameworks and that there are robust processes in place to implement change as necessary in relation to Mental Health legislation and report on ongoing and new training needs.
- Receive the results in relation to the monitoring of policies linked to the Mental Health Act and Mental Capacity Act legislation and monitor any associated action plans.
- Consider and recommend the Annual Audit Plan in relation to Mental Health Legislation.
- Receive assurance that new law guidance and best practice is disseminated and actioned appropriately.
- Each Subcommittee of the Board of Directors takes on the following role for Risks pertaining to their area of focus:
  - Review the management of the Corporate Risk Register and the Groups top risks;
  - Review the Board Assurance Framework to ensure that the Board of Directors receive assurances that effective controls are in place to manage corporate risks;
  - Report to the Board of Directors on any significant risk management and assurance issues.

**Authority:**

To act on behalf of the Board to receive assurances that effective arrangements are in place with regard to those areas within the Committee's scope across the organisation.

**Deliverables:**

Assurance to the Board re:

- The effective implementation of Mental Health Legislation within inpatient and community settings and compliance with associated Codes of Practice.
- The necessary policies and procedures in relation to mental health legislation are in place, updated and reviewed in line with legislative changes.
- The Trust's "Delegation of Statutory Functions under the Mental Health Act 1983" policy including the Schedule of Delegation appended to that policy, is reviewed annually.

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- The Trust's compliance with requirements of the Mental Health Act and Mental Capacity Act Codes of Practice in respect of the intelligent mental health legislation and activity and monitoring reports.

- The Trust's compliance with legislative frameworks and that robust processes are in place to implement change as necessary in relation to Mental Health Legislation and reporting on ongoing and new training needs.

- Effective systems and processes are in place in respect of the monitoring of policies linked to the Mental Health Act and Mental Capacity Act legislation including robust processes to ensure recommendations and action plans are completed.

- Effective systems and processes are in place in respect of the dissemination and auctioning of new law guidance and best practice.

- The risks that the Mental Health Legislation Committee is responsible for are appropriately identified and effective controls are in place.

- Recommend the Annual Audit Plan in relation to Mental Health Legislation to the Audit Committee.

**Sub Groups:**
Mental Health Act Legislation Steering Group
Any other task and finish sub groups

**Current review date: May 2021**
**Date of Board approval: July 2021**
**Date of previous review: January 2020**

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## Audit Committee
## Terms of Reference

| **Committee Name:** | Audit Committee |
|---|---|
| **Committee Type:** | Statutory committee of the Board of Directors |
| **Timing & Frequency:** | The committee will meet a minimum of five times per year but may meet more frequently at the discretion of the Chair. |
| **Committee Secretary:** | Corporate Affairs Manager |
| **Reporting Arrangements:** | The committee will report to the Board of Directors via submission of minutes and an Annual Report in April/May each year. |

| **Membership** | |
|---|---|
| **Chair:** | Non-Executive Director |
| **Deputy Chair:** | Non-Executive Director |
| **Members:** | Three Non-Executive Directors (including the Chair and Vice-Chair) |
| **In Attendance:** | - Deputy Chief Executive/Executive Director of Finance<br>- Executive Director of Commissioning and Quality Assurance<br>- Director of Corporate Affairs and Communications/Company Secretary<br>- Director of Finance/Deputy Managing Director for NTW Solutions Ltd<br>- Internal Auditors (AuditOne)<br>- Local Counter Fraud Services<br>- External Auditors<br>- Governor representative X 2<br><br>*Executive Directors and other Trust representatives will be expected to attend meetings at the request of the Chair*<br><br>*The Chief Executive should also attend when discussing the draft Annual Governance Statement and the Annual Report and Accounts.* |
| **Quorum:** | Three members (to include a minimum of one Non-Executive Director and one Executive Director of the Trust) |
| **Deputies:** | Deputies are permitted to deputise for those in attendance<br>No deputies are permitted for Non-Executive Directors |

| **Purpose** |
|---|
| To provide assurance to the Board of Directors that effective internal control arrangements are in place for the Trust and its subsidiary companies. The Committee also provides a form of independent scrutiny upon the executive arm of the Board of Directors. The Accountable Officer and Executive Directors are responsible for establishing and maintaining processes |

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for governance. The committee independently monitors, reviews and reports to the Board of Directors on the process of governance, and where appropriate, facilitates and supports, through its independence, the attainment of effective processes.

**Governance, rules and behaviours**

The committee is authorised by the Board of Directors:

- To investigate any activity within its Terms of Reference
- To obtain outside legal or other independent professional advice and secure attendance of outsiders with relevant experience and expertise it considers necessary
- Ensure that the Head of Internal Audit, representatives of External Audit and Counter Fraud specialists have a right of access to the Chair of the committee
- Ensure compliance with Monitor's Code of Governance and NHS Audit Committee Handbook

**Scope**

Integrated Governance, Risk Management and Internal Control

Oversee the risk management system and obtain assurances that there is an effective system operating across the Trust. Review the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the Trust and Subsidiary Companies that supports the achievement of the organisations objectives. In particular the committee will review the adequacy and effectiveness of:

