

## Board of Directors Part One

**Agenda and papers**  
of a meeting to be held in public

2.00pm–4.30pm  
Tuesday 25<sup>th</sup> July 2017

Lecture Theatre,  
Tavistock Centre,  
120 Belsize Lane,  
London, NW3 5BA



## BOARD OF DIRECTORS (PART 1)

Meeting in public  
Tuesday 25<sup>th</sup> July 2017, 2.00 – 5.00pm  
Lecture Theatre, Tavistock Centre, 120 Belsize Lane, London NW3 5BA

### AGENDA

PRELIMINARIES				
1.	<b>Chair's Opening Remarks</b> Prof Paul Burstow, Trust Chair		Verbal	-
2.	<b>Apologies for absence and declarations of interest</b> Prof Paul Burstow, Trust Chair	To note	Verbal	-
3.	<b>Minutes of the previous meeting</b> Prof Paul Burstow, Trust Chair	To approve	Enc.	p.1
3a.	<b>Outstanding Actions</b> Prof Paul Burstow, Trust Chair	To note	Enc.	p.7
4.	<b>Matters arising</b> Prof Paul Burstow, Trust Chair	To note	Verbal	-
REPORTS				
5.	<b>Service User Story</b> FNP Patient – video story	To note	Verbal	-
6.	<b>Service Line Report: Family Nurse partnership (FNP)</b> Ms Ailsa Swarbrick, Family Nurse Partnership Director	To discuss	Enc.	p.8
7.	<b>Trust Chair's and NED's Reports</b> Prof Paul Burstow, Trust Chair	To note	Verbal	-
8.	<b>Chief Executive's Report</b> Mr Paul Jenkins, Chief Executive	To discuss	Enc.	p.17
9.	<b>STP Revised Narrative</b> Mr Paul Jenkins, Chief Executive	To discuss	Enc.	p.42
10.	<b>a. Board Assurance Framework</b> <b>b. Risk Register</b> Mr Terry Noys, Deputy CEO and Finance Director	To approve	Enc.	p.125 p.154
11.	<b>Fire Safety Review</b> Mr Paul Jenkins, Chief Executive	To note	late	-
12.	<b>a. Workforce Race Equality</b> Mr Craig de Sousa, Human Resources Director  <b>b. Draft Race Equality Standard</b> Ms Louise Lyon, Director of Quality and Patient Experience	To approve  To discuss	Enc.	p.170  p.177

13.	<b>Performance and Quality Reports</b> Ms Louise Lyon, Director of Quality and Patient Experience & Ms Marion Shipman, Associate Director, Quality & Governance <ul style="list-style-type: none"> <li>• Quality Quarterly Report</li> <li>• Dashboard Quarterly Report</li> <li>• Waiting Times Quarterly Report</li> </ul>	To discuss	Enc.	p.204  p,207 p.216 p.231
14.	<b>IMT Quarterly Report</b> Mr David Wyndham-Lewis, Director of IM&T	To discuss	late	-
15.	<b>Responsible Officer's Annual Revalidation Report</b> Dr Rob Senior, Medical Director	To approve	Enc.	p.258
16.	<b>Finance &amp; Performance Report</b> Mr Terry Noys, Deputy CEO and Finance Director	To note	Enc.	p.262
17.	<b>Training and Education Report</b> Mr Brian Rock, Director of E&T/ Dean	To note	Enc.	p.269
<b>CLOSE</b>				
18.	<b>Notice of Future Meetings:</b> <ul style="list-style-type: none"> <li>• 12<sup>th</sup> September, Directors' Conference, 2.00 – 5.00pm, Lecture Theatre</li> <li>• 25<sup>th</sup> &amp; 26<sup>th</sup> September, Board Away Day</li> <li>• 26<sup>th</sup> September, Board of Directors' Meeting, 2.00-5.00pm, Lecture Theatre</li> <li>• 10<sup>th</sup> October, Joint Boards Meeting, 2.00 – 5.00pm, Lecture Theatre</li> <li>• 31<sup>st</sup> October, Board of Directors' Meeting, 2.00 – 5.00pm, Lecture Theatre</li> </ul>			

