# TRUST BOARD MEETING

**Thursday, 31st March 2016**

**Time: 12.00pm-2.00pm**

**Meeting room 10, Tower Building, Level -1**

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*Items that require advance notification of questions

End of the public session of the Board meeting

**Date and Time of the Next Trust Board Meeting:**

26th May 2016–at 11am, Meeting room 10
A meeting in public of the Board of the North Middlesex University Hospital NHS Trust was held on Thursday 28th January 2016 in Meeting room 10, Tower Block, Level -1, North Middlesex University Hospital at 11.28am

Present:
John Carrier Chairman
Catherine Dugmore Non-Executive Director
John Simons Non-Executive Director
Graham Coles Non-Executive Director
Dalwardin Babu Non-Executive Director
Robert Sumerling Non-Executive Director Designate
Julie Lowe Chief Executive
Martin Armstrong Director of Finance
Helen Rushworth* Director of Human Resources
Michael Marrinan Interim Medical Director
Paul Reeves Director of Nursing and Midwifery
Richard Gourlay Director of Operations

In Attendance:
Molly Clark Board Secretary
Stephanie Marfo Trust Board secretarial assistant (minutes)

*Non-voting Director

TB16/01 WELCOME

The Chairman welcomed all present and the members of the public, Mary Murphy, Loroly Jones, UCL. John James, Healthwatch, Enfield, Bryan Waterman, who had been a member of a number of Patient Experience groups within the Trust and Donald Smith, a member of the public and long term Board meeting attendee.

TB16/02 APOLOGIES FOR ABSENCE

Apologies were received from John Hurst, Non-Executive Director

TB16/03 DECLARATION OF INTEREST

There were no declarations of interest pertaining to agenda items for discussion.

TB16/04 MINUTES OF THE MEETING HELD ON 26TH NOVEMBER 2015

The interim Medical Director asked for the following changes to be made to the minutes under:

TB15/133 MORTALITY REPORT UPDATE

- Refer to ‘blip’ rather than ‘bleep’
- Refer to the low efficacy of the ‘vaccine’ rather than the ‘vaccination.’
- Refer to the ‘nationwide’ rather than the ‘trust wide’ deaths.

Subject to the above the minutes were approved and agreed as a as a true and accurate record of the meeting.
TB16/05  MATTERS ARISING REPORT

The Board reviewed the matters arising document. The Director of Nursing stated that the previous patient story (pertaining to the sickle patient) had been shown in the recent Patient Experience Group meeting and that he had attended the last Sickle Cell Group meeting and discussed some of the issues raised. The patient concerned had also been spoken with and was now very happy with the care received at the Trust.

It was confirmed all matters were as stated on the report or had been completed/referred to other Committees and there were no further comments.

The Board noted the Matters Arising Report.

TB16/06  STAFF STORY VIDEO

The Board watched a staff story video which had asked four employees pre-determined questions. The employees were: Yasmina Begun A&E apprentice, Michelle Scripps Staff nurse, Nicola Wilson, Speciality Registrar Geriatric Medicine, Mary Murphy Physiotherapy team leader.

After watching the video Dalwardin Babu stated he was impressed that the stories had been honest and open. He noted the relatively positive stories and thanked Mary for going above and beyond her duties whilst caring for elderly patients.

Dalwardin Babu suggested that the issues mentioned by Nicola about cohesion and partnership between the wards be picked up.

Catherine Dugmore, Non Executive Director confirmed agreement, adding it was important that comments made by Mary and Nicola about the suitability of the wards to be taken forward.

Action: Director of Operations

Nicola had also raised concerns around cultural issues she had found challenging whilst working at the Trust and charged the HR Department to listen to the feedback available from this cohort. Catherine Dugmore suggested that this was a challenge that the HR department should take up.

The Director of HR stated that she had been struck by the diverging views on the Trust values, demonstrated by Nicola and Mary, sentiments echoed by other Board members present. She noted the differences in their assignment types; Nicola was on rotation whereas Mary was a permanent substantive member of staff. As a result the Assistant Director Organisational Development had acquired a timeslot within the Doctors induction to deliver training on the values and to encourage staff engagement.

Robert Sumerling, Non Executive Director stated that the video warranted a certain degree of celebration. He suggested that further consideration to the comments made by Nicola on the full use of staff skills be considered.

The interim Medical Director echoed the sentiments of the Director of the HR when contrasting the stories. Many of the staff who were substantive and local had given positive feedback, whereas the staff member on rotation had been less positive, although she had had a better
experience at this Trust than in others. Executives were now attending Doctor’s induction and were encouraging engagement at a Board level.

John Simons, Non Executive Director suggested that this type of feedback could prove more useful than other forms and should be used more regularly, adding it was important to capitalise on forums that worked effectively, given the level of uptake on staff feedback.

The Chairman was assured that many of the participants were local, which was a means of demonstrating that the Trust was fulfilling strategic objective 3- to be the employer of choice in the local area. The permanent staff had all commented on personal professional development, which also encouraged the Chairman. He agreed that comments around the suitability of the Care of the elderly wards should be followed up; this was something he too had observed during a ward visit. He thanked the participants, the HR Department and the video organisers for taking part.

The Board noted the Staff Story.

TB16/07  CHAIRMAN’S REPORT

The Chairman provided the Board with an overview of key activities since the previous Board meeting. He and the Chief Executive had met with the Chair of Healthwatch, Enfield, David Burrowes MP, and Roger Klein to discuss Equality and Diversity studies. He had also attended the HFMA annual conference, where he heard talks on the main issues and from the NHS Directors of policy (he had copies of the documents discussed to provide to the Non Executive Directors). The Chairman had met Michael Fox, the Chair of Barnet, Enfield and Haringey Mental Health Trust and discussed commonalities. He had also met with Mr. Nambisan Vinny, who had discussed the formation of an ethics group for hospital. The Chairman had also met Lord Carter to discuss his take on efficiency. Finally he and the Chief Executive would be meeting with the TDA in the coming weeks.

The Board noted the Chairman’s report.

TB16/08  CHIEF EXECUTIVE’S REPORT

The Chief Executive outlined the key external issues facing the local health economy. All local health economies had been asked to draft a Strategic Transformation Plan by June 2016, which was based on nine ‘Must dos’. The Plan would need to be considered in the 2016/17 planning.

The issues facing the Trust were A&E performance; the Trust continued to experience difficulty in maintaining the 4 hour access target. The Junior Doctors strike had taken place on 12th January 2016 (Christmas day hours) a further strike planned for later that month had been suspended. However a full strike was planned for 10th February 2016 which would seriously impact the provider service. NHS Employers and the British Medical Association were in talks with ACAS on the matter.

The Chief Executive stated the Chaplin, Dominic Fenton would be leaving his position in the Trust after 14 years. She thanked him for his contribution to the Trust and wished him all the best. Following a query from Robert Sumerling, the Board were informed a tea party would be held on 26th February 2016 in his honour.
The Board noted the Chief Executive’s Report

**TB16/09 INTEGRATED PERFORMANCE REPORT**

The Director of Finance provided the Board with the Trust’s Month 9 Integrated performance report (IPR). The key issues and actions were:

- A&E access performance deterioration in December 2015.

- FFT response rates for A&E dropped in December after an improvement in November 2015.

- Cancer waiting times were below target, December figures were going to be validated, but implied an improvement.

- Diagnostic performance was below the required target; the Trust had set up a mobile Vanguard unit to assist with the additional activity and were considering accessing other independent service providers to ensure delivery of targets.

- Mortality rates had improved and would be explored further in the meeting.

- The Trust’s year to date deficit was £4.7m at month 7 which was significantly adverse to the stretch target plan as set by the TDA.

- SLA contract fines associated with non delivery of national access targets totalled £1.6m at month 9 and continued to escalate. The Director of Finance predicted fines of £0.5m in December 2016.

- QIPP delivery was behind plan

- Temporary staffing costs for the month escalated significantly, a trend which had continued into January 2016.

Catherine Dugmore queried how the Trust would get the right leadership team on board, given the challenging recruiting environment. It was suggested that this post would be ideal for a clinical research fellow or a senior registrar looking for leadership development. At night the Trust had put additional physicians support and Medical registrars to help support decision making at night.

Bed availability continued to challenge the Trust, blockages were being expedited and but more support was being given to bed meetings which would all assist patient flow. Daily Silver meetings were also being held in which patient flow and bed availability was monitored. Executives were also attending ward rounds on a rota basis to help them better understand the issues contributing to patient flow.

John Simons asked for confirmation that A&E was running safely. The Director of Operations confirmed that the Trust was looking at the incidents and that they reviewed performance behaviours and patient care.

The Director of Nursing confirmed that there had been no change in the volume of A&E incidents reported over the period in which the performance levels were materially below the standard, in comparison to the same time the prior year. The Board were informed incidents
received were around the length of time spent waiting in A&E. Barring one incident there was no indication that the Trust’s current performance was causing patients any harm.

The Director of Nursing confirmed that hourly rounding had been taking place, he and his team conducted spot checks to check compliance.

The Executive Nurse and Director of Quality, Haringey CCG had conducted spot checks onsite and confirmed that hourly rounding was taking place. Weekly governance meetings were being held to consider these types of issues and to date no major concerns had been raised. The Executives frequently visited the area and met with the Matrons. The Trust was in receipt of both hard and soft intelligence on the area and was therefore aware of many of the issues on the ground. The variety of complaints received in A&E was highlighted by the Director of Nursing (some were relatively simple in nature), response time to complaints was slower than average. The Trust was considering whether to add additional support to improve response times and to allow clinicians to focus on care.

Robert Sumerling informed the Board he had met with the Head of Legal and Complaints; they had observed the considerable improvements in complaint acknowledgement and substantive complaint response times. He stated he was assured by the process in which the all complaint letters were personally revised and signed off by the Chief Executive.

Graham Coles, Non Executive Director observed a steady improvement on KPIs, but stated that ambulance waiting times had deteriorated; he asked the current status of relations with the London Ambulance Service. He was informed that it was working well, although there were challenges. Patient hand overs at times were challenging given the number of cubicles on site. The Trust had also been in receipt of a few ambulances from the East of England service which had strained the system further. The Director of Operations stated that the expansion of the rapid assessment treatment area (from one to three beds) would better aid patient flow. However, given the winter pressures works would not be feasible and would be conducted in the new financial year.

In response to a query around sickness absence, the Board were informed that Tavistock were supporting staff in A&E and that sickness absence continued to be monitored. It was mentioned that Trust sickness rates were still below the national average.

The Director of HR stated that the Trust was also monitoring the increased use of bank and agency staff, on an almost daily basis. The Director of Nursing continued to sign off any requests for additional nursing staff. The focus on agency and bank staff usage was now around appropriate E rostering. An action plan on the matter was under the Director of Nursing and he was also attended staffing deployment meetings.

There were also weekly Executive led reviews considering the current recruitment trajectory. The Director of HR highlighted that recruitment rates were high, but below trajectory. Turnover was still high against the target set. Mandatory statutory training compliance had declined slightly. Weekly meetings occurred with the Education and Learning Centre to discuss these issues. She also confirmed that the vacancies in the Education and Learning centre had all been filled.

Appraisal rates were reviewed regularly and were currently behind target this month.

Catherine Dugmore asked for further information on the HR strategies, adding that she acknowledged that some of the benefits to these strategies would not be tangible. The prevalent strategies were the recruitment and retention strategy and the staff engagement strategy. The Director of HR was keen to separate the recruitment and retention themes and risk to better
address achievement of the Trust’s strategic objective three- ‘Employer of Choice.’ To date the Trust had not been successful in closing the retention gap; the continued inability to close this gap was considered an area of significant vulnerability by the Director of HR.

Despite the National Framework cap agency spend in the period exceeded previous years. The Director of HR explained that additional staff had been hired to meet the demand caused by extra beds in Emergency Ambulatory Care and the Vanguard unit. To meet the activity increase in December agency staff were used and controls previously in place had been lifted for the interim. It was suggested that further consideration be given to understand agency usage during this period.

*Action: Director of HR*

The Director of Finance raised his concerns around the increased agency usage following the introduction of the cap. He suggested that it was a systems and controls issue, which was difficult to monitor, but was necessary in terms of accountability and patient safety. The Director of Finance acknowledged that there were some difficult to recruit areas, but there were others which were currently nurse led. Consideration needed to be given as to whether this was cost efficient and appropriate.

Dalwardin Babu queried how the cap could be adhered to. There was some discussion around incentives to move staff from bank to permanent substantive contracts. The Director of Finance stated on a weekly basis data was submitted to the TDA with Trust breaches in the national framework cap. Implementation of the fines would get stricter with time. Therefore the Trust needed to review and consider how it would manage staff in the hard to recruit areas and the general efficiency of the service.

The current deficit was £4.7m, which as a significant divergence from the plan explained the Director of Finance and many of these issues had contributed to this position (A&E and diagnostic fines, QIPP low delivery), though some had been mitigated with non-recurrent funds identified.

In the area of recruitment the Director of Finance suggested that the impact of the schemes put in place had not as significant an impact as anticipated.

John Simons queried the productivity of staff, given the high level of bank/ agency staff usage against reduced activity (in A&E). The Director of Finance agreed that productivity was a concern and that current data green rated productivity, which meant that the information could not easily be triangulated. Nurse to patient ratios were above average, the disparity between this and the playbill was an issue it was hoped appropriate E rostering would address.

Cancer 62 day standard performance was challenging. However, compliance with target was tied in with Endoscopy and performance delays were expected into February/March. Patient pathway mapping was currently taking place to determine blockages in the system.

The Board noted the Integrated Performance report.

**TB16/10 BOARD ASSURANCE FRAMEWORK**

The Board Secretary presented the BAF, highlighting the top risks as highlighted in the cover report against strategic objectives. Most risks had already been discussed in the meeting as part of the Integrated Performance report. The changes to ratings were reported.
The score of RISK ID 1954- non-payment for SLA activity had been increased from 20 to 25 in the last Finance and Investment Committee meetings, as mentioned within the Finance and Investment Committee assurance report. The continued risk was an ongoing concern.

RISK ID 2413-Mandatory compliance and RISK ID 2997-Sustainability of mandatory training had been merged to make the risks posed consistent. The score remained at 20.

RISK ID 2790- Staff recruitment was to be separated to focus on the differing issues facing the Trust and had been scored at 15.

RISK ID 2791- Staff retention focused on the need to keep staff and had been scored at 20. The Board were reminded that risks under 15 would be removed from the BAF. The Board also noted the movement in risks highlighted within the report.

The Board received and noted the Board Assurance Framework and the movement in risk over the last two months.

The Director of Nursing presented the safe staffing report. The Board were informed that during December there was one area with less than 99% fill rate against a 1:8 nurse to patient ratio, and two clinical areas with fill rates below their planned levels, these were namely, T4 Surgical ward and the High dependency unit.

During December 2015 T4 Surgical Ward's fill rate was 89% against a 1:8 ratio due to unplanned absences and a reduced ability to fill bank and agency shifts, particularly in the Christmas period. The T4 ward manager and both the surgical deputy matron and emergency surgical practitioner worked clinically on the ward instead of working management days in order to maintain staffing levels on T4. The entire surgical nursing workforce was also flexed to support and cover T4 where required. An increase in informal complaints had been observed. However, the deterioration in patient experience had not resulted in a deterioration in patient safety, stated the Director of Nursing.

HGU staffing levels were determined by British Association of Critical Care Nurses, based on a ratio of 1 nurse to 2 HDU patients. The fill rate for planned hours based on this standard December was 95%. All HDU staff were currently in training to manage ICU patients; as a result staff were being rotated to receive said training, with ICU nurses. However, this flexing of staff was not reflected on the HDU rota.

A combined fill rate to explain the rotation had been provided within the papers and explained the planned fill rate across critical care complex was 104%.

Labour ward patient to staff ratio was 1:30. The ward currently had a vacancy rate of 11.7% and had recruited to 10 vacancies, five were in post and a further 3 would come into post within the month. The Board were assured that senior management meetings occurred daily to review the workload and consider where flexing of staff was necessary.

The Board were reminded of the data quality issues which had been highlighted to the Board in September 2015 regarding harms. Previously, the accuracy of each ward's return was
dependent on a matron review and sign off, which had lead to inaccurate data, there had also been varying view on definitions for each type of new harm (particularly VTEs). Training on these topics had been given to Ward Managers and Matrons. A safety thermometer improvement plan had been implemented and would be monitored and managed by the Associate Director of Corporate Governance.

The rate of harm was still below the required 95%. However, hospital acquired harm had dropped within the month.

Six hospital acquired C. difficile infections had been reported across the Trust within the month. This was a significant variation from the previous month. These infections were subject to root cause analysis investigations. The Director of Nursing reported that none of the six infections were attributable to staffing levels or lapses in care. As part of an audit recommendation the root cause analysis investigations had been discussed at the Infection Prevention Control meetings. In January 2016 there had been two hospital acquired C. difficile infections to date. However, the Trust did not expect to breach the target rate for hospital acquired C. difficile infections in the year.

The FFT responses in A&E and Outpatients were still lower than required. A new Matron had been appointed to Outpatients and was considering ways to improve FFT response rates. Inpatient response rates were currently good.

John Simons queried the Trust's ability to ‘flex’ staffing ratios between areas. The Director of Nursing then referred the Board to the proposal to increase the patient staff ratio on medical wards from 1:6 to 1:7 (safe staffing levels were currently 1:8). This proposal was a result of a review in the staffing levels/skill mix across the Trust as part of the Carter review. After considering the establishment the Director of Nursing was proposing these changes to support the achievement of the Trust's financial performance objectives and the delivering high quality care. The report also highlighted areas within the Trust where the establishment would not change. Before changes to the ratios could be implemented in Surgical wards, more work was needed. A skill mix review of the Surgical wards would occur in April 2016.

The proposed changes did not come without risk, stated the Director of Nursing, to assess this it was proposed to continue with the current format of the safe staffing report for Trust Board and Risk and Quality Committee which triangulated key ward level safety and patient experience information with staffing levels. To ensure that the Risk and Quality Committee continued to review the CLIP report which monitored incidents on a rolling year basis so that the impact of these changes on the number and types of incidents would be effectively scrutinise.

The development of a new Ward Quality Dashboard, which would provide detailed audit data reflecting a wide range of quality metrics across each ward. A further skill mix review in March 2016 would be conducted. As would the implementation of a twice daily safe staffing census by all wards and departments and the E-rostering software will be implemented to enable improved rostering across the Trust.

The plan had been discussed in some detail and as the element of risk was great it had been agreed to pilot these changes in Care of the Elderly and Tower wards to ensure that there was no adverse effect on care. The results would be brought back to the Trust in March 2016. Catherine Dugmore commended this approach which considered the impact on staff and patient
care; this was acknowledged by the Director of Nursing. The Chief Executive too acknowledged this and then highlighted the traditionally poor E rostering which had resulted in staff not being appropriately deployed. Correct deployment would enable the Trust to move to 1:7. Dalwardin Babu suggested that the amendments to staffing be quality impact assessed to consider the needs of staff who were often primary carers. The Director of Finance stated that the adjustments to the skill mix were within the national requirements and queried why a pilot was necessary. The Chief Executive suggested that this be considered outside of the meeting by the Executives.

**Action: Director of Nursing**

Dalwardin Babu queried whether the Trust was now using E rostering effectively, the Director of Nursing acknowledged that there had been issues, but training had been given and the Trust were trying to reclaim any unused hours. Rosters would continue to be scrutinized, but there was a present no certainty on the robustness of the rosters.

Graham Coles queried when the benefit of improved E rostering would be realised; it was suggested by April 2016. An upgrade to the current E rostering system would be implemented and consideration would need to be given on how to support staff during the implementation of the upgrade.

The Board noted the Safe staffing report and the Executives would consider the changes to the skill mix ratio outside of the meeting.

**TB16/12 WINTER PLAN**

The Director of Operations stated that the report clarified the spending of winter pressure funds received by the Trust. The appended presentation had been used in other settings and was for information following a request from Catherine Dugmore. Robert Sumerling queried whether the effect of winter pressures was still being felt within the Trust owing to a mild winter. The Chairman suggested that the effect of winter pressures was often felt in January as opposed to December. The Director of Operations confirmed that the effects were being felt. The Board noted the plan.

**TB16/13 MORTALITY REPORT UPDATE**

The Interim Medical Director presented the key highlights of the mortality report.

The report reflected the improving situation. The three alerts received had been fully invested and the CQC had accepted the Trusts findings and conclusion. The Interim Medical Director stated that the Trust had no more active mortality outliers.

The Board were then referred to the mortality rate indicators. The Interim Medical Director regarded the SHMI as an important index for historical information. The Trust was performing satisfactorily against this indicator, though the historic nature of this information was referred to. The HSMR rate highlighted the aforementioned blip. However, the monthly HSMR remained on or around the benchmark since May 2015, following a lengthy period since Aug 2014 of being significantly higher than the benchmark. He stated some time before rate would return to an
acceptable score. The Interim Medical Director had analysed the current data available and whilst some of the information stated that the Trust was an outlier, the trending overall was positive.

The Interim Medical Director confirmed that the Mortality review group had reviewed and discussed this information; the governance structure for mortality review was discussed briefly. The importance of regular review of current mortality indicators was emphasised, as in the past, the Trust had relied heavily upon historic information. The Interim Medical Director informed the Board of improved Datix reporting system. Consultants and junior doctors were now emailed for further information upon patient’s death and there was also a Datix mortality review form which was used for soft intelligence (gathering death expectancy). Wards with higher mortality expectancy such as care for the elderly, reviewed and discussed these forms weekly. Where mortality rates on current information was a concern these would be flagged. The Mortality meetings, now also reviewed morbidity and audits were carried out and reviewed on a monthly basis within the meetings. Deep dives of mortality rates in each CBU would take place on a bi-annual basis.

New reports were available via CHKS which would identify trends and would pre-empt mortality outlier alerts. The reports would be reviewed by the Risk and Quality Committee. The REMI would begin immediately; the next Mortality and Monitoring committee could take place in March 2016.

The Chairman thanked the Interim Medical Director for his assurance and for his assistance with this matter during his time at the Trust.

The Chief Executive queried whether the Board would like to continue receiving mortality report at each Board meeting. As mortality indicators were contained within the IPR which was a standing report to the Board. It was agreed that the Board should only receive mortality notifications if there were abnormal trends.

However, the Board agreed to receive one last report to the Board in March 2016 which would allow the Board to review the new report format. As attainment of the mortality indicators would factor into the coming year’s financial plans, it was agreed by the Board to receive another mortality report in March 2016, which would include the Mortality review form and data.

Action: Medical Director

The IPR would also be amended to factor in this information.

Action: Director of Finance

Members agreed that the Risk and Quality Committee would receive detailed mortality Information.

The Chairman thanked the Interim Medical Director for his time at the Trust; the new Medical Director would be at the next Board meeting in March 2016.

The Board noted and received the Mortality Report update.
The Director of Operations introduced the report which was for information purposes as it had already been submitted. The Board noted the Major incident preparedness assurance report.

TB16/15  NOVEMBER AND DECEMBER NDTASELF-CERTIFICATIONS

The Director of Finance stated that the certification were in line with the IPR, which had been discussed during the meeting. The Trust had declared a non-compliant position for Requirement 10 due to A&E performance being lower than 95%.

The Board noted the documents and retrospectively approved the Board Statement NTDA submissions for these months as submitted to the NTDA.

TB16/16  STANDING FINANCIAL INSTRUCTIONS AND STANDING ORDERS

The Director of Finance stated that the Standing financial instructions and Standing orders were now presented to the Board as part of annual review process. The documents had been reviewed and were endorsed for approval by the Finance and Investment Committee and the Audit Committee. The amendments to the documents were in section 2 of the report.

Following due consideration, the Board approved the Standing Financial Instructions and Standing Orders.

TB16/17  STATEMENT OF PURPOSE

The Board Secretary requested Board approval for the revised Statement of purpose which now included the Trust’s sexual Health service, prior to the document’s submission to the CQC. The Chairman thanked the Board Secretary for preparing the document, adding it read well.

The Board approved the Statement of Purpose.

TB16/18  CONSULTANT APPOINTMENTS

The Board noted the Consultant appointments in December 2015.

TB16/19  RISK AND QUALITY COMMITTEE

The Chief Executive focused on the matters escalated by the Committee’s chair. The A&E improvement plan had been discussed during the meeting, the Board would also go through the improvement plan in detail further the February 2016 Board seminar.

The CT reporting which had been raised under A.O.B raised a significant number of unreported scans. The Board were informed that these matters were being picked up in the Trust Access meetings and that the Radiology processes had been updated to ensure this error did not occur again. The other issues mentioned were acknowledged.

The Board noted the Risk and Quality Committee Chair’s assurance report.

TB16/20  FINANCE & INVESTMENT COMMITTEE
The Board noted the Finance & Investment Committee Chair’s assurance report.

**TB16/21  CHARITABLE FUNDS COMMITTEE**

The Board noted the Charitable Funds Committee Chair’s assurance report.

**TB16/22  WORKFORCE, EDUCATION AND TRAINING COMMITTEE**

The Board noted the Workforce Committee and Education and Training Committee Chair’s assurance report.

**TB16/23  AUDIT COMMITTEE**

Catherine Dugmore mentioned the long standing recommendations which had not been completed; a report from Radiology would come to the Committee to consider the wider issues within the Radiology department. She suggested that there was little assurance being received that the recommendations were being implemented, therefore an assurance report would be discussed at the next meeting of the Committee.

The Board noted the Audit Committee Chair’s assurance report.

**TB16/24  QUESTIONS FROM THE PUBLIC**

The Chairman asked for questions from the public.

Donald Smith asked for an update on the parking management contracts. The contracts had gone out to tender, but none of the offers met with the Trust's commercial expectations. The Trust were now considering and discussing alternative car parking arrangements internally. The Director of Operations stated that this was an opportunity for the Trust to better manage its car parking capabilities and to improve customer experience. Advice would be sought from the private sector on this matter.

Donald Smith then queried A&E information presented by the Enfield Scrutiny committee recently; he queried whether the information was comparable as the Trust's patient mix was now different. The Chief Executive stated that on attendance the committee were comparing like for like even though the patient mix at the Trust was different. However, she highlighted that A&E attendances were still lower than in previous years.

Donald Smith asked whether the departure of the Deputy Chief Executive had affected A&E performance, the Chief Executive stated that this was not the case as he had not been involved in operational issues.

Donald Smith queried whether DBS check waiting times were delaying staff from starting, the Director of HR stated that there were delays which had impacted the Trust, but that internal mechanisms had been developed to mitigate these issues. The transient nature of NHS workers at times made corroborating residential addresses challenging at times, but where this was not the case DBS checks could be obtained quickly.

Bryan Waterman asked for assurance that patients affected by the junior doctors’ strikes had received alternative appointments, it was confirmed that patients would be seen within waiting time standards, which would be based on their original referral time or relative to their ongoing
treatment. The Chief Executive apologised for the inconvenience caused to patients as a result of the strike, adding that the Trust was unaware patients had been disadvantaged as a result of the strikes.

Bryan Waterman then queried the Trust’s current payment procedure, the Director of Finance stated that the trust sought to pay its suppliers within 30 days and achieved this 60-65% of the time. The Trust’s cash position was currently stretched, but it made every effort to settle local creditors in the first instance and then its larger creditors.

Bryan Waterman queried the Radiology programs (Citrix) which support the department. He was informed that it was hoped to update the Radiology program during an upcoming Medway update, which it was hoped would streamline the process of receiving test results to patients.

John James thanked the Chairman and Chief Executive for attending the recent meeting where many of his queries had been addressed.

**TB16/25  ANY OTHER BUSINESS**

None were noted.

**TB16/26  DATE OF THE NEXT MEETING:**

The next public meeting of the Trust Board would be held on Thursday 31st March 2016 at 11.00am in the Meeting room 10, Tower Block, and Level -1 North Middlesex University Hospital.

Signed:
John Carrier
Chairman

The meeting closed at 13.38pm
<table>
<thead>
<tr>
<th>Item No.</th>
<th>Minute Ref. No</th>
<th>Issue/Action</th>
<th>Lead Director</th>
<th>Outcome</th>
<th>Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>TB/15/80</td>
<td>Integrated Performance report</td>
<td>Director of Operations to provide assurance on progress in ensuring GPs receive their discharge summaries to RQC</td>
<td>Deferred to the Risk and Quality Committee April 2016 meeting</td>
<td>October 2015</td>
</tr>
<tr>
<td>2.</td>
<td>TB16/06</td>
<td>Staff story video</td>
<td>Comments from patient story on the suitability of the wards to be taken forward</td>
<td>Director of Operations</td>
<td>March 2016</td>
</tr>
<tr>
<td>3.</td>
<td>TB16/09</td>
<td>Integrated performance report</td>
<td>An analysis of agency staff usage in December 2015</td>
<td>Deferred to the Workforce and Education Committee April meeting</td>
<td>March 2016</td>
</tr>
<tr>
<td>4.</td>
<td>TB16/11</td>
<td>Safe staffing report</td>
<td>Consider whether a pilot of 1:7 is necessary before enforcing the amendment to nursing acuity.</td>
<td>Director of Nursing</td>
<td>On agenda under item 5.1</td>
</tr>
<tr>
<td>5.</td>
<td>TB16/13</td>
<td>Mortality report update</td>
<td>The Board are to receive another mortality report in March 2016, which also includes the Mortality review form and data.</td>
<td>Medical Director</td>
<td>On agenda under item 5.2</td>
</tr>
<tr>
<td>6.</td>
<td>TB16/13</td>
<td>Mortality report update</td>
<td>The IPR would also be amended to factor in new mortality format/information.</td>
<td>Medical Director</td>
<td>On agenda under item 4.1</td>
</tr>
<tr>
<td>MEETING DATE:</td>
<td>31 March 2016</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------</td>
<td>----------------</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TITLE:</td>
<td>Chief Executive’s Report</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AGENDA ITEM:</td>
<td>3.2</td>
<td>PAPER:</td>
<td>C</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**EXECUTIVE SUMMARY:**
This paper summarises key issues from the Chief Executive over the last month. The Board is asked to note the report.

**ACTION REQUESTED OF THE MEETING:**
- For discussion
- For decision
- For noting [X]
- For assurance

**Which Strategic Objective does this paper impact most upon?:**
SO 1- Clinical outcomes

**How does the paper demonstrate progress towards the specified strategic objective?:**
The paper discusses clinical outcomes.

**LINKS WITH THE:**

<table>
<thead>
<tr>
<th>BAF:</th>
<th>Risk score:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>IPR:</th>
<th>Other:</th>
</tr>
</thead>
<tbody>
<tr>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

**THIS PAPER HAS BEEN PREVIOUSLY CONSIDERED BY:**
N/A

**AUTHOR AND TITLE:**  
Julie Lowe, Chief Executive
1. External Issues

1.1 National Staff Survey

The 2015 survey has now been published and is being discussed in depth by the Workforce Committee. We plan to have a discussion on this topic at the full Board in May and to ask ‘staff side’ colleagues to join us for that conversation. In general, our staff remain very highly motivated and positive about working for the NHS. However, there are a number of areas such as recommending the Trust to a family member, where our scores are lower than we would like and we need to work hard in the coming year to ensure that we are making the Trust a place that people want to work. The summary Trust staff survey results are incorporated as appendix A to this report.

1.2 TDA Self- Certification

These certifications have been a feature of Board meetings for a number of years but have now been discontinued by the TDA. All the information in the self-certs is covered within the Integrated Performance Report.

1.3 New Support Roles for Nursing

A consultation has just been completed by HEE into the creation of a new nursing role that will be known as an associate nurse. The associate nurse role will sit between a Care Assistant (with a Care Certificate) and a graduate Registered Nurse. The associate nurse will receive two years of training (compared with the three years for a registered nurse) and will be able to take overall care for a group of patients under the supervision of an RN. He/she will not be able to administer drugs or take overall charge of the ward. He/she will, however, be able to take blood, cannulate, undertake complex dressings and other care needs for patients. The Trust is in support of the new associate nurse role and will be exploring how we can use this new role to support care at NMUH. The Trust sees this as an opportunity to create a more flexible nursing workforce that can better meet the needs of patients.

1.4 Five Year Forward View on Mental Health

The recently published 5 Year forward view on Mental Health states the importance of the NHS providing care to patients with mental health problems. Of particular interest to the Trust is further work to try to support patients with dementia and the development of perinatal mental health services to help support women who becoming unwell as a consequence of pregnancy. Annex 2 of the document incorporates a series of recommendations for NHS organisations, partners and the government. The document is incorporated as appendix B to this document.

1.5 NHS Improvement

The Trust Development Authority and Monitor have now appointed a single executive team that will be in place from April under the leadership of Chief Executive, Jim Mackie. The regional director role for London is vacant but is being covered on a shared basis by Andrew Hines and Mark Turner.
2. Internal Issues

2.1 Trust Performance

Our performance against the ED target remains a cause of significant concern and we are now one of the most poorly performing Emergency Departments against the 4 hour target. Performance against a range of other indicators such as cancer and diagnostic waiting times is now improving. However, in February the TDA made the decision to classify the Trust as ‘challenged’.

We have put in place a number of measures to stabilise the situation and have developed plans to improve our performance in the coming months. In particular I am delighted to report that Jenny Thomas has joined us for 6 months as Programme Director for Emergency Care and is leading the Trust’s Safer, Faster, Better programme.

2.2 HENCEL Education Visit

The education and training that we offer to doctors in training as well as students in nursing and other professions was inspected last week. The report is awaited at the time of writing and will be discussed in detail by the Education & Training Committee. The Trust was issued with five Immediate Mandatory Requirements (IMRs). These were all addressed within a week of the visit, although some, such as more senior doctors at night time, reflect on-going issues that the Trust is working hard to resolve on a permanent basis.

2.3 Electronic Order Communications

I am delighted to report that we now have electronic ordering for radiology and pathology tests. This ends the time consuming practice of requesting tests via a hand written paper form. This should be time saving for our junior doctors in particular.

3. Recommendation

3.1 The Board is asked to note and receive the March Chief Executive’s report.

Julie Lowe
March 2016
2015 National NHS staff survey

Brief summary of results from North Middlesex University Hospital NHS Trust
# Table of Contents

1: Introduction to this report .................................................. 3
2: Overall indicator of staff engagement for North Middlesex University Hospital NHS Trust .......................... 5
3: Summary of 2015 Key Findings for North Middlesex University Hospital NHS Trust .................................. 6
4: Full description of 2015 Key Findings for North Middlesex University Hospital NHS Trust (including comparisons with the trust’s 2014 survey and with other acute trusts) .................................................. 14
1. Introduction to this report

This report presents the findings of the 2015 national NHS staff survey conducted in North Middlesex University Hospital NHS Trust.

In section 2 of this report, we present an overall indicator of staff engagement. Full details of how this indicator was created can be found in the document *Making sense of your staff survey data*, which can be downloaded from www.nhsstaffsurveys.com.

In sections 3 and 4 of this report, the findings of the questionnaire have been summarised and presented in the form of 32 Key Findings.

These sections of the report have been structured around four of the seven pledges to staff in the NHS Constitution which was published in March 2013 (http://www.nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution) plus three additional themes:

- **Staff Pledge 1:** To provide all staff with clear roles and responsibilities and rewarding jobs for teams and individuals that make a difference to patients, their families and carers and communities.
- **Staff Pledge 2:** To provide all staff with personal development, access to appropriate education and training for their jobs, and line management support to enable them to fulfil their potential.
- **Staff Pledge 3:** To provide support and opportunities for staff to maintain their health, well-being and safety.
- **Staff Pledge 4:** To engage staff in decisions that affect them and the services they provide, individually, through representative organisations and through local partnership working arrangements. All staff will be empowered to put forward ways to deliver better and safer services for patients and their families.
- **Additional theme:** Equality and diversity
- **Additional theme:** Errors and incidents
- **Additional theme:** Patient experience measures

Please note, the questionnaire, key findings and benchmarking groups have all undergone substantial revision since the previous staff survey. For more detail on these changes, please see the *Making sense of your staff survey data* document.

As in previous years, there are two types of Key Finding:

- percentage scores, i.e. percentage of staff giving a particular response to one, or a series of, survey questions
- scale summary scores, calculated by converting staff responses to particular questions into scores. For each of these scale summary scores, the minimum score is always 1 and the maximum score is 5

A longer and more detailed report of the 2015 survey results for North Middlesex University Hospital NHS Trust can be downloaded from: www.nhsstaffsurveys.com. This report provides detailed breakdowns of the Key Finding scores by directorate, occupational groups and demographic groups, and details of each question included in the core questionnaire.
Your Organisation

The scores presented below are un-weighted question level scores for questions Q21a, Q21b, Q21c and Q21d and the un-weighted score for Key Finding 1. The percentages for Q21a – Q21d are created by combining the responses for those who “Agree” and “Strongly Agree” compared to the total number of staff that responded to the question.

Q21a, Q21c and Q21d feed into Key Finding 1 “Staff recommendation of the organisation as a place to work or receive treatment”.

<table>
<thead>
<tr>
<th>Question</th>
<th>Statement</th>
<th>Your Trust in 2015</th>
<th>Average (median) for acute trusts</th>
<th>Your Trust in 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q21a</td>
<td>&quot;Care of patients / service users is my organisation's top priority&quot;</td>
<td>69%</td>
<td>75%</td>
<td>71%</td>
</tr>
<tr>
<td>Q21b</td>
<td>&quot;My organisation acts on concerns raised by patients / service users&quot;</td>
<td>63%</td>
<td>73%</td>
<td>69%</td>
</tr>
<tr>
<td>Q21c</td>
<td>&quot;I would recommend my organisation as a place to work&quot;</td>
<td>51%</td>
<td>61%</td>
<td>54%</td>
</tr>
<tr>
<td>Q21d</td>
<td>&quot;If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation&quot;</td>
<td>49%</td>
<td>70%</td>
<td>59%</td>
</tr>
<tr>
<td>KF1.</td>
<td>Staff recommendation of the organisation as a place to work or receive treatment (Q21a, 21c-d)</td>
<td>3.53</td>
<td>3.76</td>
<td>3.62</td>
</tr>
</tbody>
</table>
2. Overall indicator of staff engagement for North Middlesex University Hospital NHS Trust

The figure below shows how North Middlesex University Hospital NHS Trust compares with other acute trusts on an overall indicator of staff engagement. Possible scores range from 1 to 5, with 1 indicating that staff are poorly engaged (with their work, their team and their trust) and 5 indicating that staff are highly engaged. The trust’s score of 3.77 was below (worse than) average when compared with trusts of a similar type.

OVERALL STAFF ENGAGEMENT

This overall indicator of staff engagement has been calculated using the questions that make up Key Findings 1, 4 and 7. These Key Findings relate to the following aspects of staff engagement: staff members’ perceived ability to contribute to improvements at work (Key Finding 7); their willingness to recommend the trust as a place to work or receive treatment (Key Finding 1); and the extent to which they feel motivated and engaged with their work (Key Finding 4).

The table below shows how North Middlesex University Hospital NHS Trust compares with other acute trusts on each of the sub-dimensions of staff engagement, and whether there has been a change since the 2014 survey.

<table>
<thead>
<tr>
<th>Change since 2014 survey</th>
<th>Ranking, compared with all acute trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td>OVERALL STAFF ENGAGEMENT</td>
<td>• No change</td>
</tr>
<tr>
<td></td>
<td>! Below (worse than) average</td>
</tr>
<tr>
<td>KF1. Staff recommendation of the trust as a place to work or receive treatment</td>
<td></td>
</tr>
<tr>
<td>(the extent to which staff think care of patients/service users is the trust’s top priority, would recommend their trust to others as a place to work, and would be happy with the standard of care provided by the trust if a friend or relative needed treatment.)</td>
<td>• No change</td>
</tr>
<tr>
<td>KF4. Staff motivation at work</td>
<td></td>
</tr>
<tr>
<td>(the extent to which they look forward to going to work, and are enthusiastic about and absorbed in their jobs.)</td>
<td>• No change</td>
</tr>
<tr>
<td>KF7. Staff ability to contribute towards improvements at work</td>
<td></td>
</tr>
<tr>
<td>(the extent to which staff are able to make suggestions to improve the work of their team, have frequent opportunities to show initiative in their role, and are able to make improvements at work.)</td>
<td>• No change</td>
</tr>
</tbody>
</table>

Full details of how the overall indicator of staff engagement was created can be found in the document *Making sense of your staff survey data*. 
3. Summary of 2015 Key Findings for North Middlesex University Hospital NHS Trust

3.1 Top and Bottom Ranking Scores

This page highlights the five Key Findings for which North Middlesex University Hospital NHS Trust compares most favourably with other acute trusts in England.

**TOP FIVE RANKING SCORES**

**✓ KF13. Quality of non-mandatory training, learning or development**

*Scale summary score*

<table>
<thead>
<tr>
<th></th>
<th>Trust score 2015</th>
<th>National 2015 average for acute trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low-quality training</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High-quality training</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**✓ KF4. Staff motivation at work**

*Scale summary score*

<table>
<thead>
<tr>
<th></th>
<th>Trust score 2015</th>
<th>National 2015 average for acute trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not enthusiastic / absorbed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enthusiastic / absorbed</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**✓ KF8. Staff satisfaction with level of responsibility and involvement**

*Scale summary score*

<table>
<thead>
<tr>
<th></th>
<th>Trust score 2015</th>
<th>National 2015 average for acute trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unsatisfactory level of responsibility / involvement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Highly satisfactory level of responsibility / involvement</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**✓ KF3. Percentage of staff agreeing that their role makes a difference to patients / service users**

*Percentage score*

<table>
<thead>
<tr>
<th></th>
<th>Trust score 2015</th>
<th>National 2015 average for acute trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>91%</td>
<td>90%</td>
</tr>
</tbody>
</table>

**✓ KF24. Percentage of staff / colleagues reporting most recent experience of violence**

*Percentage score*

<table>
<thead>
<tr>
<th></th>
<th>Trust score 2015</th>
<th>National 2015 average for acute trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>55%</td>
<td>53%</td>
</tr>
</tbody>
</table>
This page highlights the five Key Findings for which North Middlesex University Hospital NHS Trust compares least favourably with other acute trusts in England. It is suggested that these areas might be seen as a starting point for local action to improve as an employer.

**BOTTOM FIVE RANKING SCORES**

! KF21. Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion

*(the higher the score the better)*

<table>
<thead>
<tr>
<th>Percentage score</th>
<th>Trust score 2015</th>
<th>National 2015 average for acute trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>76%</td>
<td>87%</td>
</tr>
</tbody>
</table>

! KF26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months

*(the lower the score the better)*

<table>
<thead>
<tr>
<th>Percentage score</th>
<th>Trust score 2015</th>
<th>National 2015 average for acute trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>35%</td>
<td>26%</td>
</tr>
</tbody>
</table>

! KF25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months

*(the lower the score the better)*

<table>
<thead>
<tr>
<th>Percentage score</th>
<th>Trust score 2015</th>
<th>National 2015 average for acute trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>34%</td>
<td>28%</td>
</tr>
</tbody>
</table>

! KF20. Percentage of staff experiencing discrimination at work in last 12 months

*(the lower the score the better)*

<table>
<thead>
<tr>
<th>Percentage score</th>
<th>Trust score 2015</th>
<th>National 2015 average for acute trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>17%</td>
<td>10%</td>
</tr>
</tbody>
</table>

! KF28. Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month

*(the lower the score the better)*

<table>
<thead>
<tr>
<th>Percentage score</th>
<th>Trust score 2015</th>
<th>National 2015 average for acute trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>36%</td>
<td>31%</td>
</tr>
</tbody>
</table>

For each of the 32 Key Findings, the acute trusts in England were placed in order from 1 (the top ranking score) to 99 (the bottom ranking score). North Middlesex University Hospital NHS Trust’s five lowest ranking scores are presented here, i.e. those for which the trust’s Key Finding score is ranked closest to 99. Further details about this can be found in the document *Making sense of your staff survey data.*
3.2 Largest Local Changes since the 2014 Survey

This page highlights the two Key Findings where staff experiences have deteriorated since the 2014 survey. It is suggested that these areas might be seen as a starting point for local action to improve as an employer.

WHERE STAFF EXPERIENCE HAS DETERIORATED

! KF16. Percentage of staff working extra hours
*(the lower the score the better)*

<table>
<thead>
<tr>
<th></th>
<th>Percentage score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust score 2015</td>
<td>76%</td>
</tr>
<tr>
<td>Trust score 2014</td>
<td>65%</td>
</tr>
</tbody>
</table>

! KF32. Effective use of patient / service user feedback
*(the higher the score the better)*

<table>
<thead>
<tr>
<th></th>
<th>Scale summary score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust score 2015</td>
<td>3.48</td>
</tr>
<tr>
<td>Trust score 2014</td>
<td>3.73</td>
</tr>
</tbody>
</table>
3.3. Summary of all Key Findings for North Middlesex University Hospital NHS Trust

**KEY**

- **Green** = Positive finding, e.g. there has been a statistically significant positive change in the Key Finding since the 2014 survey.
- **Red** = Negative finding, e.g. there has been a statistically significant negative change in the Key Finding since the 2014 survey.
- **Grey** = No change, e.g. there has been no statistically significant change in this Key Finding since the 2014 survey.

For most of the Key Finding scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterisk and in *italics*, the lower the score the better.

### Change since 2014 survey

<table>
<thead>
<tr>
<th>Key Finding Description</th>
<th>Score Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>KF11. % appraised in last 12 mths</td>
<td>-15%</td>
</tr>
<tr>
<td>*KF16. % working extra hours</td>
<td>-10%</td>
</tr>
<tr>
<td>*KF17. % suffering work related stress in last 12 mths</td>
<td>-5%</td>
</tr>
<tr>
<td>*KF18. % feeling pressure in last 3 mths to attend work when feeling unwell</td>
<td>0%</td>
</tr>
<tr>
<td>*KF22. % experiencing physical violence from patients, relatives or the public in last 12 mths</td>
<td>5%</td>
</tr>
<tr>
<td>*KF23. % experiencing physical violence from staff in last 12 mths</td>
<td>10%</td>
</tr>
<tr>
<td>KF24. % reporting most recent experience of violence</td>
<td>15%</td>
</tr>
<tr>
<td>*KF25. % experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 mths</td>
<td>-15%</td>
</tr>
<tr>
<td>*KF26. % experiencing harassment, bullying or abuse from staff in last 12 mths</td>
<td>-10%</td>
</tr>
<tr>
<td>KF27. % reporting most recent experience of harassment, bullying or abuse</td>
<td>-5%</td>
</tr>
<tr>
<td>KF6. % reporting good communication between senior management and staff</td>
<td>0%</td>
</tr>
<tr>
<td>KF7. % able to contribute towards improvements at work</td>
<td>5%</td>
</tr>
<tr>
<td>*KF20. % experiencing discrimination at work in last 12 mths</td>
<td>10%</td>
</tr>
<tr>
<td>KF21. % believing the organisation provides equal opportunities for career progression / promotion</td>
<td>-15%</td>
</tr>
<tr>
<td>*KF28. % witnessing potentially harmful errors, near misses or incidents in last mth</td>
<td>-10%</td>
</tr>
<tr>
<td>KF29. % reporting errors, near misses or incidents witnessed in the last mth</td>
<td>-5%</td>
</tr>
<tr>
<td>KF1. Staff recommendation of the organisation as a place to work or receive treatment</td>
<td>0%</td>
</tr>
<tr>
<td>KF4. Staff motivation at work</td>
<td>5%</td>
</tr>
<tr>
<td>KF8. Staff satisfaction with level of responsibility and involvement</td>
<td>10%</td>
</tr>
<tr>
<td>KF10. Support from immediate managers</td>
<td>15%</td>
</tr>
<tr>
<td>KF31. Staff confidence and security in reporting unsafe clinical practice</td>
<td>-1.0</td>
</tr>
<tr>
<td>KF32. Effective use of patient / service user feedback</td>
<td>1.0</td>
</tr>
</tbody>
</table>
### 3.3. Summary of all Key Findings for North Middlesex University Hospital NHS Trust

**KEY**

- **Green** = Positive finding, e.g. better than average. If a ✓ is shown the score is in the best 20% of acute trusts.
- **Red** = Negative finding, e.g. worse than average. If a ! is shown the score is in the worst 20% of acute trusts.
- **Grey** = Average.

For most of the Key Finding scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterisk and in italics, the lower the score the better.

#### Comparison with all acute trusts in 2015

<table>
<thead>
<tr>
<th>Key Finding</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>KF3. % agreeing that their role makes a difference to patients / service users</td>
<td>-15%</td>
</tr>
<tr>
<td>KF11. % appraised in last 12 mths</td>
<td>-10%</td>
</tr>
<tr>
<td>KF15. % of staff satisfied with the opportunities for flexible working patterns</td>
<td>-5%</td>
</tr>
<tr>
<td>*KF16. % working extra hours</td>
<td>0%</td>
</tr>
<tr>
<td>*KF17. % suffering work related stress in last 12 mths</td>
<td>5%</td>
</tr>
<tr>
<td>*KF18. % feeling pressure in last 3 mths to attend work when feeling unwell</td>
<td>10%</td>
</tr>
<tr>
<td>*KF22. % experiencing physical violence from patients, relatives or the public in last 12 mths</td>
<td>15%</td>
</tr>
<tr>
<td>*KF23. % experiencing physical violence from staff in last 12 mths</td>
<td></td>
</tr>
<tr>
<td>KF24. % reporting most recent experience of violence</td>
<td></td>
</tr>
<tr>
<td>*KF25. % experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 mths</td>
<td></td>
</tr>
<tr>
<td>*KF26. % experiencing harassment, bullying or abuse from staff in last 12 mths</td>
<td></td>
</tr>
<tr>
<td>KF27. % reporting most recent experience of harassment, bullying or abuse</td>
<td></td>
</tr>
<tr>
<td>KF6. % reporting good communication between senior management and staff</td>
<td></td>
</tr>
<tr>
<td>KF7. % able to contribute towards improvements at work</td>
<td></td>
</tr>
<tr>
<td>*KF20. % experiencing discrimination at work in last 12 mths</td>
<td></td>
</tr>
<tr>
<td>KF21. % believing the organisation provides equal opportunities for career progression / promotion</td>
<td></td>
</tr>
<tr>
<td>*KF28. % witnessing potentially harmful errors, near misses or incidents in last mth</td>
<td></td>
</tr>
<tr>
<td>KF29. % reporting errors, near misses or incidents witnessed in the last mth</td>
<td></td>
</tr>
</tbody>
</table>
### 3.3. Summary of all Key Findings for North Middlesex University Hospital NHS Trust

**KEY**

Green = Positive finding, e.g. better than average. If a ✓ is shown the score is in the best 20% of acute trusts.

Red = Negative finding, e.g. worse than average. If a ! is shown the score is in the worst 20% of acute trusts.

Grey = Average.

For most of the Key Finding scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterisk and in *italics*, the lower the score the better.

<table>
<thead>
<tr>
<th>Comparison with all acute trusts in 2015 (cont)</th>
</tr>
</thead>
<tbody>
<tr>
<td>KF1. Staff recommendation of the organisation as a place to work</td>
</tr>
<tr>
<td>or receive treatment</td>
</tr>
<tr>
<td>KF2. Staff satisfaction with the quality of work and patient care</td>
</tr>
<tr>
<td>they are able to deliver</td>
</tr>
<tr>
<td>KF4. Staff motivation at work</td>
</tr>
<tr>
<td>KF5. Recognition and value of staff by managers and the organisation</td>
</tr>
<tr>
<td>KF8. Staff satisfaction with level of responsibility and involvement</td>
</tr>
<tr>
<td>KF9. Effective team working</td>
</tr>
<tr>
<td>KF14. Staff satisfaction with resourcing and support</td>
</tr>
<tr>
<td>KF10. Support from immediate managers</td>
</tr>
<tr>
<td>KF12. Quality of appraisals</td>
</tr>
<tr>
<td>KF13. Quality of non-mandatory training, learning or development</td>
</tr>
<tr>
<td>KF19. Org and mgmt interest in and action on health / wellbeing</td>
</tr>
<tr>
<td>KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents</td>
</tr>
<tr>
<td>KF31. Staff confidence and security in reporting unsafe clinical practice</td>
</tr>
<tr>
<td>KF32. Effective use of patient / service user feedback</td>
</tr>
</tbody>
</table>
### 3.4. Summary of all Key Findings for North Middlesex University Hospital NHS Trust

**KEY**

- **Green** = Positive finding, e.g. in the best 20% of acute trusts, better than average, better than 2014.
- **Red** = Negative finding, e.g. in the worst 20% of acute trusts, worse than average, worse than 2014.

*Change since 2014 survey* indicates whether there has been a statistically significant change in the Key Finding since the 2014 survey.

- Because of changes to the format of the survey questions this year, comparisons with the 2014 score are not possible.
- For most of the Key Finding scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterisk and in *italics*, the lower the score the better.

<table>
<thead>
<tr>
<th>Change since 2014 survey</th>
<th>Ranking, compared with all acute trusts in 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>STAFF PLEDGE 1: To provide all staff with clear roles, responsibilities and rewarding jobs.</strong></td>
<td></td>
</tr>
<tr>
<td>KF1. Staff recommendation of the organisation as a place to work or receive treatment</td>
<td>No change</td>
</tr>
<tr>
<td>KF2. Staff satisfaction with the quality of work and patient care they are able to deliver</td>
<td>--</td>
</tr>
<tr>
<td>KF3. % agreeing that their role makes a difference to patients / service users</td>
<td>--</td>
</tr>
<tr>
<td>KF4. Staff motivation at work</td>
<td>No change</td>
</tr>
<tr>
<td>KF5. Recognition and value of staff by managers and the organisation</td>
<td>--</td>
</tr>
<tr>
<td>KF8. Staff satisfaction with level of responsibility and involvement</td>
<td>No change</td>
</tr>
<tr>
<td>KF9. Effective team working</td>
<td>--</td>
</tr>
<tr>
<td>KF14. Staff satisfaction with resourcing and support</td>
<td>--</td>
</tr>
<tr>
<td><strong>STAFF PLEDGE 2: To provide all staff with personal development, access to appropriate education and training for their jobs, and line management support to enable them to fulfil their potential.</strong></td>
<td></td>
</tr>
<tr>
<td>KF10. Support from immediate managers</td>
<td>No change</td>
</tr>
<tr>
<td>KF11. % appraised in last 12 mths</td>
<td>No change</td>
</tr>
<tr>
<td>KF12. Quality of appraisals</td>
<td>--</td>
</tr>
<tr>
<td>KF13. Quality of non-mandatory training, learning or development</td>
<td>--</td>
</tr>
<tr>
<td><strong>STAFF PLEDGE 3: To provide support and opportunities for staff to maintain their health, well-being and safety.</strong></td>
<td></td>
</tr>
<tr>
<td>KF15. % of staff satisfied with the opportunities for flexible working patterns</td>
<td>--</td>
</tr>
<tr>
<td>* KF16. % working extra hours</td>
<td>Increase (worse than 14)</td>
</tr>
<tr>
<td>* KF17. % suffering work related stress in last 12 mths</td>
<td>No change</td>
</tr>
<tr>
<td>* KF18. % feeling pressure in last 3 mths to attend work when feeling unwell</td>
<td>No change</td>
</tr>
<tr>
<td>KF19. Org and mgmt interest in and action on health / wellbeing</td>
<td>--</td>
</tr>
</tbody>
</table>
### 3.4. Summary of all Key Findings for North Middlesex University Hospital NHS Trust (cont)

<table>
<thead>
<tr>
<th>Variable</th>
<th>Change since 2014 survey</th>
<th>Ranking, compared with all acute trusts in 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Violence and harassment</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>* KF22. % experiencing physical violence from patients, relatives or the public in last 12 mths</td>
<td>No change</td>
<td>Below (better than) average</td>
</tr>
<tr>
<td>* KF23. % experiencing physical violence from staff in last 12 mths</td>
<td>No change</td>
<td>Average</td>
</tr>
<tr>
<td>KF24. % reporting most recent experience of violence</td>
<td>No change</td>
<td>Above (better than) average</td>
</tr>
<tr>
<td>* KF25. % experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 mths</td>
<td>No change</td>
<td>! Highest (worst) 20%</td>
</tr>
<tr>
<td>* KF26. % experiencing harassment, bullying or abuse from staff in last 12 mths</td>
<td>No change</td>
<td>! Highest (worst) 20%</td>
</tr>
<tr>
<td>KF27. % reporting most recent experience of harassment, bullying or abuse</td>
<td>No change</td>
<td>! Below (worse than) average</td>
</tr>
<tr>
<td><strong>STAFF PLEDGE 4: To engage staff in decisions that affect them, the services they provide and empower them to put forward ways to deliver better and safer services.</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>KF6. % reporting good communication between senior management and staff</td>
<td>No change</td>
<td>! Lowest (worst) 20%</td>
</tr>
<tr>
<td>KF7. % able to contribute towards improvements at work</td>
<td>No change</td>
<td>Average</td>
</tr>
<tr>
<td><strong>ADDITIONAL THEME: Equality and diversity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>* KF20. % experiencing discrimination at work in last 12 mths</td>
<td>No change</td>
<td>! Highest (worst) 20%</td>
</tr>
<tr>
<td>KF21. % believing the organisation provides equal opportunities for career progression / promotion</td>
<td>No change</td>
<td>! Lowest (worst) 20%</td>
</tr>
<tr>
<td><strong>ADDITIONAL THEME: Errors and incidents</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>* KF28. % witnessing potentially harmful errors, near misses or incidents witnessed in the last mth</td>
<td>No change</td>
<td>! Highest (worst) 20%</td>
</tr>
<tr>
<td>KF29. % reporting errors, near misses or incidents witnessed in the last mth</td>
<td>No change</td>
<td>! Lowest (worst) 20%</td>
</tr>
<tr>
<td>KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents</td>
<td>--</td>
<td>! Below (worse than) average</td>
</tr>
<tr>
<td>KF31. Staff confidence and security in reporting unsafe clinical practice</td>
<td>No change</td>
<td>! Below (worse than) average</td>
</tr>
<tr>
<td><strong>ADDITIONAL THEME: Patient experience measures</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>KF32. Effective use of patient / service user feedback</td>
<td>! Decrease (worse than 14)</td>
<td>! Lowest (worst) 20%</td>
</tr>
</tbody>
</table>
4. Key Findings for North Middlesex University Hospital NHS Trust

210 staff at North Middlesex University Hospital NHS Trust took part in this survey. This is a response rate of 28%\(^1\) which is in the lowest 20% of acute trusts in England, and compares with a response rate of 28% in this trust in the 2014 survey.

This section presents each of the 32 Key Findings, using data from the trust's 2015 survey, and compares these to other acute trusts in England and to the trust's performance in the 2014 survey. The findings are arranged under seven headings – the four staff pledges from the NHS Constitution, and the three additional themes of equality and diversity, errors and incidents, and patient experience measures.

Positive findings are indicated with a green arrow (e.g. where the trust is in the best 20% of trusts, or where the score has improved since 2014). Negative findings are highlighted with a red arrow (e.g. where the trust's score is in the worst 20% of trusts, or where the score is not as good as 2014). An equals sign indicates that there has been no change.

---

**STAFF PLEDGE 1: To provide all staff with clear roles, responsibilities and rewarding jobs.**

---

**KEY FINDING 1. Staff recommendation of the organisation as a place to work or receive treatment**

*(the higher the score the better)*

<table>
<thead>
<tr>
<th></th>
<th>Scale summary score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust score 2015</td>
<td>3.51</td>
</tr>
<tr>
<td>Trust score 2014</td>
<td>3.62</td>
</tr>
<tr>
<td>National 2015 average for acute trusts</td>
<td>3.76</td>
</tr>
<tr>
<td>Best 2015 score for acute trusts</td>
<td>4.10</td>
</tr>
</tbody>
</table>

**KEY FINDING 2. Staff satisfaction with the quality of work and patient care they are able to deliver**

*(the higher the score the better)*

<table>
<thead>
<tr>
<th></th>
<th>Scale summary score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust score 2015</td>
<td>3.91</td>
</tr>
<tr>
<td>National 2015 average for acute trusts</td>
<td>3.93</td>
</tr>
<tr>
<td>Best 2015 score for acute trusts</td>
<td>4.29</td>
</tr>
</tbody>
</table>

---

\(^1\)At the time of sampling, 2950 staff were eligible to receive the survey. Questionnaires were sent to a random sample of 760 staff. This includes only staff employed directly by the trust (i.e. excluding staff working for external contractors). It excludes bank staff unless they are also employed directly elsewhere in the trust. When calculating the response rate, questionnaires could only be counted if they were received with their ID number intact, by the closing date.
KEY FINDING 3. Percentage of staff agreeing that their role makes a difference to patients / service users

(less is better)

<table>
<thead>
<tr>
<th>Percentage score</th>
<th>Trust score 2015</th>
<th>National 2015 average for acute trusts</th>
<th>Best 2015 score for acute trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>91%</td>
<td>90%</td>
<td>95%</td>
</tr>
</tbody>
</table>

KEY FINDING 4. Staff motivation at work

(less is better)

<table>
<thead>
<tr>
<th>Scale summary score</th>
<th>Trust score 2015</th>
<th>Trust score 2014</th>
<th>National 2015 average for acute trusts</th>
<th>Best 2015 score for acute trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>4.05</td>
<td>3.97</td>
<td>3.94</td>
<td>4.14</td>
</tr>
</tbody>
</table>

KEY FINDING 5. Recognition and value of staff by managers and the organisation

(less is better)

<table>
<thead>
<tr>
<th>Scale summary score</th>
<th>Trust score 2015</th>
<th>National 2015 average for acute trusts</th>
<th>Best 2015 score for acute trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>3.41</td>
<td>3.42</td>
<td>3.73</td>
</tr>
</tbody>
</table>

KEY FINDING 8. Staff satisfaction with level of responsibility and involvement

(less is better)

<table>
<thead>
<tr>
<th>Scale summary score</th>
<th>Trust score 2015</th>
<th>Trust score 2014</th>
<th>National 2015 average for acute trusts</th>
<th>Best 2015 score for acute trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>3.95</td>
<td>3.85</td>
<td>3.91</td>
<td>4.08</td>
</tr>
</tbody>
</table>
KEY FINDING 9. Effective team working

(Revised label)

KEY FINDING 14. Staff satisfaction with resourcing and support

(Revised label)

STAFF PLEDGE 2: To provide all staff with personal development, access to appropriate education and training for their jobs, and line management support to enable them to fulfil their potential.