- All risk and control related disclosure statements (i.e., the Annual Governance Statement), together with any accompanying Head of Internal Audit opinion, External Audit opinion or other appropriate independent assurances, prior to submission to the Board of Directors
- The underlying assurance processes that indicates the degree of achievement of the organisation's objectives and the effectiveness of the management of principal risks.
- The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and any related reporting and self-certification
- The policies and procedures for all work related to fraud as required by NHS Protect
- The work of Internal Audit, External Audit, local Counter Fraud Specialists and other assurance functions. It will also seek reports and assurances from directors and managers as appropriate
- The development, monitoring and review of the Trust's Board Assurance Framework
- The committees relationships with other key Committees to ensure triangulation of issues relating to risk management and clinical and quality issues

Internal Audit

Ensuring an effective Internal Audit function that meets the Public Sector Internal Audit Standards and provides independent assurance to the Audit Committee, Chief Executive and Board of Directors. This will be achieved by:

- Consideration of the provision of the Internal Audit function and the costs involved
- Review and approval of the Internal Audit Plan, ensuring that this is consistent with the audit needs of the organisation as identified in the Board Assurance Framework

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- Consideration of the major findings of Internal Audit work and ensuring co-ordination between the Internal and External Auditors
- Ensuring that the function is adequately resourced and has appropriate standing within the organisation
- Monitoring the effectiveness of internal audit and carrying out an annual review.

Counter Fraud

Ensuring adequate arrangements are in place for countering fraud and reviewing the outcomes of counter fraud work. This will be achieved by:

- Consideration of the provision of the counter fraud function and the costs involved
- Review and approval of the counter fraud strategy, annual work plan and the three year risk based local proactive work plan
- Consideration of the major findings of counter fraud proactive work, review of progress against plans and the annual report on arrangements
- Ensuring that the function is adequately resourced and has appropriate standing within the organisation
- Monitoring the effectiveness of the counter fraud function and carrying out an annual review, taking into account the outcome of the NHS Protect quality assessment of arrangements

External Audit

The Committee shall review and monitor the External Auditor's independence and objectivity and the effectiveness of the audit process. In particular review the work and findings of the external auditors and consider the implications and management responses to their work. This will be achieved by:

- Discussion and agreement with the External Auditors, before the audit commences, of the nature and scope of the audit as set out in the annual plan
- Discussion with the External Auditors of their evaluation of audit risks and assessment of the Trust and impact on the audit fee
- Reviewing all reports, including the reports to those charged with governance arrangements, including the annual management letter before submission to the Board of Directors and any work undertaken outside the annual audit plan, together with the appropriateness of management responses
- Supporting the Council of Governors with their duty to appoint, re-appoint and remove the External Auditors as stipulated by Monitor's Code of Governance
- Develop and implement a policy, with Council of Governors approval, that sets out the engagement of the External Auditors suppling non-audit services.  This must be aligned to relevant ethical guidance regarding the provision of non-audit services by the External Audit firm

Other Assurance Functions

Review the findings of other significant assurance functions, both internal and external to the organisation, and consider governance implications. These will include, but will not be limited to:

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- Reviews by the Department of Health Arm's Length Bodies or regulators/inspectors (e.g. CQC, NHSLA, etc.) and professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc)
- Review the work of other committees within the Trust at its Subsidiary Companies, whose work can provide relevant assurance to the Audit Committee's own areas of responsibility. In particular, this will include the committee with the remit for clinical governance, risk management and quality
- In reviewing the work of the aforementioned committees, and issues around clinical risk management, the Audit Committee will wish to satisfy itself on the assurance that can be gained from the clinical audit function

Management

Request and review reports, evidence and assurances from directors and managers on the overall arrangements for governance, risk management and internal control. Request specific reports from individual functions within the organisation.

Financial Reporting

Monitor the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's financial performance. The committee should also ensure that the systems for financial reporting to the Board of Directors, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board of Directors.
Review the Trust's internal financial controls and review the Annual Report and financial statements before submission to the Board of Directors, focusing particularly on:

- The wording in the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee
- Changes in, and compliance with, accounting policies, practices and estimation techniques
- Unadjusted miss-statements in the financial statements
- Significant judgements in preparation for financial statements
- Letter of representation
- Explanation for significant variances

Quality Accounts

Review the draft Quality Accounts before submission to the Board of Directors for approval, specifically commenting on:

- Compliance with the requirements of the NHS Reporting Manual
- The findings and conclusion of limited assurance report from the External Auditor
- The content of the Governors' report to Monitor and the Council of Governors
- Supporting controls e.g. data quality, if appropriate

Whistle blowing

The committee shall review the effectiveness of the arrangements in place for allowing staff to raise (in confidence) concerns about possible improprieties in financial, clinical or safety matters and ensure that such concerns are investigated proportionately and independently.