**Board of Directors Meeting Minutes (Part One)**  
Tuesday 27<sup>th</sup> June 2017, 2.00 – 4.30pm

<b>Present:</b>			
Prof. Paul Burstow Trust Chair	Dr Chris Caldwell Nursing Director	Ms Helen Farrow NED	Ms Jane Gizbert NED
Dr Sally Hodges Director of CYAF	Mr David Holt NED, SID, Audit Chair	Mr Paul Jenkins Chief Executive	Ms Louise Lyon Director of Q&PE
Mr Terry Noys Deputy CEO and FD	Mr Brian Rock Director of E&T/ Dean	Dr Rob Senior Medical Director	Dr Julian Stern, Director of AFS
<b>Attendees:</b>			
Terri Burns Trust Company Secretary	George Wilkinson Governor	Paul Dugmore Portfolio Manager, Social Care, Leadership and Management (items 5 & 6)	Errol Henry D55 Student (item 5)
Amanda Hawke Complaints Lead (item 14)	David Wyndham-Lewis Director of IM&T (item 16)		
<b>Apologies:</b>			
Prof. Dinesh Bhugra NED	Ms Edna Murphy NED		

**Actions**

AP	Item	Action to be taken	Resp	By
1	3	Amendments to the minutes of the previous meeting	TB	Immed.
2	10	Share E&T recruitment forecasting model with the Board	BR	Jul 17
3	11	Amendments to the Board objectives as noted	PJ	Jul 17
5	12	Safeguarding Strategy to be presented to the Board	RS	TBC
6	13	Q2 Complaints report to be presented to the Board	AH	Sept 17

**1. Chair's Opening Remarks**

1.1 Prof. Burstow welcomed the directors to the meeting.

**2. Apologies for Absence and declarations of interest**

2.1 Apologies as above.

2.2 No further declarations of interest were made.

**3. Minutes of the Previous Meeting**

3.1

**AP** The minutes of the meeting held on 23<sup>rd</sup> May 2017 were approved, subject to the following amendments:

- Prof. Burstow to provide an amended minute for item 7
- Mr Rock to provide an amended minute for item 12
- AP7 to be removed
- Minor typographical errors

### **3a. Matters arising**

- 3a.1 Dr Senior noted that, in relation to AP3, an audit of cases had been carried out and there were no other high risk cases that had been managed inappropriately. He also noted that there was evidence of very good practice by the clinician concerned otherwise.
- 3a.2 Dr Senior reported that, in relation to AP9, it would be some time before the Trust was able to report satisfactory compliance with mandatory training levels for clinical risk. This was being reviewed by the CQSG and plans being put in place to address the issues.
- 3a.3 Mr Noys reported that, in relation to AP6, planning permission would expire in March 2018 and that the Trust was in the process of applying for it to be renewed.

### **4. Matters Arising**

- 4.1 No matters arising were raised.

### **5. Service User Story - Student**

- 5.1 Mr Errol Henry, a student, attended the meeting to speak to the Board of Directors about his experiences of studying at the Trust. My Henry was studying on the D55 course and had previously undertaken D60 at the Trust. He had a previous relationship with the Trust via supervision.
- 5.2 Mr Henry stated that the one key improvement he would like to see was the building at the Tavistock Centre and the level of connectivity and IT available for students. It could be difficult to find available rooms and they sometimes appeared shabby. Overall he found the staff at the Trust to be supportive and knowledgeable, particularly the library staff. There was an expectation of learning and producing high quality work, but without intense pressure put on students. Staff made time to meet with students and assure them whenever needed.
- 5.3 Mr Henry stated that the way he was treated at the Trust had a positive impact on the way he treated others himself. It was reassuring and fed directly into his own practice. It highlighted the importance of relationships in the Trust. In relation to his course, Mr Henry felt that more could be done to create connections between peers as group relations did not feel as though it went far enough in doing so. Mr Rock noted that the Trust was reviewing how best to develop peer to peer work.
- 5.4 The board asked whether Mr Henry found that the learning was practical and applicable in the real world. Mr Henry felt that changing the ethos around supervision would be a useful way to ensure this happened more as, in social work in particular, there was less time to review how theory could be applied to real life situations. Ring fencing time for supervision so that it became more embedded into front line practice would also be beneficial.