KEY FINDING 10. Support from immediate managers

(Revised label)

KEY FINDING 11. Percentage of staff appraised in last 12 months

(Revised label)
KEY FINDING 12. Quality of appraisals
*(the higher the score the better)*

<table>
<thead>
<tr>
<th></th>
<th>Scale summary score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust score 2015</td>
<td>3.06</td>
</tr>
<tr>
<td>National 2015 average for acute trusts</td>
<td>3.05</td>
</tr>
<tr>
<td>Best 2015 score for acute trusts</td>
<td>3.39</td>
</tr>
</tbody>
</table>

KEY FINDING 13. Quality of non-mandatory training, learning or development
*(the higher the score the better)*

<table>
<thead>
<tr>
<th></th>
<th>Scale summary score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust score 2015</td>
<td>4.14</td>
</tr>
<tr>
<td>National 2015 average for acute trusts</td>
<td>4.03</td>
</tr>
<tr>
<td>Best 2015 score for acute trusts</td>
<td>4.18</td>
</tr>
</tbody>
</table>

STAFF PLEDGE 3: To provide support and opportunities for staff to maintain their health, well-being and safety.

Health and well-being

KEY FINDING 15. Percentage of staff satisfied with the opportunities for flexible working patterns
*(the higher the score the better)*

<table>
<thead>
<tr>
<th></th>
<th>Percentage score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust score 2015</td>
<td>47%</td>
</tr>
<tr>
<td>National 2015 average for acute trusts</td>
<td>49%</td>
</tr>
<tr>
<td>Best 2015 score for acute trusts</td>
<td>58%</td>
</tr>
</tbody>
</table>

KEY FINDING 16. Percentage of staff working extra hours
*(the lower the score the better)*

<table>
<thead>
<tr>
<th></th>
<th>Percentage score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust score 2015</td>
<td>76%</td>
</tr>
<tr>
<td>Trust score 2014</td>
<td>65%</td>
</tr>
<tr>
<td>National 2015 average for acute trusts</td>
<td>72%</td>
</tr>
<tr>
<td>Best 2015 score for acute trusts</td>
<td>61%</td>
</tr>
</tbody>
</table>
KEY FINDING 17. Percentage of staff suffering work related stress in last 12 months

(\textit{the lower the score the better})

<table>
<thead>
<tr>
<th></th>
<th>Percentage score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust score 2015</td>
<td>40%</td>
</tr>
<tr>
<td>Trust score 2014</td>
<td>39%</td>
</tr>
<tr>
<td>National 2015 average for acute trusts</td>
<td>36%</td>
</tr>
<tr>
<td>Best 2015 score for acute trusts</td>
<td>24%</td>
</tr>
</tbody>
</table>

KEY FINDING 18. Percentage of staff feeling pressure in the last 3 months to attend work when feeling unwell

(\textit{the lower the score the better})

<table>
<thead>
<tr>
<th></th>
<th>Percentage score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust score 2015</td>
<td>62%</td>
</tr>
<tr>
<td>Trust score 2014</td>
<td>53%</td>
</tr>
<tr>
<td>National 2015 average for acute trusts</td>
<td>59%</td>
</tr>
<tr>
<td>Best 2015 score for acute trusts</td>
<td>46%</td>
</tr>
</tbody>
</table>

KEY FINDING 19. Organisation and management interest in and action on health and wellbeing

(\textit{the higher the score the better})

<table>
<thead>
<tr>
<th></th>
<th>Scale summary score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust score 2015</td>
<td>3.48</td>
</tr>
<tr>
<td>National 2015 average for acute trusts</td>
<td>3.57</td>
</tr>
<tr>
<td>Best 2015 score for acute trusts</td>
<td>3.97</td>
</tr>
</tbody>
</table>

Violence and harassment

KEY FINDING 22. Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months

(\textit{the lower the score the better})

<table>
<thead>
<tr>
<th></th>
<th>Percentage score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust score 2015</td>
<td>14%</td>
</tr>
<tr>
<td>Trust score 2014</td>
<td>15%</td>
</tr>
<tr>
<td>National 2015 average for acute trusts</td>
<td>14%</td>
</tr>
<tr>
<td>Best 2015 score for acute trusts</td>
<td>10%</td>
</tr>
</tbody>
</table>
KEY FINDING 23. Percentage of staff experiencing physical violence from staff in last 12 months

(\textit{the lower the score the better})

<table>
<thead>
<tr>
<th>Percentage score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust score 2015</td>
</tr>
<tr>
<td>Trust score 2014</td>
</tr>
<tr>
<td>National 2015 average for acute trusts</td>
</tr>
<tr>
<td>Best 2015 score for acute trusts</td>
</tr>
<tr>
<td>2%</td>
</tr>
<tr>
<td>6%</td>
</tr>
<tr>
<td>2%</td>
</tr>
<tr>
<td>0%</td>
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KEY FINDING 24. Percentage of staff / colleagues reporting most recent experience of violence

(\textit{the higher the score the better})

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KEY FINDING 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months

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KEY FINDING 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months

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KEY FINDING 27. Percentage of staff / colleagues reporting most recent experience of harassment, bullying or abuse

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STAFF PLEDGE 4: To engage staff in decisions that affect them, the services they provide and empower them to put forward ways to deliver better and safer services.

KEY FINDING 6. Percentage of staff reporting good communication between senior management and staff

(\textit{the higher the score the better})

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KEY FINDING 7. Percentage of staff able to contribute towards improvements at work

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ADDITIONAL THEME: Equality and diversity

KEY FINDING 20. Percentage of staff experiencing discrimination at work in last 12 months

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KEY FINDING 21. Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion

- Trust score 2015: 76%
- Trust score 2014: 73%
- National 2015 average for acute trusts: 87%
- Best 2015 score for acute trusts: 96%

ADDITIONAL THEME: Errors and incidents

KEY FINDING 28. Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month

- Trust score 2015: 36%
- Trust score 2014: 36%
- National 2015 average for acute trusts: 31%
- Best 2015 score for acute trusts: 21%

KEY FINDING 29. Percentage of staff reporting errors, near misses or incidents witnessed in the last month

- Trust score 2015: 84%
- Trust score 2014: 91%
- National 2015 average for acute trusts: 90%
- Best 2015 score for acute trusts: 97%

KEY FINDING 30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents

- Trust score 2015: 3.64
- National 2015 average for acute trusts: 3.70
- Best 2015 score for acute trusts: 3.92
KEY FINDING 31. Staff confidence and security in reporting unsafe clinical practice

(upper the score the better)

Scale summary score

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ADDITIONAL THEME: Patient experience measures

KEY FINDING 32. Effective use of patient / service user feedback

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THE FIVE YEAR FORWARD VIEW FOR MENTAL HEALTH

A report from the independent Mental Health Taskforce to the NHS in England
February 2016
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FOREWORD

For far too long, people of all ages with mental health problems have been stigmatised and marginalised, all too often experiencing an NHS that treats their minds and bodies separately. Mental health services have been underfunded for decades, and too many people have received no help at all, leading to hundreds of thousands of lives put on hold or ruined, and thousands of tragic and unnecessary deaths.

But in recent years, the picture has started to change. Public attitudes towards mental health are improving, and there is a growing commitment among communities, workplaces, schools and within government to change the way we think about it. There is now a cross-party, cross-society consensus on what needs to change and a real desire to shift towards prevention and transform NHS care.

This independent report of the Mental Health Taskforce sets out the start of a ten year journey for that transformation, commissioned by Simon Stevens on behalf of the NHS. We have placed the experience of people with mental health problems at the heart of it. Over 20,000 people told us of the changes they wanted to see so that they could fulfil their life ambitions and take their places as equal citizens in our society. They told us that their priorities were prevention, access, integration, quality and a positive experience of care. Their voices are quoted in this report and their views are reflected in our recommendations.

First, we have made a set of recommendations for the six NHS arm's length bodies to achieve the ambition of parity of esteem between mental and physical health for children, young people, adults and older people.

Second, we set out recommendations where wider action is needed. Many people told us that, as well as access to good quality mental health care wherever they are seen in the NHS, their main ambition was to have a decent place to live, a job or good quality relationships in their local communities. Making this happen will require a cross-government approach.

Finally, we have placed a particular focus on tackling inequalities. Mental health problems disproportionately affect people living in poverty, those who are unemployed and who already face discrimination. For too many, especially black, Asian and minority ethnic people, their first experience of mental health care comes when they are detained under the Mental Health Act, often with police involvement, followed by a long stay in hospital. To truly address this, we have to tackle inequalities at local and national level.

We want to thank all the Taskforce members, and the tens of thousands of people who contributed to and helped to co-produce this report.

Paul Farmer, Chair
Jacqui Dyer, Vice-Chair
EXECUTIVE SUMMARY

THE CURRENT STATE OF MENTAL HEALTH

“The NHS needs a far more proactive and preventative approach to reduce the long term impact for people experiencing mental health problems and for their families, and to reduce costs for the NHS and emergency services”.

Mental health problems are widespread, at times disabling, yet often hidden. People who would go to their GP with chest pains will suffer depression or anxiety in silence. One in four adults experiences at least one diagnosable mental health problem in any given year. People in all walks of life can be affected and at any point in their lives, including new mothers, children, teenagers, adults and older people. Mental health problems represent the largest single cause of disability in the UK. The cost to the economy is estimated at £105 billion a year – roughly the cost of the entire NHS.

POLICY CONTEXT

There has been a transformation in mental health over the last 50 years. Advances in care, the development of anti-psychotic and mood stabilising drugs, and greater emphasis on human rights led to the growth of community based mental health services. In the 1990s, the Care Programme Approach was developed to provide more intensive support to people with severe and enduring mental illness. There was a new emphasis on promoting public mental health and developing services for children and homeless people. In 1999, the National Service Framework for Mental Health was launched to establish a comprehensive evidence based service. This was followed by the NHS Plan in 2000 which set targets and provided funding to make the Framework a reality. A National Service Framework for Children, Young People and Maternity Services was then launched in 2004.

In 2011, the Coalition government published a mental health strategy setting six objectives, including improvement in the outcomes, physical health and experience of care of people with mental health problems, and a reduction in avoidable harm and stigma. The strategy was widely welcomed. However, despite these initiatives, challenges with system wide implementation coupled with an increase in people using mental health services has led to inadequate provision and worsening outcomes in recent years, including a rise in the number of people taking their own lives.
Yet, over the last five years, public attitudes towards mental health have improved, in part due to the Time to Change campaign. In turn, this increased awareness has heightened understanding of an urgent need to act on improving the experiences of people with mental health problems, both within and beyond the NHS. There is now a need to re-energise and improve mental health care across the NHS to meet increased demand and improve outcomes.

In this context, NHS England and the Department of Health published Future in Mind in 2015, which articulated a clear consensus about the way in which we can make it easier for children and young people to access high quality mental health care when they need it. This strategy builds on these strong foundations.

Mental health has not had the priority awarded to physical health, has been short of qualified staff and has been deprived of funds. We must provide equal status to mental and physical health, equal status to mental health staff and equal funding for mental health services as part of a triple approach to improve mental health care – a fresh mindset for mental health within the NHS and beyond.

MENTAL HEALTH PROBLEMS IN THE POPULATION
Half of all mental health problems have been established by the age of 14, rising to 75 per cent by age 24. **One in ten children** aged 5 – 16 has a diagnosable problem such as conduct disorder (6 per cent), anxiety disorder (3 per cent), attention deficit hyperactivity disorder (ADHD) (2 per cent) or depression (2 per cent). Children from low income families are at highest risk, three times that of those from the highest. Those with conduct disorder - persistent, disobedient, disruptive and aggressive behaviour - are twice as likely to leave school without any qualifications, three times more likely to become a teenage parent, four times more likely to become dependent on drugs and 20 times more likely to end up in prison. Yet most children and young people get no support. Even for those that do the average wait for routine appointments for psychological therapy was 32 weeks in 2015/16. A small group need inpatient services but, owing to inequity in provision, they may be sent anywhere in the country, requiring their families to travel long distances.

**1 IN 10 CHILDREN AGED 5-16 YEARS HAVE A DIAGNOSABLE MENTAL HEALTH PROBLEM**
One in five mothers suffers from depression, anxiety or in some cases psychosis during pregnancy or in the first year after childbirth. Suicide is the second leading cause of maternal death, after cardiovascular disease. Mental health problems not only affect the health of mothers but can also have long-standing effects on children’s emotional, social and cognitive development. Costs of perinatal mental ill health are estimated at £8.1 billion for each annual birth cohort, or almost £10,000 per birth. Yet fewer than 15 per cent of localities provide effective specialist community perinatal services for women with severe or complex conditions, and more than 40 per cent provide no service at all.

Physical and mental health are closely linked – **people with severe and prolonged mental illness are at risk of dying on average 15 to 20 years earlier than other people** – one of the greatest health inequalities in England. Two thirds of these deaths are from avoidable physical illnesses, including heart disease and cancer, many caused by smoking. There is also a lack of access to physical healthcare for people with mental health problems – less than a third of people with schizophrenia in hospital received the recommended assessment of cardiovascular risk in the previous 12 months.

In addition, **people with long term physical illnesses suffer more complications if they also develop mental health problems**, increasing the cost of care by an average of 45 per cent. Yet much of the time this goes unaddressed. There is good evidence that dedicated mental health provision as part of an integrated service can substantially reduce these poor outcomes. For example, in the case of Type 2 diabetes, £1.8 billion of additional costs can be attributed to poor mental health. Yet fewer than 15 per cent of people with diabetes have access to psychological support. Pilot schemes show providing such support improves health and cuts costs by 25 per cent.

**Stable employment and housing** are both factors contributing to someone being able to maintain good mental health and are important outcomes for their recovery if they have developed a mental health problem. Between 60–70 per cent of people with common mental health problems are in work, yet few employees have access to specialist occupational health services. For people being supported by secondary mental health services, there is a 65 per cent employment gap compared with the general population. People with mental health problems are also often overrepresented in high-turnover, low-pay and often part-time or temporary work. Common mental health problems are over twice as high among people who are homeless compared with the general population, and psychosis is up to 15 times as high. Children living in poor housing have increased chances of experiencing stress, anxiety and depression.
Only half of veterans of the armed forces experiencing mental health problems like Post Traumatic Stress Disorder seek help from the NHS and those that do are rarely referred to the right specialist care. NHS England is currently consulting on the future of mental health support for this group and it is essential that more is done to ensure their needs are identified early and they are supported to access specialist care swiftly.

One in five older people living in the community and 40 per cent of older people living in care homes are affected by depression. Diagnosing depressive symptoms can be difficult, and we know that some clinicians believe treatment for depression is less effective in older people, despite evidence to the contrary.

40 PER CENT OF OLDER PEOPLE LIVING IN CARE HOMES ARE AFFECTED BY DEPRESSION

People in marginalised groups are at greater risk, including black, Asian and minority ethnic (BAME) people, lesbian, gay, bisexual and transgender people, disabled people, and people who have had contact with the criminal justice system, among others. BAME households are more likely to live in poorer or over-crowded conditions, increasing the risks of developing mental health problems.

People of all ages who have experienced traumatic events, poor housing or homelessness, or who have multiple needs such as a learning disability or autism are also at higher risk.

As many as nine out of ten people in prison have a mental health, drug or alcohol problem.

Suicide is rising, after many years of decline. Suicide rates in England have increased steadily in recent years, peaking at 4,882 deaths in 2014. The rise is most marked amongst middle aged men. Suicide is now the leading cause of death for men aged 15–49. Men are three times more likely than women to take their own lives - they accounted for four out of five suicides in 2013. A quarter of people who took their own life had been in contact with a health professional, usually their GP, in the last week before they died. Most were in contact within a month before their death.
More than a quarter (28 per cent) of suicides were amongst people who had been in contact with mental health services within 12 months before their death, amounting to almost 14,000 people in the ten years from 2003-2013. However, suicides amongst inpatients in mental hospitals have significantly declined over the same period, as a result of better safety precautions.

CURRENT EXPERIENCES OF MENTAL HEALTH CARE

Nearly two million adults were in contact with specialist mental health and learning disability services at some point in 2014/15 – though we know little about the quality of their care and there remains extensive unmet need for mental health care. Three quarters of people with mental health problems receive no support at all. Among those who are helped, too few have access to the full range of interventions recommended by National Institute for Health and Care Excellence (NICE), including properly prescribed medication and psychological therapy.

Nine out of ten adults with mental health problems are supported in primary care. There has been a significant expansion in access to psychological therapies, following the introduction of the national IAPT programme (Improving Access to Psychological Therapies). However, there is considerable variation in services, with a waiting time of just over six days in the best performing areas and 124 days in the worst performing areas in 2014-15.

Of those adults with more severe mental health problems 90 per cent are supported by community services. However, within these services there are very long waits for some of the key interventions recommended by NICE, such as psychological therapy, and many people never have access to these interventions. One-quarter of people using secondary mental health services do not know who is responsible for coordinating their care, and the same number have not agreed what care they would receive with a clinician. Almost one-fifth of people with care coordinated through the Care Programme Approach (for people with more severe or complex needs) have not had a formal meeting to review their care in the previous 12 months.
In its recent review of crisis care, the Care Quality Commission found that only 14 per cent of adults surveyed felt they were provided with the right response when in crisis, and that only around half of community teams were able to offer an adequate 24/7 crisis service. Only a minority of hospital Accident & Emergency (A&E) departments has 24/7 cover from a liaison mental health service, even though the peak hours for mental health crisis presentations to A&E are between 11pm and 7am. Too often, people in mental health crisis are still accessing mental health care via contact with the police. The inquiry found that while adults were seen promptly where liaison mental health services were available in an A&E department and there were clear pathways through to community services, those aged under 16 were referred directly to children and young people’s services but seen only when services were open during office hours. This could involve waiting a full weekend and lead to a significant variation in the quality of care on the basis of someone’s age.

Admissions to inpatient care have remained stable for the past three years for adults but the severity of need and the number of people being detained under the Mental Health Act continues to increase, suggesting opportunities to intervene earlier are being missed. Men of African and Caribbean heritage are up to 6.6 times more likely to be admitted as inpatients or detained under the Mental Health Act, indicating a systemic failure to provide effective crisis care for these groups.

The number of adult inpatient psychiatric beds reduced by 39 per cent overall in the years between 1998 and 2012. For children and young people, average admissions per provider increased from 94 in 2013/14 to 106 in 2014/15. Bed occupancy has risen for the fourth consecutive year to 94 per cent. Many acute wards are not always safe, therapeutic or conducive to recovery. Pressure on beds has been exacerbated by a lack of early intervention and crisis care, and the resulting shortage leads to people being transferred long distances outside of their area.

Mental health accounts for 23 per cent of NHS activity but NHS spending on secondary mental health services is equivalent to just half of this. Years of low prioritisation have led to Clinical Commissioning Groups (CCGs) underinvesting in mental health services relative to physical health services but the degree of the disparity has largely been obscured by the way spending on mental health conditions is grouped together and reported, unlike spend on physical health care, which is disaggregated by specific conditions. Spending per capita across CCGs varies almost two-fold in relation to underlying need.
Poor mental health carries an **economic and social cost of £105 billion a year** in England. Analysis commissioned by NHS England found that the national cost of dedicated mental health support and services across government departments in England totals £34 billion each year, excluding dementia and substance use.\(^1\)

£19 billion of this is made up of government spend, though there is little or no national data available for how up to 67 per cent of mental health funding is used at a local level. Most of the remainder (£14bn) is for the support provided by unpaid carers, plus a relatively small share that is funded through the private and voluntary sectors.

Given chronic underinvestment in mental health care across the NHS in recent years, efficiencies made through achieving better value for money should be **re-invested to meet the significant unmet mental health needs** of people of all ages across England, and to improve their experiences and outcomes.

---

\(^1\) NHS England internal analysis
WHAT NEEDS TO HAPPEN - A FRESH MINDSET

“We should have fewer cases where people are unable to get physical care due to mental health problems affecting engagement and attendance (and vice versa). And we need provision of mental health support in physical health care settings - especially primary care.”

People told us that their mental health needs should be treated with equal importance to their physical health needs, whatever NHS service they are using – this is a fundamental principle of the Taskforce recommendations.

All too often people living with mental health problems still experience stigma and discrimination, many people struggle to get the right help at the right time and evidence-based care is significantly underfunded. The human cost is unacceptable and the financial cost to government and society is unsustainable.

Leaders across the system must take decisive steps to break down barriers in the way services are provided to reshape how care is delivered, increase access to the right care at the right time, drive down variations in the quality of care on offer, and improve outcomes.

Our ambition is to deliver rapid improvements in outcomes by 2020/21 through ensuring that 1 million more people with mental health problems are accessing high quality care. In the context of a challenging Spending Review, we have identified the need to invest an additional £1 billion in 2020/21, which will generate significant savings. It builds on the £280 million investment each year already committed to drive improvements in children and young people’s mental health, and perinatal care.

PRIORITY ACTIONS FOR THE NHS BY 2020/21

1. A 7 day NHS – right care, right time, right quality

“If you feel unwell in the evening, during the night or at the weekends and bank holidays there is no choice but to go to A&E. There’s no support out there during these times. It’s crucial that this is changed for the benefit of service users, their families and carers.”
People facing a crisis should have access to mental health care 7 days a week and 24 hours a day in the same way that they are able to get access to urgent physical health care. Getting the right care in the right place at the right time is vital. Failure to provide care early on means that the acute end of mental health care is under immense pressure. Better access to support was one of the top priorities identified by people in our engagement work. Early intervention services provided by dedicated teams are highly effective in improving outcomes and reducing costs.

The Care Quality Commission (CQC) found that just half of Community Mental Health Teams (CMHTs) are able to offer a 24/7 crisis service today. By 2020/21, NHS England should ensure that a 24/7 community-based mental health crisis response is available in all areas across England and that services are adequately resourced to offer intensive home treatment as an alternative to acute inpatient admission. For adults, NHS England should invest to expand Crisis Resolution and Home Treatment Teams (CRHTTs); for children and young people, an equivalent model of care should be developed within this expansion programme. Out of area placements for acute care should be reduced and eliminated as quickly as possible.

Good liaison mental health care is also needed in acute hospitals across the country, providing a 24/7 urgent and emergency mental health response for people attending A&E or admitted as inpatients to acute hospitals. Only a minority of A&E departments have 24/7 liaison mental health services that reach minimum quality standards, even though peak hours for people presenting to A&E with mental health crises are 11pm-7am. By 2020/21 no acute hospital should be without all-age mental health liaison services in emergency departments and inpatient wards, and at least 50 per cent of acute hospitals should be meeting the ‘core 24’ service standard as a minimum.

People experiencing a first episode of psychosis should have access to a NICE-approved care package within 2 weeks of referral. Delay in providing care can lead to poorer clinical and social outcomes. The NHS should ensure that by April 2016 more than 50 per cent of this group have access to Early Intervention in Psychosis services, rising to at least 60 per cent by 2020/21.

People want care in the least restrictive setting that is appropriate to meet their individual needs, at any age, and is close to home. People living with severe mental health problems, such as schizophrenia or personality disorder, should not be held in restrictive settings for longer than they need to be. The NHS should expand proven community-based services for people of all ages with severe mental health problems who need support to live safely as close to home as possible.
More ‘step-down’ help should be provided from secure care, such as residential rehabilitation, supported housing and forensic or assertive outreach teams. By April 2017, population-based budgets should be in place for those CCGs who wish to commission specialised services for people of all ages, in partnership with local government and national specialised commissioners. The Taskforce welcomes the invitation set out in NHS England Planning Guidance 2016/17 – 2020/21 for providers of secondary mental health services to manage budgets for tertiary (specialised) services, to reduce fragmented commissioning and improve full community and inpatient care pathways.

Improving the 7 day crisis response service across the NHS will help save lives as part of a major drive to reduce suicide by 10 per cent by 2020/21. Every area must develop a multi-agency suicide prevention plan that demonstrates how they will implement interventions targeting high-risk locations and supporting high-risk groups within their population.

Some people experience unacceptably poor access to or quality of care. There has been no improvement in race inequalities relating to mental health care since the end of the 5-year Delivering Race Equality programme in 2010. Inequalities in access to early intervention and crisis care, rates of detentions under the Mental Health Act 1983 and lengths of stay in secure services persist.

National and local commissioners must show leadership in tackling unwarranted variations in care. The Department of Health should address race equality as a priority and appoint a new equalities champion to drive change.

Measures must be taken to ensure all deaths across NHS-funded inpatient mental health services are properly investigated, and learned from to improve services and prevent repeat events. By April 2017, the Department of Health should establish an independent system for the assurance of the quality of investigations of all deaths in inpatient mental health services and to ensure a national approach to applying learning to service improvement.
2. An integrated mental and physical health approach

“Making physical and mental health care equally important means that someone with a disability or health problem won’t just have that treated, they will also be offered advice and help to ensure their recovery is as smooth as possible, or in the case of physical illness a person cannot recover from, more should be done for their mental wellbeing as this is a huge part of learning to cope or manage a physical illness.”

People told us that mental health support should be made easily available across the NHS - for mums to be, children, young adults visiting their GP, people worried about stress at work, older people with long-term physical conditions and people receiving care for cancer or diabetes.

People with existing mental health problems told us that services should be integrated - for example, physical health checks and smoking cessation programmes should be made available for everyone with a severe mental illness.

The impact of mental health problems experienced by women in pregnancy and during the first year following the birth of their child can be devastating for both mother and baby, as well as their families. **By 2020/21, NHS England should support at least 30,000 more women each year to access evidence-based specialist mental health care during the perinatal period.** This should include access to psychological therapies and the right range of specialist community or inpatient care so that comprehensive, high-quality services are in place across England.

**By 2020/21, at least 280,000 people living with severe mental health problems should have their physical health needs met.** They should be offered screening and secondary prevention reflecting their higher risk of poor physical health. This will reduce the health inequalities gap. We know there is low take up of information, tests and interventions relating to physical activity, smoking, alcohol problems, obesity, diabetes, heart disease and cancer. In England there are over 490,000 people with severe mental illness registered with a GP. The proportion receiving an annual physical health check ranges from 62 per cent to 82 per cent (this data does not include any information about how many people are being supported to access evidence based interventions as a result of these checks). People with a long standing mental health problem are twice as likely to smoke, with the highest rates among people with psychosis or bipolar disorder. Current incentive schemes for GPs to encourage monitoring of physical health should continue and extra efforts should be made to reduce smoking - one of the most significant causes of poorer physical health for this group. Mental health inpatient services should be smoke free by 2018.
The provision of psychological therapies for people with common mental health problems has expanded hugely in recent years. But it is still meeting only 15 per cent of need for adults. NHS England should increase access to evidence-based psychological therapies to reach 25 per cent of need so that at least 600,000 more adults with anxiety and depression can access care (and 350,000 complete treatment) each year by 2020/21. There should be a focus on helping people who are living with long-term physical health conditions or who are unemployed. There must also be investment to increase access to psychological therapies for people with psychosis, bipolar disorder and personality disorder.

3. Promoting good mental health and preventing poor mental health– helping people lead better lives as equal citizens

“If I’d had the help in my teens that I finally got in my thirties, I wouldn’t have lost my twenties.”

Prevention matters - it’s the only way that lasting change can be achieved. Helping people lead fulfilled, productive lives is not the remit of the NHS alone. It involves good parenting and school support during the early years, decent housing, good work, supportive communities and the opportunity to forge satisfying relationships. These span across national and local government, so the Taskforce has a set of recommendations to build on the Prime Minister’s commitment to a “mental health revolution.”

Prevention at key moments in life

Children and young people are a priority group for mental health promotion and prevention, and we are calling for the Future in Mind recommendations to be implemented in full. Early intervention and quick access to good quality care is vital – especially for children and young people. Waiting times should be substantially reduced, significant inequalities in access should be addressed and support should be offered while people are waiting for care.

By 2020/21, at least 70,000 more children and young people should have access to high-quality mental health care when they need it. This will require a fundamental change in the way services are commissioned, placing greater emphasis on prevention, early identification and evidence-based care. NHS England should continue to work with partners to fund and implement the whole system approach described in Future in Mind, building capacity and capability across the system so that by 2020/21 we will secure measurable improvements in children and young people’s mental health outcomes. We need to ensure that good quality local transformation
plans are put into action, invest in training to ensure that all those working with children and young people can identify mental health problems and know what to do, complete the roll-out of the Children and Young People’s Improving Access to Psychological Therapies (CYP IAPT) programme across England by 2018 and develop an access standard for Child and Adolescent Mental Health Services (CAMHS) by the end of 2016/17. This should build on the standard for children and young people with eating disorders announced in July 2015.

In addition, some children are particularly vulnerable to developing mental health problems - including those who are looked after or adopted, care leavers, victims of abuse or exploitation, those with disabilities or long term conditions, or who are within the justice system. The Departments of Health and Education should establish an expert group to examine their complex needs and how they should best be met, including through the provision of personalised budgets. The Government should also review the best way to ensure that the significant expansion of parenting programmes announced by the Prime Minister builds on the strong-evidence base that already exists and is integrated with Local Transformation Plans for Children and Young People’s mental health services.

The employment rate for adults with mental health problems remains unacceptably low: 43 per cent of all people with mental health problems are in employment, compared to 74 per cent of the general population and 65 per cent of people with other health conditions. Of people with ‘mental and behavioural disorders’ supported by the Work Programme, only 9.5 per cent have been supported into employment, a lower proportion than for some proven programmes. There is a 65 per cent point gap between the employment rates of people being supported by specialist mental health services who have more severe health problems and the general population.

Employment and health form a virtuous circle: suitable work can be good for your health, and good health means that you are more likely to be employed.

By 2020/21, each year up to 29,000 more people living with mental health problems should be supported to find or stay in work through increasing access to psychological therapies for common mental health problems and expanding access to Individual Placement and Support (IPS).
Employment is vital to health and should be recognised as a health outcome. The NHS must play a greater role in supporting people to find or keep a job. Access to psychological support must be expanded to reach at least a quarter of all people who need it. There must be a doubling of access to Individual Placement and Support programmes to reach an extra 30,000 people living with severe mental illness (so that at least 9,000 are in employment), and the new Work and Health Programme should prioritise investment in health-led interventions that are proven to work for people with mental health problems.

Creating mentally healthy communities
We heard from many people about the importance of the role of Local Government in the promotion and prevention agenda. Building on the success of local Crisis Care Concordat Plans, we recommend the creation of local Mental Health Prevention Plans, based on high quality evidence.

Housing is critical to the prevention of mental health problems and the promotion of recovery. The Department of Health, the Department of Communities and Local Government, NHS England, HM Treasury and other agencies should work with local authorities to build the evidence base for specialist housing support for vulnerable people with mental health problems and explore the case for using NHS land to make more supported housing available for this group.

In relation to the proposed Housing Benefit cap to Local Housing Allowance levels, the Department of Work and Pensions should use evidence to ensure that the right levels of protection are in place for people with mental health problems who require specialist supported housing. The Ministry of Justice, Home Office, Department of Health, NHS England and Public Health England should work together to support those in the criminal justice system experiencing mental health problems by expanding liaison and diversion schemes nationally, increasing support for Blue Light services, and for the 90 per cent of people in prison with mental health problems, drug or alcohol problems.

Ending the stigma around mental ill health is vital. The Department of Health and Public Health England should continue to help local communities build a grass roots social movement to raise awareness of good physical and mental health and support people to seek help when they need it.
**Building a better future**

“There should be even greater emphasis put on people’s experience and how experts-by-experience can be seen as real assets to design and develop services.”

The next five years will build the foundations for the next generation.

The UK should be a world leader in the development and application of new **mental health research**. The Department of Health, working with relevant partners, should publish a ten year strategy for mental health research one year from now including a co-ordinated plan for strengthening the research pipeline on identified priorities, and promoting implementation of research evidence.

A **data and transparency revolution** is required to ensure greater consistency in the availability and quality of NHS-funded services across the country. The information gathered by the NHS should reflect social as well as clinical outcomes – e.g. education, employment and housing - that matter to people with mental health problems. This requires better data linkage across the NHS, public health, education and other sectors, with absolute transparency on spending in relation to prevalence, access, experience and outcomes. **By 2020/21, CCGs should be required to publish a range of benchmarking data to provide transparency about mental health spending and performance.**
DELIVERING THIS STRATEGY

“Being both a junior doctor training in psychiatry, and a patient with mental health problems, enables me to experience both sides of the NHS, and I feel this gives me a great advantage and insight. Whilst a lot of the work I experience on both sides is very positive, I am frequently amazed by the heavy workloads of my colleagues and those treating me. And I know that for me, this can in fact contribute to deterioration in my own mental health.”

Mental health services have been chronically underfunded. We know that the presence of poor mental health can drive a 50 per cent increase in costs in physical care. The Taskforce considers it a point of basic parity between physical and mental health that types of care and therapies shown to lead to improved mental health outcomes and found to be cost-effective should be made available to people with mental health problems. Without upfront investment it will not be possible to implement this strategy and deliver much-needed improvements to people’s lives, as well as savings to the public purse.

£1 BILLION ADDITIONAL INVESTMENT NEEDED

Over the next five years additional funding should allow NHS England to expand access to effective interventions. The priority areas we have identified would require an additional £1 billion investment in 2020/21, which will contribute to plugging critical gaps in the care the NHS is currently unable to provide. Our expectation is that savings and efficiencies generated by improved mental health care e.g. through a strengthened approach to prevention and early intervention, and through new models of care, will be re-invested in mental health services.

To deliver these commitments and realise the associated savings NHS England must be able to target investment and ensure there is sufficient transparency and accountability for putting them into action. Both the current Mandate priorities and those set out in this report should specifically be reflected in the local Sustainability and Transformation plans that areas will need to produce by June 2016, in how those plans are assessed and in the processes for allocating and assuring funds.

We recommend eight principles to underpin reform:

• Decisions must be locally led
• Care must be based on the best available evidence
• Services must be designed in partnership with people who have mental health problems and with carers
• Inequalities must be reduced to ensure all needs are met, across all ages
• Care must be integrated – spanning people’s physical, mental and social needs
• Prevention and early intervention must be prioritised
• Care must be safe, effective and personal, and delivered in the least restrictive setting
• The right data must be collected and used to drive and evaluate progress

We make specific recommendations on the need to develop and support the mental health workforce, making it a career option of choice across medicine, social care, the allied health professions and the voluntary sector. We encourage the further development of personalised care, giving people choice in their own care, and the expansion of peer support.

We make a series of fundamental recommendations to hardwire mental health into how care is commissioned, funded, and inspected, across the whole NHS. These should enable mental health to be fully embedded in NHS planning and operations for the duration of the Five Year Forward View.

Co-production with experts-by-experience should also be a standard approach to commissioning and service design, with Arm’s Length Bodies (ALBs) leading by example and supporting this practice in local areas. We recommend the creation of a Mental Health Advisory Board reporting to the Five Year Forward View Board, publicly updating on progress against our recommended outcomes. We also encourage the Cabinet Office and Department of Health to put in place cross-government oversight of the wider actions we are recommending the Government should take, in addition to those being led by the NHS.

**Conclusion**
A summary of our recommendations can be found in the second annex of this report. Delivery of these recommendations is everybody’s business - for the NHS, for health and social care professionals, for providers, employers, across government and communities.

But the critical element of success will be to put the individual with their own lived experience of mental health at the heart of each and every decision which is made. We have much to be proud of in the progress that has been made in empowering people to make their own decisions, and for services to be co-designed. We now have to go a step further and truly produce services which are led by the needs of the individual, not the system.
CHAPTER ONE:

GETTING THE FOUNDATIONS RIGHT: COMMISSIONING FOR PREVENTION AND QUALITY CARE

Every person with a mental health problem should be able to say:

*I am confident that the services I may use have been designed in partnership with people who have relevant lived experience.*

People with lived experience of mental health problems, carers and health and social care professionals told the Taskforce that prevention was a top priority. Specific themes raised included support for new mothers and babies, mental health promotion within schools and workplaces, being able to self-manage mental health, ensuring good overall physical and mental health and wellbeing, and getting help early to stop mental health problems escalating. Many people discussed the importance of addressing the wider determinants of mental health, such as good quality housing, debt, poverty, employment, education, access to green space and tough life experiences such as abuse, bullying and bereavement. It was suggested that while it is particularly important to recognise loneliness in older people, these issues can affect people of any age.

1.1 THE SYSTEM NOW

The quality of local mental health commissioning is variable. We found a twofold difference in apparent per-capita spend by CCGs, a more than threefold difference in excess premature mortality in people with mental health problems in England and a fourfold variation in mortality across local authorities. For children and young people there is wide variation in spend in both the NHS and local authorities. Detentions under the Mental Health Act continue to rise
steadily year on year. Similarly, we know that many adults cannot get the right care locally, a clear demonstration of poor quality commissioning and a lack of investment to meet local need. Reductions in local authority budgets are also leading to rising pressures on important components of mental health care e.g. social care and residential housing.

**Up to ~2x variation in per-capita spend, even when adjusted**

**Unadjusted spend shows 5x variation**

Spend per PRAMH-weighted capita by CCGs and NHS England on mental health 2013/14

PRAMH model weights the population based on age, sex, prevalence of mental health conditions, markers of severity (e.g. MHA), accommodation and employment status, ethnicity and length of contact with mental health services.
Commissioning of services is fragmented between CCGs, local authorities and the NHS. More needs to be done on prevention to reduce inequalities and there needs to be a greater focus on preventing suicide. There is increasing interest in "population-based" commissioning, either by pooling budgets or through joint decision-making with other commissioners, and a number of places are combining spending power across health and social care. The use of personal health budgets is increasing and other new models of care are being developed.

However, there is a long way to go to achieve integrated, population-based commissioning that is crucial for improving mental health outcomes, and incorporates specialised commissioning.

The Crisis Care Concordat action plans are promising as a model for integrated local commissioning. We also endorse the approach set out in Future in Mind as a model for wider system reform, which involves the NHS, public health, voluntary, local authority, education and youth justice services working together through Local Transformation Plans to build resilience, promote good mental health and make it easier for children and young people to access high quality care. This builds on a range of existing legislation that concerns children and young people and which requires agencies to take a coordinated approach. The plans are also important because they address the full spectrum of need, including children and young people who have a particular vulnerability to mental health problems.

Challenges remain to breaking down barriers between how services are commissioned across the country. Within the NHS, primary, secondary and tertiary care services should deliver integrated physical and mental health outcomes. Currently needs are addressed in isolation, if at all, which is not effective or efficient. CCGs need to ensure people with multiple needs do not fall through service gaps. For example, the commissioning of alcohol and substance misuse services has been transferred from the NHS to local authorities, leading to the closure of specialist NHS addiction inpatient units. Referral pathways have become more complex and many people with mental health and substance misuse problems no longer receive planned, holistic care.

On employment, the Department of Work and Pensions forecasts that it will spend £2.8 billion in total payments to contractors to help people into work under the Work Programme between June 2011 and March 2020. Yet fewer than one in 10 people with mental health problems have gained employment through the Work Programme. We know psychological therapies and Individual Placement and Support (IPS) services have proved highly effective – with around 30 per cent moving into jobs through IPS – but these are not being commissioned at scale. The Taskforce also welcomes the introduction of a Joint Unit for Work and Health, which is already piloting new approaches and recently secured significant new investment for an innovation fund.
Commissioners need support to analyse data, moderate demand, channel individuals to appropriate care and test their use of resources against their priorities. Co-production with clinicians and experts-by-experience to ensure services are accessible and appropriate for people of all backgrounds is also essential. Commissioners also need to understand what works, be adept at the use of financial and other levers, and be fully accountable for improving the mental health of their communities.

### 1.2 THE SYSTEM IN THE FUTURE

Local communities will be supported to develop effective Mental Health Prevention plans, and use the best data available to commission the right mix of services to meet local needs. Plans should focus on public mental health, including promoting good mental health, addressing the wider social determinants of mental health problems, local approaches to challenging stigma, and targeting at risk groups with proven interventions. This approach should blend healthcare, social care and user-led support.

By 2020/21, NHS commissioning will be underpinned by a robust understanding of the mental health needs of the local population, bringing together local partners across health, social care, housing, education, criminal justice and other agencies, with a clear recognition of the mental health needs of people treated for physical ailments and vice versa, and with greater integration across agencies to build stronger, more resilient communities. Commissioners will have the knowledge and skills to embed what is proven to work, and to work in partnership with people using services, carers, and local communities to develop and evaluate innovative new models in a range of settings.

The quality of services and outcomes will be assessed on the basis of robust data. There will be clear plans in place to prevent mental ill-health and suicide. More areas will have the freedom to work jointly across whole health and social care systems, following the examples of Manchester and West Midlands.

The Taskforce welcomes the invitation set out in NHS England Planning Guidance 2016/17 – 2020/21 for providers of secondary mental health services to manage budgets for tertiary (specialised) services, to reduce fragmented commissioning and improve care pathways. This is a significant change, which should be developed as a new vanguard programme, ensuring adequate inpatient resource is maintained while preparations are made to support people who are ready to transition into community based services. NHS England should also have established new models of care to trial this new approach for perinatal and CAMHS inpatient services.
Commissioners will:
• work in partnership with local stakeholders and voluntary organisations
• co-produce with clinicians, experts-by-experience and carers
• consider mental and physical health needs
• plan for effective transitions between services
• enable integration
• draw on the best evidence, quality standards and NICE guidelines
• make use of financial incentives to improve quality
• emphasise early intervention, choice and personalisation and recovery
• ensure services are provided with humanity, dignity and respect.

1.3 THE DELIVERY PLAN BY 2020/21
Health and Wellbeing Boards should have plans in place to promote good mental health, prevent problems arising and improve mental health services, based on detailed local data for risk factors, protective factors and levels of unmet need. These should specifically identify which groups are affected by inequalities related to poor mental health and be co-produced with local communities to generate innovative approaches to care and improving quality. Each local council should have Mental Health Champions, building on the 60 that already exist. Nationally, the Department of Health should lead continued work to tackle stigma.

Co-production with clinicians and experts-by-experience should also be at the heart of commissioning and service design, and involve working in partnership with voluntary and community sector organisations. Applying the 4PI framework of Principles, Purpose, Presence, Process and Impact developed by the National Survivor and User Network will help ensure services or interventions are accessible and appropriate for people of all backgrounds, ages and experience.

We expect rapid progress in the transformation of services for children and young people following investment of £1.4 billion over five years announced by the Government in 2014/15 (including additional money for eating disorders in children and young people). Plans are ready and these will be the first major programmes set out in this strategy to be delivered.

More people with common mental health problems should be supported into work through expanding integrated access to psychological therapies and employment support in primary care. Thousands more people accessing secondary mental health services should also be supported to find or keep a job through evidence based Individual Placement and Support services.

The NHS, local authorities, housing providers and other agencies should be working together locally to increase access to supported housing for vulnerable people with mental health problems. They should also be acting to share joint
plans and information between local partners so that mainstream housing services play a more active role in preventing mental health problems arising.

While joint working between the CCG commissioners and other partners has been accepted for children and young people, further work is required across adult services. This offers a means of tackling the difficulties arising from the fracturing of commissioning pathways and escalating demand for inpatient services. Work is also required across secure services and the criminal justice system.

These are the opportunities – but there are also risks. There will be uncertainty about the role and function of commissioning as local geographies change, responsibilities shift, and budgets come under pressure. NHS England and the ALBs must be clear what they expect of commissioners and ensure they are supported.

The transformation we envisage will take a number of years and without clear information about what the best care pathways look like and good data on current levels of spending, access, quality and outcomes, it will be hard to assess the impact of organisational change and ensure mental health services are not disadvantaged. Priority should also be given to tackling inequalities and routine data must be made available so that there is transparency about how local areas are addressing age, gender, ethnicity, disability and sexuality in their plans.

We recognise that the new models of care will not be operating nationwide by 2020/21. Providers currently carry much of the risk and responsibility for improvements in quality and outcomes, with too little scrutiny of commissioning. In an increasingly devolved system, commissioners must remain responsible for meeting the needs of their local populations and must be properly held to account.

**Recommendation 1**: NHS England should continue to work with Health Education England (HEE), Public Health England (PHE), Government and other key partners to resource and implement Future in Mind, building on the 2015/16 Local Transformation Plans and going further to drive system-wide transformation of the local offer to children and young people so that we secure measurable improvements in their mental health within the next four years. This must include helping 70,000 more children and young people to access high quality mental health care when they need it. The CYP Local Transformation Plans should be refreshed and integrated into the forthcoming Sustainability and Transformation Plans (STPs), which cover all health and care in the local geography, and should include evidence about how local areas are ensuring a joined up approach that is consistent with the existing statutory framework for children and young people.
Recommendation 2: PHE should develop a national Prevention Concordat programme that will support all Health and Wellbeing Boards (along with CCGs) to put in place updated Joint Strategic Needs Assessment (JSNA) and joint prevention plans that include mental health and co-morbid alcohol and drug misuse, parenting programmes, and housing, by no later than 2017.

Recommendation 3: The Department of Health, PHE and NHS England should support all local areas to have multi-agency suicide prevention plans in place by 2017, reviewed annually thereafter and supported by new investment.

Recommendation 4: The Cabinet Office should ensure that the new Life Chances Fund of up to £30 million for outcome-based interventions to tackle alcoholism and drug addiction through proven approaches requires local areas to demonstrate how they will integrate assessment, care and support for people with co-morbid substance misuse and mental health problems. It should also be clear about the funding contribution required from local commissioners to pay for the outcomes that are being sought.

Recommendation 5: By 2020/21, NHS England and the Joint Unit for Work and Health should ensure that up to 29,000 more people per year living with mental health problems should be supported to find or stay in work through increasing access to psychological therapies for common mental health problems (see Chapter Two) and doubling the reach of Individual Placement and Support (IPS). The Department of Work and Pensions should also invest to ensure that qualified employment advisers are fully integrated into expanded psychological therapies services.

Recommendation 6: The Department of Health and the Department for Work and Pensions, working with NHS England and PHE, should identify how the £40 million innovation fund announced at the Spending Review and other investment streams should be used to support devolved areas to jointly commission more services that have been proven to improve mental health and employment outcomes, and test how the principles of these services could be applied to other population groups and new funding mechanisms (e.g. social finance).

Recommendation 7: The Department for Work and Pensions should ensure that when it tenders the Health and Work Programme it directs funds currently used to support people on Employment Support Allowance to commission evidence-based health-led interventions that are proven to deliver improved employment outcomes – as well as improved health outcomes – at a greater rate than under current Work Programme contracts.
**Recommendation 8:** NHS England should work with NHS Improvement to run pilots to develop evidence based approaches to co-production in commissioning by April 2018.

**Recommendation 9:** NHS England should ensure that by April 2017 population-based budgets are in place which give CCGs or other local partners the opportunity to collaboratively commission the majority of specialised services across the life course. In 2016/17, NHS England should also trial new models through a vanguard programme that allow secondary providers of these services to manage care budgets for tertiary (specialised) mental health services to improve outcomes and reduce out of area placements.

**Recommendation 10:** The Department of Health, Department of Communities and Local Government, NHS England, HM Treasury and other agencies should work with local authorities to build the evidence base for specialist housing support for vulnerable people with mental health problems and explore the case for using NHS land to make more supported housing available for this group.

**Recommendation 11:** The Department of Work and Pensions should, based on the outcome of the “Supported Housing” review in relation to the proposed Housing Benefit cap to Local Housing Allowance levels, use the evidence to ensure the right levels of protection are in place for people with mental health problems who require specialist supported housing.

**Recommendation 12:** The Department of Health should work with PHE to continue to support proven behaviour change interventions, such as Time to Change, and to establish Mental Health Champions in each community to contribute towards improving attitudes to mental health by at least a further 5 per cent by 2020/21.
CHAPTER TWO:

GOOD QUALITY CARE FOR ALL 7 DAYS A WEEK

Every person with a mental health problem should be able to say:
I have rapid access, within a guaranteed time, to effective, personalised care. I have a choice of talking therapy so that I can find one appropriate to me. When I need urgent help to avoid a crisis I, and people close to me, know who to contact at any time. People take me seriously and trust my judgement when I say a crisis is approaching. I can get help in a crisis, fast. Where I raise my physical health concerns, in any setting, they are taken seriously and acted on. If I am in hospital, staff on the wards can help with my mental as well as physical health needs. Services understand the importance to me of having friends, opportunities and close relationships.

The Taskforce heard that timely access to effective, good quality, evidence-based mental health pathways, with clear waiting times, is a primary concern. People also value having a choice of support, tailored to their specific needs, including access to a full range of psychological therapies. Access to treatment should be equal, and care should support people of all ages, regardless of the particular mental health problem they experience.

2.1 THE SYSTEM NOW

People who need physical health care – cancer care, for example – know what to expect and when to expect it. There are clear pathways of care, quality standards and maximum waiting times.

This is not always true of mental health care. Even though we know that the right care delivered in the right way at the right time improves and may save lives, mental health care has not benefited from the clear pathways and standards in place for secondary physical health care. Models of primary mental health care are also under-developed, and people with mental health problems are not always well supported in primary care with either their mental or physical health care needs.
The introduction of the first access and quality standards for mental health services therefore represents an important step forwards. Access to psychological therapies for common conditions such as anxiety and depression, as recommended by NICE, has increased. Work is in progress to improve services for people experiencing a first episode of psychosis, in perinatal care, crisis care and in children and young people’s services, including for those with eating disorders.

What is lacking is a comprehensive set of standards – comparable to those for physical health care – and the supporting quality and outcomes data showing what works. Combined with under-investment, most people receive currently no effective care and too few benefit from the full range of NICE-recommended interventions.

Waiting times – for first appointments and for the right follow-on support – are unacceptably long. Basic interventions are in short supply, services are under pressure and thresholds for access are being raised. As a result, people’s needs often escalate and they can become acutely unwell or experience a crisis, resulting in poorer outcomes and a reliance on higher cost care.

Crisis care is improving following the signing of the Crisis Care Concordat – but there is still a long way to go to match standards in urgent and emergency care for physical health needs. The Independent Commission on Acute Adult Psychiatric Care, established and supported by the Royal College of Psychiatrists, reported that the current reliance on acute beds means that it is often difficult for people to access care near home and that this is exacerbated by a lack of community services, particularly Crisis Response and Home Treatment Teams (CRHTTs). Only 14 per cent of adults experiencing a crisis feel they are provided with the right response and just over one third (36 per cent) feel respected by staff when they attend A&E. Less than half (48 per cent) of children and young people’s services have a crisis intervention team. Too often people in crisis end up in a police cell rather than a suitable alternative place of safety.

Adult mental health services are under intense pressure. Less than half of CRHTTs have sufficient staff to provide 24/7 intensive home treatment as an alternative to admission, putting extra pressure on hospital beds. Delayed discharge and transfers of care are as high as 38 per cent in some areas, often linked to a lack of suitable housing or social care. Bed occupancy routinely exceeds 95 per cent and the CQC ‘Right Here, Right Now’ report found that many people have to travel long distances to be admitted.

Comprehensive liaison mental health services are currently available in only one in six (16 per cent) of England’s 179 acute hospitals. The situation is better for paediatric mental health liaison, with 79 per cent of hospitals reporting cover, but these frequently do not operate out of hours.
Long stays in high cost secure hospitals and delayed discharge are common, often owing to the lack of recovery-focused care and suitable “step-down” services. Nine out of ten people in prison have a mental health or substance abuse problem – often together – but most do not receive the right care.

Some groups are disproportionately represented in detentions to acute and secure inpatient services, and are affected by long stays. For example, men of African Caribbean ethnic origin are twice as likely to be detained in low secure services than men of white British origin and stay for twice as long in those services on average. This suggests a failure to ensure equal access to earlier intervention and crisis care services.

Older people’s needs are also neglected, with many led to believe depression is a normal part of ageing.

People with mental health problems often also receive poorer physical health care. Those with severe mental illness die on average 15-20 years earlier than the general population. They are three times more likely to attend A&E with an urgent physical health need and almost five times more likely to be admitted as an emergency, suggesting deficiencies in the primary care they are receiving. The reverse is also true – people with long term physical health conditions do not routinely have mental health support included in their care package.

2.2 THE FUTURE: RIGHT CARE, RIGHT TIME, RIGHT QUALITY – 7 DAYS A WEEK

People with mental health problems, regardless of their age, ethnicity, or any other characteristic will have swift access to holistic, integrated and evidence-based care for the biological, psychological and social issues related to their needs, in the least restrictive setting and as close to home as possible.

By 2020/21, there will be a comprehensive set of care pathways in place and we expect at least a million more people will be able to get the help they need, improving outcomes and reducing reliance on acute care services. Services will provide clear data about access and waiting times and payment will be linked to the interventions delivered and the outcomes achieved.

There will be a 7 day NHS providing urgent and emergency mental health crisis care 24 hours a day, as there is for physical health, delivering 24/7 intensive home treatment and not just crisis assessment. Police cells will be used only in exceptional circumstances for people detained under the Mental Health Act. Good quality liaison mental health services will be available more widely across the country.
Mental and physical health support will be integrated. People with severe mental illness at highest risk of dying prematurely will be supported to access tests and screening to monitor their physical health in primary care. Mental health services will be delivered by multi-disciplinary integrated teams, with named, accountable clinicians, across primary, secondary and social care. They will include provision of care for substance misuse issues.

People with acute mental health needs will be able to access appropriate care, as inpatients or through community teams. Their housing, social care and other needs will be assessed on admission and the right support made available on discharge. Use of the Mental Health Act will be monitored, with a focus on Black and Minority Ethnic (BAME) groups.

People in the criminal justice system will also have their mental health needs assessed and the right care provided.

2.3 A DELIVERY PLAN FOR A 7 DAY MENTAL HEALTH SERVICE
Clinical standards, including maximum waiting times for NICE-recommended care based on the ambitions set out in Achieving Better Access to Mental Health Services by 2020/21 and the Five Year Forward View, should be rolled out nationwide. These must ensure that:

• waiting times are informed by clinical evidence and should be for effective care in line with NICE recommendations
• all services should routinely collect and publish outcomes data.

These are already in place for psychological therapies for common mental health problems, a waiting time standard for early intervention in psychosis will come into effect from April 2016 and one for children and young people with eating disorders the following year.

Urgent work is needed to establish comprehensive pathways and quality standards for the rest of the mental health system based on the timetable on page 36, which can then be implemented as funding becomes available. This programme must be co-produced with clinical experts and experts-by-experience. Work is already in happening to secure input on what robust standards for children and young people, crisis care for people of all ages, and perinatal care should look like. There should also be a referral to treatment access standard for acute care, including quality standards and outcomes measures for home treatment and inpatient care for people with acute mental health needs.
Where evidence about the effectiveness of interventions is robust and pathways are in place or are being developed there is a strong case for NHS England to invest to expand access. NHS England, the Department of Health and the Ministry of Justice should also start joint work to develop pathways across the criminal justice system.

Improved access to high quality inpatient services for children, young people and adults is needed, as highlighted by the Independent Commission on Acute Adult Psychiatric Care, established and supported by the Royal College of Psychiatrists which reported earlier this month.

Primary care (including Out of Hours services) should form a part of each of the relevant pathways within the new programme. There should also be a new focus in primary care on the physical health care of people with severe mental health problems, including psychosis, bipolar disorder and personality disorder.

Wherever it is provided care should be appropriate to people of all ages. Older people should be able to access services that meet their needs – bespoke older adult services should be the preferred model until general adult mental health services can be shown to provide age appropriate care.

**Recommendation 13:** By 2020/21, NHS England should complete work with ALB partners to develop and publish a clear and comprehensive set of care pathways, with accompanying quality standards and guidance, based on the timetable set out in this report. These standards should incorporate the relevant physical health care interventions and the principles of co-produced care planning.

**Recommendation 14:** NHS England should invest to increase access to integrated evidence-based psychological therapies for an additional 600,000 adults with anxiety and depression each year by 2020/21 (resulting in at least 350,000 completing treatment), with a focus on people living with long-term physical health conditions and supporting 20,000 people into employment. There must also be investment to increase access to psychological therapies for people with psychosis, bipolar disorder and personality disorder.

**Recommendation 15:** By 2020/21, NHS England should support at least 30,000 more women each year to access evidence-based specialist mental health care during the perinatal period. This should include access to psychological therapies and the right range of specialist community or inpatient care so that comprehensive, high quality services are in place across England.
**Recommendation 16:** The NHS should ensure that from April 2016 50 per cent of people experiencing a first episode of psychosis have access to a NICE–approved care package within two weeks of referral, rising to at least 60 per cent by 2020/21.

**Recommendation 17:** By 2020/21, NHS England should ensure that a 24/7 community-based mental health crisis response is available in all areas across England and that services are adequately resourced to offer intensive home treatment as an alternative to an acute inpatient admission. For adults, NHS England should invest to expand Crisis Resolution and Home Treatment Teams (CRHTTs); for children and young people, an equivalent model of care should be developed within this expansion programme.

**Recommendation 18:** By 2020/21, NHS England should invest to ensure that no acute hospital is without all-age mental health liaison services in emergency departments and inpatient wards, and at least 50 per cent of acute hospitals are meeting the ‘core 24’ service standard as a minimum.

**Recommendation 19:** NHS England should undertake work to define a quantified national reduction in premature mortality among people with severe mental illness, and an operational plan to begin achieving it from 2017/18. NHS England should also lead work to ensure that by 2020/21, 280,000 more people living with severe mental illness have their physical health needs met by increasing early detection and expanding access to evidence-based physical care assessment and intervention.

**Recommendation 20:** PHE should prioritise ensuring that people with mental health problems who are at greater risk of poor physical health get access to prevention and screening programmes. This includes primary and secondary prevention through screening and NHS Health Checks, as well as interventions for physical activity, obesity, diabetes, heart disease, cancer and access to ‘stop smoking’ services. As part of this, NHS England and PHE should support all mental health inpatient units and facilities (for adults, children and young people) to be smoke-free by 2018.

**Recommendation 21:** NHS England should ensure that people being supported in specialist older-age acute physical health services have access to liaison mental health teams – including expertise in the psychiatry of older adults – as part of their package of care, incentivised through the introduction of a new national Commissioning for Quality and Innovation (CQUIN) framework or alternative incentive payments, and embedded through the Vanguard programmes.
**Recommendation 22:** In 2016, NHS England and relevant partners should set out how they will ensure that standards are introduced for acute mental health care, with the expectation that care is provided in the least restrictive way and as close to home as possible. These plans should include specific actions to substantially reduce Mental Health Act detentions and ensure that the practice of sending people out of area for acute inpatient care as a result of local acute bed pressures is eliminated entirely by no later than 2020/21. Plans should also include specific action to substantially reduce Mental Health Act detentions and targeted work should be undertaken to reduce the current significant over-representation of BAME and any other disadvantaged groups within detention rates. Plans for introduction of standards should form part of a full response to the Independent Commission on Acute Adult Psychiatric Care, established and supported by the Royal College of Psychiatrists, by no later than end 2016/17.

**Recommendation 23:** NHS England should lead a comprehensive programme of work to increase access to high quality care that prevents avoidable admissions and supports recovery for people of all ages who have severe mental health problems and significant risk or safety issues in the least restrictive setting, as close to home as possible. This should seek to address existing fragmented pathways in secure care, increase provision of community based services such as residential rehabilitation, supported housing and forensic or assertive outreach teams and trial new co-commissioning, funding and service models.

**Recommendation 24:** The Ministry of Justice, Home Office, Department of Health, NHS England and PHE should work together to develop a complete health and justice pathway to deliver integrated health and justice interventions in the least restrictive setting, appropriate to the crime which has been committed.
There are a number of different mental health conditions, and the guidelines and quality standards produced by NICE are structured in line with broad diagnostic categories such as ‘psychosis’. The aim of the existing mental health access and waiting time standards programme is to ensure that a greater number of people have timely access to the full range of interventions recommended by NICE and receive the ‘right care, first time’. The proposed new standards have broadly been framed in line with NICE guidelines and quality standards, unless this makes little practical sense. For example, the crisis care standards will cut across multiple conditions because the focus must be responding rapidly to people’s needs in the most appropriate setting (although the aim will still be to ensure that people in crisis have access to care in line with NICE recommendations). The proposed programme also includes work to ensure that people who are already receiving support get care that is fully NICE-concordant, including psychological therapy, as a core part of co-produced care plans that are recovery and outcome-focused.
CHAPTER THREE:

INNOVATION AND RESEARCH TO DRIVE CHANGE NOW AND IN THE FUTURE

3.1 BUILDING ON INNOVATION

Every person with a mental health problem should be able to say:
I am confident that the services I may use have been designed in partnership with people who have relevant lived experience. I can access support services without waiting for a medical referral. I am able to access a personal budget for my support needs on an equal basis to people with physical health problems for example, to help my recovery or to stay well. My mental and physical health needs are met together.

I am provided with peer support contact with people with their own experience of mental health problems and of using mental health services. I can find peer support from people who understand my culture and identity. Peer support is available at any point in my fluctuating health – in a crisis, during recovery, and when I am managing being well. I have a place I can call a home, not just ‘accommodation’. I have support to help me access benefits, housing and other services I might need.

There were also concerns from people from BAME communities, who told us they had lost trust in services and wanted more support within the community. More widely, we heard that community and voluntary sector providers play a critical role in supporting groups that are currently poorly served by services, such as BAME communities, children and young people, older people, lesbian, gay, bisexual and transgender people, and people with multiple needs.

The Taskforce heard that there is a strong appetite for mental health research to be equitably funded and to have parity with other areas of health research. There was also support for much more research involving experts-by-experience, looking at what matters most to people in relation to prevention and care or support. Understanding the causes of mental ill health, including social and psychological factors, was considered a priority for research funding.
Delivering better care to more people not only requires increased investment. It also requires the development of new ways to improve the quality and productivity of services. We heard of many examples of approaches which had promise, but where further research was required.

This is already being applied: successful innovations, such as the Crisis Care Concordat, have led to the transformation of services, highlighting the importance of multi-agency partnerships and strong local leadership in implementing change. NHS Improvement should seek to stimulate other local initiatives building a broad pipeline of improvements from which others can learn.

Alongside new standards we need to see further innovation in three areas:

- **new models of care** to stimulate effective collaboration between commissioners and providers to develop integrated, accessible services for all - for example Integrated Personal Commissioning
- **expanding access to digital services** to enable more people to receive effective care and provide greater accessibility and choice - for example the digital initiative in London that will be operational later this year
- **a system-wide focus on quality improvement** to support staff and patients to improve care through effective use of data, with support from professional networks.

Innovation must be robustly evaluated as part of a strengthened approach to mental health research. NHS England should trial new approaches at scale, first in the 50 vanguard sites which are working to integrate health and social care, and second by creating an equivalent cohort of vanguard areas to pilot new approaches to delivering integrated specialist mental health care.

All new models must be developed in partnership with experts-by-experience, carers, and community and voluntary organisations. Psychological and social interventions, such as peer support and short-stay alternatives to hospital, are particularly valued by people with mental health problems and it is essential to demonstrate whether they also provide value for money.

We see a pivotal role for digital technology in driving major changes to mental health services over the next five years. There are already good examples of its use by NHS Choices, and there are a number of apps with a mental health theme. There is a large mental health community on social media and voluntary organisations report heavy demand on their digital services.