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| The Audit Committee Annual Report should describe how the committee has fulfilled its delegated responsibilities outlined in its Terms of Reference, and a summary following a review of its own effectiveness. It will also provide details of any significant issues that the committee considered in relation to the financial statements, key risks and how they were addressed along with other responsibilities specified in Monitor's Code of Governance. |
|---|
| **Monitoring** |
| The Committee will review its performance annually against its Terms of Reference and will report on the outcomes in its annual report to the Board. |
| **Authority** |
| The Committee independently reviews subjects within its Terms of Reference, primarily by receiving reports from the external auditor, internal auditor, local counter fraud specialist, management and any other appropriate assurances. |
| **Deliverables** |
| Assurance to the Board re:<br><br>Integrated Governance, Risk Management and Internal Control<br>The establishment and maintenance of an effective system of integrated governance, risk management and internal control across the organisation's activities (both clinical and non-clinical) that supports the achievement of the organisations objectives.<br><br>Internal Audit<br>An effective Internal Audit function that meets the Public Sector Internal Audit Standards and provides independent assurance to the Audit Committee, Chief Executive and Board of Directors.<br><br>Counter Fraud<br>That the organisation has adequate arrangements in place for countering fraud and shall review the outcomes of counter fraud work.<br><br>External Audit<br>External Auditor's independence and objectivity and the effectiveness of the audit process.<br><br>Other Assurance Functions<br>The findings of other significant assurance functions, both internal and external to the organisation and the implications for the governance of the organisation are considered. That the work of other Committees within the organisation provide relevant assurance to the Audit Committee's own areas of responsibility. The clinical audit functions effectiveness in terms of providing assurance regarding issues around clinical risk management.<br><br>Management<br>The overall arrangements for governance, risk management and internal control, having regard to evidence and assurances provided by directors and managers and specific reports from individual functions within the organisation (e.g. clinical audit). |

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Financial Reporting
The integrity of financial statements, systems for financial reporting, internal financial controls, the Annual Report and financial statements, including the wording of the Annual Governance Statement.

Annual Report and Accounts (including the Quality Account)
The draft Annual Report and Accounts (including the Quality Account) before submission to the Board of Directors for approval.

Whistle blowing
Effectiveness of the arrangements in place for allowing staff to raise (in confidence) concerns about possible improprieties in financial, clinical or safety matters and subsequent investigations.

Reporting
An Annual Report will be presented to the Board of Directors on its work in support of the Annual Governance Statement.

**Sub Groups**

There are no sub-groups of the Audit Committee

**Current review date: April 2021**
**Date of Board approval: July 2021**
**Date of previous review: April 2019**

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# Provider Collaborative & Lead Provider Committee (PCLP) Terms of Reference

**Committee Name: Provider Collaborative & Lead Provider Committee (PCLP)**

**Committee Type:** Standing sub-committee of Board of Directors

**Timing & Frequency:** 4 times a year, Wednesday of week prior to Board of Directors meeting

**Personal Assistant to Committee:** CQC Compliance Officer

**Reporting Arrangements:** Minutes and Report from Chair to Board of Directors

| **Membership:** | |
|---|---|
| **Chair:**<br>**Deputy Chair:** | Non-Executive Director<br>Non-Executive Director |
| **Members:** | Executive Director Commissioning and Quality Assurance<br>Executive Medical Director<br>Executive Nurse Director<br>Non-Executive Directors (including Chair and Deputy-Chair) |
| **In Attendance:** | Provider Collaborative Programme Managers x3<br>Head of Income & Contracting<br>Head of Commissioning & Quality Assurance<br>Group Head of Commissioning & Quality Assurance x4<br><br>Two Governor representatives<br>PA to Committee |
| **Quorum:** | Chair or Deputy Chair<br>2 Executive Director |
| **Deputies:** | Deputies Required for all members |

**Purpose:**
Provide assurance to the Board that:

- The Trust has effective systems and processes in place for the management of risks pertaining to Provider Collaborative and Lead Provider Models.
- The Trust has an effective management of Provider Collaborative and Lead Provider Contracts, including the sub-contracts of the lead provider contracts and any partnership agreements.
- The Trust complies with the law, best practice, governance and regulatory standards which are within the Committee's scope.

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**Scope:**

- Oversee and assure the successful delivery of Provider Collaborative and Lead Provider Models, including the sub-contracts of the lead provider contract. In accordance with the business cases and agreements reached by the Board of Directors.
- Each Subcommittee of the Board of Directors takes on the following role for Risks pertaining to their area of focus:
    - Review the management of the Corporate Risk Register and the Groups top risks.
    - Review the Board Assurance Framework to ensure that the Board of Directors receive assurances that effective controls are in place to manage corporate risks.
    - Report to the Board of Directors on any significant risk management and assurance issues.
- Gain assurance that the Trust's action plans in relation to compliance and legislative frameworks, which are within the scope of the Committee, are robust, completed and signed off.
- Gain assurance that each contract is managed and that there are effective systems and processes in place to ensure standards of care, compliance with relevant standards, quality, financial, risk and assurance arrangements.

- On behalf of the Board of Directors provide assurance that the financial and quality risks are articulated, evaluated and managed.

**Authority:**

To act on behalf of the Board to receive assurances that effective arrangements are in place to manage those areas within the Committee's scope across the organisation.

**Deliverables:**

Assurance to the Board re:

- The successful implementation and management of Provider Collaborative and Lead Provider models across the Trust.
- The Trust's action plans in relation to compliance and legislative frameworks are robust and completed/signed off, within the scope of this committee.
- The risks, that the Provider Collaborative and Lead Provider Committee are responsible for, are appropriately identified and effective controls are in place.