5.5 Prof. Burstow thanked Mr Henry for his time and insightful contributions.

## **6. Service Line Report: DET Social Care, Leadership & Management**

6.1 Mr Dugmore reported that it had been a very busy and challenging year for the team. He acknowledged the hard work of his colleagues. There was a risk regarding recruitment of social workers to the Trust, as many were qualifying with a masters and so were less likely to study at the Trust and then return to social work afterwards. This was under consideration by the team and plans were being drawn up to try to address the issue.

6.2 University relationships continued to be a focal point, with the Trust continuing to support their development. They were not without difficulty, however the Trust remained committed to building them further. Mr Dugmore had particularly been working on creating links with the University of Essex.

6.3 Mr Dugmore reported that there was strong opportunity for growth for the D10 course. Space and access to the library were a limiting factor, so the team were reviewing ways for potential diversification of delivery. Staff recruitment would also be an issue for consideration.

6.4 Mr Dugmore noted that the Trust had lost a bid against Tower Hamlets, however had secured a bid with Front Line to be involved in fast track training of social workers. Apprenticeships would also present a significant opportunity for the Trust and an offer was being developed for a large private sector provider. The input from the Commercial team in bid writing was praised. The Board of Directors recognised the importance of being able to react to opportunities at relatively short notice, in terms of available resources. It was noted that this was a Trust wide issue and that careful consideration was needed in deciding which services to bid for.

6.5 Succession planning and retention of visiting lecturers was identified as a significant issue, with plans to pilot an associate tutor model being considered as a solution.

## **7. Trust Chair's and NEDs' Reports**

7.1 No report was given.

## **8. Chief Executive's Report**

8.1 Mr Jenkins reported that the Trust would be reviewing any data that clinicians could stop collecting, in order to improve the speed and accuracy of the data that continued to be collected. The Board also noted that data quality had regulatory and reputational significance, particularly in light of the qualified audit opinion given to the Trust for a second year.

8.2 It was also reported that the Trust continued to face new requests for accommodation. A structural survey and costing had been carried out and a proposal for a modular building would be presented to the Board in July. Fire safety had become a priority area of public concern The Trust had been assured that it's buildings did not use cladding and safety procedures were up to date.

8.3 Mr Jenkins thanked Julia Smith for her significant contributions to the Trust over a long period of time, as she would be leaving at the end of the month.

## **9. Finance and Performance Report**

- 9.1 Mr Noys reported that the Trust was marginally ahead against budget. The main negative variance came from Education and Training but he was confident it would be brought back by year end, subject to validation. It was noted that as long as the control total for the year was met, the Trust would receive Sustainability and Transformation Development funding.
- 9.2 The Board noted the report.

## **10. Training and Education Report**

- 10.1 Mr Rock reported that MyTAP had gone live and that contingency plans were in place should any issues arise. The CPD functionality requested had not been possible, but would be written into the future timetable. There had been a 43% increase in applications and a 37% increase in offers accepted against the previous year. The recruitment forecasting model would be shared at the next Board meeting.
- AP**
- 10.2 Work on recruitment had begun earlier in the year and July was expected to be a busy month. The Programme Board had also discussed courses where recruitment was expected to be below the required level and consideration would be given to redeploying resources to address this.
- 10.3 The Board asked how the international work of the Trust was being reflected in the department. Mr Rock noted that a number of opportunities were being explored and those that were viable, given the resources available, would be pursued.
- 10.4 The Board noted the report.

## **11. Objectives for the Board**

- 11.1 Prof. Burstow introduced the paper and stated that the objectives presented reflected the planning of the Trust and both his own and Mr Jenkins individual objectives for the year. It was agreed that the first objectives sounded like it was referring to accountable care, and as such it should be stated explicitly.
- 11.2 The Head of Internal Audit Opinion issues were not thought to be drawn out well enough. It was agreed that the areas of Trust culture, data quality and control should therefore be more clearly stated in the objectives.
- 11.3 It was noted that data quality was not the responsibility of a single director, but that it was shared among executives in various roles.
- 11.4 The Board agreed the objectives, subject to the changes noted.