Provision must be increased so that:

- people can access services conveniently, have greater choice, and can network with peers to provide mutual support and guidance
- providers can deliver a more nuanced service, with contact through digital
media backed up by face-to-face interventions
• commissioners can improve outcomes through low-cost and easily scalable interventions
• providers can work securely to share patient data on electronic health records, where appropriate, to benchmark their performance and to test new service models
• people who use services, carers and the wider public can hold the system to account by using data across the entire pathway (from prevention and access through to productivity and outcomes) to scrutinise performance.

Our engagement activity brought home the critical role that people with experience of mental health problems, carers and staff can play in improving services. Yet we heard countless stories of promising ideas not being heard or taken forward. A whole-system approach is needed among the health ALBs to encourage constructive challenge.

Mental health problems account for a quarter of all ill health in the UK. Despite important new developments in mental health research it receives less than 5.5 per cent of all health research funding. Latest figures suggest that £115 million is spent on mental health research each year compared with £970 million on physical health research.

This disparity was highlighted by the Chief Medical Officer in her 2014 report. The biggest existing gaps include research into children’s mental health, the promotion of good mental health and prevention of ill health, and the links between mental and physical health. One pound spent on mental health research realises an additional return of 37p each year, the same rate of return as for research on cancer and heart disease.

3.2 DELIVERING ON INNOVATION AND RESEARCH

We aim to create a simple pathway for innovation and research:
• identify areas of innovation and research promise
• invest in research programmes which include testing approaches at scale
• review research and embed it into care pathways and new models of care.

In future, new models of care will support people’s mental health alongside their other needs, including physical health, employment, housing and social care and will have a greater emphasis on prevention, self-management, choice, peer support, and partnership with other sectors.

Specifically, new models of enhanced primary care and collaborative specialist care that meets the physical and mental health needs of people with severe mental illness will have been fully trialled.
People will also have greater choice and control over the services provided for them. They will be able to access good information, help and advice online, via live chat, email, text message and phone. Organisations will have the technology to collect data to improve their services. Mental health will be integrated into national and local transformation programmes and NHS commissioners supported to engage patients and staff in improving the quality and cost-effectiveness of care. There will be a more co-ordinated approach to research between government, private, public and philanthropic sectors over the long term and the involvement of people with lived experience of mental health problems as standard.

Mental health research should follow the roadmap set out in the ROAMER project, a collaboration of over 1,000 scientists, people using services, families, professional groups and industry representatives, published in September 2015, which identified the following priorities:

1. Preventing mental health problems arising, promoting mental health and focusing on young people
2. Focusing on the causal mechanisms of mental ill-health
3. Setting up international collaborations and networks for mental health research
4. Developing and implementing new and better interventions for mental health and wellbeing
5. Reducing stigma and empowering people with mental health problems and carers
6. Research into health and social systems.

### 3.3 NEW MODELS OF CARE

The new models of care being piloted by the vanguard sites offer opportunities to improve care for people with mental health problems by, for example:

- working with Primary and Acute Care Systems (PACS) to incorporate mental health screening and support within maternity pathways, and considering new payment models for integrating mental health care within tariff prices
- working with Multispeciality Community Providers (MCP) to provide integrated psychological support within wider primary care and community services provision, and supporting mental health inpatients more effectively to manage their physical health
- working with Urgent and Emergency Care (UEC) vanguards to ensure that sufficient liaison mental health and pathways to further care are available in acute hospitals to support those in mental health crisis.
NHS England should drive the development of new care models, starting with the implementation of NICE-recommended interventions. They should address current gaps in care and assess the work of relevant vanguards to benchmark how far mental health is reflected within their transformation plans to include:

- working with Jobcentre Plus, to expand access to IPS to help more people into employment
- trialling dedicated inpatient services for 16-25 year olds, as they transition to adulthood, following the model adopted for young cancer patients
- delivering extra training for primary care staff in supporting people with severe mental illness
- building a robust invest to save model for integrating psychological therapies into primary care through GP collaboratives
- developing new partnerships with the community and voluntary sector.

NHS England should support these innovations by working with current programmes to integrate commissioning across agencies, ensure commissioners and providers are confident to work in partnership with their communities, including people who use services and carers, and make more use of digital technology, as laid out in the National Information Board’s strategy. A co-ordinated approach across ALBs, backed by experts in clinical improvement and good quality data, is essential to give local leaders effective support to implement necessary change.

**Recommendation 25:** The MCP, PACS, UEC Vanguards and the Integrated Personalised Commissioning programme should be supported to ensure that the inclusion of payment for routine integrated care adequately reflects the mental health needs of people with long-term physical health conditions. Vanguard sites should also provide greater access to personal budgets for people of all ages, including children and young people who have multiple and complex needs, to provide more choice and control over how and when they access different services.

**Recommendation 26:** The UK should aspire to be a world leader in the development and application of new mental health research. The Department of Health, working with all relevant parts of government, the NHS ALBs, research charities, independent experts, industry and experts-by-experience, should publish a report one year from now setting out a 10-year strategy for mental health research. This should include a coordinated plan for strengthening and developing the research pipeline on identified priorities, and promoting implementation of research evidence.

**Recommendation 27:** The Higher Education Funding Council for England (HEFCE) should review funding requirements and criteria for decision-making to support parity through the Research Excellence Framework and take action
to ensure that clinical academics in mental health (including in psychiatry and neuroscience) are not disadvantaged relative to other areas of health research, starting in 2016/17.

**Recommendation 28:** The Department of Health, through the National Information Board, should ensure there is sufficient investment in the necessary digital infrastructure to realise the priorities identified in this strategy. Each ALB should optimise the use of digital channels to communicate key messages and make services more readily available online, where appropriate, drawing on user insight. Building on trial findings, NHS England should expand work on NHS Choices to raise awareness and direct people to effective digital mental health products by integrating them into the website and promoting them through social marketing channels from 2016 onwards.

**Recommendation 29:** To drive and scale improvements in integration, the Department of Health and relevant partners should ensure that future updates to the Better Care Fund include mental health and social work services.

**Recommendation 30:** NHS England and NHS Improvement should encourage providers to ensure that ‘navigators’ are available to people who need specialist care from diagnosis onwards to guide them through options for their care and ensure they receive appropriate support. They should work with HEE to develop and evaluate this model.

**Recommendation 31:** NHS England should work with CCGs, local authorities and other partners to develop and trial a new model of acute inpatient care for young adults aged 16–25 in 2016, working with vanguard sites.
CHAPTER FOUR:

STRENGTHENING THE WORKFORCE

Every person with a mental health problem should be able to say:
Services and professionals listen to me and do not make assumptions about me. Those who work with me bring optimism to my care and treatment, so that I in turn can be optimistic that care will be effective. The staff I meet are trained to understand mental health conditions and able to help me as a whole person. Staff support me to be involved in decisions at the right level. They respond flexibly and change the way they work as my needs change. Wherever possible, there are people with their own experience of using services who are employed or otherwise used in the services that support me. As far as possible, I see the same staff members during a crisis.

My culture and identity are understood and respected when I am in contact with services and professionals. I am not stigmatised by services and professionals as a result of my health symptoms or my cultural or ethnic background. The strengths of my culture and identity are recognised as part of my recovery. My behaviour is seen in the light of communication and expression, not just as a clinical problem.

The Taskforce heard a strong message that staff across the NHS need to have training that equips them to understand mental health problems and to treat people with mental health problems with dignity and respect: treating ‘the person, not the diagnosis’. This is critical in enabling people with mental health problems to play a more active role in making choices about all aspects of their care, based on a more equal and collaborative relationship between the person and professional(s). A number of people described encountering stigmatising attitudes from some staff within mental health services, as well as staff in the wider NHS (including GP surgeries and non-clinical staff). Developing a paid peer support workforce had considerable support. People also wanted clearer protocols for staff when they are working with carers.

Professionals and professional bodies wanted the NHS as an employer to pay greater regard to the health and wellbeing of NHS and social care staff, as an effective way to improve the quality of care at a time when staff are under increasing pressure.
4.1 THE PICTURE TODAY - STAFF WORKING HARD IN A TOUGH ENVIRONMENT

Building and maintaining a qualified workforce of committed staff is one of the greatest challenges facing the NHS - and it is most acute in mental health. Providing specialist care to people experiencing mental distress is difficult, demanding work and requires exceptionally dedicated, caring individuals. It calls for multi-disciplinary teams, including psychiatrists, mental health nurses, psychologists, occupational therapists and social workers. There are significant opportunities for increasing access to high quality, integrated care that rely upon an expanded workforce with the right skills, but recruitment is not easy in some areas.

Data from 2014 from Health Education England (HEE) indicate a 6.3 per cent vacancy rate for NHS consultant psychiatrist posts, and over 18 per cent of core training posts in psychiatry are currently vacant. Psychiatry has the slowest rate of growth and the highest drop-out rate of any clinical specialty.

Between 2013/14 and 2014/15, referral rates increased five times faster than the Child and Adolescent Mental Health Services (CAMHS) workforce. Some areas report one in ten appointments cancelled because of staff shortages, specialist CAMHS run by junior staff who lack the requisite skills and too few therapists with the necessary training.

According to the King’s Fund report ‘Under Pressure’ almost half of community mental health teams surveyed had staffing levels judged to be less than adequate in 2013/14 and many more were unable to provide a full multi-disciplinary team. Demand for temporary mental health nursing staff has risen by two thirds since the beginning of 2013/14. Staff shortages have contributed to deaths on inpatient wards, according to the 2015 National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, and they have also been blamed for the rise in detentions.

Mind reported that in 2011/12, there were almost 1,000 incidents of physical injury following restraint in mental health services, with considerable variation between trusts. According to NHS Benchmarking, use of restraint has increased this year.

Workforce planning for mental health across the entire care pathway has not been developed and as a result opportunities are being missed to identify how changes in skill mix could help improve delivery, retain staff and tackle the highest vacancy rates.

A chink of light has appeared in the past year; there have been small increases in staffing on adult and older people’s inpatient wards, driven by the safer
staffing initiative and new initiatives to increase social workers in mental health. However, bed occupancy rates have also risen.

In 2015, a five year plan began, led by NHS England and HEE, to set staffing levels to deliver high quality care under the existing standards programme. For example, to meet the access standard for Early Intervention in Psychosis, this has identified what staffing needs are required including psychologists, therapists, care co-ordinators, vocational workers and psychiatrists. Further work is needed by NHS England and HEE to expand this programme to put into action the full range of pathways and standards described in Chapter Two.

Staffing is not just a question of numbers. The resilience and wellbeing of staff is also critical. Morale varies widely across the system today, linked with pressure of work and level of training, according to the Commission on Acute Adult Psychiatric Care, established and supported by the Royal College of Psychiatrists. Yet the Royal College of Physicians found fewer than half of NHS trusts had a plan in place to promote staff wellbeing.

It goes without saying that people seeking NHS care need to be treated with compassion. But what is sometimes forgotten is that staff do too. The care they receive impacts on the care they are able to deliver. Ten million working days are lost each year to sickness absence in the NHS. Some 43 per cent of mental health staff cite work related stress as the cause, second only to ambulance trusts at 51 per cent. Findings from the British Psychological Society and New Savoy staff wellbeing survey for 2015 show that around half of psychological professionals surveyed report depression. Seventy per cent say they are finding their job stressful. Yet the quality of the NHS occupational health service is inconsistent and, in some cases, inadequate, according to the NHS Health and Wellbeing Review.

Despite the pressures, we heard many positive and inspiring stories about the quality of care provided by NHS staff for people with mental health problems. We also heard that some have poor attitudes to mental health. The CQC report ‘Right here, Right now’ found less than four in ten people (out of 316 surveyed) accessing A&E felt listened to, taken seriously and treated with warmth and compassion. Among those in touch with specialist mental health crisis services the response was only slightly more positive with half (of 748 surveyed) saying they were well treated. GPs, ambulance staff and the police were perceived as more caring and voluntary organisations as being the most caring of all.

Race discrimination is still perceived by some as a problem according to the CQC. The introduction of the NHS Workforce Race Equality Standard is welcome and must be monitored closely.
Primary care staff are not yet fully equipped to provide high quality mental health care. More than four out of five practice nurses have responsibilities for which they have not been trained, with 42 per cent having no training at all in mental health, according to the Royal College of GPs. The training of GPs could also be improved to ensure they are fully supported to lead the delivery of multi-disciplinary mental health support in primary care.

Drugs for mental health problems can have serious side effects, such as causing rapid weight gain, but standards in the prescribing of anti-psychotics and other medications are not consistently adhered to, according to the Prescribing Observatory for Mental Health.

Shared decision-making between the person being supported and their practitioner is known to improve the quality of care by increasing active involvement, self-management and confidence. Yet less than half (42 per cent) of people using community mental health services “definitely” have a care plan and only just over half (56 per cent) said they were “definitely” involved as much as they wanted to be. New models are appearing. In secure care services, an approach to collaborative planning has been developed called My Shared Pathway which should be robustly evaluated.

Carers have a unique role to play for some people with mental health problems, and are often responsible for navigating complex health and social care systems and providing support to help the person manage. This includes the children of parents with mental health problems, who are likely to provide a caring role. Mental health practitioners should have the knowledge and skill to involve carers appropriately, including working with the person using the service and carers to determine what information can be shared between the three parties.

Peer support is highly valued, especially by young people and BAME adults, and should be developed as a core part of the multi-disciplinary team.

**4.2 THE WORKFORCE IN THE FUTURE - MENTAL HEALTH AS THE PROFESSION OF CHOICE**

As public interest and awareness of mental health increases and stigma diminishes, many more people are considering a career in mental health. The Think Ahead programme, a “Teach First” approach for social workers in mental health, has had in excess of 2,000 applicants for its first 100 places. There is the potential to put in place an approach that encourages more young people to choose a career in mental health, and more peer support.
The right workforce with the right skills is the single most important component of good care. All frontline staff, including those in the criminal justice system, should have basic skills to provide mental health care. Urgent work to jointly develop robust health and social care workforce planning for mental health must start now to:

- identify and fill workforce gaps
- provide the right training and support
- involve carers, as appropriate
- provide annual projections for staff numbers and costs.

The ‘Public mental health leadership and workforce development framework’ has been published by Public Health England. It should be implemented in full. Staff should be trained to prevent ill health, working across traditional boundaries, in line with its recommendations. The need for access to effective social work as part of good quality mental health care should also be recognised through the routine inclusion of social workers in NHS commissioner and provider workforce planning.

Mental health staff should be trained to treat people with sensitivity, in the least restrictive way possible, prescribing in line with standards and using restraint only in exceptional circumstances. There should be a greater focus on mental health awareness for all front-line staff. This will involve cultural change and require strong leadership.

Staff should work in partnership with the people using services to develop plans based on the personal goals of the individual. Peer support should be offered from people who have had similar experiences and carers should be given help to play an appropriate role. Restraint will be used only as a last resort.

By 2020/21, measures to improve staff morale and wellbeing will be in place, backed by good data, and people with mental health problems will experience an improvement in staff attitudes. Training will have been strengthened and new models of care expanded. Most care should be provided in community and primary care settings.

Protecting the mental health of the workforce is also vital. NHS England has committed to helping staff make choices to improve their own health, and mental health is a key part of that. This should apply across the NHS – building on positive initiatives within ambulance trusts. Every NHS trust should become an ‘enabling’ environment, as recommended in the Francis Report, so people want to work there. Trusts should monitor the mental health of their staff and provide effective occupational health services.
**Recommendation 32:** HEE should work with NHS England, PHE, the Local Government Association and local authorities, professional bodies, charities, experts-by-experience and others to develop a costed, multi-disciplinary workforce strategy for the future shape and skill mix of the workforce required to deliver both this strategy and the workforce recommendations set out in Future in Mind. This must report by no later than 2016.

**Recommendation 33:** NHS England should ensure current health and wellbeing support to NHS organisations extends to include good practice in the management of mental health in the workplace, and provision of occupational mental health expertise and effective workplace interventions from 2016 onwards.

**Recommendation 34:** NHS England should introduce a CQUIN or alternative incentive payment relating to NHS staff health and wellbeing under the NHS Standard Contract by 2017.

**Recommendation 35:** NHS England should develop and introduce measures of staff awareness and confidence in dealing with mental health into annual NHS staff surveys across all settings.

**Recommendation 36:** The Department of Health and NHS England should work with the Royal College of GPs and HEE to ensure that by 2020 all GPs, including the 5,000 joining the workforce by 2020/21, receive core mental health training, and to develop a new role of GPs with an extended Scope of Practice (GPwER) in Mental Health, with at least 700 in practice within 5 years.

**Recommendation 37:** The Department of Health should continue to support the expansion of programmes that train people to qualify as social workers and contribute to ensuring the workforce is ready to provide high quality social work services in mental health. This should include expanding ‘Think Ahead’ to provide at least an additional 300 places.

**Recommendation 38:** By April 2017, HEE should work with the Academy of Medical Royal Colleges to develop standards for all prescribing health professionals that include discussion of the risks and benefits of medication, and take into account people’s personal preferences, including preventative physical health support and the provision of accessible information to support informed decision-making.
CHAPTER FIVE:

A TRANSPARENCY AND DATA REVOLUTION

The Taskforce heard from a range of stakeholder organisations that data and transparency are critical aspects of a system that delivers good outcomes. Work needs to happen to link data from different public services and agencies (the NHS, social care, education, criminal justice and others) to help identify and meet the full needs of people with mental health problems. Similarly, there should be more national support with the analysis and presentation of raw data to support good commissioning and local planning.

Organisations representing different communities emphasised the importance of equalities monitoring by providers for greater transparency about access, quality and outcomes for various groups. This should help ensure that the provisions of the Human Rights Act and the Equalities Act 2010 are being met. Several organisations also stated that there needs to be greater transparency in how resources are allocated to mental health across NHS settings, the quality of services provided and to what extent they are improving outcomes.

5.1 A “BLACK HOLE” OF DATA

Understanding how quickly people are able to access services, what sort of care they are receiving and what outcomes they are experiencing is vital to good care. Consistent and reliable data in mental health, however still lags behind other areas of health. There is good information available, but it is not co-ordinated or analysed usefully.

National data are collected through the Mental Health Services Data Set (MHSDS) by the Health and Social Care Information Centre (HSCIC) on behalf of the Department of Health. The MHSDS began operating on 1 February 2016 and its reporting capability is yet to be tested.
Prior to that point data reporting has been sporadic and the HSCIC has warned it will not be able to meet reporting needs quickly now the MHSDS is operational. Changes to the dataset can take more than 12 months which will limit the immediate usefulness of the MHSDS. For adults, data is also grouped together under ‘clusters’ which can inform how services are paid for but do not align with diagnosis or NICE guidelines so it not clear whether people are getting recommended interventions. The ‘cluster’ currency provides an indication of individual need and has demonstrated the ability of services to report high quality data (the cluster currency has been mandatory for providers since 2012). However, this approach still does not provide the right kinds of incentives i.e. across pathways of care or to promote good outcomes. It may even encourage perverse incentives, such as paying more where people move into crisis or become acutely unwell.

Some datasets are better quality than others – for example the national data on access to psychological therapies for common mental health problems are robust. Collection of data on children and young people has been subject to delays and the data itself lacks clarity. We also do not have ready access to local and national equalities data, showing us breakdowns in access and outcomes across groups protected by the Equality Act 2010.

The National Mental Health Intelligence Network (NMHIN), run by PHE, with support from NHS England and the Department of Health, presents data to help improve commissioning and service provision. In some areas, it is well developed, providing details on levels of access, spending and social care. But it lacks the analytical capacity of other health data networks. PHE publishes additional resources for children and young people on the Chimat website although it also lacks analytic power.

Financial reporting is an important indicator for scrutinising commissioning and provision. Yet it is not consistently available in mental health. Provider level data is also linked to care ‘clusters’ and reference costs for the clusters vary hugely across the country, partly due to lack of consistency in their use and partly to variations in the services provided. Clusters describe the needs that people present with but do not clearly align with the care that NICE recommends, making it difficult to establish the true funding picture. While CCG programme budgets for physical health are broken down by disease, there is only one category for mental health. Local information on investment in care, by condition, is therefore essential.

An important barrier to good care is the lack of appropriate data sharing to enable organisations to identify co-morbidities, anticipate problems and plan care in a holistic fashion. People with poor mental health may require primary care, secondary physical care and social care, as well as mental health services, but the lack of linked datasets hinders effective provision.
The Summary Care Record (SCR) is an attempt to address this by including key primary care information about an individual such as medication, allergies and adverse reactions. But it does not routinely include care plan information or allow access to mental health care records (or physical care records) which is a significant missed opportunity.

Good data are also necessary to allow people to make an informed choice of service. However, the information on mental health on 'myNHS' is limited to CQC ratings and clinical audits. Waiting times for care and the range of interventions on offer would be more relevant to choosing a provider.

### 5.2 A TRANSPARENCY REVOLUTION

The inadequacy of good national mental health data and the failure to address this issue until recently has meant that decisions are taken and resources allocated without good information, perpetuating a lack of parity between physical and mental health care.

This lack of transparency has also had a negative impact on confidence in mental health services - we heard that many people felt that additional resources didn’t reach the front line. Data about outcomes and acceptable levels of variation are unclear, but we are encouraged by the work of the NHS Benchmarking Network.

In the future, the quality of mental health services and how well they are meeting the needs of the local population will be demonstrated through the provision of accurate, relevant, timely data which will be collected routinely for each person with mental health problems receiving care.

National datasets will include information on diagnosis, interventions and outcomes and be appropriately linked with other datasets, such as for physical health and social care. The Department of Health, NHS England and PHE will lead the transformation in mental health information, with changes to HSCIC data collection backed by new funding.

The NMHIN and Chimat will provide comprehensive data resources to inform good quality commissioning and allow services to be benchmarked against each other, highlighting best practice and ensuring resources can be targeted where they have most impact. Commissioners will be able to assess prevalence, predict incidence and plan provision and identify individuals repeatedly admitted to inpatient care in order to target them for preventive interventions.
Budget reporting will be aligned to specific mental health conditions, increasing transparency. Everyone will be able to assess the responsiveness of services to local population needs, including the needs of marginalised groups covered by equalities legislation.

People using mental health services will be able to make informed choices about their care and how their data is used. Care will be increasingly personalised and measures will capture how well it is helping them achieve their goals. Individuals will be able to rate services, holding commissioners and providers to account.

5.3 PUTTING IN PLACE DATA PLANS
Providing high quality mental health care requires the collection of the right kind of mental health data, at the right time. The National Information Board has been charged with delivering this ambition. Their task now should be a national stock take of mental health data to ensure it includes the most meaningful measures, which align with national priorities, and that collecting it does not place undue pressures on clinicians and service managers. Clinical system suppliers, mental health commissioners, providers and experts-by-experience should be involved.

The transition to the MHSDS provides an opportunity to reconsider which data should be collected and reported. The HSCIC should develop a package of support to solve problems related to getting, using or sharing data.

More work is needed to ensure data can be linked across public agencies, to promote integration of care and generate insight into where people are accessing different parts of the system and, ultimately, what their needs, preferences and outcomes are.

PHE should work with other national agencies to develop the NMHIN as the trusted national repository of robust and publicly available mental health data and intelligence over the next 5 years.

A review of national clinical audits and how they supplement mandated datasets should be carried out, including the Prescribing Observatory for Mental Health UK, the National Audit of Schizophrenia and NHS Benchmarking club data. ‘Future in Mind’ also identified significant gaps in data on children and young people’s mental health and these must be addressed.

Recommendation 39: The Department of Health, NHS England, PHE and the HSCIC should develop a 5-year plan to address the need for substantially improved data on prevalence and incidence, access, quality, outcomes, prevention and spend across mental health services. They should also publish a summary progress report by the end of 2016 setting out how the specific
actions on data, information sharing and digital capability identified in this report and the National Information Board’s Strategy are being implemented.

**Recommendation 40:** The Department of Health should develop national metrics to support improvements in children and young people’s mental health outcomes, drawing on data sources from across the whole system, including NHS, public health, local authority children’s services and education, to report with proposals by 2017.

**Recommendation 41:** The Department of Health, HSCIC and MyNHS, working with NHS England, should improve transparency in data to promote choice, efficiency, access and quality in mental health care, ensuring that all NHS-commissioned mental health data are transparent (including where data quality is poor) to drive improvements in services. The CCG Performance and Assessment Framework should include a robust basket of indicators to provide a clear picture of the quality of commissioning for mental health. To complement this, NHS England should lead work on producing a Mental Health Five Year Forward View Dashboard by the summer of 2016 that identifies metrics for monitoring key performance and outcomes data that will allow us to hold national and local bodies to account for implementing this strategy. The Dashboard should include employment and settled housing outcomes for people with mental health problems.

**Recommendation 42:** NHS England and the HSCIC should work to identify unnecessary data collection requirements, and then engage with NHS Improvement to prioritise persistent non-compliance in data collection and submission to the MHSDS, and take regulatory action where necessary.

**Recommendation 43:** During 2016 NHS England and PHE should set a clear plan to develop and support the Mental Health Intelligence Network over the next five years, so that it supports data linkage across public agencies, effective commissioning and the implementation of new clinical pathways and standards as they come online.

**Recommendation 44:** By 2020/21, NHS England and NHS Improvement should work with the HSCIC and with Government to ensure rapid using and sharing of data with other agencies. The Department of Health should hold the HSCIC to account for its performance, and consult to set minimum service expectations for turning around new datasets or changes to existing datasets by no later than summer 2016.

**Recommendation 45:** The Department of Health and HSCIC should advocate the adoption of data-rich Summary Care Records that include vital mental health information, where individuals consent for information to be shared, by 2016/17.

**Recommendation 46:** The Department of Health should commission regular prevalence surveys for children, young people and adults of all ages that are updated not less than every seven years.
The Taskforce heard from a number of stakeholder organisations that the way services are contracted and paid for affects the quality of care people receive across settings. This includes a lack of transparency and accountability associated with the use of ‘block contracts’ which do not specify how many people will be supported by the service or the quality of care they should receive. The Taskforce also heard that the way services are currently paid for can prevent them from being integrated e.g. acute physical health services are not paid to include mental health support, even though this is good practice. Organisations said that the development of more effective payment models is heavily dependent on robust data about the quality of services.

6.1 THE CURRENT APPROACH TO AN UNEVEN PLAYING FIELD
Mental health services have been plagued by years of under investment. More than half of mental health trusts are paid using block contracts providing a fixed amount unrelated to how local needs are being met or the quality of care provided. This rewards those that deliver low cost interventions, regardless of outcome, and penalises those that increase access or deliver more costly interventions, even though they may improve outcomes. This payment method also affects the development of personalisation in mental health care, since without more detailed information about individuals receiving care, the costs of that care, or clear care pathways, it is difficult for funding to be released through Personal Health Budgets or integrated with social care funding to support Integrated Personal Commissioning (combined personal budgets).

Some areas are moving away from block contracts but mental health is being left behind and thus lacks the financial levers to drive change. National guidelines to reward quality and outcomes are being poorly implemented at local level. There is also a risk that new models of care will make greater use of block contracts, which is not currently appropriate for payment of mental health interventions where there is little transparency around quality and outcomes.
However, new payment approaches are being developed. Care clusters, mandated since 2012, which aim to describe a group of people with similar mental health needs, are being used by a number of providers as the basis for payment. They have been criticised for not easily mapping to diagnoses, missing the complexity of some populations and failing to incentivise outcomes but they have provided an indication of need. Very few providers have moved to contracts that reward quality and outcomes.

Two new payment models are proposed for adult care in 2016/17 (for 2017/18). One is based on the year of care or episode of care appropriate to each of the mental health care clusters. The second is a capitation-based payment tied to care clusters or similar data. Both link payment in part to quality and outcome measures. NHS Improvement and NHS England are asking commissioners and providers to adopt one of the two approaches.

Several of the vanguard sites are adopting the capitation model but are using historic spending to set annual budgets. This risks reinforcing previous underinvestment. Some CCGs are developing local outcomes-based contracts. This is also encouraging but without a national approach, opportunities to share evidence about which models deliver the best outcomes may be lost.

Presence of poor mental health drives a further 50% increase in costs

Physical healthcare costs 50% higher for type 2 diabetics with poor mental health

Annual physical healthcare costs per patient, 2014/15 (£)

Additional costs due to increased hospital admissions and complications

Annual physical healthcare costs per patient, 2014/15 (£)

Note: Does not include spend on prescribing psychiatric drugs and other mental health services
Source: Hex et al, 2012; APHO Diabetes Prevalence Model for England 2012; Long-term conditions and mental health: The cost of co-morbidities, The King’s Fund
Better integration with physical health is vital but payment models do not incentivise this. For example, payments for diabetes and cancer care do not routinely cover psychological interventions and payments for mental health care do not ensure physical health needs are met as standard.

There is one national CQUIN that rewards mental health providers for ensuring that the physical health needs of people with psychosis are met. This supports working relationships between specialist mental health providers and primary care which can avoid relapses and crises. Introduction of the CQUIN has seen physical care monitoring rise by a third, but performance is still well below target.

6.2 A FUTURE APPROACH TO A LEVEL PLAYING FIELD
In future, payments should incentivise swift access, high quality care and good outcomes, while deterring cherry picking of people who seem ‘easiest-to-treat’. Payment models should include a range of capitated or population-based approaches. Wider levers include the NHS standard contract, CQUINs, quality premiums, sanctions and regulation, which should be used to encourage good performance. A full set of principles underpinning what the new approach to payment in mental health should look like is annexed.

Payments should incentivise provision of integrated mental and physical healthcare and be adjusted to account for inequalities. Funding decisions should be transparent and public, including those of the independent Advisory Committee for Resource Allocation (ACRA) for the NHS.

NHS England and NHS Improvement will need to provide robust support to providers and commissioners to introduce new payment approaches for adult mental health based on either capitated or episodic/year-of-care payment models and which reward improved outcomes, quality and access. Where progress is not being made, regulation, assurance and enforcement may be necessary. Similar changes are needed for children and young peoples’ services and psychological therapy services, and to incentivise the provision of mental health care to people with physical health problems.

Physical health providers will need to be reimbursed for meeting mental health needs which may require re-classification of patient care described by Healthcare Resource Groups (HRGs), Treatment Function Codes (TFCs) and Office of Population Censuses and Surveys Classification of Surgical Operations and Procedures (OPCS) codes.

A new CQUIN to improve the recognition and treatment of depression in older people should be introduced, modelled on the dementia CQUIN. Since its introduction, the dementia CQUIN has raised the profile of the disease in
general acute hospitals, and is now finding 90 per cent of people with possible dementia.

NHS funding formulae must be reviewed by ACRA to ensure they support parity between mental and physical health. They should also be reviewed to ensure it correctly estimate the prevalence and incidence of conditions across the mental health spectrum.

In respect of the annual inequalities adjustment given to CCGs for people with the poorest access and outcomes in health, CCGs should also report how their spending is related to need, access and outcomes for mental health. Mental health funding should be allocated to individual conditions in the same way as physical health funding to make it easier to track. Good quality data will be needed to determine whether care is cost-effective and whether new approaches are more appropriate than existing ones.

**£19bn is spent on services for mental health conditions**

Further £18bn is spent on services linked to dementia, learning disability and substance abuse.

- **£19.0bn**
  - HMG spend on services for mental health conditions

- **£18.0bn**
  - HMG spend on services linked to other specific conditions

<table>
<thead>
<tr>
<th>Condition</th>
<th>£bn Spend</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1 Children and young people</strong></td>
<td>0.8 0.2 1.0 2.0</td>
</tr>
<tr>
<td><strong>2 Common mental health problems</strong></td>
<td>1.9 1.5 4.8 8.3</td>
</tr>
<tr>
<td><strong>3 Severe mental illness</strong></td>
<td>4.0 0.8 3.9 8.7</td>
</tr>
<tr>
<td><strong>4 Dementia</strong></td>
<td>0.6 0.8 5.5 6.9</td>
</tr>
<tr>
<td><strong>5 Substance abuse</strong></td>
<td>1.4 1.5</td>
</tr>
<tr>
<td><strong>6 Learning disability</strong></td>
<td>0.9 0.4 8.4</td>
</tr>
</tbody>
</table>

Note: Dementia healthcare expenditure only includes spend on mental health services for dementia, not on physical health co-morbidities (e.g. diabetes), which would increase spend by £3bn.
**Recommendation 47:** NHS England and NHS Improvement should together lead on costing, developing and introducing a revised payment system by 2017/18 to drive the whole system to improve outcomes that are of value to people with mental health problems and encourage local health economies to take action in line with the aims of this strategy. This approach should be put in place for children and young people’s services as soon as possible.

**Recommendation 48:** NHS England should disaggregate the inequalities adjustment from the baseline funding allocation for CCGs and primary care, making the value of this adjustment more visible and requiring areas to publicly report on how they are addressing unmet mental health need and inequalities in access and outcomes.

**Recommendation 49:** ACRA should review NHS funding allocation formulas, including the inequalities adjustment, to ensure it supports parity between physical and mental health in 2016/17. They should also be reviewed to ensure they correctly estimate the prevalence and incidence of conditions across the mental health spectrum. Membership of ACRA should be revisited with the specific goal of ensuring that mental health expertise is adequately represented across the disciplines involved, e.g. clinical, academic, policy and providers.

**Recommendation 50:** The Department of Health and NHS England should require CCGs to publish data on levels of mental health spend in their Annual Report and Accounts, by condition and per capita, including for children and Adolescent Mental Health Services, from 2017/8 onwards. They should require CCGs to report on investment in mental health to demonstrate the commitment that commissioners must continue to increase investment in mental health services each year at a level which at least matches their overall allocation increase.
CHAPTER SEVEN:

FAIR REGULATION AND INSPECTION

Every person with a mental health problem should be able to say:
I feel safe. My strengths, skills and talents are recognised and valued. I am treated as a person, not just according to my behaviour. My personal goals are recognised by support services. I choose who to consider the people ‘close to me’, who can support me in achieving mental wellbeing. I am able to see or talk to friends, family, carers or other people who I say are ‘close to me’ at any time. I can determine different levels of information sharing about me. I am confident that if I need care or treatment, timely arrangements are made to look after any people or animals that depend on me. I feel confident that my human rights are respected, protected and progressively realised in all systems of regulation and inspection.

If I raise complaints or concerns about a service these are taken seriously and acted upon, and I am told what has happened in response. If I do not have capacity to make decisions about my care and treatment, any advance statements or decisions I have made will be respected. I am supported to develop a plan for how I wish to be treated if I experience a crisis in future. As far as possible, people who see me in a crisis follow my wishes and any plan I have previously agreed. When I need medicines, their potential effects – including how they may react with each other – are assessed and explained.

7.1 THE SYSTEM TODAY: HIGH LEVELS OF SCRUTINY
PAINTING A MIXED PICTURE OF EXPERIENCE

Many stakeholders believe that the legislative and regulation framework underpinning mental health care can be improved.

The Mental Health Act 1983 provides a legal framework for the detention of individuals with mental health problems in order to be assessed and treated (including with medication) for mental illness without regard to their mental capacity or their ability to give or withhold consent. This applies if they have
a mental illness which requires assessment or care in a hospital and they are
detained because they are assessed as posing a risk to themselves or others.

The Mental Capacity Act 2005 makes no distinction between the mental and
physical with regard to decisions about care. But the 2005 Act’s provisions
about having the mental capacity to consent to care can be over-ridden in the
case of mental health care by the 1983 Act. We heard that this can act as a
barrier to making parity of esteem a reality because it enshrines differences in
the treatment of people with mental and physical health problems and frames
care as a method of social control rather than a therapeutic intervention. The
1983 Act should therefore be reviewed as part of the continuing drive for greater
parity with physical healthcare.

Commissioners, providers and the CQC should ensure that the full range of
people’s human rights are protected at a time when their capacity, autonomy,
choice and control may be compromised. This is reinforced by the Care Act
2014. However, the number of people detained and the number subject to
restrictive Community Treatment Orders (CTOs) requiring them to adhere to
particular interventions, including medication, continue to increase. The use of
CTOs is much higher than anticipated when they were introduced in 2008, yet
findings from a recent Oxford University study show they are not effective for
the majority of people.

The Health and Social Care Act 2012, as reflected in the NHS Constitution,
provides rights to specialist care, including access to consultant-led treatment
within 18 weeks of referral and a choice of provider. However, there is not
yet parity between an individual’s rights to physical and mental health care.
Although the right to choice of provider has been extended to mental health
there is no legal right to recommended interventions or maximum waiting times,
as there is for physical health care.

The CQC has a robust approach to regulating the quality of NHS service
provision. However, inspection of mental health support in primary and acute
physical health care settings should be strengthened. We must also ensure
psychological therapies are properly regulated.

The only detailed measure of people’s experience of mental health care is
through the CQC survey of community mental health services. But this is
inadequate, as revealed by the CQC’s special inquiry into crisis care which
showed that people’s experiences of mental health care across other settings
were very mixed and should be tracked on a regular basis. There is also no
measurement of people’s experience of inpatient mental health care, including
secure care, despite the nature of compulsory treatment and the potential
vulnerability of those who are detained, in some cases for months or years.
The Taskforce heard that the experience for people who are marginalised needs to be improved, with particularly strong messages coming through from BAME groups. The Workforce Race Equality Standard is a welcome development in the NHS for those providing services. But there is no equivalent for those accessing them. The 5-year Delivering Race Equality programme concluded in 2010 that there had been no improvement in the experience of people from minority ethnic communities receiving mental health care. Data since shows little change. These inequalities must be prioritised for action, and we support the recommendations of The Independent Commission on Acute Adult Psychiatric Care, established and supported by the Royal College of Psychiatrists on this issue.

There were 198 deaths of people detained under the Mental Health Act in 2013/14, the majority of which were due to natural causes, including preventable physical ill health. Care providers must ensure that they take appropriate steps to prevent the avoidable deaths of people in inpatient care, including people of all ages who are deprived of liberty through detention under the Mental Health Act. However, unlike in prison or police detention, where every death is independently investigated, there is no independent pre-inquest process in place for investigating these deaths. Care organisations themselves carry out internal investigations. As highlighted by the recent findings within Southern Health NHS Foundation Trust, the quality of internal investigations can be poor and providers are not always able to demonstrate robustly how they have learned from them and made improvements.

There are no published death rates in individual units or by CCG area, no information on whether death has occurred in a public or privately run organisation, and no information on the number or nature of deaths that have occurred in specific settings. Patterns of deaths that merit closer examination may thus escape public scrutiny. In particular, there are questions about the over-representation of black people in mental health settings and the use of force that features in some of their deaths. There is also very limited information available nationally on the number of children who have died in mental health settings.

Measurement of wider social outcomes – such as finding a job and accommodation – is also a marker of the quality of services and varies across organisations. Yet these outcomes can be more meaningful than strictly clinical outcomes such as being “symptom free”.

**THE SYSTEM IN THE FUTURE**

The full range of regulatory levers will be used to address inequalities and improve the quality and experience of people receiving mental health care. The right to equal treatment in the least restrictive setting will be clearly enshrined
in legislation, and all providers will ensure they work in accordance with Human Rights legislation.

Strengthened inspection of mental health care by the CQC will be extended to all NHS-funded providers, including primary and acute physical health care. Measures of quality will show how services compare and specialist mental health services, including inpatient care, will include self-reported outcomes. Racial and other inequalities in rates of detention will be addressed and there will be greater transparency in the causes of deaths and how they can be prevented.

**SYSTEM REFORMS BY 2020/21**

It is essential that people’s human rights to receive care in the least restrictive setting, to give or withhold consent, to use advance decisions and to maintain family life are respected and that inspections assess the extent to which these rights are supported. Individuals deprived of their liberty under the Mental Health Act should be offered information, advocacy and support. In the light of rising rates of detention and the high and potentially inappropriate use of CTOs, highlighted by research published by Oxford University in 2013, there is a strong case for considering whether the current legislative framework strikes the right balance between risk and consent. This should include consideration of how mental capacity legislation should be applied in the use of the Mental Health Act to detain a person for compulsory treatment. This is a fundamental aspect of ensuring parity between mental and physical health.

The whole NHS plays a role in preventing mental health problems and caring for people who suffer them. The inspection system should be updated to ensure it covers all aspects of mental health provision in all settings, and all physical and mental health pathways of care.

For children and young people, we support the recommendation in ‘Future in Mind’ that the CQC should work with Ofsted to develop a joint, cross-inspectorate view of how health, education and social care services are working together to improve their mental health.

In July 2015, the Secretary of State for Health announced the creation of a new Healthcare Safety Investigation Branch (HSIB). The Branch will be established from April 2016 and will provide support and guidance to NHS organisations on investigations, as well as carrying out certain investigations itself. It will also conduct national investigations into safety incidents and act as an exemplar. It will focus on incidents that signal systemic or apparently intractable risks within the local health care system. The Department of Health should ensure that the scope of the HSIB includes deaths from all causes in inpatient mental health settings and that there is independent scrutiny of the quality of investigation, local and national trends, and evidence that learning is resulting in service improvement.
Recommendation 51: The Department of Health should work with a wide range of stakeholders to review whether the Mental Health Act (and relevant Code of Practice) in its current form should be revised in parts, to ensure stronger protection of people’s autonomy, and greater scrutiny and protection where the views of individuals with mental capacity to make healthcare decisions may be overridden to enforce treatment against their will.

Recommendation 52: The Department of Health should carry out a review of existing regulations of the Health and Social Care Act to identify disparities and gaps between provisions relating to physical and mental health services. This should include considering how to ensure that existing regulations extend rights equally to people experiencing mental health problems (e.g., to types of intervention that are mandated, to access to care within maximum waiting times).

Recommendation 53: Within its strategy for 2016–2020, the CQC should set out how it will strengthen its approach to regulating and inspecting NHS-funded services to include mental health as part of its planned approach to assessing the quality of care along pathways and in population groups.

Recommendation 54: The Department of Health should consider how to introduce the regulation of psychological therapy services, which are not currently inspected unless they are provided within secondary mental health services.

Recommendation 55: The CQC should work with Ofsted, Her Majesty’s Inspectorate of Constabulary and Her Majesty’s Inspectorate of Probation to undertake a Joint Targeted Area Inspection to assess how the health, education and social care systems are working together to improve children and young people’s mental health outcomes.

Recommendation 56: The Department of Health should ensure that the scope of the Healthcare Safety Investigation Branch includes deaths from all causes in inpatient mental health settings and that there is independent scrutiny of the quality of investigation, analysis of local and national trends, and evidence that learning is resulting in service improvement.

Recommendation 57: NHS Improvement and NHS England, with support from PHE, should identify what steps services should take to ensure that all deaths by suicide across NHS-funded mental health settings, including out-of-area placements, are learned from, to prevent repeat events. This should build on insights through learning from never events, serious incident investigations and human factors approaches. The CQC should then embed this information into its inspection regime.
CHAPTER EIGHT:

LEADERSHIP INSIDE THE NHS, ACROSS GOVERNMENT AND IN WIDER SOCIETY

We have recommended an ambitious but deliverable strategy for mental health to realise improvements in prevention, access, outcomes and experience, backed by a strong clinical and economic case for investment. Implementing it will require robust leadership.

We commissioned a review by the Centre for Mental Health which identified 12 key elements necessary for the successful implementation of our vision:

1. **Leadership**: Effective national and local leadership is vital.
2. **Focus**: Strategies with a clear narrative and a set of widely supported, prioritised action points are more likely to succeed.
3. **Funding**: Funding for change and the associated double running costs is particularly important.
4. **Incentives**: Effective mental health strategies have benefited from close alignment with the incentives used in mainstream health policy.
5. **Workforce**: The most important changes are often the least amenable to policy-making and depend on the motivation of staff.
6. **Scrutiny**: Visible accountability for achieving a strategy’s goals is essential to sustain implementation.
7. **Public opinion**: Strategies that enjoy support from the public and professionals are more likely to be implemented well.
8. **Partnerships**: Mental health policy relies on organisations working together.
9. **Implementation**: Robust, stable and supportive implementation infrastructure is vital.
10. **Innovation**: Policy cannot stand still but needs to facilitate innovation.
11. **Management**: Good quality programme and project management is essential.
12. **Time**: Changing practice takes longer than policymakers think. Policies need time to be implemented effectively.

Building on this evidence, a robust governance framework should be put in place to implement a 5-year programme to transform mental health care in
England. This strategy should be refreshed in 2019/20 in the light of new data that will emerge.

The key elements should be:

- **Establishing NHS England as the lead ALB** with responsibility for overall delivery of the strategy, led by the appointment of a new Senior Responsible Officer.
- **Embedding co-production** within the design and delivery of the programme, through the involvement of those with experience of mental health services and the organisations that represent them. This should include creating an independent external advisory board to provide independent scrutiny and challenge to the programme.
- **Establishing a new cross-ALB programme board** as a single coherent governance structure for delivering the strategy at a senior operational level, including defining the best approaches for local delivery.
- **Appointing an equalities champion**, with a specific remit to tackle mental health inequalities across the health system and through cross-government action.
- **Ensuring the necessary level of resource** within the national team overseeing day-to-day implementation.

The Department of Health, Cabinet Office and NHS England should put in place clear mechanisms for ensuring that the cross-government recommendations made in this report are implemented in full, and support continued action to combat stigma and discrimination in our society.

The Independent Commission on Acute Adult Psychiatric Care, established and supported by the Royal College of Psychiatrists, makes a recommendation that a Patients and Carers Race Equality Standard should be piloted in mental health. This should be given full consideration as quickly as possible as part of the remit of the new equalities champion.

Without additional investment it will not be possible to implement this strategy and deliver much-needed improvements to people’s lives, as well as savings to the public purse. Funding is required in priority areas to help put the essential building blocks in place to improve the system over the long-term and to increase access to proven interventions that improve outcomes and deliver a return. We have identified that a minimum of £1 billion should be available in 2020/21. There should be a clear message that there is an expectation that more people are able to access NICE-evidenced services and that levels of investment in mental health should reflect this, across primary care, acute and mental health systems. Expenditure on mental health should be fully transparent.
Our proposals for investment are primarily targeted at expanding access to evidence-based care and scaling up effective programmes of work, supported by system reforms that are already happening and where the NHS can expand workforce capacity relatively quickly.

However, the Taskforce recognises the reality that reinvesting in services, planning for and recruiting into workforces that in many cases have been depleted in recent years, and initiating the essential system reforms required to support service expansion and transformation (e.g. relating to data and financial incentives) takes time.

Our proposals therefore focus on consolidating and expanding programmes for children and young people, for perinatal care and for Early Intervention in Psychosis 2016/17, in parallel to laying the ground for wider investment across the full range of priorities for action from 2017/18 onwards.

Securing new investment and realising the associated savings will require commissioners and providers, nationally and locally, to demonstrate that they are delivering high quality care and value for money within their budgets. This means implementing evidence-based standards, supporting quality improvement, improving data on outcomes and spend, a strong commitment to transparency, and integrating services at every level to meet the needs of their population. The transformation programme for Improving Access to Psychological Therapies for Children and Young People is a good example of how this can work. To make best use of new investment and ensure savings will materialise on the ground NHS England must also begin work now with ALB partners and local areas to trial new models of implementation.

We know that the scale of unmet mental health need is significant – hundreds of thousands of people go untreated each year at a cost of billions of pounds to our society and the economy. This investment would, however, make a start in plugging that gap, building on £1.4 billion of new funding over five years for children and young people’s and perinatal mental health last year, including additional funding for eating disorders.

Mental health must remain a priority in a challenging financial climate for the NHS in the next five years, which is why we have set out specific recommendations to ensure that there is proper transparency and accountability for how money is spent. At a minimum, from 2016/17 we expect CCGs to be able to demonstrate how they will increase investment in mental health services in line with their overall increase in allocation each year or in line with the growth in recurrent programme expenditure.
**Recommendation 58:** By no later than Summer 2016, NHS England, the Department of Health and the Cabinet Office should confirm what governance arrangements will be put in place to support the delivery of this strategy. This should include arrangements for reporting publicly on how progress is being made against recommendations for the rest of government and wider system partners, and the appointment of a new equalities champion for mental health to drive change.
ANNEX A:

PRINCIPLES UNDERPINNING PAYMENT APPROACHES IN MENTAL HEALTH

1. There must be no more unaccountable block contracts for mental health.

2. Providers should never entirely be rewarded for providing a number of days of care within a particular setting, but instead be rewarded for delivering whole pathways of care with achievement of defined outcomes or meeting local population need, as appropriate.

3. Both national and local outcome measures should be used as part of the payment system, these should be co-produced and developed by all stakeholders with a leading role taken by people with lived experience of mental ill health (and their families).

4. Where integrated care is needed, payment should similarly be integrated. For example, for urgent and emergency mental health care, the payment approach should be embedded within the wider urgent and emergency care payment approach, and payment for mental health care within physical care pathways should be similarly integrated.

5. Payment approaches should include access standards, where these are developed, to drive achievement of improved access to timely, evidence-based care with routine outcome measurement.

6. Payment approaches should be developed with experts-by-experience, reward engagement and delivery of access to excellent care for particular groups, where this is appropriate. This may include BAME populations and people with co-morbidities, such as substance misuse or diabetes.

7. Outcomes should be holistic and reward collaborative working across the system (e.g. stable housing, employment, social and physical health outcomes).

8. Payment systems must promote transparency and increased provision of high quality, relevant data that can drive improvement.
9. Payment systems should support improved productivity, value, efficiency and reduced costs, where possible.

10. Payment systems should support pathways through services, rewarding and incentivising step down to lower-intensity settings and a focus on care in the least restrictive setting. They should aim to reduce avoidable crises, admission and detentions, while protecting against any misalignment of incentives that might give rise to cherry-picking or other risks that might impact negatively upon those people with mental health problems who are ‘hardest to reach’.

11. National guidance should support commissioners to commission effectively using appropriate payment approaches.

12. Additional support should be provided to commissioners to build leadership, capacity and capability in commissioning services, including for the use of new payment approaches that will necessarily require new skills and competencies.
### ANNEX B:

## FULL RECOMMENDATIONS

Recommendations are listed by lead or joint lead agency for the NHS arms-length bodies

| Future in Mind | NHS England should continue to work with HEE, PHE, Government and other key partners to resource and implement Future in Mind, building on the 2015/16 Local Transformation Plans and going further to drive system-wide transformation of the local offer to children and young people so that we secure measurable improvements in their mental health within the next four years. This must include helping at least 70,000 more children and young people each year to access high-quality mental health care when they need it by 2020/21. The CYP Local Transformation Plans should be refreshed and integrated into the forthcoming Sustainability and Transformation Plans (STPs), which cover all health and care in the local geography, and should include evidence about how local areas are ensuring a joined up approach that is consistent with the existing statutory framework for children and young people. |
| Access standards and care pathways | By 2020/21, NHS England should complete work with ALB partners to develop and publish a clear and comprehensive set of care pathways, with accompanying quality standards and guidance, for the full range of mental health conditions based on the timetable set out in this report. These standards should incorporate relevant physical health care interventions and the principles of coproduced care planning, balancing clinical and non-clinical outcomes (such as improved wellbeing and employment). Implementation should be supported by:  
  • Use of available levers and incentives to enable the delivery of the new standards, including the development of aligned payment models (NHS England and NHS Improvement)  
  • Alignment of approaches to mental health provider regulation (NHS Improvement and CQC)  
  • Comprehensive workforce development programmes to ensure that the right staff with the right skills are available to deliver care in line with NICE recommendations as the norm (HEE)  
  • Ensuring that the relevant public health expertise informs the development of the new standards and that they are aligned with the new co-existing mental health and alcohol and/or drug misuse services guidance being developed for commissioners and providers of alcohol and/or drug misuse services. (PHE) |
## Perinatal mental healthcare
NHS England should invest to ensure that by 2020/21 at least 30,000 more women each year access evidence-based specialist mental health care during the perinatal period. This should include access to psychological therapies and the right range of specialist community or inpatient care so that comprehensive, high-quality services are in place across England.

## Psychological therapies for people with long term conditions
NHS England should invest to increase access to integrated evidence-based psychological therapies for an additional 600,000 adults with anxiety and depression each year by 2020/21 (resulting in at least 350,000 completing treatment), with a focus on people living with long-term physical health conditions and supporting people into employment. There must also be investment to increase access to psychological therapies for people with psychosis, bipolar disorder and personality disorder.

## Employment support
By 2020/21, NHS England and the Joint Unit for Work and Health should ensure that up to 29,000 more people per year living with mental health problems should be supported to find or stay in work through increasing access to psychological therapies for common mental health problems (see above) and doubling the reach of Individual Placement and Support (IPS). NHS England should seek to match this investment in IPS by exploring a Social Impact Bond or other social finance options.

## Early Intervention in Psychosis
NHS England should ensure that by April 2016 50 per cent of people experiencing a first episode of psychosis have access to a NICE–approved care package within two weeks of referral, rising to at least 60 per cent by 2020/21.

## Crisis services
By 2020/21, NHS England should expand Crisis Resolution and Home Treatment Teams (CRHTTs) across England to ensure that a 24/7 community-based mental health crisis response is available in all areas and that these teams are adequately resourced to offer intensive home treatment as an alternative to an acute inpatient admission. For children and young people, an equivalent model of care should be developed within this expansion programme.

## Acute liaison
By 2020/21 no acute hospital should be without all-age mental health liaison services in emergency departments and inpatient wards, and at least 50 per cent of acute hospitals should be meeting the ‘core 24’ service standard as a minimum.
<p>| Least restrictive acute care | In 2016, NHS England and relevant partners should set out how they will ensure that standards – co-produced with experts by experience, clinicians, housing and social care leads – are introduced for acute care services over the next five years. Integral to the standards should be the expectation that acute mental health care is provided in the least restrictive manner and as close to home as possible, with the practice of sending people out of area for acute inpatient care due to local acute bed pressures eliminated entirely by no later than 2020/21. Plans for introduction of the standards should form part of a full response to the Independent Commission on Acute Adult Psychiatric Care, established and supported by the Royal College of Psychiatrists, by no later than end 2016/17. NHS England and NHS Improvement should also ensure that use of the Mental Health Act is closely monitored at both local and national level, and rates of detention are reduced by 2020/21 through the provision of earlier intervention. Plans should include specific actions to substantially reduce Mental Health Act detentions and targeted work should be undertaken to reduce the current significant over-representation of BAME and any other disadvantaged groups in acute care. |
| Secure care pathway | NHS England should lead a comprehensive programme of work to increase access to high quality care that prevents avoidable admissions and supports recovery and 'step down' for people of all ages who have severe mental health problems and significant risk or safety issues in the least restrictive setting, as close to home as possible. This should seek to address existing fragmented pathways in secure care, increase provision of community based services such as residential rehabilitation, supported housing and forensic or assertive outreach teams and identify new co-commissioning, funding and service models. This work should also tackle inequalities for groups shown to be over-represented in detentions and lengthy stays, and seek to ensure that out of area placements are substantially reduced. The programme should identify where and how efficiencies could be realised within the system and reinvested, and include recommendations on the wider reforms required to make this happen, including changes to legal processes. NHS England should also roll out the proven model of teams delivering community forensic CAMHS and complex need services nationally from 2016. |
| Using and sharing data | By 2020/21, NHS England and NHS Improvement should work with the HSCIC and with Government to ensure rapid using and sharing of data with other agencies. The Department of Health should hold the HSCIC to account for its performance, and consult to set minimum service expectations for turning around new datasets or changes to existing datasets by no later than summer 2016. |
| Vanguards | MCP, PACS, UEC vanguards and the Integrated Personalised Commissioning programme should be supported to ensure that the inclusion of payment for routine integrated care adequately reflects the mental health needs of people with long-term physical health conditions within new care model programmes. Vanguard sites should also provide greater access to personal budgets for people of all ages, including children and young people who have multiple and complex needs, to provide more choice and control over how and when they access different services. |
| <strong>Physical health outcomes in people with mental illness</strong> | NHS England should undertake work to define a quantified national reduction in premature mortality among people with severe mental illness, and an operational plan to begin achieving it from 2017/18. NHS England should also lead work to ensure that by 2020/21, 280,000 more people living with severe mental illness have their physical health needs met by increasing early detection and expanding access to evidence-based physical care assessment and intervention. This will involve developing, evaluating and implementing models of primary care whereby GPs and practice nurses take responsibility for delivering the full suite of physical care screenings, outreach, carer training and onward interventions or referrals, in line with NICE guidelines. This model should include outreach workers or carer training to support people to access primary care because many people with psychosis struggle to access services, and give GPs and practice nurses the training and time they need to deliver NICE-concordant screening and care. |
| <strong>Older age specialist services</strong> | NHS England should ensure that people being supported in specialist older-age acute physical health services have access to liaison mental health teams – including expertise in psychiatry of older adults – as part of their package of care, incentivised through the introduction of a new national CQUIN or alternative incentive payments and embedded through the vanguard programmes. |
| <strong>Trialling population based budgets</strong> | NHS England should ensure that by April 2017 population-based budgets are in place which give CCGs or other local partners the opportunity to collaboratively commission the majority of specialised services across the life course. In 2016/17 NHS England should also trial new models through a Vanguard programme that allow secondary providers of these services to manage care budgets for tertiary (specialised) mental health services to improve outcomes and reduce out of area placements. We recommend testing this at scale, with a particular focus on secure care commissioning, perinatal and specialised CAMHS services. |
| <strong>Co-production evaluation</strong> | NHS England should work with NHS Improvement to run pilots to develop evidence based approaches to co-production in commissioning by April 2018. |
| <strong>CCG inequalities – funding</strong> | NHS England should disaggregate the inequalities adjustment from the baseline funding allocation for CCGs and Primary Care, making the value of this adjustment more visible and requiring areas to publicly report on how they are addressing unmet mental health need and mental health inequalities. |
| <strong>NHS staff mental health</strong> | NHS England should ensure current health and wellbeing support to NHS organisations extends to include good practice in the management of mental health in the workplace, and provision of occupational mental health expertise and effective workplace interventions from 2016 onwards. |
| <strong>Navigators</strong> | NHS England and NHS Improvement should encourage providers to ensure that ‘navigators’ are available to people who need specialist care from diagnosis onwards, to guide them through options for their care and ensure they receive appropriate information and support. In parallel, NHS England and HEE should work with voluntary and community sector organisations, experts-by-experience and carers to develop and evaluate the role of ‘navigators’ in enabling more people-centred care to be provided. |
| <strong>Trialling acute care models or 16-25s</strong> | NHS England should work with CCGs, local authorities and other partners to develop and trial a new model of acute inpatient care for young adults aged 16–25 in 2016, working with Vanguard sites. This should evaluate: developmentally and age-appropriate inpatient services for this group; supporting young people in an environment that maximises opportunities for rehabilitation and return to education, training or employment; viewing the young person within their social context; and enlisting the support of families or carers. This should build on the existing trials of new models of ‘transitional’ services for those aged 0–25. |
| <strong>NHS staff awareness</strong> | NHS England should develop and introduce measures of staff awareness and confidence in dealing with mental health into annual NHS staff surveys across all settings. |
| <strong>Staff health &amp; wellbeing</strong> | NHS England should introduce a CQUIN or alternative incentive payment relating to NHS staff health and wellbeing under the NHS Standard Contract by 2017. |
| <strong>Data stocktake</strong> | NHS England and the HSCIC should work to identify unnecessary data collection requirements, and then engage with NHS Improvement to prioritise persistent non-compliance in data collection and submission to the MHSDS, and take regulatory action where necessary. For the most important data items (including inequalities data), commissioners should use NHS standard contract sanctions (financial penalty) for a data breach where there is persistent non-return of data. Commissioners should be required to use national data flows where they exist and not place undue pressure on providers by asking for local data that duplicates national data. |
| <strong>Payment system</strong> | NHS England and NHS Improvement should together lead on costing, developing and introducing a revised payment system by 2017/18 to drive the whole system to improve outcomes that are of value to people with mental health problems and encourage local health economies to take action in line with the aims of this strategy. This approach should be put in place for children and young people’s services as soon as possible. |
| <strong>Governance</strong> | NHS England, the Department of Health and the Cabinet Office should confirm what governance arrangements will be put in place to support the delivery of this strategy. This should include arrangements for reporting publicly on how progress is being made against recommendations for the rest of government and wider system partners. |</p>
<table>
<thead>
<tr>
<th>Public Health England</th>
<th>Mental Health Taskforce Strategy</th>
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<tr>
<td><strong>Mental Health Intelligence Network</strong></td>
<td>During 2016 NHS England and Public Health England should set a clear plan to develop and support the Mental Health Intelligence Network over the next five years, so that it supports data linkage across public agencies, effective commissioning and the implementation of new clinical pathways and standards as they come online.</td>
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<tr>
<td><strong>Preventing poor physical health outcomes</strong></td>
<td>Public Health England should prioritise ensuring that people with mental health problems who are at greater risk of poor physical health get access to prevention and screening programmes. This includes primary and secondary prevention through screening and NHS Health Checks, as well as interventions for physical activity, obesity, diabetes, heart disease, cancer and access to ‘stop smoking’ services. As part of this, NHS England and PHE should support all mental health inpatient units and facilities (for adults, children and young people) to be smoke-free by 2018.</td>
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<td><strong>Preventing mental ill health</strong></td>
<td>PHE should develop a national Prevention Concordat programme that will support all Health and Wellbeing Boards (along with CCGs) to put in place updated JSNA and joint prevention plans that include mental health and comorbid alcohol and drug misuse, parenting programmes, and housing, by no later than 2017.</td>
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<tr>
<td><strong>Integrated regulation of CYP services</strong></td>
<td>The CQC should work with Ofsted, Her Majesty’s Inspectorate of Constabulary and Her Majesty’s Inspectorate of Probation to undertake a Joint Targeted Area Inspection to assess how the health, education and social care systems are working together to improve children and young people’s mental health outcomes.</td>
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</table>
| **Quality inspection across settings** | The CQC should develop regulation and inspection of NHS-funded services to include mental health as part of its planned approach to assessing the quality of care along pathways and in population groups, beyond the inspection of providers. Within its strategy for 2016–2020, the CQC should also set out how it will strengthen its approach to:  
  • How it inspects primary medical services, acute and adult social care services, so that it assesses whether these services are providing high-quality care for people with mental health problems  
  • Inspect providers on the quality of co-production in individual care planning, carer involvement and in working in partnership with communities to develop and improve mental health services (drawing on good practice such as the 4PI principles)  
  • Ensure that, from 2016, inspections of all specialist mental health services reflect the extent to which the provider ensures that people have an outcomes-focused recovery path that includes discharge and future planning and is integrated with other services, incorporating housing and other social needs.  
  • Ensure (with support from the Department of Health) that data captured about experience of inpatient mental health services is represented in a form which allows comparison and improvement monitoring at national level  
  • Incorporates good practice in information sharing with other providers and with mental health carers, to address complex issues relating to how patient confidentiality rules apply in the care of people with mental health problems. |
| NHS Improvement | Learning from deaths by suicide | NHS Improvement and NHS England, with support from Public Health England, should identify what steps services should take to ensure that all deaths by suicide across NHS-funded mental health settings, including out-of-area placements are learned from to prevent repeat events. This should build on insights through learning from never events, serious incident investigations and human factors approaches. The CQC should then embed this information into its inspection regime. |
| Health Education England | Workforce planning and development across settings | HEE should work with NHS England, PHE, professional bodies, charities, experts-by-experience and others to develop a costed, multi-disciplinary workforce strategy for the future shape and skill mix of the workforce required to deliver both this strategy and the workforce recommendations set out in Future in Mind. This review should address training needs for both new and existing NHS-funded staff and should report by no later than the end of 2016. This workforce strategy should include:  
  • Clear projections for required staff numbers to 2020/21 and what action will be taken to plug any gaps  
  • Core training in basic mental health awareness and knowledge, understanding of mental health law, public mental health, compassion and communication skills  
  • For professions involved in the care and support of people with mental health problems, tailored curricula with competencies in dealing with the common physical health problems people may present with, shared decision-making, mental health prevention (including suicide), empowering people to understand their own strengths and self-manage, carer involvement and information sharing. Drawing on the best available evidence, this should also ensure that professionals are equipped to provide age-appropriate care and reduce inequalities. HEE and PHE should develop an action plan so that by 2020/21 validated courses are available in mental health promotion and prevention for the public health workforce (including primary care). |
| Health Education England | Prescribing standards | HEE should work with the Academy of Medical Royal Colleges to develop standards for all prescribing health professionals that include discussion of the risks and benefits of medication, take into account people’s personal preferences, include preventative physical health support and the provision of accessible information to support informed decision-making. This should be completed in collaboration with relevant stakeholders by April 2017 and subject to regular review. |
# RECOMMENDATIONS FOR GOVERNMENT

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<tr>
<th>Cabinet Office</th>
<th>Co-morbid mental health and substance misuse problems</th>
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<tr>
<td>The Cabinet Office should ensure that the new Life Chances Fund of up to £30m for outcomes-based interventions to tackle alcoholism and drug addiction requires local areas to demonstrate how they will integrate assessment, care and support to people with co-morbid substance misuse and mental health problems, and make a funding contribution themselves. It should also be clear about the funding contribution required from local commissioners to pay for the outcomes that are being sought.</td>
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| Research | The UK should aspire to be a world leader in the development and application of new mental health research. The Department of Health, working with all relevant parts of government, the NHS ALBs, research charities, independent experts, industry and experts-by-experience, should publish a report one year from now, setting out a 10-year strategy for mental health research. This should include a co-ordinated plan for strengthening and developing the research pipeline on identified priorities, and promoting implementation of research evidence. |

| Equalities | The Department of Health should appoint a new equalities champion with a specific remit to tackle health inequalities amongst people with mental health problems and carers across the health and social care system and through cross-government action. This role should include responsibility for advising on operational activity within the NHS to reduce discrimination for people found to be at particular risk, including but not limited to those with characteristics protected by the Equalities Act. The Independent Commission on Acute Adult Psychiatric Care, established and supported by the Royal College of Psychiatrists, makes a recommendation that a Patients and Carers Race Equality Standard should be piloted in mental health and this should form part of the remit of the new role-holder. |

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<th>Department of Health</th>
<th>Suicide prevention</th>
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<td>The Department of Health, PHE and NHS England should support all local areas to have multi-agency suicide prevention plans in place by 2017, contributing to a 10 per cent reduction in suicide nationally. These plans should set out targeted actions in line with the National Suicide Prevention Strategy and new evidence around suicide, and include a strong focus on primary care, alcohol and drug misuse. Each plan should demonstrate how areas will implement evidence-based preventative interventions that target high-risk locations and support high-risk groups (including young people who self-harm) within their population, drawing on localised real time data. Updates should be provided in the Department of Health’s annual report on suicide.</td>
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<p>| Mental Health Act | The Department of Health should work with a wide range of stakeholders to review whether the Mental Health Act (and relevant Code of Practice) in its current form should be revised in parts, to ensure stronger protection of people’s autonomy, and greater scrutiny and protection where the views of individuals with mental capacity to make healthcare decisions may be overridden to enforce treatment against their will. |</p>
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<tr>
<th>Department of Health</th>
<th>Social work</th>
<th>The Department of Health should continue to support the expansion of programmes that train people to qualify as social workers and contribute to ensuring the workforce is ready to provide high quality social work services in mental health. This should include expanding ‘Think Ahead’ to provide at least an additional 300 places.</th>
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<td>Supported housing</td>
<td>The Department of Health, Communities and Local Government, NHS England, HM-Treasury and other agencies should work with local authorities to build the evidence base for specialist housing support for vulnerable people with mental health problems and explore the case for using NHS land to make more supported housing available for this group.</td>
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<td>Health and Justice care pathway</td>
<td>The Ministry of Justice, Home Office, Department of Health, NHS England and PHE should work together to develop a complete health and justice pathway to deliver integrated health and justice interventions in the least restrictive setting, appropriate to the crime which has been committed. This should build on the national roll out of Liaison and Diversion schemes (including for children and young people) across England by 2020/21 and the increased uptake of Mental Health Treatment Requirements (diversion through court order to access community based treatment) as part of community sentences for everyone who can benefit from them. It should also improve mental health services in prison and the interface with the secure care system, with continuity of care on release, to support offenders to return to the community.</td>
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|                     | Data improvement | The Department of Health, NHS England, PHE and the HSCIC should develop a 5-year plan to: address the need for substantially improved data on prevention, prevalence, access, quality, outcomes and spend across mental health services; set out responsibilities for each agency in providing the necessary legal, commissioning, and quality and safety information required; design and develop new datasets, linking physical health, mental health, social care and employment datasets, while ensuring that information governance adequately protects people’s rights; include mental health measures in all physical care datasets, including emergency care.  