**Subgroups:**

- PCLP Quality Group
- PCLP Commission/Contracting Group
- PC Partnership Board minutes to be received by committee

**Current review date: March/April 2021**
**Date of Board approval: July 2021**
**Date of previous review: March/April 2021**

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**Remuneration Committee**
**Terms of Reference**

| **Committee Name:** | Remuneration Committee |
|---|---|
| **Committee Type:** | Statutory Sub Committee of the Trust Board |
| **Timing & Frequency:** | A minimum of one meeting to be held per year, however, meetings can be held more frequently as required by the Chair |
| **Committee Secretary:** | Deputy Director of Corporate Affairs and Communications |
| **Reporting Arrangements:** | Due to the confidential and sensitive nature of information concerning members of the Board of Directors, the Board shall receive a verbal summary of the committee meeting (rather than committee minutes). |
| **Membership** | |
| **Chair:** | Chairman of the Council of Governors and Board of Directors |
| **Deputy Chair:** | Vice-Chair |
| **Members:** | All Non-Executive Directors |
| **In Attendance:** | Chief Executive (advisory capacity only)<br>Executive Director of Workforce and OD (advisory capacity only)<br>Director of Corporate Affairs and Communications (advisory capacity only)<br>***NB:*** *The Chief Executive and other Executive Directors shall not be in attendance when their own remuneration, terms and conditions are discussed but may, at the discretion of the Committee attend to discuss the terms of other staff.* |
| **Quorum:** | Four members |
| **Deputies:** | The Vice-Chair to deputise for Chair but no deputies are permitted for Non-Executive Directors. |
| **Purpose** | |
| To decide and review the remuneration, terms and conditions of office of the Foundation Trust's Executive Directors and comply with the requirements of NHS England/ NHS Improvement (NHSE/I)/Monitor's Code of Governance and any other statutory requirements. | |
| **Governance, rules and behaviours** | |
| • Collective responsibility/decision making arbitrated by the Chair.<br>• Compliance with the Foundation Trust's Standing Orders (where applicable) and NHS E/I/Monitor's Code of Governance | |

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- All members are expected to attend - absenteeism is an exception
- Meetings can only be cancelled by the Chair

**Scope**

To decide and review the remuneration, terms and conditions of office of the Foundation Trust's Executive Directors and comply with the requirements of Monitor's Code of Governance and any other statutory requirements.

To review the arrangements for local pay Band 8C and above in accordance with national arrangements for such members of staff where appropriate.

To decide and review the terms and conditions of office for the Directors of NTW Solutions.

**Authority**

Decision making in line with the delegated authority outlined in these terms of reference.

**Deliverables**

Decide upon, after taking appropriate advice and considering benchmarking data, appropriate remuneration and terms of service for the Chief Executive, Executive Directors employed by the Trust and Directors of NTW Solutions including:

- All aspects of salary (including any performance related elements/bonuses),
- Provisions for other benefits including pensions and cars;
- Arrangements for termination of employment and other contractual terms.

In addition, the Remuneration Committee will review the arrangements for local pay Band 8C and above in accordance with national arrangements for such members of staff where appropriate.

Ensure that remuneration and terms of service of Executive Directors takes into account their individual contribution to the Trust, having proper regard to the Trusts circumstances and performance and to the provisions of any national arrangements for such members and staff where appropriate.

Advise on and oversee appropriate contractual arrangements for such staff including the proper calculation and scrutiny of termination payments taking account of national guidance.

Receive a report on the outcomes of the appraisals for the Executive Directors from the Chief Executive.

Ensure compliance with Monitor's Code of Governance by taking the lead on behalf of the Board of Directors on:

- The Board of Directors shall not agree to a full time Executive Director taking one or more Non-Executive directorship of an NHS Foundation Trust or any

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other organisation of comparable size and complexity, nor the chairmanship of such an organisation.

- The Remuneration Committee should not agree to an Executive Director member of the Board leaving the employment of an NHS Foundation Trust, except in accordance with the Terms of their contract of employment, including but not limited to service of their full notice period and/or material reductions in their time commitment to the role, without the Board first having completed and approved a full risk assessment.

Ensure compliance with Monitor's Code of Governance relating to the appointment of Executive Directors and the appointment and removal of the Chief Executive.

- The Chairman and other Non-Executive Directors and (except in the case of the appointment of a Chief Executive) the Chief Executive, are responsible for deciding the appointment of Executive Directors, i.e. all Executive Directors should be appointed by a committee of the Chief Executive, Chairman and Non-Executive Directors.

- It is for the Non-Executive Directors (including the Chairman) to appoint and remove the Chief Executive. The appointment of a Chief Executive requires the approval of the Council of Governors.

- The roles of the Chairman and Chief Executive must not be undertaken by the same individual.

Ensure compliance with the requirements of "NHs Employers: Guidance for employers within the NHS on the process for making severance payments".

- Prior to receiving agreement to make a special severance payment from Monitor and before presenting a paper to the HM Treasury for approval, the Trust must follow the steps outlined in the guidance and be satisfied that termination of the employees employment, together with making a severance payment, is in the best interests of the employer and represents value for money. The Remuneration Committee should consider the proposal which should contain a Business Case for the severance payment.