The HSCIC should act as a data system leader and set new minimum service expectations for turning around new datasets or changes to existing datasets. The Department of Health, NHS England, HSCIC and NHS Improvement should publish a summary progress report by the end of 2016 setting out how the specific actions on data, information sharing and digital capability identified in this report and the National Information Board’s Strategy are being implemented. |
<p>|                     | Children and Young People metrics | The Department of Health should develop national metrics to support improvements in children and young people’s mental health outcomes, drawing on data sources from across the whole system, including NHS, public health, local authority children’s services and education, to report with proposals by 2017. |</p>
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<tr>
<th>Department of Health</th>
<th>Greater transparency</th>
<th>The Department of Health, HSCIC and MyNHS, working with NHS England, should improve transparency in data to promote choice, efficiency, access and quality in mental health care, ensuring that all NHS-commissioned mental health data are transparent (including where data quality is poor) to drive improvements in services. The CCG Performance and Assessment Framework should include a robust basket of indicators to provide a clear picture of the quality of commissioning for mental health. To complement this, NHS England should lead work on producing a Mental Health FYFV Dashboard by the summer of 2016 that identifies metrics for monitoring key performance and outcomes data that will allow us to hold national and local bodies to account for implementing this strategy. The Dashboard should include health and social outcomes including employment and settled housing outcomes for people with mental health problems.</th>
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<td></td>
<td>Prevalence surveys</td>
<td>The Department of Health should commission regular prevalence surveys for children, young people and adults of all ages that are updated not less than every 7 years.</td>
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<td>CCG transparency</td>
<td>The Department of Health and NHS England should require CCGs to publish data on levels of mental health spend in their Annual Report and Accounts, by condition and per capita, including for Children and Adolescent Mental Health Services, from 2017/18 onwards. They should require CCGs to report on investment in mental health to demonstrate the commitment that commissioners must continue to increase investment in mental health services each year at a level which at least matches their overall allocation increase. For children and young people, this should be broken down initially into spend in the community, on emergency, urgent and routine treatment, and for inpatient care.</td>
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<td>Parity for mental health in Health &amp; Social Care Act regulations</td>
<td>The Department of Health should carry out a review of existing regulations of the Health and Social Care Act to identify disparities and gaps between provisions relating to physical and mental health services. This should include considering how to ensure that existing regulations extend rights equally to people experiencing mental health problems (e.g. to types of intervention that are mandated or to access care within maximum waiting times).</td>
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<td>Deaths in inpatient settings</td>
<td>The Department of Health should ensure that the scope of the new Healthcare Safety Investigation Branch includes a clear focus on deaths from all causes in inpatient mental health settings, including independent scrutiny of the quality of investigation, analysis of local and national trends, and evidence that learning is resulting in service improvement. This should include the involvement of families, and build on the models and experiences of the Independent Police Complaints Commission and the Prisons and Probation Ombudsman. The Department should also work with the CQC to establish a methodology for inspecting the quality of learning from all deaths in inpatient mental health services, including introducing greater transparency around the cause of deaths within each provider.</td>
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<tr>
<td>Department of Health</td>
<td><strong>Challenging stigma</strong></td>
<td>The Department of Health should work with PHE to continue to support proven behaviour change interventions, such as Time to Change, and to establish Mental Health Champions in each community, to contribute to improving attitudes to mental health by at least a further 5 per cent by 2020/21.</td>
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<td><strong>Innovation fund for devolved areas</strong></td>
<td>The Department of Health and the Department for Work and Pensions, working with NHS England and PHE, should identify how the £40 million innovation fund announced at the Spending Review and other investment streams should be used to support devolved areas to jointly commission more services that have been proven to improve mental health and employment outcomes, and test how the principles of these services could be applied to other population groups and new funding mechanisms (e.g. social finance).</td>
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<td><strong>Digital</strong></td>
<td>The Department of Health, through the National Information Board, should ensure there is sufficient investment in the necessary digital infrastructure to realise the priorities identified in this strategy. Each ALB should optimise the use of digital channels to communicate key messages and make services more readily available online, where appropriate, drawing on user insight. Building on trial findings, NHS England should expand work on NHS Choices to raise awareness and direct people to effective digital mental health products by integrating them into the website and promoting them through social marketing channels from 2016 onwards.</td>
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<td><strong>New GPs</strong></td>
<td>The Department of Health and NHS England should work with the RCGP and HEE to ensure that by 2020/21 all GPs, including the 5,000 joining the workforce by 2020/21, receive core mental health training, and to develop a new role of GPs with an extended Scope of Practice (GPwER) in Mental Health, with at least 700 in practice within 5 years.</td>
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<td><strong>Regulation of psychological therapies</strong></td>
<td>The Department of Health should consider how to introduce the regulation of psychological therapy services, which are not currently inspected unless provided within secondary mental health services.</td>
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<td><strong>Better Care Fund</strong></td>
<td>To drive and scale improvements in integration, the Department of Health and relevant partners should ensure that future updates to the Better Care Fund include mental health. This might include making an element of payment for outcomes contingent on reducing acute admission through requiring all hospitals to comply with Crisis Care Concordat and NICE standards on liaison and crisis mental health care.</td>
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<td><strong>Summary Care Records</strong></td>
<td>The Department of Health and HSCIC should advocate adoption of data-rich Summary Care Records that include vital mental health information, where individuals consent for information to be shared, by 2016/17.</td>
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<tr>
<td>Department for Work &amp; Pensions</td>
<td>Employment support</td>
<td>The Department for Work and Pensions should ensure that when it tenders the Health and Work Programme it directs funds currently used to support people on Employment Support Allowance to commission evidence-based health-led interventions that are proven to deliver improved employment outcomes – as well as improved health outcomes – at a greater rate than under current Work Programme contracts. The Department of Work and Pensions should also invest to ensure that qualified employment advisers are fully integrated into expanded psychological therapies services.</td>
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<td>Housing</td>
<td>Benefit cap</td>
<td>The Department of Work and Pensions should, based on the outcome of the “Supported Housing” review in relation to the proposed Housing Benefit cap to Local Housing Allowance levels, use the evidence to ensure the right levels of protection are in place for people with mental health problems who require specialist supported housing.</td>
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<tr>
<td>Department for Education / Department of Health / Department for Work and Pensions</td>
<td>Parenting programmes and support for children with complex needs</td>
<td>The Departments of Education and Health should establish an expert group to examine the needs of children who are particularly vulnerable to developing mental health problems and how their needs should best be met, including through the provision of personalised budgets. The Government should also review the best way to ensure that the significant expansion of parenting programmes announced by the Prime Minister builds on the strong-evidence base that already exists and is integrated with Local Transformation Plans for Children and Young People’s mental health services.</td>
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<tr>
<td>HEFCE</td>
<td>Research</td>
<td>HEFCE should review funding requirements and criteria for decision-making to support parity through the Research Excellence Framework and take action to ensure that clinical academics in mental health (including in psychiatry and neuroscience) are not disadvantaged relative to other areas of health research, starting in 2016/17.</td>
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<td>ACRA</td>
<td>Inequalities and funding allocation formula</td>
<td>ACRA should review NHS funding allocation formulas, including the inequalities adjustment, to ensure it supports parity between physical and mental health in 2016/17. They should also be reviewed to ensure they correctly estimate the prevalence and incidence of conditions across the mental health spectrum. Membership of ACRA should be revisited with the specific goal of ensuring that mental health expertise is adequately represented across the disciplines involved, e.g. clinical, academic, policy and providers.</td>
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AGENDA ITEM NUMBER: 4.1

SUBJECT: Month 11 – Integrated Performance Report

MEETING DATE: 31st March 2016

SUMMARY:
This report summarises the Trust’s M11 and YTD performance against key national and local performance targets and other milestones as set out in the NHS Performance Framework and Trust Annual Plan for 2015-16.

BOARD ASSURANCE FRAMEWORK REFERENCE NUMBER:
Corporate objective 4: Provide services that are value for money to the tax payer

Financial Issues: X  Legal Issues:  Equality Issues:  

ACTION REQUIRED:
For information/note  X  For Agreement 
For comment  For Ratification  
For discussion  X  For Resolution 

THIS DOCUMENT HAS BEEN VIA/REQUESTED
Trust Board  X  Workforce Committee  X
Executive Management  X  Risk & Quality Committee  
Finance & Investments Committee  X  Education Committee  
Audit Committee  X  Charitable Funds Committee  

FOLLOWING BOARD ACTION THIS DOCUMENT WILL BE COMMUNICATED VIA:

EXECUTIVE LEAD: Director of Finance & Information
Integrated Performance Report

February - Month 11 - 2015-16
## Appendices to the Integrated Performance Report

**February - Month 11 - 2015-16**

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Reported to: -
### Performance Overview

**February - Month 11 - 2015-16**

#### Safe Services

<table>
<thead>
<tr>
<th>Category</th>
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<td>Standards</td>
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<tr>
<td>Maternity</td>
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<tr>
<td><strong>Overall</strong></td>
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#### Caring Services

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<thead>
<tr>
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<tbody>
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<td>Staff FFT</td>
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<tr>
<td>Standards</td>
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<tr>
<td><strong>Overall</strong></td>
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#### Effective Services

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<thead>
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<th>YTD</th>
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<tbody>
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<td>Re-admissions</td>
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<td><strong>Overall</strong></td>
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#### Responsive Services

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<tr>
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#### Well-led Services

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#### Value for Money Services

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<td><strong>Overall</strong></td>
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Dashboard Overview - Commentary

Key Issues

• A&E access performance continued to be significantly challenged during February and remains below the required 95% standard.

• Cancer Waiting Time performance has improved. Delivery during December and January has been above the required national target and the improvement trajectory agreed with commissioners.

• Diagnostic (specifically Endoscopy) performance remains outside the required target. The Trust has planned significant levels of additional and outsourced activity during March to achieve delivery of the target in month.

• Crude mortality rates increased during both January & February. Other mortality measures including HSMR and SHMI show the Trust in a better position over a 12 month rolling average.

• There was one never event in February. This related to a medication error.

• The Trust reports a YTD deficit of £7.9m at Mth 11, this is significantly adverse to its stretch target plan. The Trust cash position continues to deteriorate.

• SLA contract fines associated with non delivery of national access targets total £2.6m at Mth 11, and have escalated significantly as a product of access performance.

• The Trust reports an YTD under delivery of £2.2m against its agreed QIPP plan.

• The use of temporary and agency staffing remained high during Q4 has escalated significantly. Staffing costs during Q4 presently average over £1m a month higher than the monthly cost in Q1. Only a portion of this cost relates to additional winter capacity.

Actions taken by the Trust in response to the performance issues highlighted above are expanded under relevant domain headings across the remainder of the document.
### Safe Services - Indicators & Performance

<table>
<thead>
<tr>
<th>Category</th>
<th>Indicator name</th>
<th>Benchmark</th>
<th>Target</th>
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<td>May</td>
<td>June</td>
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<td>Falls Rate</td>
<td>14-15 outturn</td>
<td>27</td>
<td>30.7</td>
<td>37.1</td>
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<td>Infection</td>
<td>Clostridium Difficile</td>
<td>All hospital-acquired incidences</td>
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<td>1</td>
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<td>Clostridium Difficile - Variance to plan</td>
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<td>0</td>
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<td>Serious Incidents rate</td>
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<td>10</td>
<td>3</td>
<td>6</td>
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<td>1</td>
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<td>Safety</td>
<td>Grade 3 or 4 pressure ulcers</td>
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<td>0</td>
<td>0</td>
<td>1</td>
<td>3</td>
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<td>Safety</td>
<td>VTE Risk Assessment % (quarterly)</td>
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<td>97%</td>
<td>96%</td>
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<td>0.43</td>
<td>0.63</td>
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<td>Harm Free Care %</td>
<td>National</td>
<td>94.2%</td>
<td>93.9%</td>
<td>92.1%</td>
<td>92.8%</td>
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<td>0</td>
<td>0</td>
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<td>Standards</td>
<td>New Harms %</td>
<td>National</td>
<td>2.1%</td>
<td>2.9%</td>
<td>2.8%</td>
<td>4.2%</td>
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<td>Potential under-reporting of patient safety incidents resulting in death or severe harm</td>
<td>CQC</td>
<td>0.5</td>
<td>1.3</td>
<td>1.8</td>
<td>1.3</td>
<td>1.0</td>
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<td>Potential under-reporting of patient safety incidents</td>
<td>CQC</td>
<td>6.7</td>
<td>4.5</td>
<td>5.8</td>
<td>6.7</td>
<td>4.5</td>
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<td>Proportion of reported patient safety incidents that are harmful</td>
<td>CQC</td>
<td>25.8</td>
<td>27.9</td>
<td>27.8</td>
<td>23.1</td>
<td>21.9</td>
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<td>Admissions to adult facilities of patients who are under 16 years of age</td>
<td>National</td>
<td>0</td>
<td>2 (OBU)</td>
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<td>CAS alerts outstanding</td>
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<td>10</td>
<td>7</td>
<td>4</td>
<td>4</td>
<td>7</td>
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<td>Maternity Emergency C-section rate</td>
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<td>15%</td>
<td>18%</td>
<td>15%</td>
<td>17%</td>
<td>18%</td>
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<td>Maternity 1-1 Care</td>
<td>National</td>
<td>90%</td>
<td>85%</td>
<td>86%</td>
<td>85%</td>
<td>84%</td>
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† indicates an average has been used due to erroneous data being submitted
Safe Services - Commentary

Key Issues

- The Falls rate is higher than the expected range in February. No falls resulted in moderate injury, severe injury or death.
- MRSA - there remained no reported incidences of Hospital acquired MRSA YTD.
- C.Difficile - There were six incidences of hospital-acquired c.difficile in February. The joint review of incidences occurring during Q4 has not yet taken place.
- Never Events - There was one Never Events in February which related to a medication error.
- SI's - There were 11 reported Serious Incidents across the Trust in February. None of those occurred in maternity.
- Pressure Ulcers - There was one grade 3/4 pressure ulcer in month.
- VTE Risk Assessment data is available quarterly in arrears.
- Safety Thermometer - The proportion of patients experiencing harm-free care continued to improve in February.
- Emergency caesarean section rate was notably higher than the national standard last month.
- Maternity 1-1 care remained slightly below the 90% standard.

Key Actions

- Additional Safety Thermometer audit training provided to ward managers and matrons.
- Revised Safety Thermometer audit process implemented with matrons and ward managers undertaking joint surveys for next 3 months.
- Review Safety Thermometer audit template to ensure all new harms detected via safety thermometer are also reported on datix as patient safety incidents.
- Review Safety Thermometer data upload process to ensure comprehensive dataset is uploaded.
- Weekly SI tracker review process in place.
| Category       | Indicator name                        | Benchmark       | Target                        | Q1 Apr-15 | Q1 May-15 | Q1 Jun-15 | Q1 Jul-15 | Q1 Aug-15 | Q1 Sep-15 | Q1 Oct-15 | Q1 Nov-15 | Q1 Dec-15 | Q1 Jan-16 | Q1 Feb-16 | Q1 Mar-16 |
|----------------|--------------------------------------|-----------------|-------------------------------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|
| Patient FFT   | A&E - FFT % positive                 | London Trusts   | 90%                           | 81%       | 89%       | 85%       | 91%       | 90%       | 69%       | 77%       | 62%       | 58%       | 52%       | 46%       |
| Patient FFT   | A&E - FFT response rate              | London Trusts   | 20%                           | 18%       | 8%        | 3%        | 6%        | 7%        | 6%        | 7%        | 22%       | 13%       | 19%       | 25%       |
| Patient FFT   | Inpatient - FFT % positive           | London Trusts   | 95%                           | 92%       | 91%       | 95%       | 96%       | 95%       | 96%       | 97%       | 94%       | 93%       | 96%       | 95%       |
| Patient FFT   | Inpatient - FFT response rate        | London Trusts   | 20%                           | 12%       | 51%       | 22%       | 23%       | 28%       | 32%       | 24%       | 22%       | 21%       | 23%       | 26%       |
| Patient FFT   | Maternity - FFT % positive           | London Trusts   | 94%                           | 86%       | 91%       | 89%       | 91%       | 92%       | 94%       | 93%       | 94%       | 97%       | 98%       | 92%       |
| Patient FFT   | Maternity - FFT response rate        | London Trusts   | 20%                           | 18%       | 28%       | 46%       | 87%       | 48%       | 32%       | 31%       | 26%       | 29%       | 27%       | 39%       |
| Patient FFT   | Outpatients - FFT % positive         | London Trusts   | 92%                           | 89%       | 63%       | 67%       | 70%       | 77%       | 75%       | 81%       | 71%       | 69%       | 79%       | 67%       |
| Patient FFT   | UCC - FFT % positive                 | London Trusts   | 90%                           | n/a       | n/a       | n/a       | 93%       | 61%       | 69%       | 61%       | 38%       | 84%       | 55%       |
| Patient FFT   | UCC - FFT response rate              | London Trusts   | 20%                           | n/a       | n/a       | n/a       | 1.8%      | 7.3%      | 0.9%      | 6.8%      | 0.3%      | 6.2%      | 0.6%      |
| Staff FFT     | Staff FFT % recommended care         | London Trusts   | 76%                           | 69%       | 70%       | n/a       | n/a       | tbc       | tbc       | tbc       | tbc       | tbc       | tbc       | tbc       |
| Staff FFT     | Staff FFT % recommended work         | London Trusts   | 62%                           | 58%       | 65%       | n/a       | n/a       | tbc       | tbc       | tbc       | tbc       | tbc       | tbc       | tbc       |
| Staff FFT     | Staff FFT response rate              | London Trusts   | 10%                           | 5%        | 7%        | n/a       | n/a       | tbc       | tbc       | tbc       | tbc       | tbc       | tbc       | tbc       |
| Standards     | Mixed Sex Accommodation Breaches     | National        | 0                             | 0         | 0         | 0         | 0         | 0         | 0         | 0         | 0         | 0         | 0         | 0         |

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<tbody>
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<td>Staff FFT</td>
<td>Staff FFT % recommended care</td>
<td>London Trusts</td>
<td>76%</td>
<td>69%</td>
<td>70%</td>
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<tr>
<td>Staff FFT</td>
<td>Staff FFT % recommended work</td>
<td>London Trusts</td>
<td>62%</td>
<td>58%</td>
<td>65%</td>
<td>n/a</td>
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<tr>
<td>Staff FFT</td>
<td>Staff FFT response rate</td>
<td>London Trusts</td>
<td>10%</td>
<td>5%</td>
<td>7%</td>
<td>n/a</td>
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</tbody>
</table>

| Standards     | Mixed Sex Accommodation Breaches     | National        | 0                             | 0         | 0         | 0         | 0         | 0         | 0         | 0         | 0         | 0         | 0         | 0         |

Legend:
- **Outstanding**: Green
- **Good**: Light Green
- **Requires Improvement**: Yellow
- **Poor**: Red
Caring Services - Commentary

Key Issues

**A&E and UCC**
- Positive recommendations continue to fall and remained below the London average.
- Response rate improved above the London average in February.
- UCC Positive recommendations deteriorated markedly from last month.

**Inpatients**
- Positive recommendations improved toward the London average in February.
- Response rate remained above the London average.

**Maternity**
- Positive recommendations continued to show around the London average.
- Response rate remained well above the London average in month.

**Outpatients**
- Positive recommendations remained well below the London average in February

**Staff**
- There was no national survey carried out during Q3

Key Actions


- Addition of a specific staffing resource to A&E to support increased response rates. Significant improvement seen since early November.
### Effective Services - Indicators & Performance

<table>
<thead>
<tr>
<th>Category</th>
<th>Indicator name</th>
<th>Benchmark</th>
<th>Target</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
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<tbody>
<tr>
<td>Mortality</td>
<td>Hospital Standardised Mortality Ratio in-month</td>
<td>National</td>
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<td>Hospital Standardised Mortality Ratio rolling 12 months</td>
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<td>Mortality</td>
<td>Summary Hospital level Mortality Indicator (SHMI) - rolling 12 months</td>
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* indicates that final, confirmed data has not yet been published.
Effective Services - Commentary

Key Issues

HSMR
- The latest available monthly HSMR (Nov-15) shows below the benchmark.
- The 12 month rolling HSMR, though still shows the Trust as an outlier, but continues to improve over time.

SHMI
- The latest available rolling 12 month SHMI (period up to June 2015), continues to show a marginal increase in mortality and has now exceeded the standard of 100. This measure does not include palliative care.

Crude Mortality
- Monthly crude mortality increased in February. Recent monthly figures (shown by an asterisk) are based on unpublished internal data only.

Emergency Re-admissions Within 30 days
- Provisional figures relating to Dec 15 continued to show the Trust below the national average.

Key Actions
- The Trust continues to closely monitor mortality rates and formally reports to Trust Board separately on this issue.
- A new protocol for recording and reviewing patient deaths has been agreed by RQC
- Complete pilot of electronic mortality review form in Renal medicine prior to trustwide roll out for deaths occurring after 1st December.
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<td>93%</td>
<td>94%</td>
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<td>45%</td>
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<td>Written Complaints response rate within deadline</td>
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<td>21</td>
<td>18</td>
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<td>Standards</td>
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<td>Standards</td>
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<td>Standards</td>
<td>Proportion of Delayed Transfers of Care</td>
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<td>2.9%</td>
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* Provisional figures as at 12/02/2016
Responsive Services - Commentary

Key Issues

A&E
- A&E performance remained significantly below both the 95% 4 hour target and also national average performance. February performance was the lowest in England.
- There were 73 60-minute ambulance breaches and 513 30-minute breaches (the highest month to date).

Cancer
- The Trust achieved both cancer 2ww targets in February.
- The Trust achieved all Cancer 31 day and 62 day targets in January. These performance measures are always reported one month in arrears due to the timing of data collection.

Diagnostics
- The Diagnostic waiting times target was not achieved in February but did improve from the previous month. The only area of non-compliance was Endoscopy. A revised recovery plan is in place.

RTT
- RTT continues to be an area of strong performance for the Trust, and continues to exceeding the required standard for all measures.

Complaints
- Higher than expected volume of complaints in February, but the rate per 1,000 contacts just below expected levels.

Cancelled Operations
- Cancelled Ops rose significantly in February.

Key Actions

- A&E, Cancer Waiting Times and Diagnostic Remedial Action plans agreed with commissioners. Monitoring meetings in place.
- Diagnostic support commissioned from NWUSU
- Additional Endoscopy capacity came on line during December 2015.
- Outsourcing of CT reporting to reduce backlog and wait times to commence in Dec.
- Weekly Access meeting in place attended by all CBU’s.
## Well-led Services - Indicators & Performance

<table>
<thead>
<tr>
<th>Category</th>
<th>Indicator name</th>
<th>Benchmark</th>
<th>Target</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
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<td>70%</td>
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Well Led Services - Commentary

Key Issues

Staffing
• Staff sickness absence rose to 4.5% in February and remained above the required target.
• Temporary staffing expenditure also rose in-month and remained well above the target.

Workforce
• Appraisal compliance slipped further below the recommended level in February.
• Mandatory training compliance reported below the target in month.

Standards
• The Trust has received no CQC conditions or warning notices in 2015-16 YTD.
• As of the most recent CQC intelligent monitoring report, there are 14 risks and 9 elevated risks at the Trust. The CQC have informed the Trust that this is the last iteration of the Intelligent Monitoring report that the CQC anticipate publishing. The CQC is currently reviewing its approach to inspections and monitoring and the Trust is participating in the CQC’s co-production group.

Key Actions

- Continue participation in CQC NHS external co-production group looking at how the CQC designs the next phase of inspections for NHS providers.
- Monitoring of CBU appraisal plans through ‘Back on Track’ meetings.
- Weekly exec lead recruitment and temp staffing usage reviews with CBU’s.
- HR department supporting a range of Initiatives to support improved retention of staff.
- Ongoing nursing recruitment open days to support vacancy reductions.
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<tr>
<th>Category</th>
<th>Indicator Description</th>
<th>SLA 2015-16</th>
<th>Target</th>
<th>Q1</th>
<th>Q2</th>
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<td>0.72</td>
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Key Issues

- A&E activity levels remain materially below both SLA target and 14/15 levels.
- ED activity channelled through UCC is around 40% during opening hours.
- Elective activity has increased in Q$ driven by the diagnostic recovery plan.
- Emergency activity is above plan. Ambulatory Care activity has increased over the last quarter as AEC unit opening hours have expanded.
- Maternity bookings remain below plan and below post BEH expectations.
- Levels of Adult & Paediatric critical care activity have been significantly increased during Q4.
- GP referrals are above 14/15 outturn, although market share remains static.
- Emergency Length of Stay has increased significantly over the last quarter.

Key Actions

- Programme of elective and diagnostic activity in place for Q4.
- Bed reconfiguration actioned to support elective delivery and winter plan.
- Additional mobile endoscopy support came on line in early December.
- Weekly Demand & Capacity meetings to maximise SLA plan delivery.
- Review of adult and paediatric critical care capacity and demand.
- Regular activity monitoring reports to FIC and ‘Back on Track’ meetings.
- Outpatient Transformation Group with streams focusing on DNA reduction.
- Theatre transformation programme to co-ordinate improvement activity.
- ‘GP Matters’ initiative and activities led by Business Development Officer.
Key Alerts

Avoiding Premature Deaths
Commentary in respect of the Trust's performance against measures of patient mortality and associated action plan responses are provided in the separate detailed mortality report to the Trust Board.

Long Term Condition Management
The Trust has during October extended the scope and opening hours of its Ambulatory Care Unit. In addition the Trust continues to review and monitor its clinical pathway in respect of Paediatric admissions.

Recovery from Ill Health
CBU 4 is undertaking a review of elective LOS increases observed in recent months, although the relevant patient population is small. PROMs updates are provided at CBU performance meetings.

Positive Experiences of Care
Trust actions in response to A&E and Diagnostic Access targets are referenced in the ‘Responsive Services’ section of this document. A&E friends and family test commentary is provided in the ‘Caring Services’ section of the IPR.

Safe Environment/Avoiding Harm
Harm Free Care - For the previous 6 months, the Trust's safety thermometer performance has been at variance from the national average. This coincided with a change in key personnel managing the safety thermometer process. The Trust believes this to be a data quality issue.

Pressure ulcers - This alert is generated from the pressure ulcer section of the Safety Thermometer survey. There has been a persistent increase in pressure ulcers over the previous year, suggesting that this accurately indicates a deterioration in performance, rather than being a purely data quality issue.

Venous Thromboembolism (VTE) - This alert is generated from the VTE section of the Safety Thermometer survey. This coincided with a change in key personnel managing the safety thermometer process. The Trust believes this to be a data quality issue.

Emergency C-Section Rate - CBU 5 to investigate causation of the observed increase.
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<thead>
<tr>
<th>Category</th>
<th>Indicator name</th>
<th>Benchmark</th>
<th>Target</th>
<th>Q1 Apr-15</th>
<th>Q1 May-15</th>
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Above Plan / Target
At / On Target
Below Plan / Target
Key Issues

- The Trust vacancy rate remained at 10% in February.
- During February permanent staff WTE’s increased by a net 18 WTE’s.
- Over the financial year permanent staffing has increased by a net 123 WTE’s.
- Temporary staffing WTE’s utilised increased by 12 WTE’s in February.
- The increase in permanent staffing and the increase in temporary staff usage remains a significant performance and control issue.
- Turnover rates increased to 22% in the year to February.
- Sickness absence rates increased significantly during February.
- Although the pace at which remain to work interviews are undertaken remains below targets that the Trust has set.
- Overall mandatory training levels remain below Trust’s 80% target.
- Compliance with annual appraisal guidelines remains below target of 80%.
- Poor performance highlighted in Rostering practice across many ward areas.

Key Actions

- CBU’s directed to maintain focus on appraisal and training delivery.
- HR support to CBU’s in effective management of sickness absence policy.
- Ongoing nursing recruitment open days to support vacancy reductions.
- Recruitment department support to focus on Hot Spot areas.
- E-Rostering diagnostic undertaken - Action plan response - Nursing Director.
- Initiatives to support improved retention of staff.
- Redesign and application of tighter rota design and management policies.
- Review of nursing skill mix and establishment levels across all wards.
- Weekly exec lead recruitment and temp staffing usage reviews with CBU’s.
## Supporting Services - Indicators & Performance

<table>
<thead>
<tr>
<th>Category</th>
<th>Indicator name</th>
<th>Benchmark</th>
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* indicates estimate based on 15-16 average
Support Services - Commentary

Key Issues

- The volume of domestic services cleans / jobs has been consistently above 14/15 levels. February represented an in year peak in volume.
- Similarly the number of portering jobs undertaken has increased materially over the course of the year.
- Electricity consumption has increased over the winter period.
- Water used across the site has increased over the last four months.
- The volume of patient meals provided has increased considerably during 15/16 and is on average 10% higher than the preceeding year.
- The pattern of laundry items used remains erratic on a monthly basis, but has increased significantly over the last 3 months.
- The Trust continues to materially underperform against recycling targets.
- CT & MRI reporting times have improved materially over the last quarter.

Key Actions

- Portering - Daily reports sent to E&F to drive efficiencies and monitor performance outcomes.
- Security - Security are reviewing areas where access control can be fitted to limit risk.
- Catering – Trust-wide hospitality monthly cost are being benchmarked within the E&F department.
- Linen & Laundry - The tendering process has now completed and a new service provider will commence in April 2015.
- Waste - New waste initiative began from 1st November with implementation of offensive waste stream.
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<td>Workforce</td>
<td>▶</td>
<td>• Staffing stability amber-rated in-month and YTD</td>
</tr>
<tr>
<td></td>
<td>Safety</td>
<td>▼</td>
<td>• All other metrics red-rated</td>
</tr>
<tr>
<td></td>
<td>Outcomes</td>
<td>▶</td>
<td>• Safety &amp; PET scores amber-rated YTD</td>
</tr>
<tr>
<td></td>
<td>FFT &amp; PET</td>
<td>▶</td>
<td>• All other metrics red-rated</td>
</tr>
<tr>
<td>CBU2</td>
<td>Standards</td>
<td>▶</td>
<td>• Failure to achieve 62 day cancer target YTD</td>
</tr>
<tr>
<td></td>
<td>Finance</td>
<td>▶</td>
<td>• £270k to plan in-month; £2.4m YTD</td>
</tr>
<tr>
<td></td>
<td>Efficiency</td>
<td>▶</td>
<td>• Poor QIPP delivery in February and YTD</td>
</tr>
<tr>
<td></td>
<td>Workforce</td>
<td>▶</td>
<td>• Mixed performance across all metrics in-month</td>
</tr>
<tr>
<td></td>
<td>Safety</td>
<td>▼</td>
<td>• Workforce stability green-rated in February</td>
</tr>
<tr>
<td></td>
<td>Outcomes</td>
<td>▶</td>
<td>• Mandatory training and appraisal compliance amber-rated YTD</td>
</tr>
<tr>
<td></td>
<td>FFT &amp; PET</td>
<td>▶</td>
<td>• All other metrics red-rated in-month and YTD</td>
</tr>
<tr>
<td>CBU3</td>
<td>Standards</td>
<td>▶</td>
<td>• Diagnostics and RTT targets achieved in February</td>
</tr>
<tr>
<td></td>
<td>Finance</td>
<td>▶</td>
<td>• £398k to plan in-month; £3.4m YTD</td>
</tr>
<tr>
<td></td>
<td>Efficiency</td>
<td>▶</td>
<td>• Poor delivery against most efficiency metrics</td>
</tr>
<tr>
<td></td>
<td>Workforce</td>
<td>▶</td>
<td>• Sickness absence red-rated in-month; amber-rated YTD</td>
</tr>
<tr>
<td></td>
<td>Safety</td>
<td>▼</td>
<td>• Staffing stability green-rated in February</td>
</tr>
<tr>
<td></td>
<td>Outcomes</td>
<td>▶</td>
<td>• Mandatory training compliance amber-rated YTD</td>
</tr>
<tr>
<td></td>
<td>FFT &amp; PET</td>
<td>▶</td>
<td>• All other metrics red-rated</td>
</tr>
<tr>
<td>CBU4</td>
<td>Standards</td>
<td>▶</td>
<td>• Diagnostics and RTT targets achieved in-month</td>
</tr>
<tr>
<td></td>
<td>Finance</td>
<td>▶</td>
<td>• £164k to plan in-month; £1.8m YTD</td>
</tr>
<tr>
<td></td>
<td>Efficiency</td>
<td>▶</td>
<td>• Under delivery of QIPPs in-month and YTD</td>
</tr>
<tr>
<td></td>
<td>Workforce</td>
<td>▶</td>
<td>• Theatre efficiency fell in February</td>
</tr>
<tr>
<td></td>
<td>Safety</td>
<td>▼</td>
<td>• Appraisals and staffing stability green-rated in February</td>
</tr>
<tr>
<td></td>
<td>Outcomes</td>
<td>▶</td>
<td>• Mandatory training amber-rated</td>
</tr>
<tr>
<td></td>
<td>FFT &amp; PET</td>
<td>▶</td>
<td>• Sickness absence red-rated in-month, amber-rated YTD</td>
</tr>
<tr>
<td></td>
<td></td>
<td>▶</td>
<td>• All other metrics red-rated</td>
</tr>
<tr>
<td>CBU5</td>
<td>Standards</td>
<td>▶</td>
<td>• 62 day cancer target not achieved in-month</td>
</tr>
<tr>
<td></td>
<td>Finance</td>
<td>▶</td>
<td>• All RTT targets met in-month and YTD</td>
</tr>
<tr>
<td></td>
<td>Efficiency</td>
<td>▶</td>
<td>• £145k to plan in-month; £2.2% positive variance YTD</td>
</tr>
<tr>
<td></td>
<td>Workforce</td>
<td>▶</td>
<td>• Poor QIPP delivery in February</td>
</tr>
<tr>
<td></td>
<td>Safety</td>
<td>▼</td>
<td>• Theatre cases red-rated; utilisation amber-rated YTD</td>
</tr>
<tr>
<td></td>
<td>Outcomes</td>
<td>▶</td>
<td>• Sickness absence and mandatory training amber-rated</td>
</tr>
<tr>
<td></td>
<td>FFT &amp; PET</td>
<td>▶</td>
<td>• Staffing stability green-rated in February</td>
</tr>
<tr>
<td></td>
<td></td>
<td>▶</td>
<td>• All other metrics red-rated</td>
</tr>
</tbody>
</table>
Summary Financial Performance

<table>
<thead>
<tr>
<th>Annual Plan £m's</th>
<th>Budget Mth £m's</th>
<th>Actual Mth £m's</th>
<th>Variance mth £m's</th>
<th>Budget YTD £m's</th>
<th>Actual YTD £m's</th>
<th>Variance YTD £m's</th>
<th>Variance YTD %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income Earned</td>
<td>250.9</td>
<td>21.0</td>
<td>21.3</td>
<td>0.3</td>
<td>229.8</td>
<td>229.7</td>
<td>-0.1</td>
</tr>
<tr>
<td>Pay Costs</td>
<td>-145.5</td>
<td>-12.2</td>
<td>-13.2</td>
<td>-1.0</td>
<td>-131.1</td>
<td>-137.6</td>
<td>-6.5</td>
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<tr>
<td>Non Pay Costs</td>
<td>-85.5</td>
<td>-7.1</td>
<td>-8.0</td>
<td>-0.9</td>
<td>-78.4</td>
<td>-81.7</td>
<td>-3.3</td>
</tr>
<tr>
<td>EBITDA</td>
<td>19.9</td>
<td>1.7</td>
<td>0.1</td>
<td>-1.6</td>
<td>18.3</td>
<td>10.4</td>
<td>-7.9</td>
</tr>
<tr>
<td>Financing Costs</td>
<td>-19.9</td>
<td>-1.7</td>
<td>-1.6</td>
<td>0.1</td>
<td>-18.3</td>
<td>-18.1</td>
<td>0.2</td>
</tr>
<tr>
<td>( Surplus ) / Deficit</td>
<td>0.0</td>
<td>0.0</td>
<td>-1.5</td>
<td>-1.5</td>
<td>0.0</td>
<td>-7.7</td>
<td>-7.7</td>
</tr>
<tr>
<td>Technical Adjustment</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>-0.2</td>
<td>-0.2</td>
</tr>
<tr>
<td>Retained ( Surplus ) / Deficit</td>
<td>0.0</td>
<td>0.0</td>
<td>-1.5</td>
<td>-1.5</td>
<td>0.0</td>
<td>-7.9</td>
<td>-7.9</td>
</tr>
</tbody>
</table>

Surplus/(deficit) per month (£m)

Cumulative surplus/(deficit) (£m)

Income (£m)

Pay expenditure (£m)

Non-pay expenditure (£m)

EBITDA (£m)

Agency expenditure (£m)

Bank expenditure (£m)

Temp Staffing as % of workforce and pay bill

Unit Cost of Temp Staff per Month
Key Issues

- The Trust’s original financial plan targeted break-even delivery.
- A stretch target of £2m surplus was set in August 2015 by the TDA.
- An actual year to date deficit of £7.9m was reported at Month 11.
- The YTD position is at material variance to both the original & stretch plans.
- Shortfalls against QIPP plans contribute £2.2m to the overall deficit position.
- SLA income performance minus excluded drugs is some £4.1m behind plan.
- The Trust has incurred unplanned SLA performance fines of £2.5m YTD.
- Pay budgets are overspent by £4.5m. This is chiefly driven by continued reliance upon agency staffing.
- Overspends against pay budgets increased materially in February, reflecting significant unfunded increases in bank and agency expenditures.
- The decline in A&E profitability is a significant driver of the Trust’s adverse financial performance, with significantly reductions in activity and revenues combined with material escalations in cost and performance fines.

Key Actions

- Remedial action plan agreed at September Finance Committee & Board.
- ‘Back on Track’ framework set up to drive improved Business Unit delivery.
- ‘Improving Financial Delivery’ reporting and diagnostic framework set up.
- Continued focus upon substantive recruitment to reduced agency costs.
- Application of the national agency pricing cap from the 23rd November.
- Reinforcement of controls for the authorisation of temporary staffing.
- Weekly exec lead recruitment and temp staffing usage reviews with CBU’s.
- Weekly Demand & Capacity meetings to maximise SLA plan delivery.
- Redesign and application of tighter rota design and management policies.
- Review of nursing skill mix and establishment levels across all wards.
- Monthly Service Transformation meeting between CBU’s and ST office.
Trust Board – Agenda Item

**MEETING DATE:** 31st March 2016

**TITLE:** Board Assurance Framework (BAF)

**AGENDA ITEM:** 4.2   **PAPER:** E

**EXECUTIVE SUMMARY:**
The BAF highlights the highest scoring risks to the non-delivery of each of the Trust’s Strategic Objectives (SO’s). The risks are summarised by SO in the summary sheet to provide an overview of the key hotspots at a glance, and the detailed sheets for each risk with a score of >= 15 provide information on current mitigation controls and their effectiveness and further actions to manage the relevant risk. The Strategic risks summary provides an overview of the individual risks against the SO’s. This is incorporated as appendix A of this report.

This iteration of the BAF incorporates an assurance update on the outcome of the annual review of the BAF as part of the internal audit risk management audit.

The Board is asked to note the changes to the BAF (attached as appendix B) and the movement in risks over the last two months and to review the detailed mitigation and action information for the high scoring risks, incorporated as appendix C.

**ACTION REQUESTED OF THE MEETING:**

<table>
<thead>
<tr>
<th>For discussion</th>
<th>For noting</th>
<th>For decision</th>
<th>For assurance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>

**Which Strategic Objective does this paper impact most upon?**
The BAF highlights the key strategic risks to the non-delivery of each of the 5 Strategic Objectives

**How does the paper demonstrate progress towards the specified strategic objective?**
Mitigation or elimination of the risks associated with the non-delivery of each of the Strategic Objectives will enable their achievement. The detail of the mitigating controls, their effectiveness and further actions for each of the risks scoring >= 15 are outlined for discussion and assurance.

**LINKS WITH THE:**

<table>
<thead>
<tr>
<th>BAF:</th>
<th>N/A</th>
<th>Risk score: N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>IPR:</td>
<td>The BAF and the IPR need to be taken together to get a complete picture of current performance and risks associated with non-delivery of SO’s</td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td>Implementation of some of the enabling strategies will support the mitigation of risks. Committees to continue to review progress with enabling strategy implementation.</td>
<td></td>
</tr>
</tbody>
</table>

**THIS PAPER HAS BEEN PREVIOUSLY CONSIDERED BY:**
N/A

**AUTHOR AND TITLE:** Molly Clark, Board Secretary

**PRESENTER AND TITLE:** Molly Clark, Board Secretary
1. Introduction

1.1 This report updates the Trust Board on the key risks to the non-delivery of the Trust’s five Strategic Objectives (SO’s).

1.2 A summary of the Board Assurance Framework (BAF) is shown in Appendix A, with the BAF itself in Appendix B and the mitigating controls for the high risks in Appendix C.

2. 2015/16 Internal audit review of the Board assurance framework

2.1 The BAF was reviewed by RSM as part of an annual risk management internal audit review, which feeds into the Head of Internal Audit Opinion, which is a critical source of assurance supporting the Annual Governance Statement. The findings of the report were presented to the Audit Committee on 14th March 2016.

2.2 An audit opinion of amber-green was given, with a range of best practice examples of sound control design and application of controls. In addition, three medium recommendations were raised.

2.3 Firstly, RSM recommended the need to ensure consistent input of gaps in controls and assurances on the BAF, whilst clearly demonstrating a close alignment to action plans.

2.4 In addition, RSM recommended a regular review of assurances (associated with each risk) by relevant Board level committees, as well as the need to regularly review target risk ratings of risks, particularly those that were increasing in rating.

2.5 All the above recommendations will be reviewed and implemented within the early part of the 2016/17 financial year, and incorporated within the refreshed BAF, which will be presented at the May Board meeting.

3. 2016/17 Board Assurance Framework refresh

3.1 A refreshed BAF will be presented to the Board in May 2016, taking into account the 2016/17 objectives paper, which is incorporated separately under item 6.4 on the Board agenda.

3.2 In addition to the actions highlighted in section 2 of this report, the 2016/17 BAF will be refreshed to incorporate financial risks that have an impact on the 2016/17 financial period and beyond, separately or jointly as appropriate.

3.3 Further updates to the BAF will automatically include a review of the target risk rating whenever the current rating of a risk is increased.
4. **Risk assurance update**

4.1 There are no movements in risk ratings for this iteration of the BAF; however updates have been made to risks where appropriate, as highlighted in bold.

5. **Actions for the Board**

The Board is asked to:

5.1 **Note** and receive assurance from the RSM review of the Board assurance framework.

5.2 **Note** and **endorse** the actions proposed for the 2016/17 refreshed BAF, which will be presented to the Board in May 2016.

5.3 Note the updates to the BAF (attached as **appendix B**) and the movement in risks over the last two months and to review the detailed mitigation and action information for the high scoring risks, incorporated as **appendix C**.

*Molly Clark*

*Board Secretary*
BAF summary (March 2016) – moderate and high risks only

SO1 – Provision of Excellent Clinical Outcomes
- 2413 & 2997 – Failure to sustain compliance with mandatory training level targets (CC) 16
- 1542 – Failure to achieve operational targets (RG) 20

SO2 – Positive experiences for patients, GPs and all stakeholders
- 1748 – Impact of patient experiences on reputation (PR) 16

SO3 – Employer of choice
- 1459 – Staff engagement and impact on morale (HR) 15
- 2616 – Equality and diversity (HR) 12
- 2790 – Staff recruitment (HR) 15
- 2790 – Staff retention (HR) 20

SO4 – Services that are value for money
- 1953 – Delivery of 15/16 I&E control total (MA) 25
- 1954 – Non payment for SLA activity (MA) 25
- 2420 – Robust QIPP plan (MA) 25

SOS – Maximise the efficient use of the site

Key risk areas across the BAF and IPR:
- Recruitment and retention of staff and its impact on:
- 2015/16 I&E control total
- Performance against the 4-hour target
Corporate objective 1: The achievement of excellent clinical outcomes

<table>
<thead>
<tr>
<th>Gaps in assurance</th>
<th>4. Recruitment of additional health records management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Impact</td>
<td>Increased patient satisfaction by patients on the wards</td>
</tr>
<tr>
<td>Monitoring</td>
<td>Implementation of recruitment strategy</td>
</tr>
<tr>
<td>Responsible</td>
<td>Recruitment activity, monitored against key metrics such as numbers of starters per month</td>
</tr>
<tr>
<td>Responsible</td>
<td>None identified</td>
</tr>
</tbody>
</table>

Corporate objective 2: Ensuring positive experiences for GPs and all stakeholders

<table>
<thead>
<tr>
<th>Gaps in assurance</th>
<th>4. Implementation of Health records management plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Impact</td>
<td>Enhanced tracking of health records</td>
</tr>
<tr>
<td>Monitoring</td>
<td>Monitoring of FFT performance</td>
</tr>
<tr>
<td>Responsible</td>
<td>None identified</td>
</tr>
</tbody>
</table>

Corporate objective 3: To be an employer of choice with a workforce that is excellent and committed, acting as ambassadors for the Trust

<table>
<thead>
<tr>
<th>Gaps in assurance</th>
<th>4. Recruitment of additional health records management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Impact</td>
<td>None identified</td>
</tr>
<tr>
<td>Monitoring</td>
<td>Recruitment activity, monitored against key metrics such as numbers of starters per month</td>
</tr>
<tr>
<td>Responsible</td>
<td>None identified</td>
</tr>
</tbody>
</table>

Corporate objective 4: To provide services that are value for money for the taxpayer

<table>
<thead>
<tr>
<th>Gaps in assurance</th>
<th>4. Recruitment of additional health records management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Impact</td>
<td>None identified</td>
</tr>
<tr>
<td>Monitoring</td>
<td>Recruitment activity, monitored against key metrics such as numbers of starters per month</td>
</tr>
<tr>
<td>Responsible</td>
<td>None identified</td>
</tr>
</tbody>
</table>
1. The Trust has put in place an ‘Improving Financial Delivery’ framework, as part of its ‘Back on Track’ approach which seeks to boost key actions to ensure remedial and improvements actions are focused upon. There are financial opportunities. 2. The Trust has in place a detailed and agreed internal control framework that is supported by all Trust teams. 3. Monthly QIPP performance reports are provided to the NEC at each meeting. 4. Monthly review of activity delivered to enable the financial impact on the Trust to be understood. 5. Monthly QIPP progress meetings with the Finance and Operations departments.

Item 4.2 Appendix B

The delivery of the 15/16 Trust financial plan is dependent upon the control and management of expenditure within the agreed scope and expenditure. 1. Clear local health economy transformation plans that will support the redesign of service models that is sustainable and affordable for both the Trust & local commissioners.

Failure to develop a robust QIPP plan and effectively deliver year on year savings, resulting in an adverse impact on the delivery of the organisation's budget plan.

Monthly, ongoing

Monthly QIPP reports provided to NEC and Trust Board (QIPP and HRAP progress) and also accessible to all Trust management teams and clinicians. Monthly QIPP performance reports are provided to the NEC at each meeting. Monthly QIPP progress meetings with the Finance and Operations departments.

In December 2015, the Trust Board has agreed to set up a Revolving Working Capital facility to support the Trust Board to seek to maintain Capital Working Capital to ensure short term liquidity requirements are managed. Agreement of loan was completed at the FTC with a draw down in February 2016.

The Trust Board has approved a local scale transaction during 2015/16 which is expected to be completed in March 2016. Packages approved by the FTC in February 2016. PSL expected to be approved at PSL - February 2016. Reporting Cycles for each transaction outlined to the FTC.

Monthly, on-going

The Trust has defined a series of workstreams under ‘Back on Track/Financial delivery initiatives. The Trust has agreed a range of corporate activities that can support progress towards the Trust’s remedial control total target, which match actions submitted to the FTC in 2015/16. 5. Approval obtained from the November meeting of the Trust Board to seek to establish a Revolving Working Capital facility to support the Trust Board to seek to maintain Capital Working Capital to ensure short term liquidity requirements are managed. Agreement of loan was completed at the FTC with a draw down in February 2016.

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Monthly, on-going


drafted and updated plans for the past and report on progress and against 31st March 2016, as well as the next QIPP plan. The Trust has a number of initiatives in place to support the financial plan.

1. Monthly SLA income reports are presented to EMB, FIC and Trust Board and reporting is also accessible to all CBU teams and the service areas that they support.

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Monthly, ongoing

Monthly, ongoing

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Monthly, on-going


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Risk 2413: Failure to sustain mandatory training level targets, resulting in an adverse impact on the quality care provided, our financial position and ability to recruit and retain the best staff.

<table>
<thead>
<tr>
<th>Risk consequences</th>
<th>Adverse impact on quality and safety of care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk owners</td>
<td>Medical Director</td>
</tr>
<tr>
<td>Gross risk</td>
<td></td>
</tr>
<tr>
<td>Likelihood</td>
<td>4</td>
</tr>
<tr>
<td>Impact</td>
<td>5</td>
</tr>
<tr>
<td>Score</td>
<td>20</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ideal mitigating controls</th>
<th>Performed?</th>
<th>Performed by</th>
<th>Frequency</th>
<th>Monitoring method</th>
<th>Effectiveness</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Monitoring and reporting of relevant levels by department and CBUs</td>
<td>Yes</td>
<td>CBUs and Learning and Development team</td>
<td>Ongoing</td>
<td>Workforce and Education Committee assurance</td>
<td></td>
</tr>
<tr>
<td>2. Progress plan in place with trajectory to deliver 90% compliance by March 2016</td>
<td>No</td>
<td>Medical Director</td>
<td>Ongoing</td>
<td>Workforce and Education Committee assurance</td>
<td></td>
</tr>
<tr>
<td>3. Increased focus on compulsory training achievement</td>
<td>Yes</td>
<td>CBUs and Learning and Development team</td>
<td>Ongoing</td>
<td>Workforce and Education Committee assurance</td>
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</tr>
</tbody>
</table>

Overall assessment of control effectiveness: Partially Effective

<table>
<thead>
<tr>
<th>Residual risk</th>
<th>Likelihood</th>
<th>Impact</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan to improve controls where control effectiveness is ranked red or amber</td>
<td>Due date</td>
<td>Who will perform</td>
<td>Frequency</td>
</tr>
<tr>
<td>Implement plan to meet 90% compliance</td>
<td>Ongoing</td>
<td>Medical Director</td>
<td>ongoing</td>
</tr>
</tbody>
</table>

Date: March 2016
Corporate Objective 1: The achievement of excellent clinical outcomes

Risk 1542: Failure to maintain consistent achievement of good operational performance adversely impacts on patient care and outcomes and our reputation

<table>
<thead>
<tr>
<th>Risk consequences</th>
<th>Adverse impact on quality and safety of care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk owners</td>
<td>Director of Operations</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gross risk</th>
<th>Likelihood</th>
<th>Impact</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
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<table>
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<th>Ideal mitigating controls</th>
<th>Likelihood</th>
<th>Impact</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Regular oversight of Health economy wide systems resilience group</td>
<td>Yes</td>
<td>SRG/ Director of Operations</td>
<td>monthly</td>
</tr>
<tr>
<td>2. Remedial action plan, reviewed fortnightly with CCG</td>
<td>Yes</td>
<td>Director of Operations</td>
<td>fortnightly</td>
</tr>
<tr>
<td>3. Weekly access group reviews performance for diagnostics and cancer, reporting to the planning and commissioning group in terms of escalation of issues</td>
<td>Yes</td>
<td>CBU 1 Management team</td>
<td>daily</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Overall assessment of control effectiveness</th>
<th>Partially Effective</th>
</tr>
</thead>
</table>

<table>
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<tr>
<th>Residual risk</th>
<th>Likelihood</th>
<th>Impact</th>
<th>Score</th>
</tr>
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<table>
<thead>
<tr>
<th>Plan to improve controls where control effectiveness is ranked red or amber</th>
<th>Due date</th>
<th>Who will perform</th>
<th>Frequency</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Board rounds implemented on medical wards following work with Mckinsey</td>
<td>Ongoing</td>
<td>Director of Operations</td>
<td>ongoing</td>
<td></td>
</tr>
<tr>
<td>to bring total to 14 full time WTE Appointment of fulltime clinical director and additional consultants to bring total to 14 full time</td>
<td>ongoing</td>
<td>Director of Operations</td>
<td>ongoing</td>
<td></td>
</tr>
<tr>
<td>Implementation for integrated discharge team with local partners to reduce patients waiting for external capacity</td>
<td>Ongoing</td>
<td>Director of Operations</td>
<td>ongoing</td>
<td></td>
</tr>
</tbody>
</table>

Date: March 2016
Corporate Objective 1: The achievement of excellent clinical outcomes

Risk 2496: Failure to manage and stored patient notes in accordance with Trust policy, due to increase in volume and restrictions in space, adversely impacting on patient experience and quality of care

<table>
<thead>
<tr>
<th>Risk consequences</th>
<th>Adverse impact on quality and safety of care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk owners</td>
<td>Director of Operations</td>
</tr>
<tr>
<td>Gross risk</td>
<td></td>
</tr>
<tr>
<td><strong>Likelihood</strong></td>
<td><strong>Impact</strong></td>
</tr>
<tr>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Ideal mitigating controls</td>
<td></td>
</tr>
<tr>
<td>1. Recruitment of additional health records management staff</td>
<td>Partly</td>
</tr>
<tr>
<td>2. Weekly action plan review led by the Director of Operations, incorporating CBU 3 and IT programme lead</td>
<td>No</td>
</tr>
<tr>
<td>3. Enhanced tracking of health records</td>
<td>No</td>
</tr>
<tr>
<td>4. Implementation of EDMS project plan</td>
<td>Yes</td>
</tr>
<tr>
<td>5. Identification of senior leadership expertise within medical records team</td>
<td>No</td>
</tr>
<tr>
<td>Overall assessment of control effectiveness</td>
<td></td>
</tr>
</tbody>
</table>

Plan to improve controls where control effectiveness is ranked red or amber

<table>
<thead>
<tr>
<th>Plan to improve controls where control effectiveness is ranked red or amber</th>
<th>Due date</th>
<th>Who will perform</th>
<th>Frequency</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>To monitor the health records management action plan</td>
<td>ongoing</td>
<td>Director of Operations</td>
<td>ongoing</td>
<td>Silver Control Meetings</td>
</tr>
</tbody>
</table>

Date: March 2016
### Corporate Objective 2: Ensuring positive experiences for GPs and all stakeholders

**Risk 1748: Risk that the Trust fails to resolve ongoing patient experience issues, resulting in a poor reputation for the Trust and an inability to become the local hospital of choice**

<table>
<thead>
<tr>
<th>Risk consequences</th>
<th>Adverse impact on quality and safety of care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Risk owners</strong></td>
<td>Director of Nursing</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Gross risk</strong></th>
<th><strong>Likelihood</strong></th>
<th><strong>Impact</strong></th>
<th><strong>Score</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>5</td>
<td>4</td>
<td>20</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Ideal mitigating controls</strong></th>
<th><strong>Performed?</strong></th>
<th><strong>Performed by</strong></th>
<th><strong>Frequency</strong></th>
<th><strong>Monitoring method</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Real-time monitoring of patient experience via FFT</td>
<td>Yes</td>
<td>Corporate Nursing team</td>
<td>Ongoing</td>
<td>Patient Experience Group</td>
</tr>
<tr>
<td>Active monitoring of patient satisfaction by patients on the wards</td>
<td>Yes</td>
<td>Corporate Nursing team</td>
<td>TBC</td>
<td>Patient Experience Group</td>
</tr>
<tr>
<td>Development of Patient Experience strategy</td>
<td>Yes</td>
<td>Corporate Nursing team</td>
<td>TBC</td>
<td>Risk and Quality Committee</td>
</tr>
<tr>
<td>Revise Nursing and midwifery strategy to incorporate values and behaviours</td>
<td>Yes</td>
<td>Corporate Nursing team</td>
<td>TBC</td>
<td>Nursing and Midwifery Advisory Board</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Overall assessment of control effectiveness</strong></th>
<th><strong>Effectiveness</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Residual risk</strong></th>
<th><strong>Likelihood</strong></th>
<th><strong>Impact</strong></th>
<th><strong>Score</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td>4</td>
<td>16</td>
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<table>
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<tr>
<th><strong>Plan to improve controls where control effectiveness is ranked red or amber</strong></th>
<th><strong>Due date</strong></th>
<th><strong>Who will perform</strong></th>
<th><strong>Frequency</strong></th>
<th><strong>Evidence</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan to improve controls where control effectiveness is ranked red or amber</td>
<td></td>
<td></td>
<td></td>
<td>Increased uptake in FFT across the trust including A&amp;E</td>
</tr>
<tr>
<td>Development of a consolidated approach to capturing feedback across the Trust to share learning</td>
<td>ongoing</td>
<td>Director of Nursing</td>
<td></td>
<td>Action plan to be presented to RQC in October</td>
</tr>
<tr>
<td>Enhance assurance on Patient Experience including complaints at Board, RQC PEG and PPI Group</td>
<td>Ongoing</td>
<td>Director of Nursing</td>
<td></td>
<td>Action plan to be presented to RQC in October</td>
</tr>
</tbody>
</table>

**Date:** March 2016
Corporate Objective 3: To be an employer of choice with a workforce that's excellent and compassionate, acting as ambassadors for the Trust

Risk ID 2790: Failure to recruit sufficient numbers of clinical and non-clinical staff to provide high quality patient care

<table>
<thead>
<tr>
<th>Risk consequences</th>
<th>Adverse impact on staff retention and patient experience levels</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk owners</td>
<td>Director of Human Resources</td>
</tr>
<tr>
<td>Gross risk</td>
<td></td>
</tr>
<tr>
<td>Likelihood</td>
<td>4</td>
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<td>Impact</td>
<td>4</td>
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<tr>
<td>Score</td>
<td>16</td>
</tr>
<tr>
<td>Ideal mitigating controls</td>
<td></td>
</tr>
<tr>
<td>1. implementation of staff engagement strategy plan</td>
<td>Yes</td>
</tr>
<tr>
<td>Performed by</td>
<td>Director of Human Resources</td>
</tr>
<tr>
<td>Frequency</td>
<td>Bi-monthly</td>
</tr>
<tr>
<td>Monitoring method</td>
<td>Workforce and Education Committee</td>
</tr>
<tr>
<td>Effectiveness</td>
<td></td>
</tr>
<tr>
<td>2. Implementation of values and behaviours programme</td>
<td>Yes</td>
</tr>
<tr>
<td>Performed by</td>
<td>Director of Human Resources</td>
</tr>
<tr>
<td>Frequency</td>
<td>Bi-monthly</td>
</tr>
<tr>
<td>Monitoring method</td>
<td>Workforce and Education Committee</td>
</tr>
<tr>
<td>Effectiveness</td>
<td></td>
</tr>
<tr>
<td>3. Monitoring of staff FFT results quarterly and staff survey annually</td>
<td>Yes</td>
</tr>
<tr>
<td>Performed by</td>
<td>Director of Human Resources</td>
</tr>
<tr>
<td>Frequency</td>
<td>Quarterly and annually</td>
</tr>
<tr>
<td>Monitoring method</td>
<td>Workforce and Education Committee</td>
</tr>
<tr>
<td>Effectiveness</td>
<td></td>
</tr>
<tr>
<td>Overall assessment of control effectiveness</td>
<td>Partially Effective</td>
</tr>
<tr>
<td>Residual risk</td>
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</tr>
<tr>
<td>Likelihood</td>
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<tr>
<td>Impact</td>
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<td>Score</td>
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<tr>
<td>Plan to improve controls where control effectiveness is ranked red or amber</td>
<td>Due date</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Continue with the implementation of recruitment schemes and material additional staff</td>
<td>ongoing</td>
</tr>
</tbody>
</table>

Date: March 2016
Corporate Objective 3 : To be an employer of choice with a workforce thats excellent and compassionate, acting as ambassadors for the Trust

Risk ID 2791: Failure to retain sufficient numbers of clinical and non-clinical staff to provide high quality patient care

<table>
<thead>
<tr>
<th>Risk consequences</th>
<th>Adverse impact on staff retention and patient experience levels</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk owners</td>
<td>Director of Human Resources</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gross risk</th>
<th>Likelihood</th>
<th>Impact</th>
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<table>
<thead>
<tr>
<th>Ideal mitigating controls</th>
<th>Performed?</th>
<th>Performed by</th>
<th>Frequency</th>
<th>Monitoring method</th>
<th>Effectiveness</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. implementation of engagement strategy</td>
<td>Yes</td>
<td>Director of Human Resources</td>
<td>Bi-monthly</td>
<td>Workforce and Education Committee</td>
<td>Partially Effective</td>
</tr>
<tr>
<td>2. Implementation of values and behaviours programme</td>
<td>Yes</td>
<td>Director of Human Resources</td>
<td>Bi-monthly</td>
<td>Workforce and Education Committee</td>
<td>Partially Effective</td>
</tr>
<tr>
<td>3. Monitoring of staff FFT results quarterly and staff survey annually</td>
<td>Yes</td>
<td>Director of Human Resources</td>
<td>Quarterl and annually</td>
<td>Workforce and Education Committee</td>
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Overall assessment of control effectiveness: Partially Effective

<table>
<thead>
<tr>
<th>Residual risk</th>
<th>Likelihood</th>
<th>Impact</th>
<th>Score</th>
</tr>
</thead>
<tbody>
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</table>

- **Plan to improve controls where control effectiveness is ranked red or amber**
  - Due date
  - Who will perform
  - Frequency
  - Evidence
  - Back on Track Meetings and Weekly Establishment Control Meetings

- **Continue with the implementation of engagement schemes**
  - ongoing
  - Director of Human Resources
  - ongoing
  - Back on Track Meetings and Weekly Establishment Control Meetings

Date: March 2016
## Corporate Objective 4: To provide services that are value for money for the taxpayer

### Risk 1953: Failure to operate within agreed resource constraints for 2015/16 places the achievement of key statutory financial duties at risk.