- The Remuneration Committee's role is to:

  - Satisfy itself that it has the relevant information before it, to make a decision.
  - Conscientiously discuss and assess the merits of the case.
  - Consider the payment or payment range being proposed and address whether it is appropriate taking into account the issues set out under initial considerations. The Committee should only approve such sum or range which it considers value for money, the best use of public funds and in the public interest.
  - Keep a written record summarising its decision (remembering that such a document could potentially be subject to public scrutiny in various ways, for example by the Public Accounts Committee.

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| **Sub Groups** |
| --- |
| No Sub Groups |
| **Links to other sub-committees/forums** |
| Reports directly to the Board of Directors |
| **Current review date: June 2021**<br>**Date of Board approval: July 2021**<br>**Date of previous review: June 2019** |

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# CEDAR Programme Board
# Terms of Reference

**Meeting Name:** CEDAR Programme Board

**Meeting Type:** Programme Board reporting to the Board of Directors

**Timing and Frequency:** Monthly

**Personal Assistant to Committee:** CEDAR Programme Support Officer

**Reporting Arrangements:** Reports to the Board of Directors

**Membership:**

| | |
|---|---|
| **Chair:**<br>**Deputy Chair:** | Non-Executive Director<br>Executive Director of Finance and Deputy CEO (SRO) |
| **Members:** | CEDAR Programme Director<br>CEDAR Programme Consultant<br>CEDAR Programme Support Officer (Minutes)<br>Managing Director NTW Solutions<br>Director of Estates and Facilities<br>Head of Capital Development and Planning Project Manager<br>Senior Capital Projects Officer<br>Chief Operating Officer<br>Deputy Chief Operating Officer<br>Group Director x 3 (North, North Cumbria and Central)<br>Deputy Director of Workforce and Organisational Development<br>Deputy Director of Finance and Business Development<br>SRM Project Leader (Post agreement of GMP) |
| **In receipt of the papers:** | Chief Nurse<br>CEDAR Programme Consultant Clinical<br>Staff Side Lead<br>Mental Health Lead, NHS England and NHS Improvement<br>Director of Corporate Affairs and Communications /Company Secretary |
| **Quorum:** | Chair or Deputy Chair<br>2 x Group representatives |
| **Deputies:** | Deputies required for all members wherever possible |

**Purpose:**

To develop, oversee and manage the CNTW “major development” capital schemes in conjunction with NHS England New Models of Care Programmes, NHS England National Reviews, the Newcastle & Gateshead Delivering Together

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Programme and any other external stakeholder initiatives or consultations that may relate to the capital schemes in scope.

The Programme Board will develop and monitor an overall programme plan which will incorporate appropriate timescales and milestones. The overarching core focus will be the ICS funding bid, planning and construction of the Secure Integrated sites at Northgate and Ferndene, along with the adult inpatient beds at Bamburgh Unit, St Nicholas Hospital.

**Scope:**

The schemes included in the scope of the programme are:

- The development of an integrated adult mental health and learning disability secure services centre of excellence at Northgate Hospital, Morpeth, Northumberland
- The re-provision of Newcastle and Gateshead adult inpatient services to St Nicholas Hospital, Newcastle
- The re-provision of Children and Young People's (CYPS) medium secure inpatient services to Ferndene, Prudhoe, Northumberland.

All three major developments are linked to wider national and regional care model initiatives:

- NHS England New Care Models for Adult Secure Services
- Transforming Care for people with a Learning Disability
- Newcastle and Gateshead Deciding Together, Delivering Together Programme
- NHS England National CYPS Medium Secure Services review.

The primary focus is:

- New integrated medium secure facility for adults, six wards at Northgate Hospital
- Low secure wards, utilising existing Northgate Hospital buildings
- Adult acute mental health services in reconfigured Bamburgh and Bede Units at St Nicholas Hospital, Newcastle
- New integrated CYPS facility at Ferndene (medium secure, low secure, PICU and general admissions)
- Vacation of Hadrian Clinic, Campus for Ageing and Vitality site, Newcastle
- Disposal of surplus land at Northgate Hospital to create new homes and provide a contribution towards the funding of this programme.

**Authority:**

To act on behalf of the Board to receive assurances that effective arrangements are in place to manage those areas within the Programme Board's scope across the organisation, and to have delegated decision making authority with regards to achieving programme objectives.

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**Deliverables:**

The delivery of high standard care facilities for patients, carers and staff that provide healing environments to support a wide range of treatment strategies and stimulate recovery by:

- Making the best use of all available resources, by implementing affordable, sustainable solutions, including where appropriate disposal and acquisition of land assets
- Optimising patient, carer and staff experiences in the built form and surrounding environment
- Achieving full compliance with national guidance and standards concerning the built form
- Supporting and enhancing integrated patient pathways that align to wider care model developments and commissioning intentions

CEDAR will support the development of proposals in accordance with the approved business cases for all of the in-patient schemes within scope, and support the Design Team and Operations Teams in planning and operationalising the schemes to fruition.

**Sub Groups:**

- Core Programme Team
- Other specific programme specific sub-groups will be formed as and when, in response to programme needs and timescales.