<table>
<thead>
<tr>
<th>Risk consequences</th>
<th>Failure to meet our statutory obligations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk owners</td>
<td>Director of Finance and Performance</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gross risk</th>
<th>Likelihood</th>
<th>Impact</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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### Ideal mitigating controls

<table>
<thead>
<tr>
<th>Description</th>
<th>Performed?</th>
<th>Performed by</th>
<th>Frequency</th>
<th>Monitoring method</th>
<th>Effectiveness</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Trust has an improved development framework which seeks to coordinate key actions to ensure remedial actions are focussed on key improvement opportunities.</td>
<td>Yes</td>
<td>Director of Finance</td>
<td>monthly</td>
<td>Back on Track Meetings</td>
<td></td>
</tr>
<tr>
<td>The Trust has in place a detailed and audited monthly budget reporting system that is accessible to all Trust budget holders via Qlikview.</td>
<td>Yes</td>
<td>Director of Finance &amp; HR and CBU’s</td>
<td>weekly</td>
<td>FIC &amp; Workforce Committees</td>
<td></td>
</tr>
<tr>
<td>Monthly CBU performance meetings take place between the Trust Executive and CBU management teams - a key element of this agenda is the monitoring and review of CBU financial and activity delivery performance and also savings delivery achievement. This involves the discussion and identification of key variances from plan and agreement of remedial action.</td>
<td>Yes</td>
<td>Director of Operations and CBU’s</td>
<td>monthly</td>
<td>Back on Track Meetings EMB FIC Trust Board</td>
<td></td>
</tr>
<tr>
<td>Joint working and liaison between CBU specific management accounting teams and the service areas that they support</td>
<td>Yes</td>
<td>Director of Finance and Performance</td>
<td>monthly</td>
<td>Back on Track Meetings</td>
<td></td>
</tr>
<tr>
<td>The Trust has agreed a range of corporate activities that can support progress towards the Trust remedial control total target, which match actions submitted to the TDA on 21st August 2015</td>
<td>Yes</td>
<td>PCG and CMT meetings</td>
<td>monthly</td>
<td>FIC</td>
<td></td>
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</table>

### Overall assessment of control effectiveness

<table>
<thead>
<tr>
<th>Residual risk</th>
<th>Likelihood</th>
<th>Impact</th>
<th>Score</th>
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**Plan to improve controls where control effectiveness is ranked red or amber**

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<th>Due date</th>
<th>Who will perform</th>
<th>Frequency</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Director of Finance &amp; Information</td>
<td>Back on Track Meetings EMB FIC</td>
<td>FIC</td>
</tr>
</tbody>
</table>

**Date:** March 2016
Corporate Objective 4: To provide services that are value for money for the taxpayer

Risk ID 1954: Non payment for SLA delivered activity

<table>
<thead>
<tr>
<th>Risk consequences</th>
<th>Adverse impact on the Trust’s ability to meet its statutory duties</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk owners</td>
<td>Director of Finance and Performance</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gross risk</th>
<th>Likelihood</th>
<th>Impact</th>
<th>Score</th>
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<tr>
<td></td>
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<table>
<thead>
<tr>
<th>Ideal mitigating controls</th>
<th>Performed?</th>
<th>Performed by</th>
<th>Frequency</th>
<th>Monitoring method</th>
<th>Effectiveness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Detailed activity and income reports are presented to the FIC on a monthly basis, with summarised reporting presented to EMB and Trust Board.</td>
<td>Yes</td>
<td>Director of Finance and Performance</td>
<td>Bi-monthly</td>
<td>CSU/CCG meetings</td>
<td></td>
</tr>
<tr>
<td>Detailed and audited process to price and report income performance against SLA Plan (SLAM), accessible via Qlikview</td>
<td>Yes</td>
<td>Director of Finance and Performance</td>
<td>monthly</td>
<td>Back on Track Meetings and FIC</td>
<td></td>
</tr>
<tr>
<td>Weekly reviews of activity delivery at Exec chaired Demand and Capacity Group</td>
<td>Yes</td>
<td>Director of Finance and Performance</td>
<td>weekly</td>
<td>Planning &amp; Commissioning Group / FIC</td>
<td></td>
</tr>
<tr>
<td>Monthly SLA performance meetings with NCL commissioners to discuss and review YTD performance</td>
<td>Yes</td>
<td>Director of Finance and Performance</td>
<td>monthly</td>
<td>Contract Management Group FIC</td>
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</tr>
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</table>

Overall assessment of control effectiveness: Partially Effective

<table>
<thead>
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<th>Score</th>
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</table>

Plan to improve controls where control effectiveness is ranked red or amber

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<tr>
<th>Due date</th>
<th>Who will perform</th>
<th>Frequency</th>
<th>Evidence</th>
</tr>
</thead>
</table>

Remedial action plans agreed with Commissioners in respect of A&E, Diagnostics and cancer waiting times

| ongoing | Director of Finance and Performance | Ongoing | Remedial Action Plan Documents |

Date: March 2016
Corporate Objective 1: The achievement of excellent clinical outcomes

Risk ID 2997: Failure to sustain mandatory training level targets

<table>
<thead>
<tr>
<th>Risk consequences</th>
<th>Adverse impact on quality and safety of care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk owners</td>
<td>Medical Director</td>
</tr>
<tr>
<td>Gross risk</td>
<td>Likelihood</td>
</tr>
<tr>
<td>Ideal mitigating controls</td>
<td>Performed?</td>
</tr>
<tr>
<td>1. Monitoring and reporting of relevant levels by department and CBUs</td>
<td>Yes</td>
</tr>
<tr>
<td>2. Progress plan in place with trajectory to deliver 90% compliance by March 2016</td>
<td>No</td>
</tr>
<tr>
<td>3. Increased focus on compulsory training achievement</td>
<td>Yes</td>
</tr>
<tr>
<td>Overall assessment of control effectiveness</td>
<td></td>
</tr>
</tbody>
</table>

Residual risk

<table>
<thead>
<tr>
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<th>Who will perform</th>
<th>Frequency</th>
<th>Evidence</th>
</tr>
</thead>
</table>

| Implement plan to meet 90% compliance current compliance level is 84% | Ongoing | Medical Director | ongoing | Mandatory training level |

Date: March 2016
Trust Board

MEETING DATE: Thursday 26th March 2016

TITLE: Safe Staffing Report

AGENDA ITEM: 5.1 PAPER:F

EXECUTIVE SUMMARY:

This paper provides assurance to the Trust Board that there is safe staffing in place for each ward across the Trust. It outlines the actual number of hours worked versus planned hours for both registered nursing staff and unregistered care staff across the Trust. In order to provide assurance that each ward is safely staffed, a range of quality indicators encompassing patient experience and safety are included to enable effective triangulation of quality performance at a granular ward level.

The Board is asked to note and receive the safe staffing report.

ACTION REQUESTED OF THE MEETING:

<table>
<thead>
<tr>
<th>For discussion</th>
<th>For noting</th>
</tr>
</thead>
<tbody>
<tr>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>For decision</td>
<td></td>
</tr>
<tr>
<td>For assurance</td>
<td>X</td>
</tr>
</tbody>
</table>

Which Strategic Objective does this paper impact most upon?:

| SO1 – Provision of Excellent Clinical Outcomes |
| SO2 – Positive experiences for patients, GPs and all stakeholders |

How does the paper demonstrate progress towards the specified strategic objective?:

Reports ward level performance against a selection of safety and patient experience indicators.

LINKS WITH THE:

| BAF: N/A | Risk score: N/A |
| IPR: QUAL3, QUAL4, PAT1 |
| Other: N/A |

THIS PAPER HAS BEEN PREVIOUSLY CONSIDERED BY: N/A

AUTHOR AND TITLE: Paul Reeves, Director of Nursing
1.0. Introduction

1.1 The Hard Truths report placed specific responsibilities on Trust boards to demonstrate that robust systems and processes are in place to assure them that staffing capacity and capability is sufficient to deliver safe and effective care. The purpose of this report is to provide the Board with assurance of compliance with these requirements.

1.2 A range of safety and patient experience indicators that have reliable performance data at ward level have been selected to enable a triangulation between staffing data and ward level quality performance. This will assure the board that areas which fall below safe staffing levels have been identified and remedial action taken to safeguard the quality of services provided. The selected quality indicators provide the board with red flags that can suggest a ward has inappropriate levels of staffing.

1.3 This safe staffing report supplements the quality sections of the Integrated Performance Report which provides the board with a comprehensive overview of patient experience, the safety and the effectiveness of clinical services across the Trust.

2.0. Analysis of nursing and midwifery staffing levels in February 2016

2.1 NICE guideline SG1 (Safe staffing for nursing in adult inpatient wards in acute hospitals) states that there is no single nursing to staff patient ratio that can be applied across all acute adult inpatient wards. However, there is evidence of increased risk of harm associated with a registered nurse caring for more than 8 patients particularly during the day.

2.2 The Trust’s standard planned nursing establishment for non-critical care adult wards is for a ratio of one registered nurse to six patients. In critical care areas, the establishment is flexed to meet numbers of patients, taking into account patient acuity. This 1:6 ratio provides headroom to ensure we have 1:8, and is also a central aspect of the Trust’s current strategy to improve the patient experience and the Trust’s performance in national patient experience surveys.

2.3 The table below indicates the Trust’s fill rate for February 2016 based on these planning assumptions.

<table>
<thead>
<tr>
<th>Day</th>
<th>Night</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registered midwives/nurses</td>
<td>Total monthly planned staff hours</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Day</td>
<td>Night</td>
</tr>
<tr>
<td>43646.9</td>
<td>40667</td>
</tr>
</tbody>
</table>
2.4 **Appendix 1** provides a breakdown of each ward’s individual fill rate based on the 1:6 nurse to staff ratio used to determine the establishment. Where the fill rate drops below 80%, this could have a detrimental effect on the safety and quality of care provided. Wards that achieved less than 99% against a 1:8 nurse to ratio (based on nursing numbers being rounded up to the next whole time nurse) are highlighted in yellow.

2.5 During January there were 2 areas with less than 99% fill rate against a 1:8 nurse to patient ratio, and 3 clinical areas with fill rates below their planned levels:

2.6 **Charles Coward Ward**

Charles Coward ward’s fill rate declined from 102% in January to 95% in February due to an increase in sickness absence to 7.33%. It should be noted that Charles Coward reported 5 staff shortage incidents during the month. There was also 1 SOVA raised against Charles Coward during the month. This concerned a patient who developed a grade 3 hospital acquired pressure ulcer and this was subject to a RCA investigation and was not related to staffing levels on the ward in February. The Care of the Elderly matron ensured the nursing workforce was flexed in response to spikes in sickness absence to maintain safe staffing levels on Charles Coward, Pymmes 0 in particular often provided additional nursing support for Charles Coward to enable safe staffing levels to be maintained. The fill rate for Pymmes 0 ward against the 1:8 nurse to patient ratio during February was 133%.

2.7 **T4 Surgical Ward**

T4 Surgical Ward’s fill rate declined from 95% against a 1:8 ratio in January to 83% in February. The fill rate below 100% on a 1:8 ratio was due to unplanned absences and a reduced ability to fill bank and agency shifts combined with vacancy rate, although this fell from 20% in January to 13% during February. The T4 ward manager and both the surgical deputy matron and emergency surgical practitioner worked clinically on the ward instead of management days in order to maintain staffing levels on T4. These staff members are not included in the e-roster figures and so are not reflected in the fill rates for February. Furthermore, the entire surgical nursing workforce was also flexed to support and provide cover T4 when required. Notwithstanding the low fill rate for February, the FFT score was 100% for the month, and this was based on a high response rate of 66% of patients being surveyed. Likewise the T4 Safety Thermometer score for February was 100% harm free care. Therefore the actions taken to mitigate the potential impact of the low fill rate prevented deterioration in the quality of care provided to patients on T4 during February.

2.8 **High Dependency Unit (Previously known as the Progressive Care Unit)**

HDU staffing levels are determined by British Association of Critical Care Nurses, based on a ratio of 1 nurse to 2 HDU patients. The fill rate for planned hours based on this standard February appears from the e-roster data to be 68%. However this misleading and is due to the current configuration of the critical care complex rota which is yet to be amalgamated from the previous ICU and Progressive Care Units rosters following the reconfiguration of the critical care complex. As a result, the return for February shows that the critical care rota had a fill rate 115%. When the hours worked across both the High Dependency Unit and Critical Care are disaggregated, the fill rate across the entire critical care complex was 99% demonstrating that the unit was safely staffed during February. The Critical Care Matron is currently resolving the remaining rota queries ahead of implementing the new combined rota and all new starters are being added solely to the critical care rota.
2.9 Labour Ward

Labour Ward planned staffing levels are based on Birth Rate Plus (usual standard is 1:30 deliveries). The current vacancy rate in Maternity is 11% compared to 15% in January. On a daily basis senior staff meets to review staffing levels across maternity and workload and staff are moved around the unit to take up the shortfall. There was also a reduction in bank fill rates in February which resulted in increased use of agency during the month. The percentage fill across Maternity was 86% during February, a decrease of 1% from January’s figure. There were no patient safety incidents reported during February. Furthermore, the unit’s ability to provide one to one remains within satisfactory parameters.

3.0 Safety Thermometer

3.1 Appendix 3 provides ward level analysis of staffing fill rates triangulated with a selection of quality metrics including each ward’s percentages of harm free care, catheters and new UTIs, and hospital acquired VTEs as measured via the Safety Thermometer survey in January. It is important to note, however, that the quality metrics selected in appendix 3 are not singularly attributable to staffing levels, and are therefore provided for a holistic overview of the quality of care on each ward, rather than being supplied as evidence of a direct correlation, or causal relationship, between the staffing levels reported and the quality metric provided.

3.2 The table below summarises the Trust’s Safety Thermometer performance for February. There has been a significant improvement in performance regarding the Safety Thermometer following the implementation of the revised Safety Thermometer survey process. The overall percentage of patients surveyed in February who received harm free care was 94.90%, an increase from 94.42% in January but which remains below the target of 95% but was above the national average of 94.05% for February 2016. New harms (harms occurring after admission) accounted for 1.12% whilst all harms (new and existing at admission) amounted to 5.10%.

<table>
<thead>
<tr>
<th>February 2016 Safety Thermometer Performance: Trustwide</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pressure Ulcers (all)</strong></td>
</tr>
<tr>
<td>3.47%</td>
</tr>
<tr>
<td>17 patients</td>
</tr>
</tbody>
</table>

Appendix 3 confirms there were no wards with red performance against the Safety Thermometer Harm Free Care indicator, where harm free care was reported as less than 80% during February.
4.0. Patient Experience and the Friends and Family Test

4.1 The table below summarises the Trust’s FFT performance for February. The percentage of patients surveyed in February who would be either extremely likely or likely to recommend the Trust was 54.00%, a significant deterioration from the 70.38%, reported during January. The deterioration is entirely due to deterioration in feedback from patients in ED

<table>
<thead>
<tr>
<th>FFT response</th>
<th>A&amp;E</th>
<th>IP</th>
<th>All Maternity</th>
<th>Outpatients</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 - Extremely Likely</td>
<td>566</td>
<td>366</td>
<td>229</td>
<td>175</td>
<td>826</td>
</tr>
<tr>
<td>2 - Likely</td>
<td>595</td>
<td>162</td>
<td>83</td>
<td>151</td>
<td>991</td>
</tr>
<tr>
<td>3 - Neither likely nor unlikely</td>
<td>245</td>
<td>12</td>
<td>12</td>
<td>27</td>
<td>296</td>
</tr>
<tr>
<td>4 - Unlikely</td>
<td>444</td>
<td>10</td>
<td>1</td>
<td>30</td>
<td>485</td>
</tr>
<tr>
<td>5 - Extremely unlikely</td>
<td>489</td>
<td>3</td>
<td>6</td>
<td>50</td>
<td>548</td>
</tr>
<tr>
<td>6 - Don't Know</td>
<td>167</td>
<td>1</td>
<td>7</td>
<td>44</td>
<td>219</td>
</tr>
</tbody>
</table>

Response rate for each ward:
- A&E: 24.60%
- IP: 25.95%
- All Maternity: 79.16%
- Outpatients: 477 pts

| Would Recommend | 46.33% | 95.31% | 92.31% | 68.34% | 70.38 |
| Would NOT Recommend | 37.23% | 2.35% | 2.07% | 16.77% | 22.79 |

5.0. 2016/17 Skill mix review

5.1 In January the Director of Nursing presented a paper outlining a proposed skill mix change following the publication of the Carter review. The Trust (along with all other NHS Trust’s) had been asked to review skill mix as part of the Carter (2015) review and in so doing, the Director of Nursing proposed the following changes to the nursing establishment:

- To appoint a separate supernumerary nurse in nurse in charge during the day—this will ensure that patient flow and the patient experience are joined. It will provide clinical leadership and ensure that patients are managed through the system in a timely and appropriate manner.

- The nursing establishment to move from 1:6 to 1:7 for the Tower Wards and the Care of the Elderly Wards and Podium 1 ward, but with nurse in charge during the day— the Nursing and Care Quality Forum (part of the King’s Fund) is working in conjunction with the Chief Nurse for England to determine how skill mix and leadership will look moving forward. What is clear from the NCQF is that clinical leadership and effective skill mix are critical aspects of patient safety and patient experience—having a nurse in charge enables a culture of ownership.

5.2 At the time, these proposed changes to the current nursing skill mix were thought to support the achievement of the twin objectives of the continued delivery of high quality care whilst supporting long term sustainability and the Trust’s financial performance. The proposed move to a 1:7 nurse to patient ratio in the wards identified would release full year savings of £780,000.
5.3 A pilot was undertaken on Pymmes 0 (care of the Elderly) and T 8 (Medical Tower Ward). The pilot was over a one month period between middle of February and middle of March. Analysis, following the pilot showed that such a reduction would leave some areas without a supernumerary nurse in charge during the day, who is essential to maintain patient flow and ensure quality of care. Consequently the original planning assumptions underpinning the January proposals have been revisited to determine how significant savings can be realised whilst ensuring the ongoing provision of safe, high quality and responsive nursing care. The revised changes to the nursing establishment for 2016/17 will therefore be:

5.3.1 Tower Wards
   a. Reduction from 2 to 1 early band 5 shift each day
   b. Reduction from 3 to 2 HCSW long day shifts on Saturdays and Sundays
   c. The impact of these changes would be to provide uniform 3 registered plus 2 HCSW per shift with the existing additional early and late band 5, 7 days a week. In addition, the daytime supernumerary nurse in charge will be maintained to coordinate patient flow and support discharges. The nurse in charge is not required for night time shifts. This would result in a reduction to each Tower ward’s establishment of 1.21 WTE band 5 nurses and 0.71 WTE HCSW. The number of weekly nursing hours would reduce from 604.5 to 567 and the number of HCSW hours would reduce from 330 per week to 308.

5.3.2 Care of the Elderly Wards
   a. Charles Coward & Pymmes 0 Wards
      Reduction from 4 to 3 nursing night shifts combined with reduction from 3 to 2 HCSW on long day shifts and increasing HCSW on night shifts from 2 to 3 for each day of the week. The impact of these changes would be to provide 4 registered nurses plus 2 HCSW during the day, and 3 registered nurses and 3 HCSW during the night. In addition, the current early and late nursing shift each day will remain in place. Furthermore, the daytime supernumerary nurse in charge will be maintained to coordinate patient flow and support discharges. The nurse in charge is not required for night time shifts.

      - This would result in a reduction to each ward’s establishment of 2.48 WTE nursing staff with no change to the HCSW establishment. The number of weekly nursing hours would reduce from 721 to 644 and the number of HCSW hours would remain unchanged at 385.

      - The additional night time HCSW included in both Pymmes 0 and Charles Coward establishments would be flexed by site management across Care of the Elderly to reduce the need for arranging specials at short notice. These additional HSCW would not be for the exclusive use of these two wards, and would be rotated through Michael Bates if patient acuity demanded.
b. **Michael Bates ward**

Reduction from 4 to 3 nursing night shifts combined with reduction from 3 to 2 HCSW on long day shifts and maintaining the existing HCSW on night shifts at 2 for each day of the week. The impact of these changes would be to provide 4 registered nurses plus 2 HCSW during the day, and 3 registered nurses and 2 HCSW during the night. In addition, the current early and late nursing shift each day will remain in place. Furthermore, the daytime supernumerary nurse in charge will be maintained to coordinate patient flow and support discharges. The nurse in charge is not required for night time shifts. This would result in a reduction to Michael Bates ward's establishment of 2.48 WTE nursing staff and 2.48 WTE to the HCSW establishment. The number of weekly nursing hours would reduce from 721 to 644 and the number of HCSW hours would reduce to 308 from 385.

5.3.3 These changes would not only ensure that there is a nurse in charge during the day and maintain patient safety and quality. Furthermore the calculations are based the concept of nursing care hours (the unit of measuring nursing workforce efficiency advocated by Lord Carter in favour of nurse to patient ratios).

5.3.4 The combined financial impact of these changes to the tower and care of the elderly ward establishments would be to release full year savings of £662k. A summary of the cost implications of these changes can be found in appendix 4.

5.3.5 Having discussed these proposals with the Director of Operations and the Clinical Director for CBU 2 it has become evident that further discussion is required prior to implementation. The discussion will occur week commencing 11th April and a final paper will be taken to Education and Workforce Committee the end of April.

5.3.6 The Board will then have a final review at the May 2016 meeting, where the implementation plan will be presented and approved.

6.0. **Conclusion**

Ward level staffing data is provided in appendix 1. This demonstrated that the surgical and medical wards maintained safe staffing in excess of a 1:8 nurse to patient ratio during December, with the exception of T4 Surgical ward and Charles Coward wards. There were also three areas where the fill rate reported was below the planned levels, HDU, Sunrise NNU and the Labour Ward. For each of these wards and departments, an exception report has been provided by the relevant matron to explain fluctuations in activity and mitigation actions taken in month as was required in order to maintain safety. Appendices 2 and 3 triangulate this staffing data with key safety and patient experience performance data taken from the IPR for each ward area.

Paul Reeves  
**Director of Nursing and Midwifery**  
18th March 2016
## Appendix 1a: Staffing fill rates versus Trust’s planned 1:6 staffing ratio and 1:8 safe ratio.

<table>
<thead>
<tr>
<th>Ward</th>
<th>Submission Minimum Safe Staffing</th>
<th>1:6</th>
<th>1:8</th>
<th>1:6</th>
<th>1:8</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Assessment Unit</td>
<td>2424</td>
<td>1793</td>
<td>1550</td>
<td>4345.5</td>
<td>3343</td>
</tr>
<tr>
<td>Acute Medical Unit</td>
<td>2655</td>
<td>2776</td>
<td>1933</td>
<td>4709</td>
<td>4026.5</td>
</tr>
<tr>
<td>Acute Stroke Unit</td>
<td>2105</td>
<td>1793</td>
<td>1448</td>
<td>3241</td>
<td>2987</td>
</tr>
<tr>
<td>Charles Coward</td>
<td>1703.5</td>
<td>1431</td>
<td>1224</td>
<td>2655</td>
<td>2987</td>
</tr>
<tr>
<td>Labour Ward</td>
<td>3509</td>
<td>3509</td>
<td>2517</td>
<td>5182</td>
<td>4789</td>
</tr>
<tr>
<td>Maternity</td>
<td>1276</td>
<td>1633</td>
<td>862</td>
<td>2333</td>
<td>2233</td>
</tr>
<tr>
<td>Michael Bates</td>
<td>1703.5</td>
<td>1601</td>
<td>1280</td>
<td>2691</td>
<td>2581</td>
</tr>
<tr>
<td>Podium Ward 1</td>
<td>1542</td>
<td>1455</td>
<td>957</td>
<td>2506.5</td>
<td>2412</td>
</tr>
<tr>
<td>Pymmes 0</td>
<td>1384.5</td>
<td>1498</td>
<td>964</td>
<td>2348.5</td>
<td>2275</td>
</tr>
<tr>
<td>Rainbow</td>
<td>1914</td>
<td>1595</td>
<td>2526</td>
<td>5104</td>
<td>4397</td>
</tr>
<tr>
<td>Sunrise</td>
<td>2552</td>
<td>2019</td>
<td>1908</td>
<td>5104</td>
<td>4397</td>
</tr>
<tr>
<td>Surgical Ward 2</td>
<td>1703</td>
<td>1608</td>
<td>1311</td>
<td>2986.5</td>
<td>2819</td>
</tr>
<tr>
<td>Surgical Ward 3</td>
<td>1914</td>
<td>1843</td>
<td>1243</td>
<td>3190</td>
<td>3086</td>
</tr>
<tr>
<td>T3 Medical Ward</td>
<td>1542</td>
<td>1515</td>
<td>959</td>
<td>2506.5</td>
<td>2474</td>
</tr>
<tr>
<td>T4 Surgical Ward</td>
<td>1805</td>
<td>1399</td>
<td>1283.5</td>
<td>3088.5</td>
<td>2318</td>
</tr>
<tr>
<td>T5 Medical Ward</td>
<td>1542</td>
<td>1617</td>
<td>1176</td>
<td>2506.5</td>
<td>2793</td>
</tr>
<tr>
<td>T6 Medical Ward</td>
<td>1542</td>
<td>1431</td>
<td>968</td>
<td>2506.5</td>
<td>2399</td>
</tr>
<tr>
<td>T7 Medical Ward</td>
<td>1542</td>
<td>1601</td>
<td>1009</td>
<td>2506.5</td>
<td>2610</td>
</tr>
<tr>
<td>T8 Medical Ward</td>
<td>1542</td>
<td>1381</td>
<td>979</td>
<td>2506.5</td>
<td>2360</td>
</tr>
</tbody>
</table>

## Appendix 1b: Staffing fill rate versus planned staffing acuity ratio in Critical Care Complex

<table>
<thead>
<tr>
<th>Ward</th>
<th>Day</th>
<th>Night</th>
<th>Total</th>
<th>Equivalent hours</th>
<th>Proportion of hours filled</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical Care</td>
<td>3732.5</td>
<td>3894</td>
<td>4227.5</td>
<td>4129</td>
<td>6960</td>
</tr>
<tr>
<td>High Dependency Unit</td>
<td>1384.5</td>
<td>979</td>
<td>1283.5</td>
<td>927</td>
<td>2668</td>
</tr>
<tr>
<td>Combined Critical Care Complex</td>
<td>9628</td>
<td>9628</td>
<td>100.0%</td>
<td>18</td>
<td>14</td>
</tr>
</tbody>
</table>

## Appendix 2: Ward level Safe Staffing return –February 2016
### Appendix 3: Ward Quality Indicators and Red Flags

<table>
<thead>
<tr>
<th>Ward Type</th>
<th>Area</th>
<th>Planned Staff Hours</th>
<th>Actual Staff Hours</th>
<th>Registered Midwives/Nurses</th>
<th>Care Staff</th>
<th>Average Fill Rate - Registered Nurses/Midwives (%)</th>
<th>Average Fill Rate - Care Staff (%)</th>
<th>Total Monthly Planned Staff Hours</th>
<th>Total Monthly Actual Staff Hours</th>
<th>Total Monthly Planned Staff Hours</th>
<th>Total Monthly Actual Staff Hours</th>
<th>Registered Midwives/Nurses</th>
<th>Care Staff</th>
<th>Average Fill Rate - Registered Nurses/Midwives (%)</th>
<th>Average Fill Rate - Care Staff (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Assessment Unit</td>
<td></td>
<td>2424</td>
<td>1793</td>
<td>1276</td>
<td>1007</td>
<td>74.0%</td>
<td>78.9%</td>
<td>1921.5</td>
<td>1550</td>
<td>957</td>
<td>999</td>
<td>80.7%</td>
<td>104.4%</td>
<td>95.4%</td>
<td>95.6%</td>
</tr>
<tr>
<td>Acute Medical Unit</td>
<td></td>
<td>2655</td>
<td>2776</td>
<td>1595</td>
<td>1341</td>
<td>104.6%</td>
<td>84.1%</td>
<td>1921.5</td>
<td>1933</td>
<td>638</td>
<td>1006</td>
<td>100.6%</td>
<td>157.7%</td>
<td>132.5%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Ambulatory Care Unit</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Charles Coward</td>
<td></td>
<td>1703.5</td>
<td>1431</td>
<td>975.5</td>
<td>953</td>
<td>84.0%</td>
<td>97.7%</td>
<td>1283.5</td>
<td>1224</td>
<td>667.5</td>
<td>638</td>
<td>95.4%</td>
<td>95.6%</td>
<td>99.7%</td>
<td>95.6%</td>
</tr>
<tr>
<td>Michael Bates</td>
<td></td>
<td>1703.5</td>
<td>1601</td>
<td>975.5</td>
<td>1036</td>
<td>94.0%</td>
<td>106.2%</td>
<td>1283.5</td>
<td>1280</td>
<td>667.5</td>
<td>638</td>
<td>99.7%</td>
<td>95.6%</td>
<td>132.5%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Pymmes 0</td>
<td></td>
<td>1384.5</td>
<td>1498</td>
<td>638</td>
<td>943</td>
<td>108.2%</td>
<td>147.8%</td>
<td>964</td>
<td>1277</td>
<td>638</td>
<td>638</td>
<td>132.5%</td>
<td>100.0%</td>
<td>102.1%</td>
<td>113.8%</td>
</tr>
<tr>
<td>T3 Medical</td>
<td></td>
<td>1542</td>
<td>1515</td>
<td>726</td>
<td>842</td>
<td>98.2%</td>
<td>116.0%</td>
<td>964.5</td>
<td>959</td>
<td>638</td>
<td>638</td>
<td>99.4%</td>
<td>100.0%</td>
<td>101.5%</td>
<td>100.0%</td>
</tr>
<tr>
<td>T4 Medical</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>T5 Medical</td>
<td></td>
<td>1542</td>
<td>1617</td>
<td>726</td>
<td>916</td>
<td>104.9%</td>
<td>126.2%</td>
<td>964.5</td>
<td>1176</td>
<td>638</td>
<td>638</td>
<td>121.9%</td>
<td>100.0%</td>
<td>104.6%</td>
<td>100.0%</td>
</tr>
<tr>
<td>T6 Medical</td>
<td></td>
<td>1542</td>
<td>1431</td>
<td>726</td>
<td>687</td>
<td>92.8%</td>
<td>94.6%</td>
<td>964.5</td>
<td>968</td>
<td>638</td>
<td>638</td>
<td>104.0%</td>
<td>100.0%</td>
<td>104.6%</td>
<td>100.0%</td>
</tr>
<tr>
<td>T7 Medical</td>
<td></td>
<td>1542</td>
<td>1601</td>
<td>726</td>
<td>660</td>
<td>103.8%</td>
<td>90.9%</td>
<td>964.5</td>
<td>1009</td>
<td>638</td>
<td>638</td>
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**Safe staffing and quality report - February 2016**
### STAFFING

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### EXPERIENCE

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## Appendix 4: Summary Impact of Nursing Skill Mix Review

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**EXECUTIVE SUMMARY:**
This paper provides an updated mortality assurance report. The new mortality governance processes are included that are designed to improve timeliness and effectiveness of local and Trust wide mortality review meetings. This is the final iteration of the report and is presented to the Board in its current form for completion.

The Board is asked to note and receive the mortality report.

**ACTION REQUESTED OF THE MEETING:**

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**Which Strategic Objective does this paper impact most upon?**

| Strategic objective 1: The provision of excellent clinical outcomes |
|----------------------|---------------------------------------------------------------|

**How does the paper demonstrate progress towards the specified strategic objective?**

Mitigation or elimination of the risks associated with the non delivery of each of the Strategic Objectives will enable their achievement. The detail of the mitigating controls are incorporated in the summary/actions section of the report.

**LINKS WITH THE:**

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**THIS PAPER HAS BEEN PREVIOUSLY CONSIDERED BY:**

| N/A |

**AUTHOR AND TITLE:**

Dr Catherine Cale, Medical Director

**PRESENTER AND TITLE:**

Dr Anne Yardumian, Associate Medical Director.
Trust Mortality Report
March 2016

Report Purpose

This report contains comprehensive information about patient deaths at the Trust. The contents of the report, together with an explanation of how they should be understood, are provided in the document, with methodological notes where relevant.

Why measure mortality rates?

Not only do they help us better understand the risks of hospital treatments for individual patients, changes in patterns over time can pinpoint where improvements may need to be made. They can also help those people wishing to make a choice about the hospital where they may want to have their treatment.

Mortality ratios are not, in themselves, complete indicators of quality of care but an indication of where further, more detailed reviews should take place. The Department of Health (DH) has previously said that:

"A high HSMR is a trigger to ask hard questions. Good hospitals monitor their HSMRs actively and seek to understand where performance may be falling short and action should not stop until the clinical leaders and the Board at the hospital are satisfied that the issues have been effectively dealt with."

When it comes to measuring mortality rates, there are three main statistics used by the Trust:

1. **Crude mortality rate** - produced locally by the Trust itself
2. **Hospital standardised mortality rate (HSMR)** - published nationally by Dr Foster Intelligence / CHKS
3. **Summary hospital-level mortality indicator (SHMI)** – published nationally by the Health and Social Care Information Centre (HSCIC) & CHKS
Trust Mortality Report

Mortality Statistics Used

Crude Mortality

A hospital’s crude mortality rate looks at the number of deaths that occur in a hospital in any given year and then compares that against the amount of people admitted for care in that hospital for the same time period. The crude mortality rate can then be set as the number of deaths for every 100 patients admitted. What it tells you is how a hospital or Trust’s mortality rate changes over time.

The data used in calculating crude mortality is derived from the Trust’s Patient Administration System and provides summary information of mortality rates and how they compare year against year or over a defined time period.

HSMR

While crude mortality rates are important, it is very hard to use this information to compare and contrast what’s happening between hospitals. This is because every hospital is different, both in the treatments it offers and the make-up of its local population. A hospital that carries out higher-risk operations, such as organ transplants or treats more patients who are elderly and/or come from areas of greater poverty, will have a mortality rate that is very different from one that doesn’t provide such higher-risk operations and/or whose local population is younger and more affluent.

HSMR is a statistical methodology that seeks to support comparison between hospitals. HSMR is published nationally by Dr Foster Intelligence / CHKS.

The HSMR scoring system works by taking a hospital’s crude mortality rate and adjusting it for a variety of factors – population size, age profile, level of poverty, range of treatments and operations provided, etc. The idea is that by taking these factors into account for each hospital, it is possible to calculate two scores – the mortality rate that would be expected for any given hospital and its actual observed rate.

When comparing local HSMR scores, a figure of 100 would mean that it is completely as expected, compared to England. A figure more than 100 means the risk of the outcome is greater than expected. A figure less than 100 means the risk of the outcome is smaller than expected. HSMR excludes palliative care coded activity.

SHMI

The Summary Hospital-level Mortality Indicator (SHMI) is a score that reports on mortality rates at trust-level across the NHS in England, using a standard and transparent methodology. It is produced and published quarterly as an official statistic by the Health and Social Care Information Centre (HSCIC) and was published first in October 2011.

Following the recommendations from the national review of the Hospital Standardised Mortality Ratio (HSMR), the Department of Health commissioned the HSCIC to produce and publish SHMI. As part of the review, the Department of Health also commissioned independent statistical modelling work, which was carried out by the School of Health and Related Research (ScHARR) at the University of Sheffield.

The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. In essence, therefore, SHMI is trying to do the same things as HSMR – it’s just that different variable factors are taken into account in calculating the scores. The principle one of these is that SHMI includes deaths following a patient’s discharge (within 30 days), and includes palliative care activity.
Trust Mortality Report

Mortality Governance & Assurance Framework

The Trust’s mortality governance and assurance framework seeks to embed three elements:

1. A robust structure underpinned by reliable processes at each level of the organisation
2. High quality and reliable information
3. Clinical leadership and proactive engagement with the mortality agenda

The revised structure and process by which reviews of mortality data and issues are undertaken is set out in the chart attached. This will be fully operational by the first quarter of 2016/17.

The Risk and Quality Committee reviewed the robustness and consistency of the mortality governance structure in August where the new Mortality Review Policy was presented.

An electronic mortality review form has been piloted in 1 specialty and a modified version is being rolled out across the Trust.
Trust Mortality Report

Key Mortality Governance Forums

Specialty Level Mortality and Morbidity Meetings
Clinical specialties conduct a departmental mortality review for all patient deaths to determine whether the death was inevitable, expected or potentially avoidable. Where deaths are identified as being potentially avoidable, these must be investigated to determine learning. The output from the departmental specialty level M&M meetings are reported to the Trustwide Mortality Review Group which is chaired by the Medical Director.

Each clinical specialty has an identified consultant lead for mortality. Dependent on the size of the specialty department, this role may be merged with other responsibilities, but a senior clinician is responsible for coordinating the mortality reviews within each individual specialty and reporting the output of these reviews to the Mortality Review Group. The mortality lead for ED is the patient safety lead consultant who attends both the Mortality Review Group and the Patient Safety Group.

Frequency - Dependent upon Specialty and number of deaths

Mortality Review Group
The Mortality Review Group monitors the specialties to ensure that mortality reviews are conducted. It also reviews the findings of specialty mortality meetings in order to identify learning that is relevant across other specialties. In addition, the Mortality Review Group reviews Dr Foster mortality alerts upon receipt, to evaluate the alert and determine the Trust’s response. The Mortality Review Group is one of the trust’s patient safety strategy workstreams and reports to the Patient Safety Group.

The Mortality review group comprises the mortality leads for each specialty as well as the Medical Director (chair of the mortality review group), Associate Medical Director for Patient Safety (deputy chair) and the Associate Director of Governance.

Frequency - Bi Monthly
This group will be replaced in the first quarter of 2016/17 by the mortality monitoring committee with revised terms of reference and strengthened membership

Patient Safety Group
The Patient Safety Group scrutinises the work of each patient safety strategy workstream including the mortality review group and reviews the patient safety metrics to determine whether the safety of services is improving. This is to enable the Trust to have a timely oversight of changes in trustwide mortality. Where a deterioration in the safety of a service is identified, the Patient Safety Group tasks the relevant workstream with determining and subsequently implementing the interventions required to deliver improvements. For the mortality review group, the metric that the Patient Safety Group has selected to monitor is crude mortality. Regarding the work of the mortality review group; a deterioration in the Trust’s mortality in December 2014 was noted by the Patient Safety Group and so the mortality workstream and sepsis workstream undertook a deep dive mortality review. Similarly, the present ongoing review in response to the Dr Foster Mortality alerts is being monitored at the Patient Safety Group. The Patient Safety Group is chaired by the Medical Director and reports to the Risk and Quality Committee.

The Patient Safety Group comprises each patient safety strategy workstream lead(s) from across the Trust. The Patient Safety Group is an MDT constituting a combination of consultants, senior nurses and allied health professionals as well as senior leadership such as the Medical Director, Associate Medical Director for Patient Safety, Director of Nursing, and Associate Director of Governance.

Frequency - Bi Monthly
Trust Mortality Report

Crude Mortality Rate

The graphs attached display firstly the total volume of hospital deaths between Jan-14 and Feb-16 and secondly the crude mortality rate per 100 admissions for the same period i.e. the ratio of deaths to admissions.

Key Points for Consideration

The crude mortality rate across the Jan-14 to Feb-16 period remains broadly flat, with observed increases over the winter period. The exception to this pattern relates to the 2014-15 winter period, which observed a much greater peak in the volume of deaths in the hospital and also in the corresponding crude mortality rate (it is now clear that there was a national spike with highest level recorded throughout England since 1999).

The crude mortality rate steadily fell from the peak observed in January 2015, reaching its lowest level for nearly 2 years in July 2015. It has then generally stayed below the mean rate since then, with an observed increase above the mean in Jan and Feb-16.
Trust Mortality Report

SHMI Rate

As previously noted SHMI is an alternative adjusted mortality metric, which includes deaths that take place within 30 days of discharge from hospital and includes the effect of palliative care, which can sometimes distort the figures produced as HSMR (deaths coded as occurring while palliative care was being delivered are excluded in HSMR). SHMI is produced both by CHKS and by the Health and Social Care Information Centre (HSCIC).

It is important to note that the availability of SHMI data is always at least 6-9 months in arrears. As a result the most recent data available is up to June 2015.

Key Points for Consideration

The individual monthly SHMI scores report that in the last 12 months of available data the Trust has exceeded the 100 threshold on 7 occasions, the impact of these peak instances underpins an observed upward trend across the rolling annual average position. The most up to date rolling average SHMI average continues to run just below the 100 mark at 99.66, and as such remains within the mortality rate expected.

The Trust SHMI for the latest year available (Jul-14 to Jun-15) shows the Trust at the very middle against national peers - to be expected with a rolling 12 month performance of 100. Whilst the lag in terms of contemporary SHMI reporting must be emphasised, the gradual upward trend over the last year remains an issue for attention, as is the monthly volatility of the SHMI score in the most recent report. The Trust continues to monitor this alongside the other mortality indicators.
Trust Mortality Report

HSMR Rate 1

The latest HSMR data that is available to the Trust is up to Nov-15.

The monthly HSMR has remained on or around the benchmark of 100 since May-15, following a lengthy period since Aug-14 of being significantly higher than the benchmark.

This has resulted in a rolling 12 month HSMR value above 100 since Oct-15. Recent good monthly performance has resulted in measure moving back towards 100, but it will take several months to return to an acceptable score.
The Trust HSMR position improved in the most recent 3 months compared to the most recent full 12 months. The position for most recent 3 months was below the benchmark of 100.

The Trust HSMR score has exceeded 100 in eight of the last 12 months. The increase is specifically marked in between Dec-14 and Apr-15.

HSMR for July 15 was very low. - but this is in line with a similar dip in crude mortality.

A comparison of HSMR observed deaths for Sep-15-Nov-15 (3 months), compared with the same report over the 12 months from Dec-14-Nov-15, confirms the recent improvement in HSMR performance.

In June 2015 the Trust received mortality alerts from the Dr Foster unit at Imperial College in relation to three specific diagnosis groups (1). Septicaemia [except in labour], (2) Acute Cerebrovascular Disease, (3) Urinary Tract Infections.

A further alert regarding procedures on the jejunum and ileum has been received. A case note review did not highlight any specific concerns. The majority of these patients were complex with a number of co-morbidities and the procedure was part of their overall management rather than a primary diagnosis or procedure.
North Middlesex University Hospital NHS Trust
Future organisational model

1. Executive Summary

The NMUH has a clear vision for the future of the hospital providing emergency and planned care for a 300,000 population in East Enfield and East Haringey – focusing on meeting the needs of a diverse population with high levels of deprivation. This picture of services at NMUH was clearly stated within the BEH clinical strategy (2013/14) and the board is now looking at what organisational model for the hospital will best support its continued role as a vibrant and respected hospital for this part of north London.

The board recognises that hospitals cannot work in isolation and that it needs strong links with other hospitals to ensure that it can attract and retain high calibre clinical staff and be able to offer fast access to specialist care when necessary.

The Royal Free London (RFL) has proposed the creation of a hospital group encompassing hospitals in North Central London and within Hertfordshire. The group brings together the advantages of economies of scale for support services and also access to larger clinical teams who are able to sub-specialise and offer the best outcomes for patients. The RFL group is part of one of the new models of care ‘Vanguards’ sponsored by the NHS nationally. At the moment it is undergoing an accreditation process to allow it to establish a group.

Many of the details of the group structure and governance have yet to be finalised and formal changes to the governance of this Trust would require a due diligence process to be completed.

The NMUH has the opportunity to join this group as a founder member and this paper proposes that the Board formally endorses the Trust making a request to RFL to become part of the group.

A joint partnership board will then be set up to steer this project forward and NMUH intends to play an important role in helping to design the group structure and in particular how hospitals such as NMUH can retain their local accountability whilst sitting within a larger organisation.
2. Introduction

This paper proposes that a commitment is made by the North Middlesex University Hospital (NMUH) board to join the hospital group being proposed by Royal Free London Foundation Trust (RFL). This way forward for the organisation is seen as the best way of ensuring that it can deliver its clinical vision for 2020 delivering high quality safe care serving a 300,000 population in East Enfield and East Haringey – focusing on meeting the needs of a diverse population with high levels of deprivation.
3. Building on the Barnet, Enfield and Haringey (BEH) clinical strategy 2013/14

The BEH strategy set out a clear role for NMUH as a local hospital providing high quality care to meet the specific needs of its local residents. At its core are the accident and emergency, maternity, paediatrics and intensive care units with all of the necessary support for these vital services including acute medicine, surgery and elderly care and a full range of diagnostic services. This picture of care at NMUH is summarised in the diagram above.

In this paper it is proposed that the best way of continuing to deliver these services and meet the needs of the local population is for the NMUH to become part of a hospital group being set up by RFL – tapping in to the benefits of being linked with the Royal Free and other London hospitals to share expertise, provide mutual support and provide patients with access to the best clinical expertise locally where possible, and in a specialist centre where necessary.

4. Why not remain as a separate organisation?

The board has recognised that its long term financial model (LTFM) based on its current portfolio of services is not sustainable and it is unlikely to generate sufficient revenue for it to become an NHS Foundation Trust. It could remain as an NHS Trust but this model is not seen as being sustainable in the long term.

In an NHS where the emphasis is on networks of care, links with other hospitals and streamlined patient pathways the opportunity to become part of a group with other London hospitals presents the board with a unique opportunity to help create an organisation that will secure the long term future of the hospital. Local hospitals cannot work in isolation. They need robust links with other hospitals so that they can share expertise and tap into more specialist care when this is necessary. They need to be able to compete to attract the best clinical staff and being part of a larger organisation which has a reputation for high quality clinical care and cutting edge research is the best way of doing this.

5. Benefitting from developments in NHS policy

The NHS – five year forward view published in October 2014 presented a vision for the future of health care with an emphasis on breaking down the traditional barriers between health and social care, GP and hospital care, and physical and mental health. It also suggested how local hospitals could arrange their services in collaboration and integration with other providers to meet the needs of their local populations. The report emphasised:

- that there is a continuing role for local hospitals, in contrast to pressure in the past to close local hospitals and centralise services.
• local hospitals will be enabled to form partnerships with other hospitals further afield and with specialist hospitals to enhance the provision of care for their local populations.
• local hospitals will need to limit their activity to treatments that can be delivered locally in a safe and efficient way.
• complex surgery is likely to need to be delivered from specialist centres where patients can get the benefit of improved quality from higher volumes of activity.

6. Finding the best organisational form

Sir David Dalton published a report *Examining new options and opportunities for providers of NHS care* in December 2014 and emphasised that organisational form should always be designed to support the delivery of models and standards of care. He recommended that NHS Trust boards ‘consider fundamentally whether their existing form is best designed to deliver new models of care and ensure the delivery of required standards’ He put the emphasis on ‘organisational form which will be most appropriate to meet the needs of the populations they serve through a range of clinical models.’

7. What is the hospital group model being proposed by the Royal Free London hospital

The Royal Free London NHS Foundation (RFL) Trust management team are a new models of care Vanguard site (together with Salford Royal Hospitals and Northumbria Healthcare) for the development of a *Foundation Group*. They have asked NMUH to consider membership of this group and indeed to help them develop the model for member organisations.

The Royal Free London NHS Foundation Trust already incorporates Barnet General hospital and Chase Farm hospital as well as the Royal Free hospital in Hampstead. In joining the proposed RFL group NMUH will benefit from being part of a large hospital provider serving north central London.

8. Why join a hospital group?

The Royal Free has proposed the creation of a hospital group to bring about significant improvement in patient health outcomes, patient experience and cost improvements. Specific benefits identified by the Royal Free include:

• Shorter lengths of stay, reduced mortality and fewer complications by standardisation of clinical care processes across hospitals in the group based on clinical best practice.
• Consolidation of clinical activity and clinical support services to drive increased specialisation through pooled specialty specific staff and other resources.
• Earlier diagnosis, reduced time to treatment and reduction in unnecessary admissions through the development of whole system pathways, utilising more effective patient navigation through triage and GP support.
• Improved research outcomes through delivery of clinical trials on a larger scale.

The group structure will also enable hospitals to make better use of scarce resources by implementing standard clinical processes, eliminating unnecessary clinical activity and reducing patient length of stay. The cost of supplies and consumables can be reduced and back office and clinical support service costs can be reduced by working on a larger scale.

The larger scale provided by the group structure will help smaller hospitals attract and retain the best talent and help them maintain a highly skilled workforce and offer better career progression opportunities. Patients will benefit from this by being treated by the best health professionals in their local hospitals – settings that are familiar to them and where they have confidence in their local NHS.

9. What would be the implications of joining the hospital group?

We understand that there will be a range of different membership options with varying degrees of responsibility and risk transferred to the group, from full membership to arm’s length buddying arrangements. Group members may be hospitals, such as NMUH or groups of GP practices. Members may also include mental health providers of NHS care.

10. How do you retain local accountability within a group structure?

Within a group structure, it is likely that there will be a central board with governance responsibility for a group of hospitals. It will be important for there to be robust arrangements in place for hospitals in the group to retain their accountability to their local community. Whilst the exact nature of these arrangements have yet to be defined, local people will be involved in holding the group to account for the services provided at its local hospital and for the performance of their local hospital.

11. What immediate benefits will there be for NMUH arising from its commitment to join the group?

In signalling its intention to become a member of the hospital group, NMUH will be able to tap into expertise at RFL, for example to help it address operational issues.

12. How will the hospital group model be developed?
The RFL have given a commitment to work in partnership with NMUH to develop the group model and in doing this, to ensure that local stakeholders are given the necessary reassurance that the group model is in the best interest of the local communities served by the hospitals joining the group. In doing this the RFL and NMUH will work with a range of partners including:

- Patient groups, staff, members and governors
- Other NHS organisations developing group models
- Local commissioners of NHS care
- Local providers of NHS care who may sit outside of the group
- Regulators including Care Quality Commission (CQC), Monitor and NHS Improvement

13. Next steps

The formal request to join the group signals the start of a process. The work to develop the group model will be led by a joint partnership board including senior staff from both NMUH and RFL. Specific funding will be accessed to ensure that the management and leadership within NMUH can remain focussed on performance and delivering high quality care with financial stability.

14. Conclusion and recommendation

It is recommended that the board support a formal request to RFL to become founder members of the group. Joining the group offers the Trust a way forward that enables our patients to access the benefits of a larger organisation. It also offers a way to retain the identity and focus of North Mid on the patients that we serve.
## EXECUTIVE SUMMARY:

The Annual Board Cycle enables the Trust Board to monitor the delivery of the strategic objectives.

An Annual Board Cycle provides the Trust Board with a structured mechanism of conducting routine business. The Annual Board Cycle is laid out over the following key areas:

- Patient and Staff engagement
- Quality and Safety
- Strategy
- Performance and Risk assurance
- Strategy and Governance
- Board Committee Chair Assurance reports

The purpose of this report is to present the proposed Annual cycle of Business of the North Middlesex Trust Board between the periods of May 2016 to April 2017.

One of the key themes arising from the 2015/16 Board evaluation survey has highlighted the need for an enhanced emphasis on monitoring against strategic objectives in relation to the 2016/17 period.

Consequently the Board will consider the strategic monitoring mechanisms for review and evaluation.

Board Committee work plans will be devised for the 2016/17 period and reviewed by the Board, following the completion of the review of all the strategic objectives and their associated monitoring mechanisms, which will be fed into the Board Committee work plans as appropriate.

The Trust Board is asked to **approve** the Annual Board Cycle of the Trust for the period of May 2016 to April 2017.

### ACTION REQUESTED OF THE MEETING:

For discussion
- For noting
- For decision  
- For assurance

**Which Strategic Objective does this paper impact most upon?:** Strategic objective 2

**How does the paper demonstrate progress towards the specified strategic objective?**

The Annual Board Cycle enables the Board to monitor the delivery of strategic objectives, whilst monitoring the mitigations associated with key risks and performance initiatives. This in turn enables the Board to maintain oversight of positive outcomes for patients and key stakeholders.

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**THIS PAPER HAS BEEN PREVIOUSLY CONSIDERED BY:** N/A

**AUTHOR AND TITLE:** Molly Clark, Board secretary
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**EXECUTIVE SUMMARY:**

The Trust risk management strategy is presented to the Board for annual approval and review, as part of the annual assurance process supporting the system of internal control.

In approving the strategy, the Board is also asked to review and confirm the risk appetite statement still reflects their risk tolerance, as part of the annual review and approval of the risk management strategy.

The Board is asked to note and approve the strategy incorporated as Appendix A.

**ACTION REQUESTED OF THE MEETING:**

For decision  
For assurance  
For noting

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**THIS PAPER HAS BEEN PREVIOUSLY CONSIDERED BY:**

N/A

**AUTHOR AND TITLE:**  
Molly Clark, Board Secretary
1.0 Annual Risk Management Strategy update

1.1. The updated Risk Management Strategy was reviewed at the March Audit Committee as part of the annual assurance mechanisms to evidence the maintenance of the system of internal control during the 2015/16 period.

1.2. The strategy was part of the internal audit review by RSM as part of the year end BAF and risk management internal audit, and a rating of amber-green was awarded.

1.3. In approving the strategy, the Board is also asked to review and confirm the risk appetite statement still reflects their risk tolerance, as part of the annual review and approval of the risk management strategy.

1.4. The Board has been discharging its responsibilities (as set out within the strategy in section 12.1.6) by ensuring strategic risks are mitigated sufficiently within the risk tolerance levels through the Board Assurance Framework (BAF).

1.5. Key priorities for implementation during the 2016/17 period include the proactive risk management aspects of the strategy, as outlined in section 8.4 (Quality impact assessment tool) and Early warning trigger tool, as outlined in section 8.6.

1.6. The Board is asked to endorse the Risk appetite statement set out in sections 5.19 to 5.23.

1.7. In addition, further to the last update, the strategy has been updated to incorporate updates in the committee structure.

1.8. Specifically, updates to the strategy include:

- **Section 11.2**
  - Revision of board committee names to include the merged Workforce, Education and Training Committee, and the removal of the Foundation Steering Committee

- **Section 11.5**
  - Update on the frequency of Audit Committee meetings from bi-monthly to quarterly.

- **Section 11.6.7**
  - Updates to the Risk and Quality Committee sub group structure

- **2.0 Recommendation**
  - The Board is asked to review and approved the attached strategy, incorporated as appendix A of this report.
North Middlesex University
Hospital Trust

Risk Management Strategy

2014 - 2018

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1 INTRODUCTION

1.1 Risk management is a key component of both governance and quality due to its continuous and inherent nature, leading to uncertainty in outcomes and action which may present opportunities or threats to safety, the effectiveness of care and patient experience, which together, make a quality service (NHS Operating Framework 2013/14, Darzi 2008).

1.2 Risk management is demonstrably led from Board to Ward and embedded in every day working routines and activities of the organisation. Risk is defined as an uncertain event or set of events which, should it occur, will have an effect on the achievement of objectives.

1.3 North Middlesex University Hospital Trust is committed to providing high quality patient services in an environment where patient safety is paramount. The provision of healthcare carries an inherent level of risk that cannot be eliminated, and this Risk Management Strategy identifies how the principal risks and hazards which may prevent this occurring are assessed, prioritised, and controlled, supporting the safe development of clinical care and maintaining continuity of service delivery.

1.4 The Trust promotes a just, fair and responsible culture that fosters learning and improvement, whilst encouraging accountability. It is the intention of the Trust that all staff must feel able to raise issues of concern and be listened to.

1.5 The business of healthcare is by its nature, a high-risk activity and the process of risk management is an essential control mechanism. Effective risk management processes are central to providing the Board with assurance on the framework for clinical, non-clinical and corporate governance.

1.6 The Trust Board recognises that complete risk control/avoidance is impossible, but that risks can be minimised by making sound judgements from a range of fully identified options.

1.7 To this end the Trust Board is fully committed to ensuring a robust process is in place to ensure risks are identified, evaluated, mitigated to an acceptable level in a timely manner.

2 PURPOSE

2.1 The purpose of the Risk Management Strategy is to detail the Trust’s framework within which the Trust leads, directs and controls the risks to its key functions in order to comply with Health and Safety legislation, and consequent Terms of Authorisation and its strategic objectives. The Risk Management strategy underpins the Trust’s approach to managing its performance and reputation and is fully endorsed by the Trust Board.

2.2 The Trust Risk Management Strategy provides the framework for the continued development of the risk management process, building on the principles and plans linked to the Trust’s Board Assurance Framework, the Trust Risk Register, the requirements Regulators such as the CQC and national priorities.

2.3 The Risk Management Strategy aims to deliver a pragmatic and effective multidisciplinary approach to Risk Management, which is underpinned by a clear accountability structure from Board to ward level.
3 RISK MANAGEMENT STRATEGIC OBJECTIVES

3.1 Organisational Strategic Objectives This strategy will support the delivery of the Trust’s Strategic Objectives, which are:

- The achievement of excellent clinical outcomes
- Ensuring positive experiences for patients, GPs and all stakeholders
- To be an employer of choice with a workforce that is excellent and compassionate, acting as ambassadors for the Trust
- To provide services that are value for money for the taxpayer
- Maximise the efficient use of the site through closer working with other organisations and fostering education, teaching and research

3.2 These objectives are articulated in the Integrated Business Plan (IBP), coordinating the strategic drivers derived from supporting strategies, such as the Quality Strategy, Workforce & Organisational Development strategy, Patient Experience Strategy and the Estates strategy.

3.3 To deliver its’ quality strategy, the Trust has an on-going programme of continuous service improvement, which will aim to improve outcomes in patient safety, patient experience and clinical effectiveness. This will include supporting staff and service user participation in research, clinical audit and innovation.

3.4 The Strategies are geared up to address the opportunities and challenges of a large and diverse estates portfolio and emerging new technologies. These are drawn together in a single coherent strategy for the provision of high quality services using fit for purpose facilities, modern technologies and an outstanding workforce that offers high performing services.

3.5 The primary aim of the strategy is to identify and manage the risks that may prevent the achievement of Trust objectives.

3.6 To this end, the Board will monitor the delivery of these strategies and mitigations for associated risks through its Committees. Each Committee of the Board will retain responsibility for ensuring risks to the delivery of these strategies are identified, and monitored as part of an overall work-plan.

3.7 Section 13 of this Strategy provides more detail on specific Committees and their specific responsibilities.

4 OBJECTIVES OF THE RISK MANAGEMENT STRATEGY

4.1 The key objectives of the Risk management strategy are:

I. To proactively identify, manage and monitor significant risks that the Trust is exposed to during the delivery of its services, as articulated within the objectives set out in paragraph 3.1.1

II. To ensure that risks that can materially impact on the Trust’s ability to attain FT status and its (consequent) terms of authorisation as a Foundation Trust are identified, assessed and controlled

III. To enhance the risk maturity of the Organisation over the next three years from Risk Aware to Risk Enabled
1. To manage significant risks that the Trust is exposed to in pursuit of its objectives

4.2 As highlighted by the five strategic objectives articulated in the IBP, and summarised in section 3 above, the Strategic Objectives of the Trust evidence the Board’s prioritising of patient safety, quality of care, staff wellbeing and development and the achievement of national standards.

4.3 The Trust Board revised its Committee structure in July 2013 to enhance the Quality assurance arrangements through the inception of a Risk and Quality Committee, which has the primary role of monitoring the delivery of the Quality Strategy and the mitigations of associated risks. The role of the Risk and Risk and Quality Committee is described in more detail in section13.7 below.

4.4 The Trust Performance Management Framework will be integrated with risk management, to ensure risks related to performance indicators are identified, treated and monitored to minimise the impact on quality. This will include the integration of performance indicators with the Board Assurance Framework.

4.5 At an operational level, the Trust will apply a proactive risk management approach to identify risk through analysis of performance data, via an Early Warning Trigger Tool, which is described in more detail in section 8.10.6 of this strategy.

4.6 A quality impact assessment tool will also be used to identify possible risks to quality arising from service re-design, savings initiatives or variations in service delivery, such as bed pressures.

4.7 Themes arising from serious incidents, complaints, and claims will be used to identify risks to quality, and trends used to assess whether previously identified risks are being managed appropriately

4.8 The Trust will also use learning as a risk mitigation approach.

4.9 This is covered in more detail in section 13 of this strategy.

2. To ensure that risks that can materially impact on the terms of authorisation as a Foundation Trust are identified, assessed and controlled

4.10 Monitor authorises NHS foundation trusts on the basis that they are well governed, financially robust and legally constituted. Monitor’s Compliance Framework sets out the conditions which must be fulfilled to ensure an NHS foundation trust maintains its viability including:

4.10.1 Staying solvent
4.10.2 Being well governed from both a financial and quality perspective
4.10.3 Operating effectively within their constitutions
4.10.4 Engaging with patients, service users and commissioners
4.10.5 Providing all the services that they are required to deliver by law and
4.10.6 Complying with other conditions set out in their terms of authorisation

4.11 The Board will put sufficient measures in place to ensure the attainment of Foundation Trust status.
4.12 Once authorised, the Board will take primary responsibility for compliance with authorisation through a process of certification of Board statements.

4.13 The Board Chairman will ensure that the Board monitors the performance of the Trust effectively and satisfies itself that appropriate action is taken to remedy problems as they arise. Monitor tests a Board’s certification using performance against governance indicators, financial performance, exception reports and third party information.

4.14 The Monitor Compliance Framework service performance targets and indicators will be monitored by the Board monthly, with more detailed scrutiny of any areas of concern considered by the Risk and Quality Committee or Finance and Resources Committee, as appropriate The Trust aims to ensure that its overall score in this area is no more than amber green.

4.15 The Monitor Compliance Framework Financial Risk Rating is received by the Board on a bi-monthly basis, with more detailed scrutiny of any areas of concern considered by the Finance and Investment Committee.

4.16 The Long Term Financial Model sets out the financial risk rating from 2013/14 to 2018/19 moving from a rating of 3 in the first two years to 4 in the subsequent years

4.17 The Trust Board will devise a coordinated approach to identifying learning from Section 52 interventions and breaches as applied by Monitor, which include consolidation with the Board development plan, as well as delegation to key Committees of the Board, where relevant.

**Objective 3:** To enhance the risk maturity of the Organisation over the next three years from Risk Aware to Risk Enabled

*Figure 1: Risk Maturity scale*

4.18 Figure 1 above show a Risk Maturity scale, which shows the different levels of risk maturity that the Trust can aim to achieve as risk managements gets more embedded in the organisation.

4.19 An internal self-assessment of the Risk Maturity of the Trust indicates that the Trust is currently between ‘Risk Aware’ and ‘Risk Defined’.
4.20 It is the intention of the Trust Board to increase the risk maturity of the organisation to ‘Risk Defined’ by March 2015, and to move towards ‘Risk Enabled’ status by 2017, depending on the prevailing appetite of the Trust Board to invest any resources required for this achievement.

4.21 The Board will review its risk maturity on annual basis, as part of the Annual Governance Statement disclosure.

4.22 The Annual internal audit of risk management will include an assessment of the risk maturity of the organisation. The Audit and Risk & Quality Committees will monitor the implementation of recommendations arising from this audit.

5 RISK APPETITE

5.1 Risk appetite is the degree of risk exposure, or potential adverse impact from an event, that the Trust is willing to accept in pursuit of its objectives.

5.2 It is recognised that the pursuit of one objective may hinder the achievement of another and this will impact upon the associated risk appetite. Similarly, the relative importance of one objective against another may be influenced by external factors, such as changes in national policy or expectations of stakeholders.

5.3 The Board recognises the importance of a robust and consistent approach to determining risk appetite in order to ensure:

5.3.1 The organisation’s collective appetite for risk and the reasons for it are widely known to avoid erratic or inopportune risk taking, or an overly cautious approach which may stifle growth and development.

5.3.2 Managers in the Trust know the levels of risks that are legitimate for them to take, as well as appropriate opportunities when they arise, in order to ensure service improvements and patient outcomes are not adversely affected.

5.4 In order to value and compare the relative merits and weaknesses of different risks, the Trust Board will determine the level of risk the organisation is willing to tolerate in different areas.

5.5 This will include deciding whether the Trust will treat, tolerate, transfer or terminate a risk (as reflected in Figure 2 below) and what the organisation’s ‘target risk’ should be. Operating within risk tolerances provides the Trust Board with greater assurance that the organisation will remain within its risk appetite and, as a result, achieve its objectives.

5.6 Risk appetite will thus be quantified for each Board Assurance Framework risk in the first instance, with the aim of all risks having a target risk informed by risk appetite by the end of the longevity of this strategy.

5.7 The Trust Board will put systems in place to manage risks to an acceptable level within its level of tolerance. The parameters of this tolerance are set within the Risk Tolerance Matrix.

5.8 In setting risk appetite levels, the Trust Board will take account of risk tolerance and opportunity risk.
5.9 The Executive Team will recommend to the Board whether to tolerate certain risks from the point at which they are identified. The Executive Directors will provide ongoing assurance to the Trust Board that existing controls are sufficient to mitigate risks above the tolerance levels, particularly where the cost of treating the risk is more than the potential benefits.

5.10 Target risk ratings shall be set for all risks entered onto the Datix Risk Management System. A target risk rating is the estimated residual risk following the application of identified controls.

5.11 The target risk rating will be based on the estimated lowest level of risk that is acceptable or tolerable for particular risks.

5.12 Some risks will require the approval of the Board to determine tolerance levels, particularly where the application of controls is restricted by external factors.

5.13 Risks that have reached the agreed target rating will also be treated as tolerated risks.

5.14 Risks should be accepted as tolerated /acceptable risks only when the mitigation plan has been implemented as far as is reasonably practical and there is sufficient assurance that controls are effective.

5.15 The Trust classifies risks according to a risk classification matrix which allocates a colour to indicate the level of risk associated with a hazard (green = very low, yellow = low, orange = medium, red = high or extreme). Risks are considered in relation to all staff, patients and the public.

5.16 Risks falling in the green ‘insignificant’ risk category are considered ‘acceptable’, although the Trust will still need to take action on these risks where the assessment has identified that risks can be easily minimised.

5.17 A significant risk is one that requires action in the short to mid-term to reduce the likelihood of harm.

5.18 The Trust regards risks that fall into the red ‘high’ category as significant and actions to control the risk must be taken.

Figure 2: Risk Treatment options:
RISK APPETITE STATEMENT

5.19 The Trust endeavours to establish a positive risk culture within the organisation, where unsafe practice (clinical, managerial, etc.) is not tolerated and where every member of staff feels committed and empowered to identify and correct/escalate system weaknesses.

5.20 The Trust Board is committed to ensuring a robust infrastructure is in place to manage risks from ward level to board level, and that where risks crystallise, demonstrable improvements can be put in place.

5.21 North Middlesex University Hospital Trust’s appetite is to minimise the risk to the delivery of quality services within the Trust’s accountability and compliance frameworks whilst maximising performance within value for money frameworks.

5.22 In order to deliver safe, quality services, the Trust will encourage staff to work in collaborative partnership with each other and service users and carers to minimise risk to the greatest extent possible and promote patient well-being. Additionally, the Trust seeks to minimise the harm to service users arising from their own actions and harm to others arising from the actions of service users.

5.23 The Trust wishes to maximise opportunities for developing and growing its business by encouraging entrepreneurial activity and by being creative and pro-active in seeking new business ventures consistent with the strategic direction set out in the Integrated Business Plan, whilst respecting and abiding by its statutory obligations.
6 THE BOARD ASSURANCE FRAMEWORK

6.1 The Board Assurance Framework provides the Board with a mechanism of identifying and assessing risks significant to the delivery of that strategy, whilst evaluating the effectiveness of controls, and monitoring the action plans.

6.2 The Board Assurance Framework is a critical aspect of the system of internal control and also provides the Board with a mechanism of monitoring strategy on an exception basis.

6.3 The Board Assurance Framework is a simple but comprehensive method for:

   6.3.1 The management of the principal risks to meeting the organisation’s objectives.

   6.3.2 Providing evidence for the Annual Governance Disclosure statement.

   6.3.3 Providing evidence and assurance for the regulatory bodies including Monitor and the Care Quality Commission.

6.4 The Board Assurance Framework (BAF) is based on six key elements:

   6.4.1 Clearly defined principal objectives together with clear lines of responsibility and accountability.

   6.4.2 Clearly defined principal risks together with an assessment of their potential impact and likelihood.

   6.4.3 Key controls by which these risks are being and can be managed.

   6.4.4 Quantification of the strengths and weaknesses of potential and actual assurances that the risks are being properly managed.

   6.4.5 Board reports identifying that risks are being reasonably managed and objectives being met, together with gaps in assurances and gaps in risk control.

   6.4.6 Board action plans which ensure the delivery of objectives control of risk and improvements in assurances.

6.5 The BAF provides direct evidence to support the Chief Executive’s Annual Governance Statement Disclosure.

6.6 Process for assessing and identifying Strategic Risks (Board Assurance Framework)

   6.6.1 The risks which may prevent the Trust from achieving the Strategic Objectives will be set out in the Board Assurance Framework, and assessed annually.

   6.6.2 At the end of each financial year, the Head of Risk Management will undertake a review of the Board Assurance Framework, in association with the Executive Team.

   6.6.3 The Executive Team will jointly approve new risks proposed for inclusion on the Board Assurance Framework, on the basis of strategic impact, prior to inclusion on the Board Assurance Framework.

6.7 Further new risks proposed for inclusion on the Board Assurance Framework will be added following the agreement of the lead Director and Executive Director of Nursing and Governance.
6.8 Each risk in the BAF will be scored using the Trust’s Risk Scoring Matrix and will also be on the Trust Risk register.

6.9 The Board Assurance Framework is reviewed bi-monthly by the Trust Board. Figure 3 below, summarises the information flows between the BAF and Trust Risk register.

**Figure 3: Information flows between the risk register & the Board Assurance Framework**
1 RISK MANAGEMENT PROCESS
Figure 4 Risk Management process

Manage

Risk Assessment

(a) Assess severity of risk
Ascertain likelihood and impact of risk
= Gross risk

(b) Identify and grade controls in place
= risk mitigation.

(c) Reassess severity of net risk
= Current risk

Risk Monitoring

Risk Acceptable?

• Manage locale and review regularly within CBU meetings.
• Performance monitoring of CBUs at trust level meetings.

Risk Evaluation

• Identify further controls
• Validate proposed controls
• Assign Lead
• Set implementation date
• Set review dates
• Identify and articulate
• Resources required
• Escalate risks in accordance with risk

Risk Monitoring

• Risk assessment by Executive Director
• Monitor implementation of risk mitigation plans
• Provide monthly update to SMT
• Escalate risks in accordance with risk tolerance matrix
• Monitor progress against residual risk target date

Communicate risk to Stakeholders

Internal
• Local Staff
• Managers
• Contractors
• Committees

External
• Commissioners

Review using key indicators

• Feedback from staff
• Incidents
• Complaints
• Claims
• Performance Reports

Renew Completed Actions

• Re-assess and re-grade residual risk
• Accept sign-off residual risk
• Set review date
6.10 The Risk Management process is summarised in figure 4 above, and incorporates a proactive and reactive approach.

6.11 Risk assessment is an iterative process and all risks are periodically reviewed and re-assessed in view of contextual changes.

6.12 Re-assessment is undertaken proactively at intervals proportionate to the risk magnitude and risk appetite as well as reactively in response to anticipated or known changes.

6.13 The trust will explore its risk appetite for significant risks through a review of the Board Assurance Framework, Trust risk register and evidence considered for whether residual risks are acceptable or not.

6.14 All strategic risks are reviewed by the Executive Team who confirms their management through the content of the BAF in preparation for presentation to the Board for their presentation.

6.15 All significant risks (risk score 15-25) are reviewed by the Executive Team who confirms their management through the content of the Trust risks register in preparation to the Board for their consideration.

6.16 All lower level risks (risks score less than 15) are reviewed and managed locally by the Clinical Business Unit Directors and Managing Directors within the Governance meetings.

6.17 Risks which are not considered acceptable at a local level will be escalated as appropriate, and managed out through strategic and operational change or transferred (e.g. by contracting out) leaving acceptable (and opportunity) risks.

6.18 Such risks are managed and mitigated through the Risk Management processes and retained risks are recorded and reviewed through the Trust’s risk registers.

7 PROACTIVE RISK MANAGEMENT APPROACH

7.1 Internal inspections/reviews and assessments

7.2 Risks will be identified, assessed and mitigated through internal inspections or reviews, such as:
   7.2.1 CQC internal self-assessment
   7.2.2 Delivery of clinical audit plan
   7.2.3 Health, safety and fire inspections
   7.2.4 Internal infection control visits
   7.2.5 CQC Peer reviews
   7.2.6 Internal audit reviews
   7.2.7 Internal assessment of risks
   7.2.8 Clinical Audit

7.3 Risks identified will be escalated in accordance with the thresholds set out in the Risk Tolerance Matrix.
7.4 Quality impact assessment tool

7.4.1 A Quality Impact Assessment Tool provides a consistent approach to ascertaining the impact on quality associated with service changes.

7.4.2 It is intended to support quality governance by assessing the impact of CIPs and service change on quality.

7.4.3 It involves an initial assessment (stage 1) to quantify potential impacts (positive or negative) on quality from any proposal to change the way services are delivered. Where potential negative impacts are identified they should be risk assessed using the risk scoring matrix to reach a total risk score.

7.4.4 Where a negative impact score of 8 and above is identified a detailed quality impact assessment is required, with associated mitigations.

7.4.5 The Risk and Quality Committee will monitor action plans associated with a negative impact score of 15 and above, and also action plans resulting in a positive impact. Quality impact assessments with an adverse impact will be generated onto the Trust risk register and monitored in line with other quality risks.

7.4.6 Risks will be escalated in accordance with the levels set out in the risk tolerance matrix.

7.5 Learning from external sources

7.5.1 The Trust Board Development Programme incorporates learning from various sources, such as Section 52 NHS Act interventions by Monitor and also warning notices by the Care Quality Commission.

7.5.2 Where appropriate and relevant, the Board will delegate the monitoring of action plans to specific Committees, receiving assurance through Chair Assurance reports.

7.5.3 The Trust ensures that there is a systematic approach to the analysis of incidents, complaints and claims to enable learning and improvement as part of the implementation of this strategy, the Head of Compliance and Risk Management will put in place a robust process to ensure that risks identified from learning are added to the corporate risk register, where appropriate, with associated action plans which are reviewed regularly by nominated group, as detailed in the Learning from Experience Policy.

7.6 Early Warning Trigger Tool

7.6.1 The Trust will develop an Early Warning Trigger Tool (EWTT) which offers a set of automatically weighted indicators (with a possible maximum score of 50) that when taken together give an indication of how well an individual ward is functioning, but most importantly, it provides an early warning, preempting more serious concerns and enabling action to be taken before things go wrong.

7.6.2 The output of the EWTT also enables ward managers and CBU directors to benchmark the overall risk on their wards with others, resulting in the identification of remedial action in a timely manner.

7.6.3 The EWTT provides robust and reliable information from ‘Ward to Board’ offering the Trust Board further assurance of the quality of care specifically at an individual clinical team level.
7.6.4 The table below summarises the risk escalation process based on ranges of EWTT scores:

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<th>Early Warning Trigger Tool score</th>
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</tr>
<tr>
<td>Trust-wide Performance monitoring , Executive Director monitoring and Risk and Quality Committee escalation and assurance</td>
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</tr>
<tr>
<td>CBU Director and Trust-wide Performance escalation</td>
<td>20-30</td>
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<tr>
<td>General Manager escalation</td>
<td>10-20</td>
</tr>
<tr>
<td>Service /Ward Manager escalation</td>
<td>0-10</td>
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8 REACTIVE RISK MANAGEMENT APPROACH

8.1 As part of the delivery of this strategy, the Trust will identify risks arising from serious incidents, claims, complaints and incidents and formulate action plans to reduce risks to a tolerable level.

8.2 The Trust operates a fair blame culture to ensure that staff feels able and confident to report events or concerns.

8.3 Complaints, Incidents and near misses rated 8 or above (‘amber’ or ‘red’) using the Trust’s Risk Scoring Matrix will be entered on the Trust Risk Register and be escalated in accordance with the Trust’s risk escalation process as articulated in the risk tolerance matrix.

8.4 Claims are scored using the Trust’s Risk Scoring Matrix and those rated 8 or above) will be entered on the Trust Risk Register and are escalated in accordance with the Trust’s risk escalation process.

8.5 The Head of Risk Management will review reports produced by the Internal and External Audit with an audit opinion of limited assurance and ensure risks are identified and placed on the risk register as appropriate.

9 REGULATORY COMPONENTS OF RISK MANAGEMENT

9.1 As part of the delivery of this strategy the Trust will give consideration to the following aspects of statutory compliance, and the management of associated risks.

This will include the following:
9.1.1 Health and Safety Legislation

a) The Trust has a statutory responsibility under the EC framework directive (89/91/EEC) and the Management of Health & Safety Regulations 1992 (Amended 1999) to ‘evaluate the risk to the safety and health of workers and anyone else who may be affected by its activity but not in its employment’. This statutory requirement extends to patients, visitors, volunteers and others and is discharged through current Trust approved policies.

b) Under the Management of Health and Safety at Work Regulations 1992 (Amended 1999), supplementary to the Health and Safety at Work etc. Act 1974, employers are required to implement systems with which to identify, assess and minimise risks within the workplace and to provide employees with “comprehensible and relevant information on the risks they face and the preventative and protective measures that control those risks” and to “have effective arrangements in place for planning, organizing, controlling, monitoring and reviewing preventative and protective measures”.

c) Sections 2 and 3 of the Health and Safety at Work etc. Act 1974 place the responsibility for ensuring the health and safety of workers and for reducing risks to others affected by work activities (e.g. patients and other members of the public) upon employers, who are required to prepare and to make sure staff know about a written statement of all relevant health and safety policy and the arrangements in place to put it into effect.

9.1.2 Care Quality Commission

a) In undertaking its statutory obligations under the Health and Social Care Act 2008, the Trust will maintain compliance with the regulation within the Act that governs its activity.

b) As part of the delivery of this strategy the Trust will identify and mitigate associated risks relating to CQC compliance.

9.1.3 NHS Litigation Authority

a) The NHS Litigation Authority (NHSLA) requires Board level accountability for risk management to be clearly defined, with clear lines of accountability for managing risk throughout the organization, leading to the Trust Board.
b) The NHSLA require a risk management process, covering all risks, to be embedded throughout the organization at all levels, including the Trust Board, with key indicators being used to demonstrate performance and continuous monitoring and review of the whole system of risk management up to and including the Trust Board, in order to learn from and make improvements to the system.

9.1.4 Health & Safety Executive

a) The Health and Safety Executive are the enforcing body for health and safety and can inspect the trust at any reasonable time. The Health and Safety Executive require the Trust to have robust systems in place to identify hazards and associated controls and from this, evaluate the level of risk and to control all health and safety hazards to the lowest level reasonably practicable.

9.1.5 Statutory Annual Governance Statement Disclosure

a) The Department of Health requires organization’s to produce an annual Governance statement disclosure which is assured by an effective risk management system.

b) This statement is produced as part of the Trust’s annual report and must be signed by the Chief Executive. It aims to demonstrate that the organization is doing its “reasonable best” to manage its affairs efficiently and effectively through the implementation of internal controls to manage risk, (HSC 2001/005. Governance in the new NHS: Controls Assurance Statements 2000/2001).

10  RISK MANAGEMENT DUTIES

10.1 Chief Executive

10.1.1 As Accountable officer of the Trust, the Chief Executive Officer has overall responsibility for maintaining a sound system of internal control that supports the achievement of the trust’s aims and objectives, whilst safeguarding public funds and trust assets

10.1.2 The Chief Executive will ensure that executives have appropriate access to annual training and education for risk management in healthcare to enable them to undertake their roles effectively.

10.1.3 The Chief Executive is responsible for ensuring that the trust is administered prudently and economically and that resources are applied efficiently and effectively, in accordance with the Accountable Officer Memorandum.
10.2 **Executive Team**

10.2.1 The Executive Team is accountable to the Chief Executive for all areas of risks and assurance in respect of areas within their remit, including the maintenance of live risk registers which are monitored regularly.

10.2.2 As such, in addition to being collectively accountable for the management of risks, the Executive Team will ensure risk management arrangements are embedded within their areas of responsibility.

10.3 **Director of Nursing**

10.3.1 The Executive Director of Nursing and Governance has delegated overall responsibility from the Chief Executive for the management of risk within the Trust, and is the Executive Lead Director for ensuring that all risks and assurance processes are devised, implemented and embedded throughout the organisation.

10.3.2 The Executive Director of Nursing and Governance will provide specialist advice on risk management to the Executive Team and Board, and will recommend the incorporation of key risks on the Board Assurance Framework.

10.3.3 The Executive Director of Nursing and Governance is also the Trust Director of Infection Prevention and Control.

10.3.4 In their capacity as Security Management Director, the Director of Nursing will oversee the delivery of the Local Security Management Specialist Services (LSMS work plan), receiving assurance on the management of security risks and reporting to the Audit Committee.

10.4 **Medical Director**

10.4.1 The Medical Director will ensure medical staff complies with all safety and risk management procedures, providing assurance on the management of risks related to their professional practice, liaising with professional bodies as required.

10.5 **Deputy Chief Executive**

10.5.1 The Deputy Chief Executive is also the Senior Information Risk Owner (SIRO) and has executive responsibility for the identification, scoping definition and implementation of an information security risk programme.

10.5.2 The key responsibilities of the SIRO are to oversee the development of an Information Risk strategy and related policies and procedures; ensure that the Trust’s approach to information risk is effective in terms of resource, commitment and execution and provide a focal point for the resolution of information risk issues.

10.5.3 The SIRO will act as an advocate for information risk on the Board and in internal discussions, and will provide written advice to the Accountable Officer on the content of the annual Governance Statement in regard to information risk.
10.6 **Director of Finance and Information**

10.6.1 The Director of Finance and Information has responsibility for ensuring that the Trust operates within financial constraints and balances competing financial demands and overseeing the delivery of the internal audit plan and associated internal audit recommendations.

10.6.2 The Director of Finance and Information is accountable to the Board for the delivery of the Long term Financial Model and Commercial strategy, and for managing associated risks.

10.6.3 The Director of Finance and Information is responsible for ensuring the timely identification of risks to performance indicators within the National Operating Framework and Monitor Compliance Framework.

10.7 **All Staff**

10.7.1 All staff have a responsibility to:

- a) Be familiar and comply with the Trust’s risks management policies and processes
- b) Mitigate risks over which they have control in their daily work
- c) Cooperate with their line managers in respect of the line manager’s responsibilities
- d) Undertake appropriate training identified by their line manager.
- e) Report breaches of compliance with the risks management policies whether by others or by themselves

11 **GOVERNANCE ARRANGEMENTS FOR RISK MANAGEMENT**

11.1 **Trust Board**

11.1.1 According to section F.2 of Monitor’s Code of Governance, the role of the Board is to set strategy and monitor its delivery.

11.1.2 This includes the identification, treatment and monitoring of risks signification to the delivery of the organisation’s strategic objectives, which is aided by the use of a Board Assurance Framework.

11.1.3 The Board Assurance Framework document has been established by the Board and is reviewed on a bi-monthly basis.

11.1.4 The Executive Team retains operational ownership and maintenance of the Board Assurance Framework. Its key elements include:

- a) Board agreed organisational objectives and identification of the principal risks that may threaten the achievement of these objectives
- b) Identifying the design of key controls intended to manage these principal risks
- c) Setting out the arrangements for obtaining assurance on the effectiveness of key controls across all areas of principal risk
d) Identifying assurances and areas where there are gaps in controls and/or assurances

e) Putting in place plans to take corrective action where gaps have been identified in relation to principal risks

f) Maintaining dynamic risk management arrangements including a well-founded risk register

11.1.5 The Board is responsible for monitoring the internal control arrangements in each financial year in order to support the Annual Governance Statement Disclosure declaration.

11.1.6 As part of the delivery of this strategy, the Board will:

a) Ensure significant strategic risks are mitigated sufficiently within the risk tolerance levels in a timely manner through the Board Assurance Framework and, sufficiently monitored on the Board agenda

b) Assess and evaluate the appropriateness of risk tolerance levels set out in the risk tolerance matrix and formally agree any amendments.

c) Monitor significant quality risks via the Board Assurance Framework, whilst receiving assurance from the Risk and Quality Committee and other Board committees where relevant, on the implementation of mitigating actions

Board Committees

11.1.7 The Board has a robust committee structure, which is enhanced by Non-Executive Director Chairmanship, enabling the Board to focus on its core business whilst receiving regular assurance. There is an established mechanism to maximise the effectiveness of its Committees through comprehensive work plans as well as the alignment of the Board’s meetings and that of its Committees. This ensures timely monitoring of areas of responsibility delegated by the Board to the Committees through receipt of Chair assurance reports and minutes.

11.1.8 Each Committee of the Board has specific responsibility for seeking ongoing assurance on the effectiveness of the arrangements for managing key risks.

11.2 The Committees of the Board are the:

11.2.1 Audit Committee
11.2.2 Risk and Quality Committee
11.2.3 Finance and Investment Committee
11.2.4 Workforce Education and Training Committee
11.2.5 Remuneration Committee
11.2.6 Charitable Funds Committee
11.3 The Board will review the effectiveness of each Committee annually to support the review of the system of internal control.

11.4 In addition, the Board Committees all have responsibility for elements of the risk management system, with the Audit Committee providing assurance on its effectiveness.

11.5 **Audit Committee**

11.5.1 The Audit Committee supports the Board in reviewing the effectiveness of the system of internal control, through a structured annual work plan. The main role of the Committee is to seek assurance that the Trust’s governance and risk management systems are fit for purpose, adequately resourced and effectively deployed.

11.5.2 The Non-Executive Committee members of the Audit Committee play a key role in the internal control assurance processes by scrutinising the effectiveness of management actions in mitigating risks through regular reviews of the Trust risk register.

11.5.3 To aid this assurance, the coverage of the Committee’s work plan incorporates the review of the organisation’s risk management processes, and associated risk registers, from service to corporate level. These are reviewed on a cyclical basis, to seek assurance that systems in place are effective.

11.5.4 As part of the delivery of this strategy the Committee will monitor action plans associated with the delivery of this strategy.

11.5.5 The Audit Committee meets quarterly and will provide assurance to the Board on the effectiveness of the system of internal control through:

a) Monitoring of significant corporate and strategic risks on behalf of the Board by monitoring the Trust risk register at every meeting

b) Monitoring of the implementation of the internal audit plan, and the implementation of associated internal audit recommendations, requesting further assurance on internal audits with limited assurance opinion

c) Monitoring the effectiveness of the information risk management arrangements through the Senior Information Risk Owner (SIRO) reports and chair assurance reports from the Information Governance Group

d) Monitoring the effectiveness of key financial controls and challenging deviation from practice, for example through monitoring of Standing Orders waivers.

e) Receiving assurance on the management of security risks via assurance updates on the delivery of the Local Security Management Specialist services action plan, and annual reports
f) Formally reviewing the system of internal control on a bi-annual basis taking assurances from the Board Committees on the management of detailed risks

11.6 **Risk and Quality Committee**

11.6.1 The role of the Risk and Quality Committee is to ensure that there are systems in place to monitor the quality of health and care services, ensuring the best clinical outcomes and experiences for patients.

11.6.2 As part of its remit, the Committee has a key responsibility to monitor the delivery of the Quality Strategy, Clinical Strategy and associated risks. The Risk and Quality Committee meets monthly and will review risks on a bi-monthly basis.

11.6.3 In discharging its role, the Risk and Quality Committee will review current and future risks to quality and safety, which extend to risks identified by Clinical Business units as well as corporate departments of the Trust.

11.6.4 The Risks to Quality are risks that fit into the following categories:

   a) Clinical Effectiveness
   b) Patient Safety
   c) Patient Experience
   d) Productivity and Innovation
   e) Statutory duty of Quality
   f) Staffing
   g) Equality

11.6.5 The Risk and Quality Committee will review all risks with a residual rating of 15-25, on a bi-monthly basis.

11.6.6 Risks that fall below this threshold will be monitored by the Groups of the Committee, with assurance updates provide via a Chair’s report. These groups will discuss quality risks at each meeting, held on a bi-monthly basis.

11.6.7 The groups reporting to the Risk and Quality Committee are:

   a) Clinical Effectiveness and Outcomes Group
   b) Patient Safety Group
   c) Patient Experience Group
   d) Risk and Safety Group
   e) Infection Prevention and Control Group
   f) Safeguarding Adults Group
   g) Safeguarding Children Group
   h) Information Governance Group
   i) Patient and Public Involvement Group
11.6.8 The Risk and Quality Committee is directly responsible for overseeing the Trust’s compliance with CQC outcome 16: Monitoring the Quality of Service provision and associated risks to compliance.

11.6.9 As part of the implementation of this strategy the Risk and Quality Committee will:

a) Monitor the Trust’s compliance with quality indicators derived from the Monitor Compliance Framework and the National Operating Framework, including the mitigations of associated risks within the residual risk rating threshold of 15-25.

b) Review assurances on learning and how this is embedded within service lines to manage risks. The Committee will take into account the EWTT indicator relating to recurring themes from incidents, complaints and SIs to aid that assessment.

c) Request detailed reports on the top strategic risks to quality as highlighted on the Board Assurance Framework, providing assurance to the Board via Committee Chair assurance reports.

d) Provide assurance to the Audit Committee on the progression of significant quality risk monitoring.

e) Monitor compliance with CQC outcome 16, including the risks to compliance, either arising from internal assessments or CQC visits.

f) Report to the Audit Committee on a bi-annual basis on the effectiveness of internal control arrangements within its remit, of the Annual Governance Disclosure statement.

11.7 Finance and Investment Committee

11.7.1 The purpose of the Finance and Investment Committee is to provide the Board with assurance concerning all aspects of finance and resources relating to the provision of care and services in support of getting the best value for money and use of resources.

11.7.2 Meetings will be held on a bi-monthly basis and as part of the delivery of this strategy the Finance and Investment Committee will:

a) Review risks rated 15-25 that fall within its remit as a standing agenda item.

b) Receive assurance on risks below this residual rating threshold from its groups, via Chair assurance reports.

c) Monitor the implementation of the Long –term financial model and the mitigations of associated risks, providing updates to the Board via the Committee Chair’s assurance reports.
d) Oversee the processes for ensuring the Trust meets Monitor financial performance targets and a favourable financial risk rating during the transition to Foundation Trust status and beyond.

e) Monitor the implementation of the IMT and Estates Strategies and the mitigations of associated risks

f) Report to the Audit Committee on a bi-annual basis on the effectiveness of internal control arrangements within its remit, of the Annual Governance Disclosure statement.

11.8 Workforce, Education and Training Committee

11.8.1 The purpose of the Committee is to provide the Board with assurance concerning all aspects of workforce and organisational development relating to the provision of care and services in support of getting the best clinical outcomes and experience for patients and staff.

11.8.2 In addition, the purpose of the Committee is to oversee the development and delivery of the Education Strategy and associated initiatives, whilst receiving assurance that risks are being proactively managed.

11.8.3 Meetings will be held on a bi-monthly basis and as part of the delivery of this strategy the Committee will:

- Review risks rated 15-25 that fall within its remit as a standing agenda item
- Receive assurance on risks below this residual rating threshold from its groups, via Chair assurance reports
- Monitor the implementation of relevant strategies and associated risks, providing updates to the Board via the Chair’s assurance reports
- Oversee the processes for ensuring risks associated with workforce compliance requirements are managed appropriately.

11.8.4 Meetings will be held on a bi-monthly basis and the Committee will:

a) Review risks rated 15-25 that fall within its remit as a standing agenda item

b) Receive assurance on risks below this residual rating threshold from its groups, via Chair assurance reports

11.9 Monitoring the Implementation of this Strategy

11.9.1 The implementation of this strategy will be monitored by:

- Routine monitoring of the risks by the Risk and Quality Committee, and independent assurance updates to the Audit Committee
- The Trust’s progress against its strategic and corporate objectives;

- Assurance from internal and external audit reports that the Trust’s risk management systems are being implemented.
## Monitoring and Assurance of this Policy – Actions for monitoring compliance and non-compliance

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Measurable Policy Objective</th>
<th>Method</th>
<th>Who performs monitoring</th>
<th>Reported to and reviewed by</th>
<th>Responsibility for action plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annually</td>
<td>Organisational risk management structure detailing all those committees/sub-committees/groups which have some responsibility for risk</td>
<td><strong>Annual Corporate Risk Management Report</strong> – Audit the Terms of Reference for the Trust Board and each of the committees mentioned in section 6.1 to audit compliance with the NHSLA’s minimum requirements as stipulated in Level 1, Standard 1, Criterion 3. Audit of each relevant committee’s minutes to verify responsibilities as outlined in Terms of Reference have been performed and met.</td>
<td>Head of Risk Management</td>
<td>Audit, Committee</td>
<td>Action plan will be designed by Head of Risk Management for implementation by Chairman of Trust Board or chair of relevant committee/sub-committee/group identified as deficient. Implementation of the action plan will be monitored at Audit Committee</td>
</tr>
<tr>
<td>Annually</td>
<td>Process for board or high level committee review of the organisation-wide risk register</td>
<td><strong>Annual Corporate Risk Management Report</strong> – Audit of Trust Board Committee and Trust Board minutes to verify whether review of organisation-wide risk register has occurred as specified. Audit of AAGC minutes to identify weaknesses or deficiencies with the design of the BAF and organisation-wide risk register, the information in it, or its implementation.</td>
<td>Head of Risk Management</td>
<td>Audit, Committee</td>
<td>Action plan will be designed by Head of Risk Management for implementation by Chairman of Trust Board or chair of relevant committee/sub-committee/group identified as deficient. Implementation of the action plan will be monitored at Audit Committee</td>
</tr>
<tr>
<td>Annually</td>
<td>Process for the management of risk locally, which reflects the organisation-wide risk management strategy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td><strong>Annual Corporate Risk Management Report</strong> – Audit of Risk Assessments, Risk Registers, CBU Management Meeting minutes and Patient Safety Risk Register Reports to verify whether local CBU management of risk has complied with each of the steps specified in the local risk management process.</td>
<td>Head of Risk Management</td>
<td>Audit Committee</td>
<td>Action plan will be designed by Head of Risk Management for implementation by Clinical Director for relevant Clinical Business Unit identified as deficient. Implementation of the action plan will be monitored at Audit Committee</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Monthly</th>
<th>Process for the management of risk locally, which reflects the organisation-wide risk management strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Monthly CBU Performance Meeting Action points</strong> – Local risk management performance will be reviewed at the monthly CBU performance meetings. Areas of non-compliance or poor performance to be addressed will the captured in the Performance Meeting Action Points and followed up at subsequent CBU Performance Meetings</td>
<td>Head of Risk Management</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Annually</th>
<th>Duties of the key individuals for risk management activities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annual Corporate Risk Management Report</strong> – The report will include an examination of the individuals and the performance of those specific duties with regards to risk as outlined in this strategy.</td>
<td>Head of Risk Management</td>
</tr>
<tr>
<td>Annually</td>
<td>Authority of all managers with regard to managing risk</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Annually</td>
<td>Process for ensuring that all board members and senior managers receive relevant risk management awareness training</td>
</tr>
<tr>
<td>Annually</td>
<td>Process for Recording attendance</td>
</tr>
<tr>
<td>Annually</td>
<td>Process for following up non-attendance</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Annually</td>
<td>Process for assessing all types of risk</td>
</tr>
<tr>
<td>Annually</td>
<td>Process for ensuring a continual, systematic approach to all risk assessments is followed throughout the organisation</td>
</tr>
<tr>
<td>Annually</td>
<td>Assignment of management responsibility for different levels of risk within the organisation</td>
</tr>
</tbody>
</table>
| Ad hoc | How risks are escalated through the organisation | **Patient Safety Risk Report**  
This report will include whether new risks rated 15 or greater were escalated in accordance with the process outlined in the Corporate Risk Management Strategy.  
**Board Assurance Framework Report**  
This report will include whether new risks rated 15 or greater were escalated in accordance with the process outlined in the Corporate Risk Management Strategy. |  |  |
9 References
NHSLA Risk Management Standards for NHS Trusts providing Acute, Community, or Mental Health & Learning Disability Services and Independent Sector Providers of NHS Care 2012/13

10 Associated Documentation
   Risk Assessment Form
   Risk Grading Matrix
   Trust Board and Committee Terms of Reference
   Maternity Risk Management Strategy
Appendix 1 - Equality Assessment Screening Tool

To be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Yes/No</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. <strong>Does the policy/guidance affect one group less or more favourably than another on the basis of:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>i</td>
<td>Age</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>ii</td>
<td>Disability</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>iii</td>
<td>Gender Reassignment</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>iv</td>
<td>Marriage/ Civil Partnership</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>V</td>
<td>Pregnancy / Maternity</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>vi</td>
<td>Race, Nationality, Culture, Ethnic origins</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>vii</td>
<td>Religion or belief</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>viii</td>
<td>Sex (Gender)</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>ix</td>
<td>Sexual Orientation</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>2. <strong>Is there any evidence that some groups are affected differently?</strong></td>
<td></td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>3. <strong>If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?</strong></td>
<td></td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>4. <strong>Is the impact of the policy/guidance likely to be negative?</strong></td>
<td></td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>5. <strong>If so can the impact be avoided?</strong></td>
<td></td>
<td>Not applicable</td>
<td></td>
</tr>
<tr>
<td>6. <strong>What alternatives are there to achieving the policy/guidance without the impact?</strong></td>
<td></td>
<td>Not applicable</td>
<td></td>
</tr>
<tr>
<td>7. <strong>Can we reduce the impact by taking different action?</strong></td>
<td></td>
<td>Not applicable</td>
<td></td>
</tr>
</tbody>
</table>
# Risk Register Form

## Description of Risk

Please complete **ALL** sections on pages 1 and 2.

<table>
<thead>
<tr>
<th>Ref No.</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Summary description of risk (title - no longer than 128 characters)</td>
<td></td>
</tr>
<tr>
<td>Clinical Business Unit</td>
<td></td>
</tr>
<tr>
<td>Specialty</td>
<td></td>
</tr>
<tr>
<td>Risk Type (clinical/corporate/etc)</td>
<td></td>
</tr>
<tr>
<td>Location (if known)</td>
<td></td>
</tr>
</tbody>
</table>

| How was the risk identified: |  |
| Assessor(s): |  |
| Risk Owner (e.g. GM/HoS/Director) |  |
| Date of risk assessment: |  |
| Date risk notified to GM/HoS/Dir: |  |

Please enter **ONE** risk only on a risk register form

### Risk/Hazard (and relevant legislation issues if known)

### Persons at risk (if applicable)

### Existing Control measures in place

### Assurance Framework Risks

#### Assurance sources

#### Location of Assurance documents

#### Gaps in Assurance

### Risk Grading: please give numerical scores (refer to risk grading matrix or Report & Learn leaflet)

<table>
<thead>
<tr>
<th>Severity</th>
<th>Likelihood</th>
<th>Risk rating (severity x likelihood):</th>
</tr>
</thead>
</table>

### What action is going to be taken? (Treat, tolerate, terminate, transfer)
## Action Plan

<table>
<thead>
<tr>
<th>Actions Required to treat, transfer or terminate the Risk</th>
<th>Action Lead</th>
<th>Date Action Began</th>
<th>Cost of Actions</th>
<th>Review Date</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

**Barriers to treating risk**

Please use additional pages if required.

### Check List

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>All sections completed</td>
<td></td>
</tr>
<tr>
<td>Risk Owner agreement given</td>
<td></td>
</tr>
<tr>
<td>Action Lead agreement given</td>
<td></td>
</tr>
<tr>
<td>GM/HoS/Director agreement given</td>
<td></td>
</tr>
<tr>
<td>Review date given</td>
<td></td>
</tr>
</tbody>
</table>

All actions must be monitored locally and progress reported back to Head of Risk to ensure the risk register is maintained as an up-to-date record of the Trust’s risk status.

**Completed By:**
**Date:**
**Manager’s Signature:**

Please send this form to the Perry Djahit, Head of Risk. Patient Safety & Quality Department, 4 Bull Lane. Incomplete forms will be returned to the Assessor.
## Risk Assessment

### Likelihood Score (L)

<table>
<thead>
<tr>
<th>Descriptor</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Achievement of Objectives / External Standards</strong></td>
<td>No effect</td>
<td>External standards being met. Minor impact on achieving objectives</td>
<td>Adverse effect on delivery of secondary objective</td>
<td>Major adverse effect on delivery of key objective. Affects Care Quality Commission rating.</td>
<td>Does not meet key objectives. Prevents achievement of a significant amount of external standards</td>
</tr>
<tr>
<td><strong>Patient Harm</strong></td>
<td>No harm/near miss</td>
<td>Any patient safety incident requiring extra observation or minor treatment and causes minimal harm.</td>
<td>Any patient safety incident that resulted in a moderate increase in treatment and which caused significant but not permanent harm.</td>
<td>Any patient safety incident that appears to have resulted in permanent harm.</td>
<td>Any patient safety incident that directly resulted in one or more deaths.</td>
</tr>
<tr>
<td><strong>Injury (not patient)</strong></td>
<td>Minor injury not requiring first aid</td>
<td>Minor injury or illness, first aid treatment needed</td>
<td>Lost time injury or RIDDOR / Agency reportable &gt; 3 days absence</td>
<td>Fractures, amputation, extensive injury or long term incapacity/ RIDDOR reportable</td>
<td>Death or major permanent incapacity</td>
</tr>
<tr>
<td><strong>Service / Business Interruption</strong></td>
<td>Loss / interruption more than 1 hour</td>
<td>Loss / interruption more than 8 hours</td>
<td>Loss / interruption more than 1 day</td>
<td>Loss / interruption more than 1 week</td>
<td>Permanent loss of service or facility</td>
</tr>
<tr>
<td><strong>Financial/ Litigation</strong></td>
<td>local management tolerance level</td>
<td>Loss less than 0.25% of budgeted operating income</td>
<td>Loss less than 0.5% of budgeted operating income. Improvement notice</td>
<td>Loss less than 1% of budgeted operating income. Significant claim. Prosecution or Prohibition Notice</td>
<td>Loss more than 1% of budgeted operating income. Multiple claims.</td>
</tr>
<tr>
<td><strong>Quality</strong></td>
<td>Minor non-compliance with internal standards</td>
<td>Single failure to meet internal standards or follow protocol</td>
<td>Repeated failures to meet internal standards or follow protocols</td>
<td>Failure to meet national standards. Failure to comply with IR(ME)R</td>
<td>Gross failure to meet professional standards</td>
</tr>
<tr>
<td><strong>Reputation</strong></td>
<td>Rumours</td>
<td>Local media – Short term. Minor effect on staff morale</td>
<td>Local media – Long term. Significant effect on staff morale</td>
<td>National Media less than 3 days. Major loss of confidence in organization.</td>
<td>National media more than 3 days. MP Concern (Questions in House). Severe loss of public confidence.</td>
</tr>
<tr>
<td>Frequency</td>
<td>Not expected to occur for years</td>
<td>Expected to occur at least annually</td>
<td>Expected to occur at least monthly</td>
<td>Expected to occur at least weekly</td>
<td>Expected to occur at least daily</td>
</tr>
<tr>
<td>-------------------------</td>
<td>---------------------------------</td>
<td>-------------------------------------</td>
<td>-----------------------------------</td>
<td>----------------------------------</td>
<td>----------------------------------</td>
</tr>
<tr>
<td>Less than 1%</td>
<td></td>
<td>1 – 5%</td>
<td>6 – 20%</td>
<td>21 – 50%</td>
<td>Greater than 50%</td>
</tr>
<tr>
<td>Probability</td>
<td>Will only occur in exceptional circumstances</td>
<td>Unlikely to occur</td>
<td>Reasonable chance of occurring</td>
<td>Likely to occur</td>
<td>More likely to occur than not</td>
</tr>
</tbody>
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## EXECUTIVE SUMMARY:
This paper summarises the progress made by the Trust against its 2015/16 corporate objectives. It outlines the challenges facing the organisation as we enter 2016/17. It notes that the Trust’s overall objectives remain relevant for the coming year. It asks the Board to approve a number of short term and sub objectives in support of the overall achievement of the Board’s objectives.

The Board is asked to **approve** a number of short term objectives.

### ACTION REQUESTED OF THE MEETING:

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### Which Strategic Objective does this paper impact most upon?:

### How does the paper demonstrate progress towards the specified strategic objective?:

### LINKS WITH THE:

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### This Paper Has Been Previously Considered By:

| N/A |

### Author and Title:

**Julie Lowe, Chief Executive**
North Middlesex University Hospital NHS Trust

Corporate Objectives 2016-17

1. **Background**
   The Board has retained the same core objectives for a number of years and this position has been supported by a range of reviews involving Board members, stakeholders and the wider organisation. These are:

   - The provision of excellent clinical outcomes
   - Ensuring positive experiences for patients and GPs
   - To be an employer of choice with a workforce that is efficient and compassionate acting as ambassadors for the Trust
   - Provide services that are value for money for the tax payer
   - Develop the site to deliver high quality, core services for staff and patients together with a range of enabling services

They are supported by the Trust’s agreed values and behaviours - helpful, caring, open and honest and teamwork.

2. **Reviewing our 2015/16 Corporate Objectives**
   The 2015/16 objectives were agreed at the Trust Board meeting in March 2015. Performance against them has been measured in year by the relevant Board sub-committees and through the integrated performance report. A year end summary will be provided at the May 2016 Board.

3. **Specific Quality Objectives and priorities**
   Specific quality priorities for 2015/16 were outlined in the Quality Accounts for 2014/15. These quality objectives will be fully reviewed in the 2015/16 Quality Account which will be available in June. Quality objectives for 2016/17 will in turn be agreed as part of the Quality Accounts process with input from our key stakeholders.

4. **Objectives for 2016/17**
   The NHS as a whole is being encouraged to see 2016/17 as a year of stabilisation and a time to put in place plans that will enable us to deliver the changes we need to meet with healthcare challenges that come with an ageing population and modern lifestyle.

   All NHS organisations are taking part in system wide Service Transformation Plans (STP). North Mid is part of the North Central London (NCL) STP.

   With this in mind our suggested local objectives for 2016/17 are relatively few in number and this reflects the need for the Board to focus on doing a small number of important things well.

   The proposed objectives are therefore:

   a. **To achieve a CQC Chief Inspector of Hospitals Rating of ‘Good’ or better**
      The Trust was last inspected by the CQC in 2014. We are very likely to be re-inspected during 2016/17. It is very important to the patients that we look after that they know that the hospital offers care that is of a high standard; the CQC inspection is now the ‘gold standard’ by which this is measured. We know that the CQC see the staff survey results as a key barometer of a Trust’s overall performance and so we will ensure, as part of this objective, further work is undertaken to ensure we listen to staff to improve those scores. We will also continue to work hard to ensure that we have staff available to ensure safe staffing
levels on every ward, every shift and that more of those staff are permanently employed staff as part of our recruitment and retention work. We are already developing a national and local reputation for our high quality work with apprentices and this needs to continue to encompass wider and new roles. We will also review our performance against other relevant standards, such as the London Quality Standards, to ensure that we are meeting levels of quality and outcomes that benchmark well.

b. **To meet our constitutional standards on service delivery**

This means achieving the 4 hour emergency care standard in the course of the year so that over 95% of our patients are once again seen and either discharged or admitted within 4 hours of arrival at the hospital. It means maintaining our strong performance against the ‘18 weeks’ Referral to Treatment standard for planned and elective care. It means holding onto our recent performance improvements in cancer and diagnostics.

c. **To ensure financial stability**

In line with most of the provider sector we have experienced significant financial pressures this year. During 2016/17 we need to ensure a return to stability. We need to demonstrate that we are working in the most efficient way possible and delivering at least year 1’s savings highlighted by the Carter review. We need to be using our capital wisely and in ways that help create a secure platform to develop our services in the future.

CBU objectives, departmental objectives and personal objectives will be aligned to our core objectives and sub-objectives, underpinned by the organisation’s values and behaviours.

5 **Recommendations**

The Board is asked to approve:

1. That the Trust’s overall objectives remain the same for 2016/17
2. The additional short term and sub objectives outlined in Section 5 above.

---

Julie Lowe  
Chief Executive  
March 2016
EXECUTIVE SUMMARY:

The Local Audit and Accountability Act 2014 brings in significant changes to the local public audit regime and replaces the central appointment of external auditors to local appointment. This requires the establishment of a Trust Auditor Panel which will be responsible for the appointment of the external auditor.

The Trust Board is required to appoint the Auditor Panel in time to oversee the appointment of external auditors, which must be made by 31st December 2016.

The Audit Committee met on 14th March and reviewed and endorsed (for board approval) the revised Audit Committee terms of reference, which now to incorporate the Auditor Panel role. In addition, terms of reference for the Auditor Panel were also endorsed.

Subject to Board approval, it is anticipated that the Auditor Panel needs to be in place in the early part of 2016 to allow for the procurement process to take place during summer 2016 and an appointment before the December 2016 deadline.

The Board is asked to approve the terms of reference of the Audit Committee and Auditor Panel, incorporated as appendix A and B respectively.

ACTION REQUESTED OF THE MEETING:

For discussion  X  For noting  X
For decision
For assurance

Which Strategic Objective does this paper impact most upon?:  SO4
How does the paper demonstrate progress towards the specified strategic objective?:  Demonstrates the trust’s compliance with corporate governance requirements

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THIS PAPER HAS BEEN PREVIOUSLY CONSIDERED BY:  None

AUTHOR AND TITLE:  Molly Clark, Board Secretary
1  Main Functions of the Auditor Panel

The main functions of the Auditor Panel are to advise the Trust Board on:

1.1 **The selection and appointment of the external auditor.** This will include ensuring that the process for selecting the auditors is in line with the Trust’s procurement rules. The Panel will then be required to recommend the appointee to the Trust Board. Any proposal to enter into a limited liability arrangement with the auditor must also be raised with the Trust board.

1.2 **The maintenance of an independent relationship with the auditor.** This must ensure that the relationship and communications with the auditor are professional.

1.3 **The purchase of non-audit services from the auditor.** The Panel must develop and approve a Trust policy on the purchase of non-audit services from the Trust’s external auditor. This must ensure that independence is maintained.

1.4 **The decision to remove the auditor or the resignation of the auditor.** Following resignation, the auditor Panel must investigate the circumstances of the resignation and take appropriate action. In both cases the Auditor Panel must then appoint new auditors within 3 months.

1.5 The Board will appoint the Audit Committee to act as its Auditor panel, which will report directly to the Board. Members shall comprise of independent non-executive members of the audit committee.

1.6 Trust Standing orders and standing financial instructions will be revised accordingly.

2.  Procurement Process for Appointing External Audit

2.1 As noted above the appointment of the auditors must be in line with the Trust’s procurement rules. Auditors can be appointed for more than 1 year but there must be a new appointment process at least once every 5 years. An auditor can be re-appointed for further terms.

2.2 It is anticipated that once the Auditor Panel has been established a paper will be presented to the members that outlines the process to be undertaken. This will include a review of the available frameworks and options available eg. direct award / mini competition. Discussions have already commenced with the procurement service and an invitation to tender and specification are being drafted to ensure that the documentation is available when required.

3.  Timelines

The timetable below is proposed to ensure that the deadlines are met.

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<th>Committee</th>
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<tr>
<td>March</td>
<td>Audit Committee</td>
<td>Present paper outlining the requirements for an Auditor Panel, and agreement to use HFMA example terms of reference as a basis for Panel</td>
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<tr>
<td>Month</td>
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<td>Task Description</td>
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<tr>
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<td>March</td>
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<td>ToR to be submitted to the March Trust Board meeting.</td>
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<td>Trust Board to appoint Auditor Panel and approve terms of reference.</td>
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<td>May</td>
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<td>Approve the process for the tendering of the external audit service.</td>
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<td>September</td>
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<td>Commence the procurement process.</td>
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<td>September</td>
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<tr>
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Failure to appoint an auditor by 25th March 2017 will result in the Secretary of State or NHS Improvement directing the Trust to appoint or appoint directly.

4. Next Steps

In order to meet the requirements of the Local Audit and Accountability Act 2014 and the Local Audit regulations 2015, the Trust Board is required to:

4.1 **Appoint an Auditor Panel.**

It is proposed that the Audit Committee serves as the Auditor Panel, as this is an established committee with independent non-executive members. In addition the committee already has a relationship with the auditors and receives and reviews the audit reports throughout the year, including the statutory accounts. Revised terms of reference of the committee are attached as appendix A

4.2 **Approve terms of reference for the Auditor Panel.**

Draft terms of reference of the Auditor Panel are incorporated as appendix B

5. Recommendations

The Trust Board is asked to:

5.1 Approve the appointment of the Auditor Panel, and the associated amendments to the Trust Standing Orders

5.2 Approve the revised terms of reference of the Audit Committee, incorporated as appendix A

5.3 Approve the terms of reference of the Auditor Panel, incorporated as appendix B

Molly Clark
Board Secretary
March 2016
Item 6.5 Appendix A

North Middlesex University Hospital NHS Trust

AUDIT COMMITTEE
TERMS OF REFERENCE

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<td>Name of executive lead:</td>
<td>Director of Finance</td>
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<tr>
<td>Date issued:</td>
<td>March 2016</td>
</tr>
<tr>
<td>Review date:</td>
<td>March 2017</td>
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1 AUTHORITY

1.1 The Audit Committee is constituted as a Standing Committee of the Board. Its constitution and terms of reference shall be as set out below, subject to amendment by the Board.

1.2 The Committee derives its powers from the Board and has no executive powers, other than those specifically delegated in these Terms of Reference.

1.3 The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any member of staff and all members of staff are directed to co-operate with any request made by the Committee.

1.4 The Committee is authorised by the Board to request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary.

1.5 The Committee is authorised by the Board to engage the services of a specialist advisor where it is deemed necessary.

2 PURPOSE

2.1 The Board is responsible for ensuring there is a system of effective internal control including:

2.2 Management of the Trust’s activities in accordance with statute and regulations.

2.3 The establishment and maintenance of a system of internal control to give reasonable assurance that assets are safeguarded, waste or inefficiency avoided and reliable financial information produced, and that value for money is continuously sought.

2.4 The Committee shall provide the Board with a means of independent and objective review of the Trust’s financial, corporate governance, risk management and internal control arrangements. In addition the Committee shall:

2.5 Seek assurance of the independence of external and internal audit through annual assessment.
2.6 Seek assurance on the Trust’s Corporate Governance compliance (e.g. compliance with Monitor’s Guidance for Applicants, Terms of Authorisation & Constitution, Codes of Conduct, maintenance of Register of Interest).

3  MEMBERSHIP

3.1 The Committee shall be appointed by the Board, and shall be composed of three independent non-executive directors, (not including the chairman) at least one of whom should have recent and relevant financial experience.

3.2 The Chairman of the Committee will be an independent non-executive director, but will not be the chair of the Board. In the absence of the Committee Chairman and/or appointed deputy, one of the remaining members present shall elect themselves to chair the meeting.

3.3 Only members have the right to attend meetings of the Audit Committee. The Chair will on occasions where it is deemed appropriate, invite other independent Non-Executive Directors to attend meetings.

3.4 Internal auditors and the Local Counter fraud Specialist shall attend every meeting of the Committee, in order to facilitate the Head of Internal Audit Opinion, and to allow the Committee to monitor progress of internal audit plans.

3.5 The External Auditor will be invited to attend meetings of the committee on a regular basis, especially when matters concerning corporate governance, internal control, risk management and value for money are being discussed.

3.6 The Director of Finance and Deputy Chief Executive shall normally attend all routine meetings of the Committee. Other officers of the Trust may be requested to attend all or part of any meeting as and when appropriate.

3.7 The Chief Executive will be invited to attend the Audit Committee at least annually to present the Annual Governance Statement

3.8 The Board Secretary will provide guidance to ensure the Committee is properly constituted and advised, enabling it to fulfil its collective responsibility.

3.9 Appointments to the Committee shall be for a period of up to three years, which may be extended for a further three year period, provided the non-executive director concerned remains independent, and a member of the Board. Directors’ independence will be assessed in line with the criteria outlined in section A.3.1 of Monitor’s Code of Governance.
4 REPORTING RESPONSIBILITIES

4.1 The committee will report to the Board on a bi-annual on its work in support of the Annual Governance Statement, specifically commenting on the effectiveness of the Board Assurance Framework and the completeness and accuracy of significant control issues where appropriate.

4.2 The committee shall report such matters to the board relating to audit activities that it considers require action and/or improvement to be made, ordinarily through the Chair’s report to the Board.

4.3 The committee shall make whatever recommendations to the Board it deems appropriate on any area within its remit where action or improvement is needed.

5 QUORUM

5.1 The Quorum necessary for the transaction of business shall be two members. A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee.

6 FREQUENCY OF MEETINGS

6.1 The Committee shall meet on a quarterly basis and otherwise as required. The Committee Chairman, External Auditor or Head of Internal Audit may also request a meeting if they consider that one is necessary.

7 NOTICE OF MEETINGS

7.1 Meetings of the committee shall be summoned by the secretary of the committee (at the request of the Committee Chairman, or at the request of external or internal auditors if they consider it necessary.) The Board Secretary or their nominee shall undertake the role of secretary to the Committee.

7.2 Unless otherwise agreed, notice of each meeting confirming the venue, time and date together with an agenda of items to be discussed, shall normally be forwarded to each member of the committee and any other person required to attend, no later than five working days before the date of the meeting. Supporting papers shall be sent to committee members and to other attendees as appropriate, at the same time.
8 MINUTES OF MEETINGS

8.1 The secretary shall minute the proceedings of all meetings of the committee, including recording the names of those present and in attendance.

8.2 The secretary shall ascertain, at the beginning of each meeting, the existence of any conflicts of interest and minute them accordingly. Minutes of committee meetings shall be circulated promptly to all members of the committee and, once finalised, to all members of the Board.

9 DUTIES

9.1 The duties of the Committee can be categorised as follows:

9.2 Governance, Risk Management and Internal Control

9.3 The Committee shall review the implementation and on-going effectiveness of the system of, risk management and internal control, across the whole of the organisation’s activities (both clinical and non-clinical), that supports the achievement of the organisation’s objectives. In particular, the Committee will review:

9.4 The effectiveness of the Trust’s system of internal control, board assurance framework and risk management systems, including:

9.5 The adequacy of the Annual Governance Statement together with any accompanying Head of Internal Audit Opinion statement, external audit opinion or other appropriate independent assurances, before making recommendations to the Board.

9.6 The underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements.

9.7 To approve the statements to be included in the annual report, including those pertaining to internal controls and risk management.

9.8 The adequacy and effectiveness of the whistleblowing arrangements in the Trust, as part of the framework for monitoring the system of internal control.

9.10 The arrangements supporting the implementation of policies and procedures relating to Counter-Fraud activities as set out in the Secretary of State Directions and performed by NHS Protect, (formally known as Counter-Fraud and Security Management Service).

9.11 The policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions or relevant contract and as
required by NHS Protect.

9.12 In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these areas. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of risk management and internal control, together with indicators of their effectiveness.

9.13 This will be evidenced through the Committee’s use of an effective Board Assurance Framework to guide its work and that of the audit and assurance functions that report to it.

9.14 On an annual basis, the Chairs of the:

- Risk and Quality Committee
- Charitable Funds Committee
- Workforce, Education and Training Committee
- Finance and Investment Committee

will attend the Audit Committee and submit an annual assurance report, on the extent to which the clinical/corporate governance arrangements and implementation support the Trust’s system of internal control.

10 Internal Audit

10.1 The Committee shall ensure that there is an effective internal audit function established by management that meets mandatory NHS Internal Audit Standards and provides independent assurance.

10.2 Specifically the Committee will:

10.3 Consider the appointment of the Head of Internal Audit, and any questions of resignation and dismissal.

10.4 Review the internal audit strategic and annual plans, consider the major findings of internal audit investigations (and management’s response), and ensure co-ordination between the Internal and External Auditors.

10.5 Discuss with the Head of Internal Audit any matters arising from audit work as appropriate.

10.6 Ensure that the Internal Audit function is adequately resourced and has appropriate standing within the organisation.

10.7 Review and monitor management’s responsiveness to the findings and recommendations of the internal auditor.
10.8 Approve the Annual Audit Plan.

10.9 Receive quarterly progress reports against the Annual Plan.

10.10 Review and monitor the organisation’s counter-fraud arrangements, through the Local Counter Fraud Specialist’s Annual Work Plan, updates and annual report.

10.11 Meet the Head of Internal Audit at least once a year, without management being present, to discuss their remit and any issues arising from the internal audits carried out.

10.12 The Head of Internal Audit shall be given the right of direct access to the Chairman of the Board and to the Chairman of the Committee.

11 External Audit

11.1 The Committee will oversee the Trust’s relationship with the External Auditor and receives independent assurance reports. In addition, the Committee will assess the Trust’s external auditor’s work and fees on an annual basis to ensure the work is of a sufficiently high standard and reasonable, as per section 23(6) of Schedule 7 of the NHS Act 2006.