**Current review date: May 2021**
**Date of Board approval: July 2021**
**Date of previous review: May 2019**

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**Charitable Funds Committee**
**Terms of Reference**

| **Committee Name:** | Charitable Funds Committee |
|---|---|
| **Committee Type:** | Statutory Sub Committee of the Corporate Trustee *(CNTW Board of Directors)* |
| **Timing & Frequency:** | Meetings will be held quarterly, however meetings can be held more frequently as required by the Chair |
| **Committee Secretary:** | Chief Executive's Office |
| **Reporting Arrangements:** | The Committee will report into the Corporate Trustee on a quarterly basis. |

| **Membership** | |
|---|---|
| **Chair:** | Les Boobis, Non-Executive Director |
| **Deputy Chair:** | Alexis Cleveland, Non-Executive Director |
| **Members:** | James Duncan, Deputy Chief Executive and Executive Director of Finance<br>Tracey Sopp, Director of Finance and Deputy Managing Director, NTW Solutions Ltd<br>Gary O'Hare, Executive Director of Nursing and Chief Operating Officer<br>Lisa Quinn, Executive Director of Commissioning and Quality Assurance<br>Ailsa Miller, Patients Finance & Cashiers Manager<br>Shaun Dixon, Head of Accounting and Processing<br>Debbie Henderson, Deputy Director of Communications and Corporate Affairs<br>Adele, Joicey, Head of Communications<br>Fiona Grant, Lead Governor/Service User Governor |
| **In Attendance:** | Other Trust representatives may be invited to attend at the request of the Chair |
| **Quorum:** | Four members to include:<br>- At least one Non-Executive Director (including the Chair);<br>- At least one Executive Director<br><br>Decision will be made by a majority vote. In circumstances where the vote is tied, the Chair of the meeting will have a second and casting vote. |
| **Deputies:** | The Vice-Chair to deputise for Trust Chair but no deputies are permitted for Non-Executive Directors. |

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| **Purpose** |
|---|
| Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust Charity is registered with the Charity Commission with Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust as the Corporate Trustee (as a unitary Board of Directors).<br><br>The aim of the Charitable Funds Committee is to undertake the routine management of the Charity, in accordance with the Trust's Scheme of Delegation, and to give additional assurance to the Corporate Trustee that the Trust's charitable activities are within the law and regulations set by the Charity Commission for England and Wales. It does not remove from the Corporate Trustee the overall responsibility for stewardship of Charitable Funds but provides a forum for a more detailed consideration and management of all charitable activity within the Trust. |
| **Governance, rules and behaviours** |
| • Collective responsibility/decision making arbitrated by the Chair.<br>• Compliance with the Trust's Scheme of Delegation and the requirements of the Charity Commission<br>• All members are expected to attend - absenteeism is an exception<br>• Meetings can only be cancelled by the Chair<br>• If all members agree, meetings may be held by telephone conference call or video skype (in exceptional circumstances only) |
| **Scope and duties** |
| Specific duties of the Charitable Funds Committee include:<br><br>• The day to day management of the Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust Charity (CNTW Charity) on behalf of the Corporate Trustee;<br><br>• Ensure the Charity complies with current legislation and regulation;<br><br>• Review new legislation, regulation and guidance and its impact on the Charity, making recommendations to the Corporate Trustee if changes in practice or policy is required;<br><br>• Review and approve any returns and information required to be submitted by legislation to the regulator, the Department of Health or the Charity Commission;<br><br>• Oversee the implementation, update and maintenance of procedures and policies required to ensure the efficient and effective operation of the Charity and in accordance with Charity Commission guidance;<br><br>• Develop an overarching Charity Strategy and supporting plans including setting spending targets, budgets, fundraising and investment, ensuring plans are in line with the objectives of the Charity;<br><br>• Seek assurance that investments are in compliance with the Charity's investment policy and make recommendations to the Corporate Trustee if changes are proposed; |

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- Determine the management arrangements for the Charity's investments and review performance regularly against agreed benchmarks;
- Review the policy for expenditure of funds including the use of investment gains;
- To approve all individual charitable fund expenditure and proposals for expenditure. The Committee has authority to seek approval via email with ratification of all decisions at the next meeting;
- Review individual fund balances within the overall charitable funds on a regular basis, seek expenditure plans from individual fund holders and oversee expenditure against the charitable funds in accordance with the Scheme of Delegation;
- Agree guidance and procedures for the fund holders and ensure they are publicised to those who need to be aware of them;
- Receive and review the Annual Accounts and Annual Reports for the Charity and submit them to the Corporate Trustee for approval;
- Review and act on any internal and/or external audit recommendations;
- Encourage a culture of fund raising within the Trust, raise the profile of the Charity and monitor progress of the Fundraising Strategy;
- Receive regular reports on the performance of fundraising activities for the Charity;
- Approve the policy and standards around promotion of the Charity on behalf of the Corporate Trustee to ensure that material does not endanger the Charity's reputation.

**Authority**

The Committee is authorised by the Corporate Trustee. Decision making is in line with the delegated authority outlined in these terms of reference.