11.2 Specifically the Committee will:

11.3 Undertake the role of Auditor Panel in accordance with the Local Audit and Accountability Act 2014, for the purposes of appointing external auditors, directly managing the resulting contract and relationship, with effect from 2017/18.

11.4 In summary the Auditor Panel will:

11.5 Consider and make recommendations to the Board, in relation to the appointment, re-appointment and removal of the appointment of the External Auditor.

11.6 Approve fees for the remuneration of the External Auditor, whether fees for audit or non-audit services.

11.7 Discuss with the External Auditor, before the audit commences, the nature and scope of the audit, and ensure co-ordination, as appropriate, with other External Auditors in the local health economy.

11.8 Review and approve the annual audit plan and ensure that it is consistent with the scope of the audit engagement.

11.9 Review the findings of the audit with the External Auditor. This shall include, but not be limited to the following:
A discussion of any major issues, including their local evaluation of audit risks, which arose during the audit.
- Any accounting and audit judgements.
- Level of errors identified during the audit.

11.10 Review any representation letter(s) requested by the external auditor before they are signed by management.

11.11 Consider the management letter and management’s response to the auditor’s findings and recommendations.

11.12 Review External Audit reports, including value for money reports and annual audit letters, together with the management response.

11.13 Meet the External Auditor at least once a year, without management being present, to discuss their remit and any issues arising from the audits carried out.

12 Financial Reporting

12.1 The Committee shall monitor the integrity of the published financial statements of the trust, and any other formal announcement relating to its financial performance, reviewing significant financial reporting issues and judgements which they contain. The committee shall also review summary financial statements, significant financial returns to regulators and any financial information contained in other official documents, including the Annual Governance Statement.

12.2 To aid this process, the committee shall review and challenge where necessary:

12.3 The consistency of, and any changes to, accounting policies both on a year on year basis and across the (foundation trust) and its subsidiary undertakings. In addition, the Committee shall approve accounting policies of the Trust.

12.4 The methods used to account for significant or unusual transactions where different approaches are possible.

12.5 Whether the trust has followed appropriate accounting standards and made appropriate estimates and judgements, taking into account the views of the external auditor.

12.6 All other material information presented with the financial statements, (insofar as it relates to the audit and risk management).

12.7 Key issues raised by the External Auditor within the ISA 260 report (Communication of Audit Matters to Those Charged with Governance).
12.8 The meaning and significance of the figures, notes and significant changes.

12.9 Explanation of estimates or provisions having material effect.

12.10 The schedule of losses and special payments.

12.11 Any reservations and disagreements between the External Auditors and management not satisfactorily resolved.

13 Whistleblowing

13.1 The Committee shall review the Trust’s arrangements for its employees to raise concerns, in confidence, about possible wrongdoing in financial reporting or other matters. The committee shall ensure that these arrangements allow proportionate and independent investigation of such matters and appropriate follow-up action.

14 Quality Accounts

14.1 Following the agreement of Quality Account priorities at the start of each financial year, the Committee will scrutinise and challenge the appropriateness of the proposed metrics devised by senior executives to deliver the Quality Accounts.

14.2 The Committee will receive assurance on a bi-annual basis on progress in the delivery of the quality account metrics, to enable an assessment of the completeness of the Quality Account disclosure.

14.3 At the end of the financial year, the Chair of the Audit Committee will formally report to the Board on the appropriateness of the Quality Account disclosure, for incorporation into the Annual Governance Statement.

15 Standing Orders

15.1 The Committee shall undertake a regular assessment of the application of the Trust Standing orders and Standing Financial instructions and associated documentation on behalf of the Board. Specifically this will include:

15.2 To review on behalf of the Trust Board the operation of, and proposed changes to, the standing orders and standing financial instructions, codes of conduct and standards of business conduct,

15.3 To monitor the effective maintenance of the register of interests and hospitality register.

15.4 To examine the appropriateness of circumstances where there is significant departure from the requirements of any of the foregoing,
whether those departures relate to a failing, an overruling of suspension of standing orders.

16  MONITORING EFFECTIVENESS

16.1 The constitution, terms of reference and progress of the Committee shall be reviewed annually, and revised, if appropriate, as part of the organisation's progression to Foundation Trust status.

16.2 The Committee will review its own performance and terms of reference to ensure it is operating at maximum effectiveness and recommend any changes it considers necessary to the Board for approval, on an annual basis. The self assessment of the Committee will form part of the assurances to support the Annual Governance Statement disclosure.

16.3 The Committee will establish an annual work programme which will be submitted to the Board for approval as part of the assurance arrangements.

16.4 In particular, the annual programme coverage will incorporate all key areas within the Committee’s duties, as set out in section 9 of its terms of reference.
North Middlesex University Hospital NHS Trust

AUDITOR PANEL
TERMS OF REFERENCE

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North Middlesex University Hospital NHS Trust

Auditor Panel
Terms of Reference

1. CONSTITUTION

1.1 The board/ governing body hereby resolves to nominate its audit committee to act as its auditor panel in line with schedule 4, paragraph 1 of the 2014 Act. The auditor panel is a non-executive committee of the board/governing body and has no executive powers, other than those specifically delegated in these terms of reference.

1.2 Boards/ governing bodies can – if they choose – nominate a ‘sub-set’ of the audit committee to act as the auditor panel. If a sub-set is used, there must be at least 3 members with a majority who are independent and non-executive members of the board/governing body.

1.3 If a ‘sub-set’ of the audit committee is nominated to be the auditor panel the membership should be specified.

1.4 Regulation 2 of the Local Audit (Health Service Bodies Auditor Panel and Independence) Regulations 2015 allows for instances where a member of the board/ governing body may not satisfy the independence criteria and still be a member of the auditor panel. Such instances are likely to be rare. If there are non-independent members they must be in the minority.

1.5 If a specially established panel is nominated with new members (i.e. not from the existing audit committee) a full recruitment process must be followed in line with regulation 3. This means that any prospective members who are not on the board/ governing body must be appointed in response to an advertised vacancy and after submitting an application.

1.6 Key issues to bear in mind are that the chairperson must be independent and a non-executive member of the board/ governing body AND the chairperson of the organisation itself must not be a member of the auditor panel.

1.7 This rule should also be adhered to if the auditor panel is a sub-set of the audit committee.

2. MEMBERSHIP

2.1 The auditor panel shall comprise the entire membership of the audit committee with no additional appointees.

2.3 In line with the requirements of the Local Audit (Health Service Bodies Auditor Panel and Independence) Regulations 2015 (regulation 6) each member’s independence must be reviewed against the criteria laid down in the regulations.

3. CHAIRPERSON

3.1 Either the audit committee chairperson will be appointed by the board/ governing body to chair the auditor panel OR one of the auditor panel’s members shall be appointed chairperson of the auditor panel by the Board.

4. REMOVAL/RESIGNATION
4.1 The auditor panel chairperson and/or members of the panel can be removed in line with rules agreed by the Board

5. QUORUM
5.1 To be quorate, independent members of the auditor panel must be in the majority AND there must be at least two independent members present or 50% of the auditor panel’s total membership, whichever is the highest.

6. ATTENDANCE AT MEETINGS
6.1 The auditor panel’s chairperson may invite executive directors and others to attend depending on the requirements of each meeting’s agenda. These invitees are not members of the auditor panel.

7. FREQUENCY OF MEETINGS
7.1 The auditor panel shall consider the frequency and timing of meetings needed to allow it to discharge its responsibilities but as a general rule will meet on the same day as the audit committee.
7.2 Auditor panel business shall be identified clearly and separately on the agenda and audit committee members shall deal with these matters as auditor panel members NOT as audit committee members.
7.3 The auditor panel’s chairperson shall formally state at the start of each meeting that the auditor panel is meeting in that capacity and NOT as the audit committee.

8. NOTICE OF MEETINGS
8.1 Meetings of the Committee shall be summoned by the secretary of the committee (at the request of the Committee Chairman, or at the request of external or internal auditors if they consider it necessary.) The Board Secretary or their nominee shall undertake the role of secretary to the Committee.
8.2 Unless otherwise agreed, notice of each meeting confirming the venue, time and date together with an agenda of items to be discussed, shall normally be forwarded to each member of the committee and any other person required to attend, no later than 5 working days before the date of the meeting. Supporting papers shall be sent to committee members and to other attendees as appropriate, at the same time.

9. MINUTES OF MEETINGS
9.1 The secretary shall minute the proceedings of all meetings of the Committee, including recording the names of those present and in attendance.
9.2 The secretary shall ascertain, at the beginning of each meeting, the existence of any conflicts of interest and minute them accordingly. Minutes of committee meetings shall be circulated promptly to all members of the committee and, once finalised, to all members of the Board.

10. CONFLICTS OF INTEREST
10.1 Conflicts of interests must be declared and recorded at the start of each meeting of the auditor panel.

10.2 A register of auditor panel members’ interests must be maintained by the panel’s chairperson and submitted to the Board in accordance with the organisation’s existing conflicts of interest policy.

10.3 If a conflict of interest arises, the chairperson may require the affected auditor panel member to withdraw at the relevant discussion or voting point.

11. AUTHORITY

11.1 The auditor panel is authorised by the board/governing body to carry out the functions specified below and can seek any information it requires from any employees/relevant third parties. All employees are directed to cooperate with any request made by the auditor panel.

11.2 The auditor panel is authorised by the board/governing body to obtain outside legal or other independent professional advice (for example, from procurement specialists) and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary. Any such ‘outside advice’ must be obtained in line with the organisation’s existing rules.

12. FUNCTIONS

The auditor panel’s functions are to:

12.1 Advise the organisation’s board/governing body on the selection and appointment of the external auditor. This includes:
   12.1.1 Agreeing and overseeing a robust process for selecting the external auditors in line with the organisation’s normal procurement rules
   12.1.2 Making a recommendation to the board/governing body as to who should be appointed
   12.1.3 Ensuring that any conflicts of interest are dealt with effectively

12.2 Advise the organisation’s board/governing body on the maintenance of an independent relationship with the appointed external auditor

12.3 Advise (if asked) the organisation’s board/governing body on whether or not any proposal from the external auditor to enter into a liability limitation agreement as part of the procurement process is fair and reasonable

12.4 Advise on (and approve) the contents of the organisation’s policy on the purchase of non-audit services from the appointed external auditor

12.5 Advise the organisation’s board/governing body on any decision about the removal or resignation of the external auditor.

13. REPORTING
13.1 The chairperson of the auditor panel must report to the board/governing body on how the auditor panel discharges its responsibilities.

13.2 The minutes of the panel's meetings must be formally recorded and submitted to the board/governing body by the panel's chairperson. The chairperson of the auditor panel must draw to the attention of the board/governing body any issues that require disclosure to the full board/governing body, or require executive action.

14. RENUMERATION

14.1 Payments to auditor panel members shall be in line with the organisation's existing approach to remuneration and allowances.

15. ADMINISTRATIVE SUPPORT

15.1 The organisation's secretary (or governance lead) shall be responsible for organising effective administrative support to the auditor panel. The duties of the person appointed to fulfill this role shall include:

15.1.1 Agreement of agendas with the chairperson
15.1.2 Preparation, collation and circulation of papers in good time
15.1.3 Ensuring that those invited to each meeting attend
15.1.4 Taking the minutes and helping the chairperson to prepare reports to the board/governing body
15.1.5 Keeping a record of matters arising and issues to be carried forward
15.1.6 Arranging meetings for the chairperson
15.1.7 Maintaining records of members' appointments and renewal dates etc
15.1.8 Advising the auditor panel on pertinent issues/areas of interest/policy developments
15.1.9 Ensuring that panel members receive the development and training they need
15.1.10 Providing appropriate support to the chairperson and panel members.
EXECUTIVE SUMMARY:

Since 27th November 2014, Executive and Non-executive director appointments must be made subject to the Fit and Proper Persons Test (FPPT) as set out in regulation 5 of the Health and Social Care Act 2008 (Regulations of Regulated Activities) Regulations 2014.

A Trust Fit and Proper Persons policy has been developed and will take effect from 1st May 2016.

The policy and annual declaration process has the provision to apply to individuals who may act in a director capacity, or have autonomous responsibility when acting on behalf of a director.

The Board is asked to note and receive the annual fit and proper person’s assurance update, and delegate authority to the Workforce and Education Committee to approve the draft Fit and Proper person’s policy.

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For decision  X
For assurance    

Which Strategic Objective does this paper impact most upon?:

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How does the paper demonstrate progress towards the specified strategic objective?:

A sound Board with a robust assurance structure will ensure the achievement of excellent clinical outcomes and positive experiences for patients, GPs and all stakeholders.

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THIS PAPER HAS BEEN PREVIOUSLY CONSIDERED BY:  N/A

AUTHOR AND TITLE:  Molly Clark, Board Secretary

PRESENTER AND TITLE:  Molly Clark, Board Secretary
1. Background

1.1. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (the 2014 Regulations) places a duty on NHS providers not to appoint a person or allow a person to continue to be an executive director or equivalent or a non-executive director (NED) under given circumstances.

1.2. The Care Quality Commission (CQC) has set out NHS providers’ roles and responsibilities in their guidance document entitled *Guidance for NHS bodies on the fit and proper person requirement for directors and their duty of candour*.

1.3. Compliance with the regulations will be monitored and enforced by the CQC, using specific key lines of enquiry under the ‘safe’ and ‘well led’ domains to ensure compliance.

2. Fit and Proper Persons Compliance Requirements

2.1. The Regulations place the burden on employers to ensure that any person who is appointed as a director or who fulfils the role of director meets the requirements of the Fit and Proper Persons Test. The CQC expect providers to put in place a regular review programme. It will be the responsibility of the Trust chairman to ensure all directors meet the fitness test.

2.2. As part of the inspection process the CQC may cross-check notifications about new directors against any other information that they hold or have access to, in order to decide whether they want to look further into an individual’s fitness.

2.3. The CQC may also ask Trusts to demonstrate the appropriate pre-employment checks have been done and on-going employment assurance can be evidenced via the CQC inspection regime.

2.4. There is also the possibility that a concern received directly by the CQC about the fitness of a director may trigger a review by the CQC of the Trust’s processes of gaining assurance of compliance.

2.5. The Trust has put in place arrangements in place to enable annual compliance monitoring with the requirement for fit and proper persons - Regulation 5, which stipulates a requirement for board level members to be of good character.

2.6. This regulation states that the Trust must not appoint or have in place an individual to such a role unless the individual is:

2.6.1. Of good character
2.6.2. Has the necessary qualifications, skills and experience
2.6.3. Is not have been responsible for any misconduct or mismanagement in the course of any employment with a CQC registered provider
2.6.4. By reason of their health (subject to reasonable adjustments) is able to properly perform tasks intrinsic to the office/position
2.6.5. The individual has not been responsible for, or been privy to, contributed to or facilitated any serious misconduct or mismanagement (unlawful or not) in the course of carrying out a regulated activity (regulated by the CQC) or which would have been regulated if it had been provided in the UK.

2.7. The regulations also state that individuals are deemed ‘unfit’ if they are:

2.7.1. The person is an undercharged bankrupt or a person whose estate has had a sequestration awarded in respect of it and who has not been discharged

2.7.2. The person is the subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland

2.7.3. The person is a person to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986(40)

2.7.4. The person has made a composition or arrangement with, or granted a trust deed for, creditors and not been discharged in respect of it

2.7.5. The person is included in the children’s barred list or the adults’ barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland.

2.7.6. The person is prohibited from holding the relevant office or position, or in the case of an individual from carrying on the regulated activity, by or under any enactment.

2.7.7. The person has been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity, or discharging any functions relating to any office or employment with a service.

2.8. All members of the Board (with the exception of the newly appointed Medical Director) will shortly be receiving a letter from either the Chairman or the Chief Executive requesting them to complete the annual FPPT declaration.

2.9. Completed declarations will be reviewed by the Chairman, or Chief Executive.

2.10. From May 2016, all relevant individuals will be required to comply with the Fit and Proper Persons Policy, which is currently in draft form.

2.11. It is proposed that the policy is approved by the Workforce, Education and Training Committee at its meeting in April.
3. **Recommendations:**

3.1. The Board is asked to:

3.1.1. Note and receive the Fit and Proper Persons annual assurance report and receive assurance from current and proposed actions

3.1.2. **Delegate** authority to the Workforce and Education Committee to approve the draft Fit and Proper person’s policy.
EXECUTIVE SUMMARY:

Monitor’s code of governance places a requirement on aspiring and existing Foundation Trust Boards to undertake an annual evaluation of its own performance and that of its own committees and individual directors.

The Annual Governance Statement disclosure guidance requires NHS Boards to assess and evaluate their performance against the UK Corporate Governance Code.

The Board has undertaken an annual self-assessment based on Monitor’s Code of Governance and the Intelligent Board. The survey focussed on the effectiveness of the Board’s systems and processes for maintaining oversight of:

- Delivery of Objectives
- Strategy oversight
- Performance monitoring
- Board infrastructure
- Risk Management
- Board Committees

This Board has considered an overview of the Board evaluation survey, which confirms the Board’s compliance with the UK Corporate Governance code.

A series of next steps will be agreed and taken forward as part of the 2016/17 Board evaluation process.

The Board is asked to **note** and **receive** the Board evaluation assurance update.

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| THIS PAPER HAS BEEN PREVIOUSLY CONSIDERED BY: | N/A |

| AUTHOR AND TITLE: | Molly Clark, Board Secretary |
|-------------------|

| PRESENTER AND TITLE: | Molly Clark, Board Secretary |
1. **Summary of Key Actions and Decisions Arising:**

   The agenda was reviewed in full.

   - A new Dr Foster **MORTALITY ALERT** has been received, relating to patients who have at some point during their in-patient stay had a “therapeutic operation on jejunum and ileum” (small bowel). The death is not necessarily directly related to the procedure. A review of coding has been completed suggesting that excess mortality is not due to coding variance. Results of the preliminary clinical investigation were not available to the committee and will be reviewed at the next meeting. The committee was assured that an appropriate investigation was in place. Of note, we were not already aware of this variance in mortality through internal processes as this is not a standard ‘mortality basket’. This is the fourth mortality alert this year. Information was not available on the expected number of outlier alerts a Trust such as NMUH might expect to receive. Renal medicine have been piloting a new process to review all in patient deaths which is being rolled out across the Trust. It was recognised that delivery of this would be most challenging for Elderly Medicine because of the much higher number of deaths.

   - The **EMERGENCY DEPARTMENT ASSURANCE FRAMEWORK** was discussed in detail. The committee recognises the continuing scale of the challenge around ED performance. The committee was assured that an action plan to begin to improve performance is now place, and that appropriate procedures were activated to closely monitor performance and the success (or otherwise) of the various proposed interventions. Performance and patient experience has continued to decline in the meantime.

   - The **CT SCANS DELAYS ASSURANCE REPORT** was received and discussed. The committee recognises that the responsibility for acting on requested investigations is shared between the referring clinician and investigational service. Whilst assured that the direct effects on patients affected have been appropriately investigated, and that radiology reporting appears on the radiology department performance dashboard, it was disappointing to learn that the request for assistance with this from individual clinicians was not high. In addition, and further to the last RQC chair report, the CT scan delay problem highlights a generic question, relevant to the audit committee, of how robust our internal process audits are.
• The CLIP and SI REPORTS continue to provide a narrative of individual incidents. There was concern that the actions (recommendations) arising from SI did not appear to have a named person responsible for delivery of that action, nor a timescale for completion of mitigation. In addition, SI learning and completion of recommendations is then monitored within individual CBUs without further oversight, additionally risking missing opportunities to share learning across Departments. This appears highly relevant in the view of generic issues emerging from inspection of these reports, such as failure to escalate care appropriately. The committee were assured that the previous Interim Medical Director is leading a review of SI, including proposal for a new SI Committee.

• The RSM AUDIT OF COMPLAINTS MANAGEMENT was received and discussed. This makes disappointing reading, particularly in light of the specific questions raised around complaints in the 2014 CQC inspection. The committee is assured that a specific review of complaints is being led by Mr Robert Summerling (NED and previous RQC chair). An update on complaints handling is to be presented as the next RQC meeting in April 2016.

• The continued good work around both infection control and safeguarding was noted. However, both of these reports highlighted that the greatest challenge was the delivery and UPTAKE OF (MANDATORY) TRAINING. This has been referred to the February Workforce and Education Committee meeting for review.

2. Progress against delivery of annual work-plan:

   The committee considered all matters due for review in accordance with the annual work plan. Following the February RQC ‘Away Day’ the work plan of the RQC and its sub-committees will be reviewed. The committee has completed a review of outstanding Matters Arising actions and additions to the Matters Arising will now be reviewed by the Chair.

3. Assurances received from Sub-Committees:

   • Patient Safety Group
   • Infection Prevention and Control Committee
   • Patient Experience Group
   • Clinical Effectiveness Group – an October meeting was not held and the December meeting was not quorate. The committee itself has recognised the need to revisit its TOR and to ‘re-launch’.
   • Safeguarding Adults Group
• Safeguarding Children Group
• Risk and Safety Group
• Cancer Board
• Maternity Board
• Information and Governance Committee
• Performance and Quality Oversight and Assurance Group (see comments below)

4. **Risk Assurance Update:**

As discussed above under summary of key actions.

5. **Matters for Escalation to the Board:**

In addition to noting the above, I invite the Board to consider that:

• RQC received a combined **BERWICK, KEOGH, FRANCIS and CAVENDISH ASSURANCE REPORT**. I understand that the Board has previously delegated responsibility for monitoring delivery of actions required in these reports to RQC. Given the significance of these reports, and implications of any failure to be compliant with them, the Board may wish to consider receiving and discussing this report. Some of the outstanding actions relate directly to the Board, including strengthening the Board ‘walkabout’ process.

• RQC received the minutes of the **PERFORMANCE and QUALITY OVERSIGHT and ASSURANCE GROUP**. The Board will be aware of the significance of this committee through which the Executive Team, CCG leads and TDA (chairing) provide Trust oversight. I invite the Board to consider receiving the minutes of this meeting directly, rather than via RQC

6. **Recommendation to the Board:**

The Board is asked to note and receive this report and the ratified minutes of the December meeting.
A meeting of the Risk and Quality Committee was held on Tuesday, 15th December 2015 at 9.34am in Meeting Room 4, Trust Headquarters, North Middlesex University Hospital

Present: John Hurst Non-Executive Director and Chair of the Committee  
John Carrier Chairman  
Dalwardin Babu Non-Executive Director  
John Simons Non-Executive Director  
Paul Reeves Director of Nursing and Midwifery  
Michael Marrinan Interim Medical Director  
Anne Yardumian Associate Medical Director  
Dane Satterthwaite Associate Director of Corporate Governance  
Des Lane Associate Director of Performance  
Paul Weaving Associate Director Infection Prevention and Control  

In Attendance:  
Adaeze Okpue Specialist Nurse-Organ Donation  
Gillian Belfon-Johnson Matron-Critical care  
Neil Hardy-Lofaro Interim Managing Director CBU3 (designate for Director of Operations)  
Behanu Kassayie Non-Executive Director Apprentice  
Zena Abdullah Darzi Fellow  
Stephanie Marfo Trust Board Secretary Assistant (minutes)  

RQ15/140 WELCOME  
The Chair welcomed all present to the meeting.  

RQ15/141 APOLOGIES FOR ABSENCE  
The following apologies were received from Richard Gourlay, Director of Operations and Frances Evans, Associate Medical Director, Molly Clark, Board Secretary. The interim Managing Director CBU3 would arrive late to the meeting.  

RQ15/142 DECLARATIONS OF INTEREST  
There were no interests received.  

RQ15/143 MINUTES OF LAST MEETING DATED 27TH OCTOBER 2015  
The Chair requested that the acronym for UCLH be amended throughout the minutes. Subject to these changes the Committee approved the minutes of 27th October 2015 as a true and accurate record.  

RQ15/144 MATTERS ARISING REPORT  
The Director of Nursing arrived to the meeting.  

The Chair highlighted that the report was not completely aligned to the agenda; the Committee were informed that future reports would correlated. Consequently, some items would be deferred to the next meeting.  

Item 1 RQ15/69 (Item 3.8 London Quality Standards Review) would be brought to the February meeting, the Director of Nursing stated that there were currently new identified compliance problems. Item 2 RQ15/32 (Item 3.7 Kirkup Report) and RQ15/88 (Item 2.3 Annual report on midwifery supervision), a report was on the agenda. The Director of Nursing confirmed that the Kirkup report had been discussed in the recent Maternity Board meeting, amongst other issues such as the birthing centre and contracting issues.  

full report of the National Frameworks standards would be provided at the February meeting.

Item 3 RQ15/38 Health and Safety Executive Sharps Review and RQ15/85 (Item 1.4 Matters Arising Report), HSE had confirmed that the Trust was now fully compliant. Item 4 RQ15/103 (Item 4.5 Clinical Effectiveness Group), this would need to be referred to the Associate Medical Director – Professional Leadership for comment.

Item 5 RQ15/96 (Item 3.4 CLIP report), this would be added to the Q3 report. Item 6- RQ15/94 (Item 3.2 Berwick, Keogh, Francis and Cavendish next steps), an update would be brought in February and include the Clwyd report. Item 7 RQ15/96 (Item 3.4 CLIP report) a verbal update would be given to the Board. Item 8 RQ15/88 (Item 2.3 Annual report on midwifery supervision) this had been deferred to the Workforce, Education and Training Committee and would be considered in its December meeting. Item 9 RQ15/116 (Item 1.4 Matters Arising Report) this would be referred to the Associate Medical Director-Patient Safety for comment. The Chair requested that timescales be provided for the review.

Action: Associate Medical Director-Patient Safety to add time scales.

Item 10 RQ15/117 (Item 3.2 Blood Transfusion Mock Inspection) and Item 12 RQ15/118 (Item 3.8 Medical Records Update) were on the agenda. Item 11 RQ15/117 (Item 3.2 Blood Transfusion Mock Inspection), the Director of Nursing had agreed to hold a Committee away day in which topics of this nature would be discussed. Item 13 RQ15/118 (Item 3.8 Medical Records Update), this would be referred to the Board Secretary for an update. Item 14 RQ15/118 (Item 3.8 Medical Records Update) it was suggested that the Director of Operations bring a verbal update to the January 2016 Board meeting. Item 15 RQ15/9125 (Item 3.6 S.I Report (including Child Death) Update, the Committee were informed that whilst co-morbidities were collected, no thematic review had been conducted.

Item 16 RQ15/93 (Item 3.1 Safe staffing report), this was ongoing. Item 17 RQ15/64 (Item 2.5 Policy Update), the policy required further amendments to facilitate recommended amendments following the Paris terrorist attacks. Following a query from Non-Executive Director, Dalwardin Babu, it was confirmed that the training was being given to staff. The Board were also to receive PREVENT training during the December Board Seminar.

The Non-Executive Directors suggested that the Committee be tougher on assigning actions for members, as the current Matter’s arising report was very lengthy. The Committee also agreed that the current length of the agenda was too long.

**RQ15/145 CORPORATE RISK REGISTER**

The Associate Director of Corporate Governance highlighted the new risks added to the corporate risk register since the last review at the previous risk and quality committee.

**RISK ID 2478 over reliance on temporary files from medical records**, had been escalated from the CBU4 risk register to the corporate risk register due to current medical record availability for CBU4 specialties. This risk is linked to the existing medical records risk on the corporate risk register (ID 2496). The committee noted that the Managing Director for CBU3 was attending the committee meeting and had provided a report (Paper J) for assurance, outlining the medical records improvement project.

**RISK ID3240 Adverse impact on the Trust following A&E conversation of concern**, the Associate Director of Governance explained that this risk had been identified as a reputational risk following the HENCELED ED visit and reviewed the controls in place.

**RISK ID: 3283 Endoscopy wash fire**, the circumstances of the fire were explained. The current mitigation in place was to loan additional scopes and a contract with St. Thomas and
Guys hospital which enabled the Trust to use their washers for off-site decontamination. The Trust were plumbing in the second washer and conducting water tests; however there is a four week time lag between the water sample being taken and the result being ready. The Trust hoped to have washers running in January. The Committee acknowledged that the timing of the fire caused additional frustrations, given the Trust was currently seeking to expand its Endoscopy capacity. Due to demand exceeding capacity in this area the Trust did not expect to be compliant with the six week target until the end of February 2016 stated the Associate Director of Performance. The Committee requested assurances that the service given to patients in these circumstances remained high.

**Action: Director of Operations.**

It was confirmed that all the cost of facilitating this contract had been considered. John Simons, Non-Executive Director asked whether the Trust could have anticipated this business continuity risk. The Director of Nursing suggested that these circumstances were exceptional in that the fire had not only damaged one of the washers beyond repair, but had also contaminated the second, adjacent washer beyond repair. Whilst the Trust could manage the loss of one washer without too much disruption to services, the simultaneous loss of both washers was not something the Trust had anticipated in existing contingency arrangements. The Director of Nursing confirmed that Trust was seeking a contract with Guys and St. Thomas for off-site decontamination whilst replacement washers were procured, installed and commissioned.

The Associate Director of Corporate Governance explained that two claims had been submitted to the NHSLA (one for the property expense arising from the damage caused by the fire, and a second claim for the business interruption expense) and evidence had been provided as requested. The Trust was awaiting their response and would have to pay an excess of £40,000 per claim. The Committee were made aware that since the fire on 21st November, the Trust had deferred operations and lost 20% of planned activity. This had been declared as an SI, the reputational risk was acknowledged, Communications had prepared a brief statement on the matter, if needed.

In response to a query, the Committee were assured that all two week waits were being seen as a matter of priority, other patients would be seen in turn. NHSE were also considering how to provide the Trust with additional capacity and determining whether patients could be moved to help reach the wait list initiatives targets. The Chair queried whether any additional support was needed; none could be identified at this time.

In addition to reviewing the new risks on the corporate risk register, the Committee then focused on the following risks:

**Risk ID 1542-Failure to maintain consistent achievement of good operational performance adversely impacts on patient care and outcomes and out reputation**,

patient flow continued to be an issue at the Trust. Noteworthy measures implemented to improve flow were the Northmid at Home service which was launched on 1st December with 10 virtual beds, as capacity was based on numbers of visits required the service could hold more than 10 actual patients. Demand for this service currently exceeded supply. Additionally, from November 2015 the AEC had extended their opening hours to help support A&E and patient flow over the weekends. The Committee were informed that whilst these measures were helpful attendances were high and the Trust was still unable to achieve the 4 hour standard target. NHSE had asked Mckinsey to assist the Trust in improving its A&E performance; Mckinsey had successfully assisted other trusts. There were a few work streams being led by Executives, these were to improve the ward rounds, patient flow throughout the Trust and reducing the time taken to initial assessment in A&E. Unlike in other instances, where trusts were reviewed for months, Mckinsey were only on site at the Trust for 2/3 weeks. The Chair acknowledged the efforts made to try and meet this standard, which seemed to have had little effect. Mckinsey’s recommendations were
expected in the beginning of January. The Associate Director of Performance stated that the McKinsey report would either corroborate or refute the Trust understanding of its 4 hour target issues. It was reiterated that McKinsey were here to support the Trust. The interim Medical Director was concerned about the short length of the intervention. There were currently issues within A&E pertaining to personnel, working practices and leadership problems, which he stated at this present time made the intervention very controversial. He stated that McKinsey had conducted a short analysis and were now focusing on solutions. However, he thought an extended analysis would have been more beneficial to the Trust. The Chair stressed the importance of ensuring that any solutions undertaken from the intervention did not worsen A&E performance, to simply mitigate pressures from external bodies. Dalwardin Babu, Non-Executive Director suggested that the Board provide their concerns about the short intervention to NHSE. This had already been done, but it was agreed to report concerns from a Board level.

Action: Board of Directors

The Director of Nursing reminded the Committee that non-achievement of the 4 hour target was a large risk; fines for non-achievement were mounting.

The interim Medical Director was meeting with the A&E consultants to discuss their concerns. He stated that this week was important for the Trust as there was a threat of direct external management at the Trust. The interim Medical Director then stressed the importance of using the recommendations to improve quality and safety. He wanted to ensure that this was a positive experience for A&E staff.

The Associate Director of Performance hoped McKinsey would feedback the Trust’s recovery plan to NHSE.

The Committee agreed that the problems faced by A&E were symptomatic of the issues within the whole Trust. The interim Medical Director suggested that better triangulation of the patient flow issues was needed across the organisation, exit blocks was not the only issue, the Committee agreed.

RISK ID 3228- Blood transfusion laboratories MHRA Compliance, the committee noted that the Managing Director for CBU3 was attending the committee and had provided an update report on the progress with the MHRA Blood transfusion action plan which was on the agenda at item K for assurance.

RISK ID 2529 Delay in reporting radiology examinations was also highlighted to the Committee. The CBU3 management team were completing a review of the reporting backlog and would present an update to commissioners at the next CQRG.

The Committee noted the report.

RQ15/146 NHS ORGAN DONATION REPORT

The Chair thanked Specialist Nurse-Organ Donation and Matron-Critical care for coming to the meeting. A short presentation was given. Between 1st April 2015 -30th September 2015 the Trust had four potential BDB donors with suspected neurological deaths, one proceeded to donate the others did not. In addition to this neither of the eligible DCD donors proceeded to donation. John Simons, Non-Executive Director requested further information to determine whether the Trust’s rates were on par with national trends.

The Specialist Nurse- Organ Donation highlighted that organ donation consent was lower in the Trust than the national target; the Committee discussed the need to raise awareness about organ donation consent. The Specialist Nurse- Organ Donation stated that there were potential organ donation losses because nurses were not always asking patients to consent. The Specialist Nurse- Organ Donation wanted to spend more time in A&E providing training
and speaking with patients/relatives where possible. Two potential donors had been missed. Dalwardin Babu suggested that thought be given to an internal campaign.

A query was raised as to whether there were cultural issues which restrained consent number. However, the Committee were reminded that there was no religion against organ donation. Following a query on cornea donation, the Committee were informed that cornea was classed as tissue donation, the Trust did not facilitate tissue donation but made referrals for it. The Chair asked the next report (due for six months timer) to include information on tissue donation and benchmark information. The Non-Executive Directors asked for the report to consider a longer period.

Action: Specialist Nurse-Organ Donation and Matron-Critical care

The Associate Director Infection Prevention and Control joined the meeting.

The Chair thanked Specialist Nurse-Organ Donation and Matron-Critical care and the team for their work and they left the meeting.

RQ15/147 KIRKUP REPORT

The report was published in early 2015 and investigated care and delivery at Morecambe Bay Hospital, the report criticised the hospital's maternity services heavily. The report made a series of recommendation, both short and long-term. To address the long term recommendations (namely recommendations 20, 22 and 41) the RCM have begun to develop a plan of work. The Trust conducted a gap analysis and following the implemented of a series of measure to meet the recommendations, the Trust’s action plan was largely green rated. The Kirkup report had been discussed at the last MAB meeting, but not exclusively, as many of the issues raised in the report formed part of the discussion naturally. The Chairman was pleased with the Trust’s response to the report, as stated within the report. He asked whether maternity SIs followed the same procedure as other SIs identified at the Trust, it was confirmed they did. The Associate Director of Corporate Governance informed the Committee that under the Stethoscope metrics the percentages of patient safety incidents resulting in harm were lower than expected and that the trust’s incident reporting rate was good when benchmarked against other Trusts. Therefore, whilst the Trust was a higher report of incidents, these were no harm/lower harm in comparison to the percentages of incidents reported at other trusts.

Whilst there was no statutory requirement to adhere to these recommendations, the Trust wanted to adhere to best practice in the area. The Chair requested that the actions be given clear timescales for implementation, the Director of Nursing agreed to add these to the report and bring back an update for the Committee.

Action: Head of Nursing and Midwifery

Dalwardin Babu stated that Trust feedback was fairly static; he would like to see a triangulation of feedback from various Trust surveys, the feedback from attending service users and the report to see improved survey responses. It was suggested that this would fall under patient experience and be reported within that project.

RQ15/147 SAFE STAFFING REPORT

The Committee were reminded that wards were staffed at a ratio of 1:6, but the national requirement was to staff wards at a ratio of 1:8. During November 2015 four areas had a fill rate of less than 99% against the 1:8 nurse to patient ratio, or the relevant recognised staffing levels. These areas were, Progressive care unit (where staff were on rotation to allow training to be undertaken) and the Labour ward (where activity was below the expected target), it was also explained that there was no requirement to staff wards based on this ratio. The other wards were Charles Coward (where staff were moved around to ensure that staffing levels remained safe at all times) and T4 Surgical ward (where the ward manager worked clinically instead of taking planned management days to ensure that staffing levels remained safe).
The Associate Director of Governance highlighted that the Stethoscope reporting system had identified the Trust as an outlier on a number of safety thermometer elements in September, but explained that this was due to data quality issues that had arisen as a result of the safety thermometer survey process in use at that time. This survey process had been reviewed and amended and November was the first month for which this new process had been implemented. There was an increase in the number of patient who received harm free care in November 2015 at the Trust. However, the Director of Nursing highlighted to the Committee the numbers of patients admitted to Pymmes 0 from community care who had not received harm free care. As the Trust reported any harm under care whether attributable to community care or the Trust, this distorted the Trust’s figures. The Trust was working with its commissioners to understand the cause of this increase care with harm in the community, particularly with patients from care homes. The Associate Director of Performance highlighted the differences between infection prevention control, where hospital acquired infections were attributable to the Trust and pressure ulcers where there was no such differentiation.

The Trust’s C. difficile target remained on trajectory. The Committee noted the report.

RQ15/148 PERFORMANCE REPORT

As the committee meeting had been scheduled for an earlier date in the month than usual, the November report was not ready in time for inclusion in the committee papers. The Committee were presented with the October reporting data for consideration. A verbal update of key November issues was also given.

The Associate Director of Performance highlighted the key issues, such as A&E access performance, FFT rate in A&E remaining below benchmark (although the response rate had improved due to additional apprentices in the area, the Chair asked that thanks to be passed onto relevant staff), improving cancer waiting times, but the challenges faced with 62 day target compliance (a recovery plan was in place, the Trust had informed commissioners that they would be noncompliant until early 2016), diagnostic performance which was below target, the size and profile of Radiology CT waiting lists (commissioners had been informed of this matter), improving mortality rates (crude mortality was below the mean, the different reporting mechanisms and the challenges posed by each were discussed briefly) and volume of bank and agency staff against slow achievement of the recruitment trajectory.

The Associate Director of Performance informed the Committee of a requested by the Trust’s Finance and Investment committee (after it had considered emergency readmissions audit performance) to review a deep dive on specific conditions as it had been revealed there were some outliers. The Director of Nursing requested that any subsequent audit in this area consider whether this was a quality or risk issue. The Chairman asked that weekend data be considered during the audit. The latest deep dive findings would be published in early January 2016 and reported back to committee at the next meeting.

Action: Associate Director of Performance

Dalwardin Babu queried when the new agency rate tariff framework would come into force, it was confirmed that they were in force already. The interim Medical Director stated that these tariffs would have a system wide impact. The Associate Director of Performance stated that there was currently no exact guidance to inform trusts of what sanctions there would be for trusts who paid above the framework, and theoretically the Trust should approach the NTDA each time it engaged staff above the framework set. Dalwardin Babu was surprised agencies and trusts were still operating above the framework. The Director of Nursing confirmed that most agencies had put their rates in line with the set framework, but agencies outside of that list had not. The contracts were HR managed. The Director of Nursing confirmed that the Trust was reporting exceptions and suggested that the impact of the new framework be considered by the Workforce, Education and Training Committee.
The Chair recognised that these issues not only affected workforce, but also risk and quality. He would raise this issue within his Chair’s report to the Board.

The Chairman suggested that this was a topic for Board discussion (potentially a part II discussion), particularly when the McKinsey’s recommendations were received. This could then be discussed with any Executive plans. John Simons, Non-Executive Director stated that he was unsure whether the Trust had a clear vision aligned to actions proposed. The interim Medical Director assured the Committee that these issues particularly the A&E issues were high on the Executives agenda; there was a clear plan in place.

As the A&E issues were multifaceted the interim Medical Director suggested that issues with the junior doctors would be considered in January, but that the HR issues would take time to resolve. He again reiterated the difficulty in recruiting strong leaders which were needed in the Trust’s A&E department. He stated that it was difficult for poor performing trusts to attract the calibre of leadership required.

The Committee noted the Performance report provided.

RQ15/149 CLIP REPORT

The report was taken as read stated the Associate Director of Corporate Governance, it recorded the incidents in Q2 2015.

Incidents: The key themes were a reduction in falls overall, however, there was an increase in falls which caused moderate harm. The Trust had seen an increase in the number of grade 3 and 4 pressure ulcers. Root cause analyses were currently underway.

Complaints: These had increased across each CBU with the exception of CBU4. The Trust was responding to 47% of complaints within the 30 day target. Where complaints ran over 30 day target complainants were informed. Trends were detailed in the appendices. The Chairman asked whether appendix two could be adapted to include the relative severity of each complaint so as to enable the committee to identify those complaints which expressed a deep dissatisfaction with the service received. The Associate Director of Corporate Governance agreed to amend the format of the CLIP report to include this additional information.

Action: Associate Director of Corporate Governance

The Director of Nursing advised that a new Deputy Director of Nursing would start was starting in February 2016 who would oversee patient experience and complaints. An update would be brought back to the Committee in April 2016.

Action: Deputy Director of Nursing

John Simons highlighted the complaint increases in CBU5, the Associate Director of Performance stated that these increases were difficult to reconcile against improving FFT results in the area.

The Chair asked for more information on the Trust’s processes in light of the ‘narrative verdict’ (inquest date 19th August 2015) given to the CBU1 death on 16th March, it was confirmed that an SI investigation had been done as a result of this death and had been reported in the CLIP report for Q1 2015. It was agreed that the Committee should be sighted on SI’s in each meeting, rather than quarterly as is currently the case.

Action: Associate Director of Corporate Governance

The Committee noted the report.
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RQ15/150 PATIENT EXPERIENCE ACTION PLAN
There was no document presented to the Committee, though a detail report from the Patient Experience Group was included in the Committee papers.

RQ15/152 PATIENT EXPERIENCE GROUP
The Chairman queried the sixth bullet point on the report from the subcommittee. It was explained that staff would work within the hospital in small groups to address specific issues mentioned about Patient Experience; these groups would feed into the Patient Experience Group, which in turn report to this Committee. Service users would be engaged to rate the service and assist the development of service improvements.

The Chairman also queried the penultimate sentence in page three of the minutes dated 5th November 2015 which stated that the patient stories were not reflective of Trust issues. The Non Executives present stated that they had seen videos with criticism and praise for the Trust. The Director of Nursing stated that this was an opinion, patient stories were designed to give a broad overview of a patient’s voice and to provide the Board/staff with insight and opportunities for learning. He informed the Committee that vox pops would be the new way of collating patient stories. The difficulty in engaging patients to provide patient stories was mentioned. Dalwardin Babu wanted the Board to have further oversight of instances where care did not go to plan. The Director of Nursing stated that this was addressed at a local level and would be overseen by the new Deputy Director of Nursing corporately.

RQ15/153 INFECTION PREVENTION AND CONTROL ASSURANCE REPORT
Levels of community acquired C. difficile had increased in contrast to an analysis on last year, explained the Associate Director Infection Prevention and Control. The Trust had reported no cases of MRSA since February 2014. He highlighted the Endoscopy fire, which posed an infection control incident and confirmed that the mitigating factors put in place meant that the Trust had not used any unsafe equipment. A water safety plan had been drafted and approved by the Water safety Group; this would be presented to the Infection Prevention and Control Committee for approval. The Chair thanked the team for their hard work. The Committee noted the report.

RQ15/154 INFECTION PREVENTION AND CONTROL COMMITTEE
The Associate Director Infection Prevention and Control stated that 21 cases of C. difficile had been declared, two were judged to be associated with lapses in care (caused by antibiotic prescribing and surgical prohealthsys).

RQ15/155 MEDICAL RECORDS UPDATE
The interim Managing Director CBU3 jointed the meeting. The interim Managing Director CBU3 stated that there had been some marked improvements since the last meeting. 6 new starters in Medical records on short term contracts (between three- six months). Medical records were discussed daily at Trust Silver Command meetings. There had been a backlog of filing notes, since the last meeting, the Medical records team had managed to reduce the number of outstanding cages from five/six to one. These were then sent to prefile. The Trust was working with an external company to improve investigate location based filing solution; the paper detailed the current milestones. The interim Managing Director CBU3 confirmed that patients were being seen in clinic with appropriate information. He stated that the Trust now needed to focus on restricting access to records libraries, reducing the number of temporary records and providing full case notes. Staff were being encouraged to use CIP and electronic notes. John Simons commended the work done to mitigate this matter. The Associate Director of Performance queried the number of duplicate files, the interim Managing Director CBU3 speculated around 15-20%, which was causing logistical problems; other trusts would have in the region of 10%. It was proposed that a team were to be put in place to merge electronic and physical files. The Associate Director of
Performance stated that the number of duplicate files posed a clinical risk. Dalwardin Babu asked about the long term plans, the interim Managing Director CBU3 stated that vacant medical records posts were not being filled because of the implementation of EDMS was supposed to run alongside the current system. As this was no longer plausible staff would be allocated to these vacant posts until EDMS was operational. The Committee noted the updated.

RQ15/156 **BLOOD TRANSFUSION MOCK INSPECTION**
The interim Managing Director CBU3 explained the work gone into resolving relationship issues with HSL. HSL were now providing the assurances that were lacking previously. Item reference 3.1 and item 1.1.8 were being addressed. Meetings had taken place with the HSL team and a robust risk assessment had been agreed. This assessment would be added to the revised contract, which would monitor quality of service as well as performance. The Associate Medical Director-Patient Safety acknowledged that previously communication between HSL and the Trust had been poor. There was still room to improve clinical engagement with the contract in place. The interim Managing Director CBU3 stated the importance of holding HSL accountable to their contract, sanctions were now contained within the contract for noncompliance; he confirmed that the appropriate levels of escalation for issues identified were now in place. Future key milestones would be shared with the Committee and the contractual arrangements shared with Trust management. John Simons queried whether this should be reviewed by the Trust’s Finance and Investment Committee. It was reiterated that quality measure were now built into the contract. The Chairman stated that the Pathology contract signed earlier in the year had contained some quality measure. The Chair suggested that he raise this as a matter for escalation to the Board. The Committee noted the Blood Transfusion mock inspection.

The interim Managing Director CBU3 was thanked for his time, he also reported another matter pertaining to Radiology CT scans, which was taken under any other business, he then left the meeting.

RQ15/157 **ANNUAL ADULT SAFEGUARDING BOARD REPORTS**
The document was presented for assurance purposes explained the Director of Nursing. The Committee noted the Annual Adult safeguarding report.

RQ15/158 **SAFEGUARDING ADULT’S GROUP**
The documents were taken as read and the Committee noted the Safeguarding Adult’s Group report and minutes.

RQ15/159 **SAFEGUARDING CHILDREN’S GROUP**
The Chairman requested that the figures stated in reference 12 of the minutes dated 15th September 2015 been queried. The Chair noted the report and minutes.

*Action: Named Nurse*

RQ15/160 **PATIENT SAFETY GROUP**
The report was taken as read. The Associate Medical Director had prepared a short presentation to address some of the queries raised in previous meetings. She had considered deaths by the day of admission and by day of death and could confirm that there was no weekend effect. Time of death was also presented with a slight increase in the early morning but no striking effect. The length of stay was considered as was death by wards, which proved unsurprising with AMU and Critical care wards reporting more deaths. Deaths by ethnicity had also been considered with deaths among white British being disproportionately high, although this did not factor in the age of the patient. The Chair referred to external research in this area and stated that Tuesday appeared to be the day of the week when most deaths occurred. John Simons pointed out that admission rates on different weekdays were likely to vary, and that the data should correct for this -
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the AMD agreed and will undertake this refinement. [The interim Medical Director stated that compliance with London quality standards were designed to address any weekend fluctuations in performance. The Chair noted the report and minutes.

RQ15/161 RISK AND SAFETY GROUP
No documents were presented to the Committee.

RQ15/162 POLICIES FOR APPROVAL: C DIFF POLICY
The C. difficile policy was presented to the Committee for consideration, the Associate Director Infection Prevention and Control confirmed that there were no significant changes to the policy. The Committee approved the C. difficile policy.

RQ15/163 MATTERS TO REPORT
The Chair stated he would escalate the following matters to the Board in his report. The work to remediate the relationship/working contract with HSL. The intervention by Mckinsey and the wider A&E issues or poor performance. The Radiology issue taken under any other business and the Endoscopy fire.

RQ15/164 ANY OTHER BUSINESS
The following items were being brought to the attention of the Committee under A.O.B:

1. 657 Radiology CT examinations which dated back to summer 2015 had been left unallocated on the Trust's pervious computer system. A three phased approach had started to ensure that the backlog was being cleared. 36 scans had found some unexpected clinical findings. 48 hour reports were being conducted. These scans were outpatient requested and had been classed as low priority. However, the magnitude of the error was now understood. The CCGs had been informed and the Trust was awaiting their response. An internal Root Cause Analysis investigation would occur and an external SI investigation would be done if required by the CCGs in the event of a patient suffering harm as a result of the delayed reporting. John Simons wanted to understand the shortcomings in the system that allowed this to occur. He stated that the Trust audit systems should pick up system/process deficiencies and if they were not, they could not be robust enough. It was explained that the focus and capacity of clinical audit could not provide for this at present. Clinical Audit focus resource on the management of NICE Clinical Guidelines, National Confidential Enquiries and National Clinical Audits. Internal Audit undertakes a risk based audit plan, based on high level clinical and operational risks identified on the risk register. This error was caused by Trust system and process combined with increasing demand on the imaging services stated the interim Managing Director CBU3. As such it was not identified as a system requiring an Internal Audit Review. Further consideration of this matter needed to be given outside of the meeting. The Committee received the businesses.

2. Revised Statement of purpose was tabled to the meeting. The Trust's statement of purpose was being amended to allow the Trust to facilitate the new Sexual Health Service. The documents would be submitted the Hospital inspector. Another amendment would be made in coming months around the library relocation. The tabled documents required noting and approval. The Committee received the businesses and noted the amendments to the Trust's Statement of purpose. The tabled documents pertaining to the new Sexual Health Service were approved.

There being no further business to address the meeting was closed at 12.23pm.
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NORTH MIDDLESEX UNIVERSITY HOSPITAL

COMMITTEE CHAIRMAN ASSURANCE REPORT

<table>
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<td>Catherine Dugmore</td>
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Summary of key actions and decisions arising in Committee meeting

The committee received the 2016/17 Internal Audit Plan and 2016/17 Local Counter Fraud Plan.

2015/16 Year end reports

RSM presented the initial draft Head of Internal Audit Opinion report for the 2015/16 period, which gave an opinion of significant assurance based on the work of Internal audit to date, such as the risk management audit, which received an amber green rating. This report was considered alongside the draft 2015/16 Annual Governance statement and Annual Senior Information risk report. Final versions of the reports will be received at the May meeting of the Committee.

Internal audit progress reports

The Committee received an internal audit progress report updated which incorporated a Red rated audit opinion in relation to Medical Records.

The Director of Operations presented the Committee with an overview of actions taken to address issues identified in the audit, as well as mitigations to address the associated risk on the Board Assurance Framework.

Radiology presentation

Further to the escalation of the issues pertaining to Radiology in January report to the Board, the Director of Operations presented an assurance report at the March meeting of the Audit Committee. A further update will be given during the course of the financial year.

Assurances received from sub-committees:

Assurance reports were reviewed at this meeting from Risk and Quality Committee on the systems and processes in place to maintain oversight of risks within the organisation.

Risk assurance update:

The Committee received and endorsed the Risk Management Strategy for Board approval. The Corporate Risk Register was received in the March meeting.

Matters for escalation to the Board:

The Board is asked to note the Red rated audit opinion issued in relation to a recent internal audit review of medical records.

Recommendation to the Board:

The Board is asked to note and receive the attached report and ratified minutes of the January 2016 meetings.
A meeting of the **Audit Committee** was held on **Tuesday, 8th September 2015** in Meeting Room 10, Tower Block, Lower Ground Floor at 10.02am.

**Present:**
- Catherine Dugmore  Non-Executive Director and Chair
- Dalwardin Babu  Non-Executive Director
- Graham Coles  Non-Executive Director

**In Attendance:**
- Martin Armstrong  Director of Finance
- Molly Clark  Board Secretary
- Dane Satterthwaite  Associate Director of Corporate Governance
- Ray Conley  Deputy Director of HR
- Nick Atkinson  Partner, Baker Tilly
- David Foley  Director – Fraud Risk Services, Local Counter Fraud Specialist, Baker Tilly
- Hannah Wenlock  Senior Consultant, Local Counter Fraud Specialist, Baker Tilly
- Dr. Vipin Asopa  Locum Consultant and WHO Checklist lead
- Stephanie Marfo  Trust Board Secretarial Assistant (minutes)

**AC15/64 WELCOME**

Catherine Dugmore welcomed all present.

**AC15/65 APOLOGIES FOR ABSENCE**

Apologies were received from John Hurst Non-Executive Director, Ailsa Bawn, Deputy Director of Finance, Tom Kenny, Head of Financial Services Kerri Barnes, Robert Grant of BDO and Richard Gourlay, Director of Operations

**AC15/66 DECLARATION OF INTEREST**

There were no declarations of interest pertaining to agenda items for discussion.

**AC15/67 MINUTES OF THE MEETING 14TH MAY 2015 AND 2ND JUNE 2015**

14th May 2015 minutes:

- **AC15/54 PROGRESS REPORT –2014/15 LCFS ACTIVITIES INCLUDING FRAUD RISK ASSESSMENT** to amend the target referral rate to eight to 16 per year.

- **AC15/46 MATTERS ARISING REPORT** to add that an Executive Director Lead would be asked to attend the committee meeting where their relevant audit was given an amber/red rating.
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- **AC15/47 CORPORATE RISK REGISTER**, the Committee asked that the following sentence be added to the minute to ensure that it recorded the discussion that took place around Risk ID: 2496 - Staffing and Space within Health Records and Risk ID: 2529 – Delay in reporting radiology examinations, “The Committee then discussed the following risks:”
- To amend meeting attendees’ departures with reference to the AC details rather than the agenda item number.
- **AC15/47 CORPORATE RISK REGISTER** the wording ‘which had indicated’ would be removed from the second sentence of the second paragraph.

2nd June 2015 minutes:

- **ACEX15/04 DIRECTOR OF FINANCE OVERVIEW & FINANCIAL STATEMENTS** to amend the heading of the item.
- **ACEX15/08 HEAD OF INTERNAL AUDIT OPINION** to amend the wording, which would be supplied by Nick Atkinson.

*Action: Trust Board Secretarial Assistant*

Subject to the amendment stated above it was agreed to approve the minutes of 14TH MAY 2015 AND 2ND JUNE 2015 were accurate records of the meetings.

AC15/68 MATTERS ARISING REPORT

The Deputy Director of HR arrived at the meeting.

The Committee reviewed the matters arising report and agreed that all actions were as stated within the report.

Graham Coles, Non-Executive Director queried item 10 **AC15/48 Review of Trust Policies**, the Associate Director of Corporate Governance confirmed that the number of polices had been reviewed, by the relevant staff groups and after some discussion about the usefulness of amalgamating policies, it had been decided to keep them at their current level.

Following a query, it was confirmed to Dalwardin Babu, Non-Executive Director that item 11 **AC15/54 Progress report- 2014-15 Local Counter Fraud Specialist Activities including fraud risk assessment** would be addressed within the Equality and Diversity group forum.

Nick Atkinson confirmed that item 15 **AC15/52 Progress Report – 2014/15 Internal Audit Activities** related to implementation timeline and these were now present within the report. He then asked that item 1 be marked as completed as Baker Tilly were aware of the requirement and would continue to comply; this was agreed.

The Committee noted the Matters Arising report.

AC15/69 ANNUAL PLANNER FOR 2015/16

The planner was noted by the Committee.

AC15/70 PROGRESS REPORT – REVIEW OF INTERNAL AUDIT PROGRESS REPORT

Nick Atkinson presented the report to the Committee.
WHO Surgical Safety Checklist –Follow up

The follow up had been undertaken at the suggestion of the Committee, following a Red audit opinion in 2014/15. The follow up report was positive about the Trust’s progress in implementing the recommended actions. The recommendations were relayed to the Committee.

The Committee was also informed of the Blue Spire system, which was a theatre module within Medway PAS; the system was still under development. Once developed this would enable better access to the checklist. Nick Atkinson stressed the importance of project managing the integration of this system into the Trust.

The WHO checklist workshops were applauded, there was currently work in progress to make WHO checklist training mandatory for staff in Theatres. The content of the course had been reviewed by the Auditors and it met with their approval.

Dr. Asopa had been tasked to lead the WHO Surgical Checklist audit project at the end of 2014 following the audit. Patient safety was a primary concern.

To implement some of the recommendations around completion of the checklist, Dr. Asopa had created procedure simulations and asked teams to complete the checklist. Teams were able to watch one another complete the checklists and provide feedback. After the session all noted the significant improvement in the completion of the checklist by the second team. Theatre junior doctors had also conducted a mock audit using Baker Tilly’s report; the findings again indicated a marked improvement. The primary challenge to providing mandatory simulation training was time; the course was currently run on Friday evenings (and was unpaid). There were also debriefing meetings after each simulation training event. He suggested that some of this time be used to provide the training in ‘working hours’ within debrief sessions that training could be run, but this would need to be approved by the area lead.

Utilising the above information, Dr Asopa had designed the training programme, the third WHO Checklist simulation training would take place on 11th September 2015. The emphasis had been on learning and education. Theatre staff were now engaged in completing the checklist accurately. Monthly internal audits were taking place and staff were now concerned about the completeness of the forms. He stated that this was a change in office culture, which took time to engender. Dalwardin Babu stated that debriefs were a large cultural change, but that the widespread benefits would be observed; Dr Asopa agreed. The improved patient safety benefits in implementing the audits/training/debriefs were now fully understood. Dr Asopa highlighted the positive attitudes of all involved and that initiatives of this nature would boost the profile of the Trust.

The Director of Finance suggested that responsibility for monitoring the WHO Surgical Checklist and the completion of the remaining audit recommendations be delegated to the Risk and Quality Committee. Where applicable the committee’s assurance report to the Audit Committee would highlight the progress on the implementation of these recommendations. All matters related to mandatory training would be delegated to the Workforce Committee and Education & Training Committee.

The Chair thanked Dr. Asopa for his attendance and the good work he had conducted as the project lead, he then left the meeting. The Chair was confident that controls were in place to implement the recommendations from the Baker Tilly Audit. She applauded the engendering of cultural change in this area.

Medical Appraisal and Job Planning
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The Non-Executive Directors present commented on the late arrival of the revised Internal Audit Progress report and suggested that reports not be amended once issued to members. Nick Atkinson stated that the updates provided timelines for responses to the audit; the Director of Finance suggested that the responses in the revised report were more meaningful. The Chair and Chief Executive had discussed the slow response of clinicians to Baker Tilly’s audits. Both agreed that it was important for all staff to revert on internal audit queries in a timely manner. Nick Atkinson informed the Committee that there was increased involvement from clinicians.

The Committee reviewed the comments with the status and stated that little progress had been made on the audit. Nick Atkinson informed the Committee that three recommendations had been closed, and though there had been some movement, the department were behind on their target dates. He then stated that job planning was an issue across the NHS. Nick Atkinson suggested that compliance in this area could be transformation and help the Trust’s CIP targets. The deadline for implementation was 30th September 2015. The Committee were informed of the efforts of the Director of Finance and the Deputy Director of Finance in following up audit information requests. There was Executive involvement on this matter, but the need to engage lower level staff in responding was stipulated by Nick Atkinson.

Follow up

The Trust’s progress in completing internal audits was highlighted; to date 90% of internal audit recommendation had been implemented by the due date. The schedule for the rest of the year was in place and some had been brought forward. Where scheduled audit dates had been amended the rationale had been requested and agreed upon. Many deadlines had been set for 30th September 2015, but Baker Tilly was satisfied with the progress to date.

The Committee observed that some recommendations were over six months old, these were considered significant delays. The Chair queried whether these were considered by the Executives, she was informed that these were considered on a bi monthly basis and triangulated against the risk and the workload in the area. As a result there were in certain circumstances an acceptance of delays. The Chair pointed out the continued implementation delays of the Radiology audit recommendations and requested feedback from the Director of Operations.

Action: Director of Operations

The Chair queried the Whistleblowing audit recommendations which had a completion date of 30th September 2015, as training in this area now formed part of a wider HR Skills programme, that the department had recently started, the Deputy Director of HR suggested that a new target date of 30th October 2015 be set. The Chair suggested that status updates should provide the context for any delays.

Action: Baker Tilly.

Graham Coles requested better clarity within the reports of the due/overdue items (Section 4, Follow up of internal audit recommendations). Nick Atkinson explained that items within the report that were ‘being implement’ were not yet complete. The subsequent update then provided further clarity on actions, but it was agreed that additional context and clarity would be provided, where possible, especially within the management comment sections to provide better understanding of the mitigating actions. Nick Atkinson also explained that internal audit would only chase items that were due for completion.

Action: Baker Tilly.
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The Chair suggested that some of the comments received by the internal auditors from staff were not adequate. It was suggested that management be given an opportunity to review comments provided this was agreed, deadlines would be set earlier to facilitate this.

Action: Baker Tilly.

IT Service Continuity

The Chair queried recommendation 3.7 within the report, she was informed that backup restore tests had been conducted. However, the overall programme for these tests needed to be designed, to ensure that tests occurred on a regular basis. In response to a query from Graham Coles, the Committee were informed that the IT Service Continuity was a subset of the overall Business Continuity plan. Audit follow ups had commenced.

Pre-employment Checks

The Chair thanked the Deputy Director of HR for attending the meeting and speaking to the paper. Nick Atkinson confirmed that overall there were areas of good compliance. However, full assurance could not be given because one of the 20 files requested could not be located during the audit. Nick Atkinson acknowledged that the Trust in some instances would permit one as opposed to two references to be obtained for new employees, but he stressed the need to ensure that clear procedures were in place to regulate these occasions. The Deputy Director of HR stated that if/when the Trust departed from national pre-employment check guidelines his authorisation was required (which would only be given once the potential risk to the Trust had been properly assessed). He confirmed to the Committee that this process was being followed robustly for all staff particularly those allowed to start without a full DBS check. It was suggested that a form be drafted to document the decision making where one reference was accepted as opposed to two.