In line with the Scheme of Delegation, any requests for disbursement of monies from general funds, and disbursement from individual funds of more than £1000 will require approval by Committee members. Approval can be sought via email. Approval can only be deemed valid via agreement of the majority of Committee members (including a minimum of one Non-Executive Director and one Executive Director).

The Patient Finance and Cashiers Manager may in exceptional circumstances approved disbursements of monies up to £500 from general funds. In such instances, the Committee should be contacted in advance of such disbursement.

The Committee shall have the authority to seek external legal advice or other independent professional advice on request by the Chair.

The Committee can establish and approve terms of reference for such sub-committees, groups or task and finish groups as it believes are necessary to fulfil its terms of reference.

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| **Reporting** |
| --- |
| The minutes of each meeting, as agreed with the Chair, will be submitted to the Corporate Trustee. Where a significant risk emerges either through a report or through discussion at the meeting, this will be reported to the Corporate Trustee by the Committee Chair. |
| **Links to other sub-committees/forums** |
| Reports directly to the Corporate Trustee |
| **Review** |
| **Date of current review: June 2021**<br>**Date of Board approval: July 2021**<br>**Date of previous review: March 2020** |

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# Corporate Decisions Team
# Terms of Reference

| |
|---|
| **Committee/Group Name:** Corporate Decisions Team (CDT)<br><br>**Committee/Group Type:** Decision Making<br><br>**Timing & Frequency:** Meetings are held monthly<br><br>**Personal Assistant to Committee/Group:** Administration Officer, Chief Executive's Office<br><br>**Reporting Arrangements:** Minutes to Trust Board |

| **Membership:** | |
|---|---|
| **Chair:** | Chief Executive |
| **Deputy Chair:** | Nominated Executive Director |
| **Members:** | • Executive Directors<br>• Locality Group Directors (x 12)<br>• Group Nurse Director of Safer Care<br>• Group Medical Director of Safer Care<br>• Director of Research and Development, Innovation and Clinical Effectiveness<br>• Managing Director of NTW Solutions Limited<br>• Clinical Director of AHP and Psychological Services<br>• Chief Pharmacist<br>• Director of Medical Education*<br>• Director of Informatics<br>• Chief Clinical Information Officer*<br>• Director of Transformation, Trust Innovations<br>• Director of Communications and Corporate Affairs |
| **In Attendance:** | *Full members but open to attend as Agenda dictates |
| **Quorum:** | Chair, Deputy Chair, two Executive Directors, one representative from each locality group |
| **Deputies:** | By agreement with the meeting Chair |

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**Purpose:**

The Corporate Decisions Team is responsible for:

- Supporting the Board of Directors in the development of the Trust's strategy, supporting strategies and operational plans.
- The co-ordination, oversight and delivery of the Trust's strategy, supporting strategies and operational plans and for managing the risks associated with the delivery of these through the implementation of the Trust's risk and control framework – monitored through CDT- Risk with minutes to CDT.
- Making decisions according to the authority delegated to the Corporate Decisions Team, as agreed within the Decision-Making Framework, or where appropriate making recommendations to the Board of Directors in line with the Trust's vision, values and strategic ambitions.
- Ensuring that effective arrangements are in place to develop and manage partnerships and stakeholder relationships and engagement.
- Ensuring that the needs of service users and carers are paramount and inform all discussions and decisions of the CDT.
- Sharing good practice, promoting improvement and ensuring CDT members are aware of policy, national guidance and local developments.
- To oversee and secure the Trust's influence and involvement at neighbourhood, Local Authority, Integrated Care Partnership (ICP) and Integrated Care System (ICS) level working in the best interests of our service users and carers, and local people more generally.

**Authority:**

To act on behalf of the Board making decisions, according to the authority delegated within the Decision-Making Framework, or where appropriate to recommend decisions to the Board of Directors in line with the Trust's vision, values and strategic ambitions.

**Deliverables:**

**Strategy, Planning and Partnerships**

- Collective understanding of strategic challenges, opportunities and agreement on actions.
- Development of draft Operational Plans, including Financial, Workforce and Estates and Facilities Plans, on behalf of the Board of Directors, with recommendations for consideration by the Board of Directors - monitored through CDT- Business with minutes to CDT.
- Horizon scanning and intelligence, including national/local policy developments and operational/strategic partnerships, their impact on the Trust and its services, strategic and operational risks and mitigations.

**Standards and Assurance**

- Oversight of the delivery of the Trust's Strategy, key supporting strategies, operational plans and financial, workforce and estates and facilities plans,

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including action plans, risks and mitigation, reporting to the Board as appropriate – monitored through formal sub groups of CDT with minutes received routinely

- Oversight of Trust standards and assurance (including patient safety, integrated commissioning and assurance reports and service user and staff experience), action plans, risks and mitigations, reporting to the Board as appropriate - monitored through CDT- Quality with minutes to CDT.

**Communication, Engagement and Involvement**

- Agreement regarding key messages, communication, involvement and engagement programmes including those with staff (e.g. Speak Easy) and key stakeholders.

**Decision Making**

- Decision making, in line with the authority delegated to the Corporate Decisions Team within the Decision Making Framework, where appropriate making recommendations to the Board of Directors in respect of decisions reserved to the Board.

**Monthly Development Session**

- Each meeting will set aside time to focus on a key development, policy change or other key topic area ensuring messages/improvement activity and good practice is shared (this time at each meeting is open to wider Business Delivery Group members)

**Sub Groups:**
Business Delivery Group
Business Delivery Group - Safety
CDT - Quality
CDT - Workforce
CDT - Risk
CDT - Business
CDT - Climate
CDT - Digital
CQC Quality Compliance Group

**Current Review Date: May 2021**
**Date of Board Approval: July 2021**
**Date of Previous Review: July 2019**

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**Report to the Board of Directors**
**7 July 2021**

| **Title of report** | **Amendment to Scheme of Reservation and Delegation** |
|---|---|
| **Report author(s)** | **Sarah Jones, Director of Legal & Commercial Services, NTW Solutions Limited** |
| **Executive Lead (if different from above)** | **James Duncan, Deputy CEO & Executive Director of Finance** |

| **Strategic ambitions this paper supports (please check the appropriate box)** | | | |
|---|---|---|---|
| Work with service users and carers to provide excellent care and health and wellbeing | | Work together to promote prevention, early intervention and resilience | |
| To achieve "no health without mental health" and "joined up" services | | Sustainable mental health and disability services delivering real value | x |
| To be a centre of excellence for mental health and disability | | The Trust to be regarded as a great place to work | x |

| **Board Sub-committee meetings where this item has been considered (specify date)** | |
|---|---|
| Quality and Performance | |
| Audit | |
| Mental Health Legislation | |
| Remuneration Committee | |
| Resource and Business Assurance | |
| Charitable Funds Committee | |
| CEDAR Programme Board | |
| Other/external (please specify) | |

| **Management Group meetings where this item has been considered (specify date)** | |
|---|---|
| Executive Team | x |
| Corporate Decisions Team (CDT) | |
| CDT – Quality | |
| CDT – Business | |
| CDT – Workforce | |
| CDT – Climate | |
| CDT – Risk | |
| Business Delivery Group (BDG) | |

| **Does the report impact on any of the following areas *(please check the box and provide detail in the body of the report)*** | | | |
|---|---|---|---|
| Equality, diversity and or disability | | Reputational | |
| Workforce | | Environmental | |
| Financial/value for money | x | Estates and facilities | |
| Commercial | | Compliance/Regulatory | x |
| Quality, safety, experience and effectiveness | | Service user, carer and stakeholder involvement | |

| **Board Assurance Framework/Corporate Risk Register risks this paper relates to** |
|---|
| Corporate governance |

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**Report Title – Amendment to Scheme of Reservation & Delegation**
**Trust Board Meeting**
**7 July 2021**

## 1. Executive Summary

The Board of Directors of the Trust approved amendments to the Trust's Standing Financial Instructions (SFIs) and Scheme of Reservation and Delegation at the February 2021 Board Meeting.

Under the Scheme of Reservation and Delegation the Board of Directors have reserved to themselves as a board the power to approve documents that amount to guidance that is regarded as key to the corporate governance framework. The Scheme of Reservation and Delegation falls within this category and there is therefore a requirement for the Board of Directors to approve any proposed amendment to this document.

Following the approval of the Scheme of Reservation and Delegation in February 2021, the Director of Commissioning and Quality Assurance has been required to approve contracts between the Trust and other healthcare providers, and to authorise related payments that are in excess of her limits as currently set out in the Scheme of Reservation and Delegation. This is as a result of Cumbria, Northumberland, Tyne & Wear NHSFT becoming a Lead Provider for three Specialised Services, namely Secure, CAMHS and Adult Eating Disorders on 1st April 2021. It is therefore proposed that the Scheme of Reservation and Delegation is updated to reflect this position.

The proposed amendments are as follows:-

- It is proposed that for the purposes of approving contracts and related payments to other healthcare providers the level of expenditure for the Director of Commissioning and Quality Assurance is increased from £500,000 to £4,000,000 per instance.

  The SFIs already delegate overall responsibility for contracts between the Trust and other healthcare providers to the Director of Commissioning and Quality Assurance so do not require amendment.

- It is also proposed that members of the Director of Commissioning and Quality Assurance's wider team have increased authorisation limits so as to enable them to authorise payments under existing contracts. It is proposed that the relevant limits for the Heads of Income and Contracted Services are increased from £10,000 to £50,000 per instance.

Furthermore, following the adoption of the revised Scheme of Reservation and Delegation in February 2021, the former Executive Directorate of Nursing and Operations has become two separate directorates. We have taken this opportunity to vary to the document to reflect this structural change and other changes to colleagues' job titles.

Finally, further minor amendments are required to the Scheme of Reservation and Delegation due to the proposed introduction of the Trust's Investment Policy, (which is to be submitted to the Board of Directors for approval at a later meeting).

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## 2. Risks and mitigations associated with the report

If action is not taken to update the Scheme of Reservation and Delegation the governance document will not align with necessary operational practices.

## 3. Recommendation/summary

The Board of Directors is requested to consider and approve the proposed amendments to the Scheme of Reservation and Delegation.

**Sarah Jones**
**Director of Legal & Commercial Services**
1 July 2021

**James Duncan**
**Deputy CEO & Director of Finance**

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