Action: Deputy Director of HR

The Chair queried the file that could not be located during the audit. The Deputy Director of HR confirmed that the file could not be located at the time the audit occurred, but explained that the HR department had been moving offices. After some discussion it was agreed that the inability to locate a file did adversely impact on the auditor's ability to provide full assurance to the Committee on the robustness of the Trust's pre-employment screening processes. Nick Atkinson confirmed that this single issue (one file not being located) meant that an Amber/Red rating had been awarded for the audit. He stated that all other controls in place were functioning well. Additionally, the other recommendations from the audit had been rated ‘medium’/’low’. The Chair asked what assurance the Committee could have that the checks for the individual whose file was missing had indeed been undertaken. The Deputy Director of HR confirmed that the Trust had access to the individual's pre-employment checks as the majority of checks were undertaken electronically. There was some discussion around whether the audit rating should be amended if the electronic records could be provided to the Auditors and/or the file could now be located. It was agreed that the rating should not be changed retrospectively, as at the time of the audit; these control issues had been highlighted. Members stated that if the sample was representative of the Trust, then there would be a significant control issue. The
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Chair requested confirmation that a new file would be collated for the employee and/or the original file be located. It also agreed that an audit of this file would be completed.

**Action:** Deputy Director of HR

The Board Secretary suggested that this item be reviewed at the upcoming Workforce Committee and Education and Training Committee meeting, the committee would then provide assurances to the Audit Committee.

**Action:** Board Secretary

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**Safeguarding Children and Adults**

The overall concern in respect to safeguarding children was that staff were not in receipt of training they should have undertaken, which constituted a patient safety risk. The Associate Director of Corporate Governance confirmed that work was being done to ensure that staff were trained to the appropriate level, particularly back office staff, where training rates were lowest. Nick Atkinson acknowledged that training rates had improved; the Associate Director of Corporate Governance confirmed the training rates with the Committee, the total number of employees would be confirmed.

**Action:** Associate Director of Corporate Governance

The recommendations around a centralised database for safeguarding alerts were addressed; the alerts were now logged onto the Trust's online incidents system rather than a spread sheet. This was to enable the management of the investigations to be robustly tracked and managed. In relation to the alerts, the Associate Director of Corporate Governance informed the meeting that monthly meetings with care homes and the Trust Matrons had commenced to discuss problems relating to patient transfers following discharge. This was to ensure that SOVAs were not being raised against the trust by care homes erroneously.

It was agreed that the implementation dates of recommendations reference 1.2 and 2.1 should be 1st January 2016, this was agreed.

**Action:** Baker Tilly

The Chair was comforted by the Associate Director of Corporate Governance responses.

Dalwardin Babu queried how the Trust assessed patients with learning difficulties that resulted in safeguarding needs, the Associate Director of Corporate Governance suggested that if the condition related to the reason for attending, the need would be recorded in the patient's medical records or noted upon admittance to the Trust. However, if the need did not relate to the reason for attending the need would ideally be identified by the attending physician. Dalwardin Babu requested clarification as to whether this information would be
stored permanently on Trust systems. He also requested clarification around the Enfield and Haringey safeguarding arrangements, which would be taken forward outside of the meeting.

**Action:** Associate Director of Corporate Governance

**Cost Improvement Programme**

This report had also been given an Amber/Red rating, Nick Atkinson highlighted that similar ratings had been given to other trusts, particularly in London. He highlighted that the pressure to attain these targets could result in risks.

The Committee were reminded that many of the Trust's QIPPs were back loaded, which placed the Trust under significant pressure if they could not delivered in full as there was limited recourse, the Trust was currently behind on many of their CIP targets.

The Committee were also informed that many of the QIPPs proposed had not undergone a quality impact assessment (the Chair agreed to raise this as part of her assurance report to the Board), the risks associated with adopting the schemes that had yet to undergo this process had been discussed in the Finance and Investment Committee meetings.

Graham Coles had been of the understanding that all QIPPs had been signed off by the Medical Director and the Director of Nursing. The Director of Finance agreed that this was also his understanding. The report stated that there was no information to demonstrate their approval. The completion dates were set for September 2015. In the absence of the Deputy Chief Executive, the Director of Finance had assumed responsibility for QIPPs. The Director of Finance stated that the QIPPs were not currently delivering the savings required or projected and that remedial action would need to be put in place to recover the Trust’s position; these would be looked at during the next Board meeting and at the Finance and Investment Committee meeting. The Chair wished to raise the quality impact assessment sign off with the Director of Nursing and the Medical Director.

**Action:** Chair

The management of the QIPP savings was discussed, the Trust had engaged short term contract project managers to deliver QIPP targets, Nick Atkinson queried the Trust’s current approach to achieving the QIPP targets. The Director of Finance agreed with the Trust’s approach, suggesting that the skill set needed to meet QIPP targets in Outpatients would be different from the skills needed in AMU or Critical care. The Committee were then reminded of the clear lines of accountability in the form of the PMO Director who was a long term member of staff.

Graham Coles queried the level of clinician involvement and whether appropriate action was being taken. He was informed that there was clear clinical representation and that whilst there were some monitoring arrangements that did not work well, there was general satisfaction around the level of input from the PMO director. A follow up would occur and an update would go to the Finance and Investment Committee.

The Chair requested that in future the review of internal audit progress reports be taken after the administrative matters on the agenda to accommodate staff coming to speak to any reports.

**Action:** Trust Board Secretarial Assistant

Baker Tilly’s adoption of the global RSM branding was mentioned to the Committee.
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The Deputy Director of HR left the meeting.

The Committee noted the Internal Audit Progress Report.

AC15/71 ANNUAL EXTERNAL AUDIT LETTER 2014-15

Grant Thornton had provided the Trust with a summary of the key findings arising from the audit and approval of the Trust accounts for 31st March 2015. The document was taken as read and noted by the Committee.

AC15/72 EXTERNAL AUDIT PLANNING LETTER 2015-16

The planning letter was introduced by the Director of Finance. The Chair queried whether a formal handover session would occur between the incoming and outgoing external auditors; she was informed that this would occur. The Committee was reminded that fees payable to the external auditors were set by the Audit Commission via an agreed framework. The incoming external auditors would attend the January 2016 meeting. The External Audit planning letter 2015-16 noted by the Committee.

AC15/73 REVIEW OF LCFS PROGRESS REPORT

LCFS had arranged Immigration Training from a Home Office Officer on 21st/22nd September 2015 for the Human Resources department. The cross year LPE had been completing work on the Trust’s sickness absence.

An assessment of the National Fraud Initiative matches had been concluded; Hannah Wenlock detailed to the Committee the identification verification procedure in place for staff where further enquiries were deemed appropriate. She then informed the Committee of a case where after an investigation and interview identification documents could not be verified substantively; as a result the employee was promptly suspended from service. It was confirmed that staff were given an appropriate length of time within which to supply the requested documentation and HR and the Home Office (where appropriate) were involved throughout the process.

Dalwardin Babu queried the LCFS connections with the local police. Hannah Wenlock confirmed that LCFS had contacts for both intelligence and practical assistance with the local police and the Head of Trust Security. The local police in turn had links with National Border agencies. The Committee were informed of the national Fraud Initiative database that assisted the LCFS in their investigations. Hannah Wenlock confirmed that there was information sharing across these agencies, she also informed the Committee of the First Case system within NHS Protect which logged investigations of this nature was accessible by appropriate NHS persons, and this would prohibit a person suspected of fraud from gaining employment within the NHS.

The Chair commented on the removal of fraud and bribery awareness training from the marketplace induction, Hannah Wenlock explained that they were approaching awareness training in a different way, working in collaboration with the Trust’s Security Department, distributing information on wards to staff, which had been successful.
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Graham Coles queried the alleged bribe in section 3, the Director of Finance explained that the contract in question had been awarded fairly and that any further issues would be dealt with under the National Fraud initiative framework.

Dalwardin Babu thanked LCFS for their work, noting the amount undertaken.

The Committee approved the Review of LCFS progress report.

AC15/74 ANNUAL COMMITTEE SELF-ASSESSMENT SURVEY

The Chair, the Board Secretary and the Director of Finance had met and discussed the outcomes of the survey and the presented action plan. The Board Secretary confirmed that the Non-Executive Director membership had been reviewed and with effect from January 2016 it had been agreed that John Hurst would become a member of this Committee; Dalwardin Babu would step down. The Chair thanked Dalwardin Babu for his contribution to the Committee.

The Committee noted the Annual Committee self-assessment update.

AC15/75 CHARITABLE FUNDS COMMITTEE

The Committee received and noted the report, it was agreed that this report would be provided to the Committee annual rather than bi-annually reviewed the report

Action: Trust Board Secretarial Assistant

AC15/76 CORPORATE RISK REGISTER

The Associate Director of Corporate Governance presented the report.

One new risk had been added:

-Risk ID2994 Dr Foster Mortality Outliers- this risk was added to the register after receipt of three Dr Foster Mortality alerts. The CQC had also contacted the Trust and requested further information, the Trust had responded and the CQC requested that monitoring of the mortality rate continue with the local CQC inspector. Graham Coles queried when mortality as a risk was placed on the Trust risk register. The Associate Director of Governance stated that it had been placed on the register after receipt of the Dr. Foster alerts; this had been reflected in the July BAF paper. He queried whether this risk should have been identified earlier, it was explained that the Trust had noted a slow increase in mortality, but these could have been explained reasonably by seasonal trends. An added difficulty was the reporting regime for mortality which was mostly in arrears. Graham Coles raised concerns about the assurances received from Board sub committees, in light of this risk. The Director of Finance commented that the key issue was whether the Trust was putting items on the BAF in a timely manner, and whether issues were being fully triangulated. Nick Atkinson advised that the Trust needed to analyse the way Board sub committees reviewed risk in their meetings and how these issues were escalated. The NEDs agreed and requested that an analysis of the sub committee’s review of their risk registers and the triangulation of issues be reviewed and brought back to the next Committee meeting.

Action: Associate Director of Corporate Governance

The Associate Director of Corporate Governance commented that Datix had been updated with the Workforce Committee risks; a full explanation was in Appendix 1 of his report.
ITEM 7.2 – APPENDIX A MINUTES

-Risk ID 2496- Non Availability of medical records- this risk had been reworded, per item 8 on the meeting Matter’s Arising report.

-Risk ID2493 Critical Care Junior Doctors capacity, per item 9 on the meetings Matter’s Arising report, the Associate Director of Corporate Governance had prepared a detailed case study of the risk scoring process. The Chair stated that this was a useful analysis and requested that it continue.

Action: Associate Director of Corporate Governance

Graham Coles used this risk as another illustration of a Trust risk score moving in a reactionary method as opposed to an anticipatory and perceptive management method. Dalwardin Babu queried whether the removal of the Junior Doctors could have been anticipated; the Associate Director of Corporate Governance commented that although the GMC survey scores had been poor for a long time, the Trust’s had not anticipated the immediate withdrawal of the trainees. This withdrawal had also seriously impacted other specialities within the Trust. The Director of Finance stated that the actions of HENCEL had been grossly disproportionate and could not have been envisaged, even considering the poor GMC survey results.

Graham Coles stressed the need for the risk register to discern changing behaviours, not just assess impact or record bad news.

The Chair agreed with Graham Coles’ comments and stated that the Trust needed to ensure that the correct governance framework surrounded the risk registers, the outcomes of the recent Quality Summit also needed to be factored into the register.

Dalwardin Babu stated that the challenge would be maintaining relationships with the wider community; he suggested that more emphasis was needed in this area.

The Chair stated that much of this discussion would be highlighted to the Trust Board in her assurance report.

The Committee noted the corporate risk register.

AC15/77 DECLARATION OF INTEREST AND HOSPITALITY POLICY

The policy had been updated and merged with the Gifts and Hospitality policy. The policy was represented to the Committee by the Board Secretary for ratification. It was agreed that should any members wish to provide comments could be forwarded to the Board Secretary.

The Committee approved the Declaration of Interest and Hospitality Policy.

AC15/78 REVIEW OF LOSSES AND SPECIAL PAYMENTS

The Director of Finance presented the report to the Committee, which was an update for the period. The report was noted and received.

AC15/79 REVIEW OF BAD DEBTS AND WRITE OFFS

The Director of Finance presented the update for the period to the Committee. The report was noted and received.
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AC15/80 MATTERS TO REPORT TO THE BOARD

It was agreed that the following matters in the Board report:

- The shortfall in the CIP target
- The Quality Impact Assessment in relation to the CIP targets not being undertaken
- Concerns around the corporate risk register and the assurances being received from the sub Committees, and the proposed analysis of the effectiveness of the risk register process within the Committee structure. The Internal Audit review of the BAF would be conducted in September 2015.

AC15/81 ANY OTHER BUSINESS

It was agreed to extend the timings of the meetings from January 2016 to 3 hours.

Action: Trust Board Secretarial Assistant

AC15/82 DATE OF NEXT MEETING

The next meeting would be on 13th January 2016 at 10am-1pm in meeting room 4, Trust Head Quarters, North Middlesex University Hospital.

The meeting ended 12.19pm
ITEM 7.3

NORTH MIDDLESEX UNIVERSITY HOSPITAL

COMMITTEE CHAIRMAN ASSURANCE REPORT

<table>
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<tr>
<th>Committee Name</th>
<th>Finance and Investment Committee</th>
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<tr>
<td>Committee Chair Name</td>
<td>Graham Coles</td>
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<tr>
<td>Reporting period</td>
<td>February 2016</td>
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</tbody>
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Summary of key actions and decisions arising in Committee meeting

1. FINANCIAL PERFORMANCE

   • I&E deficit reported to end of month 10 of £6.5m, £6.4m short of budget, the shortfall still being driven by SLA underperformance (due to lower activity in A&E and maternity, and penalties relating to particularly, but not only, A&E underperformance), payroll overspend and QIPP under-delivery.

   • This deficit would be forecast to grow to £9.6m by the end of the year without mitigation as a result of a continuation (and worsening in respect of performance penalties) of the above factors. This would be £9.6m below budget, and £11.6m short of the revised Control total.

   • Mitigating opportunities totalling £3.0m were identified and reported to the Board in October. Limited progress has been made to implement these opportunities and incomplete delivery is now probable.

   • As previously reported, an opportunity to sell land has been identified which could close the residual gap. An Outline Business Case has been approved by the Trust Board, and as detailed below, the Full Business Case has been approved by FIC.

2. SLA DISCUSSIONS

   • The magnitude of unresolved disputes between the Trust and CCG’s in respect of the SLA contract continues at a very material level. While the Trust is confident that it has properly reflected the probable outcome of these unresolved disputes in its outturn, until the disputes are settled, nothing is certain.

   • As previously reported, this level of disputes consumes management energy and creates uncertainty both at the Trust and at the CCG’s, with little benefit either to the patient or the taxpayer. The Executive have presented a range of other contract mechanisms that may result in a more harmonious relationship.

3. BUDGET

   • The Executive have prepared a top-down Financial Plan, suggesting a Control Total (after Service and Transformation Support of £9.8M) of £4.0M surplus. This compares with a Control Total Target of £11.1M surplus. There is thus a material shortfall. Furthermore, achievement of the Control Total is dependent on delivery of CIP schemes of £9.4M which have not yet been identified.
• The Executive will discuss the shortfall with the TDA and report back to the March Board with a proposed budget. The March Board will need to consider the deliverability of this proposed budget, and in particular the deliverability of any supporting CIP schemes.

4. MATTERS APPROVED

• Following approval of the OBC for the Land Sale by the Board in January, FIC reviewed the FBC to ensure there were no material changes to the transaction since OBC approval, and on that basis approved the FBC (subject to subsequent TDA approval).

• The November Trust Board approved an application for an interim revolving working capital facility of £10,852k. This has been progressed by the Executive. FIC approved the transaction in its final form.

5. Progress against delivery of annual work-plan:

• The scheduled review of SLR performance has been deferred to April. FIC requested that a Marketplace report also be presented to the April meeting. The Committee remains otherwise satisfied that the overall 2015/16 workplan for the year satisfies FIC’s objectives and is deliverable.

6. Assurances received from sub-committees:

• Assurance has been received from the Planning & Commissioning Group

7. Risk assurance update:

• FIC has maintained Risk 1954: Delivery of SLA plan at 25 reflecting the magnitude of disputes between the Trust and the CCG’s, and continuing concerns regarding potential performance fines, both as described above.

• FIC has maintained Risk 2420: QIPP Delivery at 25 with target benefits on quantified QIPPs in total falling materially of budget.

• FIC has maintained Risk 1953: Delivery of Financial Plan at 25 reflecting continuing concerns regarding payroll cost control, SLA activity and QIPP delivery with operational mitigating actions unlikely to significantly recover the position. The Land Sale discussed above has the potential to close the reported shortfall, but, being a non-recurring item, this will not of itself change the underlying financial performance of the trust.
8. **Matters for escalation to the Board:**

This Risk Assurance relates to achievement of objectives during the 15/16 financial year. Risks attaching to achievement of objectives relating to the 16/17 financial year have not been quantified. However:

- The draft Financial Plan for 16/17 at present assumes the very material level of underperformance fines currently being imposed will cease from the beginning of the financial year. This will require a very rapid turnaround in operational performance under a number of headings.

- The draft Financial Plan for 16/17 assumes delivery of an ambitious CIP target that has been prepared on a top-down basis. The deliverability of this target is dependent on identification of specific schemes with specific financial benefits and specific accountabilities. Progress in achieving the required specificity has been below expectations.

The Trust faces substantial operational and financial challenges in the short-to-medium term. Management capacity may be a constraint preventing resolution of these challenges, both at Senior Management level (as previously reported) and at CBU management level.

**Recommendation to the Board:**

The Board is asked to note and receive this report and the ratified minutes of the December 2015 meeting.
MINUTES

A meeting of the Finance and Investment Committee was held on Wednesday, 16\textsuperscript{th} December 2015 in Meeting Room 4, Trust Offices.

**Present:** Graham Coles Non-Executive Director & Chair
Catherine Dugmore Non-Executive Director
Martin Armstrong Director of Finance & Information
Richard Gourlay Director of Operations
Ailsa Bawn Deputy Director of Finance (FM)
David Paris Deputy Director of Finance (FP)
Crista Findell Project Accountant
Desmond Lane Associate Director of Performance
Beena Jhoree SLA Contract Lead

**In Attendance:** Kevin O’Hart PMO Director (from item 3.3)

FIC15/108 WELCOME

Graham Coles welcomed all present.

FIC15/109 APOLOGIES

There were no apologies for absence.

FIC15/110 DECLARATIONS OF INTEREST

There were no declarations of interest pertaining to agenda items for discussion.

FIC15/111 MINUTES OF THE MEETING HELD ON 28\textsuperscript{th} OCTOBER 2015

The Committee agreed the minutes of the meeting held on 28\textsuperscript{th} October 2015 as an accurate record.

FIC15/112 MATTERS ARISING REPORT

The Director of Finance confirmed that all matters had been included on the agenda where required, adding that SLA fines would be included in the SLA contract report going forward and item 6 to be carried forward to February.
FIC15/113  FIC ANNUAL WORKPLANNER

The Director of Finance reported that the all the workplan items were on the agenda other than Costing & SLR where there was currently nothing to report, this item will be carried forward to the February 2016 meeting.

FIC15/114  ASSURANCE FRAMEWORK & RISK REGISTER REVIEW

The Director of Finance presented the report, referring to annex B which identified key financial risks. He advised the Committee that he had updated the register to include the Trust’s liquidity position but considered that there were no changes which required amendments to the current scores of the 3 key risks, 1953, 1954 and 2420. Graham Coles noted the recommendation and informed the Committee that the scores of these key risks would be reviewed again at the end of the meeting.

The Committee agreed to review the ratings at the end of the meeting and noted that there were no other issues to report.

FIC15/115  REPORT FROM SUB GROUP – CAPITAL WORKING GROUP

The Director of Finance presented the report, highlighting the process for the approval of the 15/16 capital programme and the key projects included in the programme. He reported that the majority of the year to date plan had now been completed and that the final quarter included a contingency of approximately £100k.

The Committee then discussed how equipment needs were assessed, it was noted that a replacement programme is in place but that emergencies such as the endoscopy washer fire could not be predicted. The Director of Finance updated the Committee on the current plans for endoscopy, outlining the changes from the original requirement of a 3rd room in the 15/16 programme to the current needs for a 3rd and 4th room that were deferred to the 16/17 capital programme. Adding that additional capacity was being provided by Vanguard until the capital works had been completed. The Committee then discussed the implications of the fire and the subsequent insurance claim.

The issue of the need for emergency capital funding was discussed further, with the Director of Finance indicating that there were capital schemes that could be delayed in the event of an emergency. It was noted that there was a gap between the funding required for future capital expenditure across all categories of spend and the funding available, and that the land sale was a possible source of additional funding.

The Committee noted the report.

FIC15/116  SLA CONTRACTS UPDATE

The SLA Contracts Lead presented this report and referred the Committee to section 9, noting that the trust had received 14 contract performance notices relating to A&E, cancer and diagnostics.
The relationship with the CCGs was discussed, with the Director of Finance acknowledging that whilst this had deteriorated during the year it was the result of the financial pressures on both sides. It was noted that the risk of a PbR contract increased with operational and performance failures and that the current issues should be considered when reflecting on the contract form for 2016/17. The Director of Finance then advised the Committee that sessions were to be held in the new year to review contract options for 2016/17, Graham Coles asked that an options paper be presented to the February committee meeting.

**Action:** Director of Finance to present 2016/17 SLA options paper to February committee.

The Committee then discussed emergency readmissions, highlighting the variance between the Trust’s view of the financial impact and that of the CCG and noting that there was no evidence of reinvestment. The Director of Operations added that the trust was able to demonstrate readmissions as a result of lack of community support. Catherine Dugmore then enquired as to the high level of unresolved challenges, the Associate Director of Performance responded that the figures were high due in part to delays by the CCG in resolving the challenges, adding that this would be incorporated into year-end settlement agreement. It was noted that the Director of Finance had met with Haringey CCG to start initial discussions around a settlement. The SLA Contracts Lead then updated the Committee on the issues surrounding the fines relating to duty of candour, advising that there was a difference of opinion but that the Trust was working to produce a solution going forward.

**Action:** SLA Contracts Lead to include financial values on Appendix 1.

The issue of LAS fines was then discussed, noting that the CCGs had not yet issued notices but they were aware of the issues. The Director of Operations informed the Committee that he was working with LAS to understand why the performance was deteriorating and looking at providing extra space for A&E handover to help improve the position. Graham Coles asked if this had been raised at Risk &Quality Committee, the Associate Director of Operations confirmed that general A&E performance had been discussed. It was agreed that this specific issue to taken to Part II of the Trust Board.

**Action:** Director of Operations and Director of Nursing to present a paper relating to the specific issues around A&E handover to Part II of the January Trust Board.

The Committee noted the report.

**FIC15/117 FIC POLICIES UPDATE**

The Deputy Director of Finance (FM) presented the report, she confirmed that all relevant policies were up to date and that no further action was required.

The Committee noted the report.

**FIC15/118 REVIEW OF SFIs AND SOs**

The Deputy Director of Finance (FM) presented the report, she advised the Committee that the only changes required to the SFIs and SOs were to update the reference to the Audit Commission. She then added that the paper would be taken to the January Audit Committee and the Trust Board for approval. The Committee had no further comments to make on the proposed changes.
The Committee noted the report.

FIC15/119 COMPREHENSIVE SPENDING REVIEW BRIEFING

The Director of Finance presented this report. He outlined how the £8bn additional funding would be released to the NHS, with £3.8bn frontloaded in 2016/17. He explained that £1.8bn of this would be allocated to a transformation fund to cover the provider deficit, adding that there was no detail as yet as to how this would flow to the trusts but that this would be discussed by the TDA. He also updated the Committee on recent tariff updates, with a net 1% tariff uplift being proposed and further detail expected by the end of December. The Committee also discussed better care fund and value based commissioning, with the Director of Operations explaining that both were still progressing slowly. The Committee agreed that a paper should be presented to Part II of the January Trust Board to outline key messages of the 2016/17 planning process, to include contract form and central funding streams available.

Action: Director of Finance to present key messages for the 2016/17 budget to the Part II of the January Trust Board

FIC15/120 FINANCE REPORT – MONTH 8

The Director of Finance presented the Month 8 Finance Report, outlining the revised format that replicates the new IPR. He informed the committee that the in month position was a small deficit of £276k, taking the year to date position to a £3.2m deficit, adding that the position continued to be supported by non recurrent benefits.

He then outlined the issues around SLA performance with fines having a significant impact on performance, noting that the pace of fines was increasing specifically in A&E. Other key issues that were driving the income position were readmissions, the NHSE marginal rate, access performance fines, most notably A&E, diagnostics and cancer 62 day wait. The Trust has remedial action plans with the Commissioners which are monitored to track progress.

The Director of Finance then reported that pay costs had increased as the Trust had taken on the sexual health service but that there had also been a net increase as the additional cost of new permanent staff had not been offset by a smaller than planned reduction in temporary staff.

The Committee then discussed the Executive process for managing QIPP delivery, noting that they were monitored through the Back on Track meetings. The Director of Finance added that given the current operational challenges the organisation did not focus enough on QIPP delivery. Graham Coles asked if the milestones were being managed, the Director of Operations responding that they were for larger schemes such as ambulatory care and Hospital at Home, and confirmed that all schemes were signed off by the director of Nursing for quality and safety. It was agreed that the 2016/17 QIPP target needed to be more realistic and that 2015/16 QIPPS included some one off benefits.

The Committee noted the Finance report – Month 8.
FIC15/121 OUTTURN FORECAST REPORT

The Director of Finance presented the report, updating the Committee on the mitigation projects and noting that both the nursing skill mix and e rostering papers were to be presented at the Workforce Committee. He explained the key graph on page 8 of the report, outlining the worst, likely and best cases which looked at the level of delivery of mitigations and a reduction in fines. He reported that the likely outturn was a £5m deficit, although this could easily deteriorate if actions weren’t taken. Graham Coles added that there had been no evidence that mitigation schemes were being delivered. The Director of Finance said that the Trust needed to focus on operational performance whilst pursuing the land sale and technical mitigations. The Committee discussed how the Trust could manage the operational issues and focus on finance too, specifically with winter approaching. The staffing and capacity issues in A&E were seen as a priority to resolve to then allow the executive and management teams to focus on other areas. The lack of cost control and lack of management capacity to deal with operational issues was seen as an issue that needed to be raised urgently by the Committee, with Graham Coles confirming that it would be discussed at the non-executive meeting the following day.

Action: Graham Coles to raise the issue of lack of cost control and management capacity to deal with operational issues at the non-executive meeting.

The Committee noted the report.

FIC15/122 TRANSFORMATION PROGRAMME UPDATE

The PMO Director presented the report, focussing on 2 specific projects. He gave the Committee an overview of the AEC, providing a background to how the unit had been operating and how the changes would take pressure off A&E. He explained the type of patient this pathway was aimed at, the potential savings and the link to the 2015/16 CQUIN. Catherine Dugmore felt that a visit to the AEC to see it in operation would assist in understanding how the pathway worked and where the benefits could be realised.

Action: The PMO Director to arrange a visit to the AEC for Catherine Dugmore and Graham Coles.

The PMO Director then gave an overview of the Outpatients project, which would commence in Q4 but was to be a significant project for 2016/17. He informed the Committee of the intelligent postal solution that was to be use to better manage bookings and reduce DNAs. It was noted that 2016/17 would be a challenging year and that the transformation programme should be geared up to support it.

The Committee noted the update.

FIC15/123 IMPROVING FINANCIAL DELIVERY PROGRAMME

The IFD Project Manager updated the Committee on the programme, informing them of the expansion of metrics provided and giving details of the back on track meetings which bring quality and finance together. She explained that attendance and representation by the CBU teams differed. She also gave the Committee an update on the changes within the finance department that allow the finance managers more time to concentrate on IFD issues. Outlining the current issues of endoscopy, e rostering and bed changes, with the key areas of focus for 2016/17 being reviews of pathways and productivity.
The Director of Finance added that benchmarking was being used to identify the areas to focus on, this involved working with operational colleagues to translate the findings into a work plan and with other trusts to identify best practice. The PMO Director explained how the PMO and IFD teams were working together with the CBUs to produce 2016/17 CIPs.

The IFD Project Manager then updated the Committee on a number of issues currently being addressed through this work, notably paediatric critical care income loss, poor income recording in CBU3 and the profitability of the phlebotomy service.

The Committee noted report.

FIC15/124 LAND SALE

The Director of Finance presented this report, giving an update of the process being followed to progress the land sale. He reported that the Trust had engaged Sweett to provide support in the production of an OBC for the January Trust Board followed by an FBC in February. He acknowledged the Trust Board discussions to date and recognised that the case would be required to provide opportunities for the Trust.

The Committee noted report.

FIC15/125 BUSINESS PLANNING

The Director of Finance outlined the key features for budget setting for 2016/17, noting that DH guidance was not yet published. Catherine Dugmore enquired about the Trust’s application to the TDA for cash support. The Director of Finance confirmed that discussions were underway with the TDA who were supportive of the need for revolving working capital and that this would be followed up with a request for permanent support if required.

The Committee noted report.

FIC15/126 CARTER REVIEW

The Director of Finance gave an overview of the work that the Trust had been involved in as part of the 2nd cohort of trusts contributing to the Carter review. This included submission of data and visits from the Carter team who were specifically interested in the Trust’s work around business intelligence. He reported that the initial report indicated that the Trust could achieve savings of £20m compared to the model hospital, also showing that the Trust was more efficient with an index of 93, this is in line with reference costs. It was noted that this report gave the Trust areas for focus and that the IFD team would lead on further work to identify savings opportunities.

The Committee noted report.

FIC15/127 LTFM REFRESH

The Director of Finance reported that this paper had been presented to the November Trust Board and was included in this agenda to allow for any further discussion. There were no questions and Graham Coles added that he understood the challenge faced by the Trust.

The Committee noted report.
The Committee agreed that the risks relating to the financial plan and savings should both remain at 25, they discussed if the risk relating to the SLA should remain at 20 or be increased to 25. Given the risk of volatility in the SLA income position and the need to raise this with the Trust Board, it was agreed that this risk be increased to 25.

It was agreed that the following items would be reported to the Trust Board; Risk rating for risk 1954 be increased to 25, the other 2 key risks to remain at 25. The Committee is concerned with the available capacity of the business is sufficient to address the issues currently faced.

None noted.

The next meeting of the FIC would be held on Wednesday, 24th February 2016 at 8.30am.

Meeting closed 11.05am
ITEM 7.4
WORKFORCE, EDUCATION & TRAINING COMMITTEE CHAIR’S REPORT
NORTH MIDDLESEX UNIVERSITY HOSPITAL
COMMITTEE CHAIRMAN ASSURANCE REPORT

<table>
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<tr>
<th>Committee Name</th>
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<tr>
<td>Committee chair name</td>
<td>Dalwardin Babu</td>
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Summary of key actions and decisions arising in Committee meeting

Workforce and Organisational Development

The committee received the workforce report and workforce risk register, which are standing assurance items on the committee’s annual planner.

The Committee received an assurance update on controls in place to manage bank and agency expenditure. The Director of Nursing will be presenting a further e-rostering update to the meeting in April in order to enable the committee to assess its effectiveness, specifically in relation to its impact on bank and agency usage.

The Committee noted the trust’s sickness absence was at 3.8%, and was informed an April update will be given of specific initiatives that are being put in place to address underlying issues within the Trust, including the Emergency Department, which was an outlier in terms of sickness rates and other workforce indicators.

The Committee reviewed the Workforce Race Equality Standard (WRES) update as well as the 2015/16 staff survey, which highlighted challenges in enabling compliance with the 5 WRES related questions where the Trust’s scores were below the national average.

The Committee was informed that this particular area would be reviewed by the Equality Impact Group, and a further update given as part of the staff survey action plan, which will be received in April 2016.

Education and Training

The Committee reviewed the assurances to support the HENCEL visit, which took place on 15th and 16th March 2016.

The risk register was also discussed at the meeting in detail, and actions were agreed for future monitoring at the April meeting.

Progress against delivery of annual work-plan:

The annual workplan is being achieved, and a further iteration will be presented for the 2016/17 period.

Assurances received from sub-committees:

Assurances were given from the following subcommittees:

- Medical Education Committee
- Undergraduate Education Committee
- Research and Development Committee
**Risk assurance update:**
The committee reviewed the top workforce and education risks. The committee will continue to monitor the implementation of the mitigations associated with these risks.

**Matters for escalation to the Board:**
None

**Matters for approval:**
None

**Recommendation to the Board:**
The Board is asked to note and receive the attached report and ratified minutes of the committee's February 2016 meetings, attached as appendix A and B
A meeting of the Workforce Committee was held on Wednesday, 16th December 2015 in Meeting Room 4, Trust Head Quarters, North Middlesex University Hospital NHS Trust (the “Trust”).

Present: Dalwardin Babu Non-Executive Director and Chair of the Workforce Committee  
Graham Coles Non-Executive Director  
John Carrier Chairman  
Helen Rushworth Director of HR  
Richard Gourlay Director of Operations  
Paul Reeves Director of Nursing  
Ray Conley Deputy Director of HR  
Paul Clay Head of Management Accounts (delegate for the Deputy Director of Finance)

WC 15/95 WELCOME  
Dalwardin Babu welcomed all present to the meeting.

WC 15/96 APOLOGIES  
Apologies were received from the Deputy Director of Finance, the Assistant Director of Organisational Development, the Assistant Director of HR and the Board Secretary.

WC 15/97 DECLARATION OF INTEREST  
There were no declarations of interest.

WC 15/98 MINUTES OF THE MEETING HELD ON 28TH OCTOBER 2015  
The minutes of 28th October 2015 were approved as a true and accurate record.

WC 15/99 MATTERS ARISING REPORT  
ITEM 1 WC 15/56 (ITEM 3.9 ANNUAL COMMITTEE SELF-ASSESSMENT): It was agreed that the Annual Committee self-assessment would be deferred to the next meeting.  
ITEM 2 WC 14/78 (ITEM 2.2 WORKFORCE STRATEGY DEVELOPMENT DISCUSSION): It was agreed that the Workforce Strategy would be deferred to the April meeting.  
ITEM 3 WC 15/33 (ITEM 3.2 DIVERSITY REPORT): In the absence of the Assistant Director of HR it was agreed to defer this item until the next meeting.

WC 15/100 COMMITTEE PLANNER  
It was agreed the planner would be reviewed and updated. It was agreed that, as far as possible, Committee meetings would not be scheduled during school holidays. The Director of HR and Board Secretary were tasked with reviewing the meeting schedule for 2016. The Committee noted the planner.  
Action: Director of HR/Board Secretary

WC 15/101 WORKFORCE RISK REGISTER  
The Deputy Director of HR referred the Committee to the circulated paper. The Trust’s ten highest-ranked workforce risks had been reviewed since the last meeting, as had their individual ratings. A new risk had been added to the register, namely ‘The Trust fails to engage with junior doctors and their representatives and fails to properly prepare for proposed industrial action by junior doctors’. The Deputy Director of HR confirmed that, although planned industrial action by junior doctors in December had been postponed, there remained a strong possibility further action
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could be taken in the new year. During the two months preceding the planned December industrial action close working relationships with local and regional BMA representatives - as well as the Trust’s junior doctors – had been developed. Steps had been taken to identify which services would be affected by planned industrial action and to mitigate this as far as was possible. The Deputy Director of HR confirmed that, should further industrial action be taken, the Trust would take similar steps and had laid the groundwork for constructive discussions with BMA representatives/junior doctors in future. In response to questions from the Chair and Chairman, the Deputy Director of HR confirmed that the Secretary of State still held the view that – should national negotiations on new terms and conditions of employment for junior doctors prove unsuccessful - a new contract would be imposed; similarly, the BMA still held the view that ‘all-out’ strike action could be taken in response to such a move. The Committee noted the workforce risk register.

WC 15/102 WORKFORCE REPORT

The Deputy Director of HR presented the workforce report. Highlighted issues included the Trust’s sickness absence rate, which stood at 3.49% as at November 2015 against a target rate of 3%. The Deputy Director of HR reiterated the steps being taken to manage sickness absence levels and the various stages in Trust procedures to secure improvements in absence rates. The Deputy Director of HR also highlighted the Trust’s TUPE-adjusted turnover figure of 16.3%; this was above the target rate of 15% but – as demonstrated in a paper submitted to the last Committee meeting – still compared reasonably favourably to other London Trusts. Discussions on vacancy and appraisal rates were deferred to items appearing later on the agenda.

Graham Coles asked if the workforce report could be presented in a format that mirrored the Trust’s IBP; the Deputy Director of HR confirmed this would be considered.

Action: Deputy Director of HR/Assistant Director of HR

The Committee noted that agency spend was decreasing in relation to bank spend. The Committee questioned the impact the nationally-imposed cap on agency rates was having at the Trust on agency usage and spend. The Head of Management Accounts confirmed that the cap was being introduced on a staged basis, and significant decreases in permitted agency spend would not fully impact until the new year. It was likely that imposition of capped agency rates would particularly impact on medical locum usage, not just at NMUH but also at most other Trusts. The Head of Management Accounts confirmed that breaches of the current capped agency spend limit were being reported (as required) to the TDA. To date, the Trust had not received any feedback from the TDA on its reported breaches. Similarly, to date, it was not apparent how agencies themselves intended reacting to capped rates. The Committee noted the Workforce Report.

WC 15/103 WRES UPDATE

In the absence of the Assistant Director of HR and Board Secretary this item was deferred to the next meeting.

Action: Assistant Director of HR and Board Secretary

WC 15/104 E ROSTERING ANALYSIS

The Director of Nursing presented an update to the Committee on the implementation of e-rostering within the Trust. The Director of Nursing confirmed that the Trust had a purchased system (from Allocate) and had identified resources
to support the implementation of the system. The Lead Nurse for Workforce had undertaken an audit of each of the Trust’s 66 clinical rotas, meeting with each of the officers responsible for the rotas, reviewing allocated shifts and identifying net hours either owed by or owed to staff. The vast majority of clinical areas were now fully operating an e-rostering system - A&E and Maternity wards were expected to be fully compliant by February 2016. The Director of Nursing confirmed that the Trust was considering migrating to a newer e-rostering version (V10) as the current version used would cease to be supported by Allocate at the end of March 2016.

In response to a query from the Chairman, the Director of Nursing confirmed that the Trust was complaint with the recommendation made by Lord Carter that all Trusts implement an e-rostering system. The Committee noted the assurance given that all clinical areas would be operating the Trust’s e-rostering system by the end of March 2016 and requested an update at the April meeting

*Action: Director of Nursing.*

The E Rostering analysis was noted.

**WC 15/105 JUNIOR DOCTORS MONITORING UPDATE- ACTION PLAN**

The Director of Operations confirmed that the next junior doctor monitoring exercise will be conducted in January 2016. Given national discussions on junior doctor terms and conditions it was likely the next exercise would be the last in its current format. The Trust was again doing all possible to reduce the risk of breaches in the next monitoring round. CBU’s had been working with the Trust’s Medical HR Manager to identify all rotas and those staff working on these rotas. Templates were being produced to record any doctor claiming to work beyond rostered requirements and these would be contemporaneously challenged. Diary monitoring will be closed two days after the final monitoring dates to deter late recording by junior doctors. The Director of Operations confirmed that the action plan presented to previous Committee meetings will continue to be implemented. The verbal update was noted.

**WC 15/106 JUNIOR DOCTOR’S MONITORING NEGOTIATIONS**

The Deputy Director of HR confirmed that negotiations with the BMA on reaching a mutually satisfactory settlement to the monitoring exercise conducted in June/July 2015 were on-going. Five rotas monitored had the potential to attract higher banding payments than allocated, and the Trust was seeking to agree a level of payment with the BMA which would negate the need to dispute these outcomes at Banding Appeals and/or Employment Tribunals. The Deputy Director of HR stated he was confident a settlement could be reached which would significantly reduce the financial liabilities faced by the Trust as a result of this last monitoring exercise. The Committee requested that an update be given at the next meeting. The verbal update was noted.

**WC 15/107 STAFF ENGAGEMENT STRATEGY**

The Director of HR presented a paper highlighting the actions taken since the last Committee meeting to implement the Trust’s Staff Engagement and Experience Action Plan. The Director of HR stated that the purpose of these actions was to produce a better motivated and committed workforce in order to reduce the number of staff leaving the Trust each month. The Committee congratulated the Director of HR on the range of initiatives that had been implemented and the positive impact these were having. The Director of HR highlighted that the majority of the actions in the Plan had now been implemented; as such, together with the Assistant Director of Organisational Development, she intended rewriting the Staff Engagement and
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Experience Strategy, with specific emphasis on addressing long-standing cultural issues within the Trust. The Director of HR confirmed the updated Strategy would be submitted to the April meeting.

Action: Director of HR/Assistant Director of Organisational Development

The Staff Engagement strategy was noted.

WC 15/108 RECRUITMENT STRATEGY AND ACTION PLAN UPDATE

The Deputy Director of HR presented an update on implementation of the Trust’s recruitment action plan. He specifically highlighted the increase in the Trust’s staffing establishment since 1 April 2015 (that is, newly created vacancies since this date) and benchmarking information demonstrating the success of the Trust’s recruitment plan when compared to other London Trusts. He accepted that the Trust target of a 5% vacancy rate by 30 September had not been met and acknowledged the need to continue to focus on reducing the number of vacancies within the Trust in order to contribute to a reduction in bank and agency spend.

The Committee commended the recruitment team on the significant progress made in increasing the number of staff employed by the Trust since 1 April and in reducing the vacancy rate. However, it was noted that the 5% vacancy rate set by the Trust was a particularly challenging target and, as such, the successes of the Trust in addressing its recruitment issues were not being reflected when measured against the internally-set 5% vacancy target rate. The Committee urged the Trust to review its target vacancy rate and to set a target which challenged and stretched the recruitment team and recruiting managers whilst still remaining achievable. The Committee also asked that benchmarked data be considered when setting challenging/achievable workforce targets.

In response to a question from Graham Coles, the Deputy Director of HR stated that data/KPIs on the Trust’s recruitment processes would be submitted to the next meeting.

Action: Deputy Director of HR

The Committee noted the Recruitment Strategy and Action Plan Update.

WC 15/109 APPRAISAL UPDATES

The Director of HR provided an update on progress made in achieving the Trust’s appraisal compliance target of 80%. Compliance at the end of November stood at 72.6%; at the time of the Committee meeting it stood at 77.6%. There was variable progress amongst CBUs; remedial action (as detailed in the paper submitted) would continue to be taken in order to achieve the target rate. The Appraisal update was noted.

WC 15/110 NHS CONSTITUTION COMPLIANCE ASSURANCE

The Deputy Director of HR presented a paper assuring the Committee that the Trust complies with Part 4 of the NHS Constitution – ‘Staff – Your Rights and NHS Pledges to You’. The NHS Constitution compliance assurance was noted.

WC 15/111 HR POLICY UPDATE

The Assistant Director of HR provided an update on the following policies:

- Career Break Policy
- Dignity at Work policy and procedure
- Disciplinary Policy and Procedure
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- Personal & Family Relationships

The Committee raised two queries on the Career Break Policy – it was requested that an appeal mechanism be included in the policy (should a request for a career break be denied) and that guidance be provided on the superannuation implications for both the Trust and the individual concerned should a career break be granted. The update was noted.

WC 15/112 POLICY APPROVAL
The Committee considered the following policies:

- Career Break Policy
- Dignity at Work policy and procedure
- Disciplinary Policy and Procedure
- Personal & Family Relationships

The above policies were approved subject to the amendments to the Career Break Policy detailed above.

WC 15/113 MATTERS TO REPORT TO THE BOARD
It was agreed to escalate the Trust’s breaches of the agency cap to the next Board meeting.

WC 15/114 ANY OTHER BUSINESS
None

WC 15/115 DATE OF THE NEXT MEETING
The next Committee meeting was scheduled for 24th February 2016 at 11.00am in meeting room B, Ground Floor, Trust HQ
A meeting of the Education and Training Committee was held on 16th December 2015 in Meeting Room 4, Trust Head Quarters at 15.35pm.

Present:  
Dalwardin Babu  Non Executive Director and Chair  
John Carrier  Chairman  
Helen Rushworth  Director of Human Resources  
Paul Reeves  Director of Nursing  
Jacqueline Dudley  Assistant Director for Medical Education and Development  
Nicholas Rollitt  Director of Postgraduate Medical Education  
Edward Webb  Head of IT Services

In Attendance:  
Diane Odling-Smee  Interim Director of Education  
Sampson Duah  Education & Learning Lead (Career Pathways)  
Stephanie Marfo  Trust Board Secretarial Assistant (Minutes)

ETC15/80 WELCOME  
The Chair welcomed all present to the meeting, introductions.

ETC 15/81 DECLARATION OF INTERESTS  
The Chairman stated his interest as the Chair Obs& Gynaecology, Speciality Advisory Group London.

ETC 15/82 APOLOGIES FOR ABSENCE  
Apologies were received from Jonathan Ainsworth, Research and Development Director, Molly Clark, Board Secretary, Janet Saldiray, Assistant Director of Organisational Development and Elizabeth Maposa, Associate Director for Multi-Professional Education and Training. Paul Maxwell, Undergraduate Sub-Dean was absent.

ETC 15/83 MINUTES OF THE MEETING HELD ON 28TH OCTOBER 2015  
The date on first page of the minutes should read Wednesday 28th October 2015 and the meeting location should read room B, these errors would be corrected. Subject to the above the Committee approved the minutes of the meeting held on 28th October 2015 as a fair and correct record of events.

ETC 15/84 MATTERS ARISING REPORT  
The Chairman took the Committee through the report.

Item 1-ETC15/30 Research and Development Report including R&D Ethical Compliance would be deferred till February.

Item 2ETC15/59 Undergraduate Education Committee the Undergraduate Sub Dean was using ‘What's App’ to communicate with undergraduates on this matter. It was agreed the matter could be closed.

Item 3ETC 15/68 Committee Planner the updated planner focused on governance and current issues in education which the Trust needed to address and was on the agenda as was Item 4ETC 15/69 Education and Learning Update.

Item 5ETC 15/69 Education and Learning Update had been incorporated into item 3.3 on the agenda.

Item 6ETC 15/69 Education and Learning Update it was agreed that these would be reviewed by the February 2016 meeting.

Item 7 ETC 15/69 Education and Learning Update and Item 8ETC 15/69 Education and
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Learning Update had been completed, the matters could be closed.

Item 9ETC15/72 Report on Undergraduate Education the Occupational Health Manager had reviewed the query raised and was satisfied that the policy was in line with legislation. The provision queried had been misunderstood/misinterpreted. The matter could be closed. The Committee wanted to ensure that the Undergraduate Sub Dean who had raised the query was aware and assured.

Item 10ETC15/74 Medical Education Committee (MEC) new planners had been devised and the requested information would be brought to the Committee in February 2016 (the meeting scheduled for 1st December 2015 had been cancelled due to the junior doctors strike).

Items 11ETC15/76 Undergraduate Education Committee, Item 12 ETC15/75 Research and Development Committee, Item 13 ETC15/76 Undergraduate Education Committee would all be brought to the Committee in February 2016.

Item 14ETC 15/45 Risk Register, there was no further risks to add, therefore the matter could be closed.

Item 15 ETC15/32 Report on Undergraduate Education an update would be brought in February 2016.

Item 16 ETC 15/06 Laparoscopic Surgery Training – Risks, Rewards & Resources at NMUH Presentation this had been resolved by the creation of a temporary simulation suite onsite in the West Rotunda. Though the facility was not currently used for debriefing it had the capacity to be used for that purpose. Two rooms had been set up with videoconferencing facilities stated the Assistant Director for Medical Education and Development and though this was not a long time solution the interim fix worked well. It was agreed that this item could be closed.

Item 17 ETC 15/47 Update on Bands 1-4 Development & Work Placement this item had been deferred to the Workforce Committee. The Director of HR advised the Committee that the Trust did not currently have systems which could generate the information requested. Consequently the matter was closed.

The Chairman queried Item 22 ETC 15/45 Risk Register, it was confirmed that the GMC publish current conversations of concerns on their website. The Completed actions were noted.

The Committee duly noted the matters arising report.

ETC 15/85 COMMITTEE PLANNER
The revised planner was noted and approved.

ETC 15/86 NURSES REVALIDATION
The Nursing and Midwifery Council had agreed the new requirements that nurses and midwives must meet to renew their registration every three years. From December 2015 registrants would need to show they:

- Had completed the required hours of practice (450 over 3 years or 900 if dual registered), it was clarified that this related to the registrants current role, whether clinical or managerial.
- Had completed learning activity through CPD (35 hours, 20 of which must be participatory), the Chairman queried how social media would be used to meet CPD requirements, it was explained that there were a number of social media sites containing pages which were very renowned. The Chair wanted to ensure that patient confidentiality was not breached in fulfilling CPD requirements, this was confirmed. The Education & Learning Lead (Career Pathways) stated that items
listed in section 6 of the report were suggestions not stipulations. The Director of Nursing confirmed that guidance would be provided to staff.

- Had evidence of reflection on the CPD, code or feedback. The Assistant Director for Medical Education and Development advised the Committee that the GMC provided stringent training to their revalidation appraisers on ‘good’ CPD; this approach was viewed favourable. The Director of Nursing informed the meeting that a Professional development nurse would consider whether revalidation documentation provided constituted ‘good’ CPD. It was also considered important to ensure that sign offs occurred with staff skilled in the area that the registrant was seeking to revalidate i.e. clinical/managerial.
- Had sought and received practice related feedback from 5 sources
- Third party confirmation - had received confirmation from someone ‘well placed to comment on their fitness to practice,’ the Chairman also queried the confirmation, as registrants could most likely pick their validator. The Director of Nursing would examine whether the registrants line manager was the most appropriate person.

Information on the revalidation process had been placed on the Trust intranet and workshops had been run across the Trust.

The Director of Nursing had already written to nurses and midwives on site who would need to revalidate by April 2016. HR were operating a database to informed the Corporate nursing team of expiring registrations. The Corporate nursing team would then write to effected staff a few months prior to their revalidation date.

Failure to revalidate would result in a loss of registration and it could take up to six weeks to regain registration. There was also a risk that some nurses/midwives would not be revalidated. It was agreed that a report on the effect to the Trust workforce, both in terms of nurses/midwives who failed to meet the revalidation criteria and those who allowed their registration to lapse should go to the next Workforce, Education and Training Committee.

*Action:* Professional Development Lead Nurse

**ETC 15/87 QUALITY VISIT**

The yearly educational quality visit by Middlesex University in collaboration with City and Hertfordshire Universities took place in April 2015 explained the Education & Learning Lead (Career Pathways). 11 areas of practice were reviewed, whilst feedback overall was positive, the quality audit identified areas of ongoing development:

- Staff completing triennial reviews (three yearly reviews)
- Attendance at mentorship updates to be monitored, the Education & Learning Lead (Career Pathways) confirmed that mentors were now attending and the link lectures were supporting the workshops regularly.
- Development of future sign off mentor numbers. The Trust currently had 148 sign off mentors who had been signing off student nurses at the end of their training as per NMC guidelines, the reviewers were concerned that there were not enough mentors in some areas, however, after further consideration and review it was agreed that there were enough. Further work to prepare additional sign off mentors was being conducted with link mentors. In Midwifery there have been an introduction of a single assessment tool to support student appraisals. Following a query from the Chairman, the Education & Learning Lead (Career Pathways) clarified the training received by students to manage the change from theoretical nursing to practical nursing.

The Trust received high levels of feedback from students, which were positive overall. However, some of the concerns raised were around less mentoring time due to staff shortages and student nurses feeling as though they were being treated as Healthcare Assistants. The Education & Learning Lead (Career Pathways) informed the meeting that there had been ongoing recruitment activities including the appointment of additional Healthcare Assistants to remedy some of these concerns.
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The Education & Learning Lead (Career Pathways) informed the meeting that he had run Friday sessions (open forum) to meet students, for teaching sessions and to obtain feedback and these session had been well evaluated.

The Education & Learning Lead (Career Pathways) was thanked for his time and left the meeting.

The Committee noted the report.

ETC 15/88 RISK REGISTER

The Committee noted that many of the risks would be discussed during the meeting.

RISK ID3240 Adverse impact on trust following A&E conversation of concern, the review commissioned of clinical concerns raised by the junior doctors before the quality visit had been postponed till 12th January 2016. The Chairman queried the work conducted by John Launer, he was informed by the DPME that the Trust was awaiting his report, but that junior doctors had not reported any further incidents of bullying since November 2015.

RISK ID2597 Junior Doctors workforce concerns, the vacancies had been advertised and a number of posts had been recruited to. Health Care assistants were also going to be recruited. It was suggested that this risk be reduced to 12.

RISK ID1737 Clinical Leaders development, no such programme existed, it was suggested that the risk be removed.

RISK ID2413 Staff and mandatory training compliance, this item was on the agenda and would be discussed during the course of the meeting.

RISK ID 2808 Staff unable to complete e-learning courses due to compatibility issues, this would be discussed during the course of the meeting.

RISK ID2539 Failure to meet the standards and requirements of the IG Toolkit, this matter had been addressed, the risk could now be closed.

RISK ID 2997 Failure to Develop Education and Learning Centre, the smaller renovations were being conducted, and the long term issues were being considered.

RISK ID1733 Research, teaching and education investment, further information on this risk would be requested from the Research and Development Director.

RISK ID 1773 Inadequate Major Incident and Business Continuity Training & Exercising, the training was in progress, the programme started in July 2015 and was ongoing.

The Chair requested that the risk register be updated and made available to the visitors, if needed.

The risk register was received and noted by the Committee.

ETC 15/89 QUALITY ASSURANCE AND QUALITY MANAGEMENT OF POST GRADUATE MEDICAL EDUCATION

The Assistant Director for Medical Education and Development explained that the Trust wide and speciality Quality visit would now take place on 11-12th January 2016 and consider the GMC set of revised standards within Promoting Excellence. The Trust would be assessed against these standards and the HENCEL combined action plan, which was continuously under review by the Trust and HENCEL. The summary of action plan compliance was presented to the meeting and had been RAG rated in the five key areas. The Assistant Director for Medical Education and Development would summit the Combined action plan to HENCEL on 18th December and anticipated that a number of actions would be closed.

The Chair requested assurance that there were clear lines of accountability for actions contained within the summary, the DPME confirmed that this was the case. The interim Director of Education explained that each speciality had tutors responsible for meeting the training and servicepoints set out in the action plan, though she pointed out that some were more responsive than others.
The Chair wanted assurance that staff were being supported to deliver the action plan, that the work undertaken would improve training at the Trust and protect its reputation. The interim Director of Education stated that the Trust had strengthened its governance arrangements within the local faculty/sub groups. Where there were any issues identified in implementing the action plan, these issues were to be escalated to the CBU performance meetings. The DPME stated that a trainees' experience was a subjective matter. However, measures had been taken to ensure that issues identified had been addressed, which it was hoped would constitute to a better training environment. Efforts had been made to listen to the trainees concerns. The Trust had held drop in sessions and provided information to trainees on wards of local lines of escalation (these would be re-emphasised in light of upcoming winter pressures). Every effort had been made to address points raised in A&E and the progress against the action plan and improvement in environment were commended.

The Education leads would meet with the visit team and make a presentation showing the improvements and detailing areas for further improvement. The Director of HR asked whether the DPME was providing assurance that the Trust had progressed within reasonable expectation since the last quality visit, this was confirmed. She then requested more information on where the risks were, and confirmation of the systems in place to mitigate the risks identified. The DPME confirmed that the Trust had considered the previous action plan, devised measures to meet the plan and implemented them; this evidence would be submitted to HENCEL on 18th December 2015. He stated that there were areas where there were remaining concerns including workload, handover and in one of the specialties, trainees were routinely unable to attend regional teaching due to the demands of their rota. The other specialty where ongoing issues had been identified was potentially Obstetrics and Gynaecology. The DPME confirmed that he had received no additional comments about bullying or harassment in the Trust since this was highlighted in the November 2015 A&E action plan. Survey monkey questionnaires had also been given to trainees to allow the Trust to better understand any issues.

The issues were considered dual faceted and included, patient safety concerns (trainees had stated that they received little feedback when they raised concerns). The second facet was the bullying and harassment claims which needed to be investigated separately and was a Trust wide issue. £300,000 had been provided for training to support Anaesthetics and Critical care. This included training for 20 nurses to attend an ITU course. The ‘upskilling’ of current A&E middle grades was also taking place.

In Surgery steps had been taken to improve workload and consideration was being given as to how the Trust could provide surgical trainees with more theatre exposure, which was a primary concern of the trainees following discussions with the Surgery Educational supervisor. The Chairman asked whether the surgical trainees ARCP’s were effected, the Assistant Director for Medical Education and Development stated that trainees caught up on any time missed and that trainees obtained a wide range of experience.

Following a query from the Chairman, the DPME confirmed that the visitors would provide broad comments within their report, but would give any items for immediate action to the Trust swiftly after the visit. The Director of HR stated that these actions would then be provided to the relevant Executive. The Executive would also be available to provide responses where needed.

The Trust approach to the visitors during the upcoming presentation was discussed. The interim Medical Director suggested that the Trust should be acknowledged it was busy but go on to view this as a challenge which it was prepared to meet and excel in. After some discussion, it was agreed to reference the need for library refurbishment in the presentation.

The Chair asked for any additional support to be communicated to the Committee. He wanted tutors to be more responsive and have clear lines of escalation. The interim Medical Director suggested that the Chair write to the Executive Board to ask the training leads to
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engage with this matter. The Executives present would raise it with the other CBU leads and demand assurance that the department are prepared for the visit.

Action: Chair

The Director of HR requested advice from the interim Medical Director, he advised the department to be open, honest and state the deficiencies wherever they exist, particularly the A&E issues, the Chair agreed.

The interim Director of Education confirmed that they were preparing a presentation. The interim Medical Director agreed to work with the interim Medical Director and the DPME on the presentation. The interim Medical Director suggested that the Chief Executive, the Director of Finance and the Medical Director attend the visitor’s presentation. It was suggested that the consultants and Educational supervisors also attend. It was agreed that invites be sent, subject to discussions with the visit team.

Action: DPME

A brief would also be prepared for the Executives.

Action: Interim Director of Education

The Chair thanked the Interim Director of Education, the Assistant Director for Medical Education and Development and the DPME for their efforts.

The Committee noted the Quality Assurance and Quality Management of Post Graduate medical education report.

ETC 15/90 MULTI PROFESSIONAL EDUCATION AND LEARNING UPDATE

Overall compliance declined by 1%, in November 2015. The decline in compliance was apportioned to staff transfers from which the training records had yet to transfer (issue escalated to IBM) and a number of current staff training requiring renewal. Environmental Services compliance rates continued to improve during the period.

The Education and Training department were now targeting specific staff group, with low compliance. Compliance of Registrars and consultants were particularly low and would be passed onto the interim Medical Director.

The subjects with the lowest compliance rates were Information Governance, Infection, Prevention Control, Fire Safety and Moving and Handling. The department were to extend opening hours in the Learning Centre. Resuscitation training was particularly low and a recovery plan was being implemented to improve compliance rates.

There was a robust plan in place to improve the Trust compliance rate to 90%, the department were confident in the plan and related the details and challenges in trying to attain 90%. The team were considering implementing mobile E Learning, it was agreed that a cost analysis be conducted.

Action: Associate Director for Multi-Professional Education and Training

The interim Director of Education was concerned about accessing E Learning on wards, there was some discussion around whether internet access could be restricted to E Learning usage. The Head of IT stated that the internet could not be restricted in this manner.

The interim Director of Education congratulated the department on achieving the London Streamlining standard for achieving a Trust wide training rate of 80%. The Trust’s training improvements were recognised and applauded.

The HENCEL training needs analysis process for 2016/17 cycle would take place early next year and the department had begun the process of gathering information on the learning needs for staff at all bands. It would be updated against the Trust training plan.
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The Committee noted the Multi professional education and learning update.

ETC15/91 EDUCATION STRATEGY UPDATE
The interim Director of Education provided the update, the strategy was starting to be embedded and followed the Committee’s receipt of the Education strategy and delivery plan in July 2015. An Education strategy delivery group had been established; the group had met and agreed the Terms of reference. The revised structure was detailed in the paper and was part of improving the departments governance structure. Site reviews had been conducted and some minor adjustments were being made including the carpet in the Library. However, there was currently insufficient funding. It was agreed to obtain costings for the carpet.

Action: Interim Director of Education

The Committee noted the report.

ETC15/92 STRATEGIC DEVELOPMENT PLAN FOR LIBRARY SERVICE AT NORTH MIDDLESEX UNIVERSITY HOSPITAL
The interim Director of Education was scheduled to speak with Paul Ayris in January to discuss the managed services. The Committee were informed that the UCL option did not included any capital expenditure. The department had been eager to take up the service if the cost was within budget, but the cost greatly exceeded the current budget. The plans for development if the Library facilitated would be considered against the budget for the coming year.

The services offered by the UCL managed service were related to the Committee, the importance of ensuring that it was cost effective was emphasised. All acknowledged that the library was in need of an upgrade. The inability for students to use London university hospital library facilities was discussed; the Chairman requested that this be checked.

Action: Interim Director of Education

The Chair stated that any service offered need to be affordable, the costings needed to be drawn up. The Director of HR was concerned that the Trust would be criticised for not completing this action, this item would now need to be withdrawn from the Trust action plan. The department had also lost the Head librarian which effected the service offered.

The Committee noted the report.

ETC15/93 EDUCATION & TRAINING POLICY/STRATEGY UPDATE
The policy’s list would be reviewed in time for the meeting in February 2016.

ETC15/94 POST GRADUATE MEDICAL EDUCATION COMMITTEE (MEC)
The meeting had been cancelled due to the junior doctors strikes scheduled for 1st December 2015. A meeting would be held in January 2016. The difficulty in receiving reports from various departments was highlighted to the Committee.

The Committee noted the Medical Education Committee report.

The Head of IT left the meeting.

ETC15/95 RESEARCH AND DEVELOPMENT COMMITTEE
The report was taken as read and the Committee noted the Research and Development Committee report.

ETC15/96 UNDERGRADUATE EDUCATION COMMITTEE
The Assistant Director for Medical Education and Development gave apologies for the Undergraduate Sub Dean, she confirmed that there had been no meeting since the Committee’s September 2015 meeting. The report confirmed that the mock OSCE final year student examinations had gone well. The Group were currently awaiting feedback from a
ITEM 7.4 – APENDIX B MINUTES

UCL Medical School visit. It was noted that the lack of WIFI in the Trust Education facilities had been cited as a cause for concern during the visit.

ETC 15/97 MATTERS TO REPORT TO THE BOARD
The Committee agreed to highlight the Quality visit scheduled for 11-12th January 2016 and their support for a letter to the Executive Board.

ETC 15/98 ANY OTHER BUSINESS
There was no other business raised by members.

ETC 15/99 DATE OF NEXT MEETING
The date of the next meeting would be 24th February 2016 between 11.00am-2.00pm.

The meeting closed at 17.16.