**AP**

## 12. Safeguarding Annual Report

12.1 Dr Senior reported that demand for safeguarding continued to rise and this in turn placed a considerable demand on capacity. The expansion of GIDS and the GIC service had also contributed to this. The requirement for training was also significant, including mandatory and PREVENT training.

12.2 Dr Senior assured the Board that the Trust continued to deliver high quality performance, however the evidence of this was not seen in data recording. This would be a likely topic of challenge on inspection. Training was taking place for the use of Carenotes, alongside communication about how important it's use was in recording information.

12.3 It was agreed that the Safeguarding Strategy would be presented to the Board.  
**AP**

## 13. Complaints at GIC

13.1 Ms Hawke reported that the Trust had received 39 complaints for quarter one of the year, with 33 of them being about the GIC service. This equalled the total for the Trust for the whole of the previous year. All those related to GIC had been upheld and they were primarily to do with communication issues.

13.2 Dr Hodges reported that issues with letters in the GIC service were being addressed immediately and work on the website was ongoing, with service user involvement. Addressing delayed or cancelled appointments would take longer to resolve, as they had previously been booked up to a year in advance. It was noted that appointment scheduling was not an issue at all in the GID service.

13.3 It was agreed that a further report would be presented to the Board at the end of quarter two.  
**AP**

## 14. Reference Costing Exercise

14.1 Mr Noys reported that the Board were being asked to agree a process that was undertaken annually. It had not changed since the previous year. EY had given the Trust a zero assurance rating, however it was noted that their assessment was not relevant to the Trust and meeting their requirements would not derive any benefit. There were no implications resulting from their rating.

14.2 The Board agreed that it was right that the Trust did the minimum required of it to comply with the submission requirements, as to do otherwise would not be beneficial or value for money.

14.3 The Board confirmed that:

- Costs will be prepared with due regard to the principals and the standards set out in Monitor's approved Costing Guidance;
- Appropriate costing and information systems are in operation;

- Costing teams are appropriately resourced to complete the reference costs return within the timescale set out in the reference cost guidance;
- Procedures are in place such that the self-assessment quality checklist will be completed at the time of the reference cost return; and
- the Trust will submit its return in accordance with the guidance.

## **15. Audit Committee Terms of Reference**

- 15.1 Mr Noys reported that there had been only minor amendments to the Terms of Reference and that there was nothing of substance to report.
- 15.2 The Board agreed the revised Terms of Reference.

## **16. Outline Business Case for Trust wide Scheduling**

- 16.1 Mr Wyndham-Lewis reported that technology was a small percentage of the project and that the majority would involve changing working practices. The approach had been broken down into phases, following which the team would return to their respective departments in the Trust. There were several scheduling platforms available and transferring higher education to the clinical timetabling at the proposed new premises would be a key part of the modelling.
- 16.2 An experienced project manager had been recruited and there was additional capacity to recruit specialists where required. Any slippage in the timetable would have a significant impact, with contingencies in place in the plans.
- 16.3 The Board noted their preference for option four, with a focus on people rather than capital being important.
- 16.4 The Board approved the recommendation to proceed with option four of the Outline Business Case.

## **17. Notice of future meetings**

- 17.1 The next meeting of the Board of Directors was noted as 25<sup>th</sup> July 2017, 2.00-5.00pm, Board room, 120 Belsize Lane.

## **18. Any Other Business**

- 18.1 No other business was raised.

Action Point No.	Originating Meeting	Action Required	Director / Manager	Due Date	Progress Update / Comment
1	Jan-17	Develop Race Equality Strategy	Louise Lyon	Apr-17	Due May , revised to June
2	Mar-17	Arrange annual event for interactive discussion of Serious Incident cases to share learning amongst all clinicians	Rob Senior	Sep-17	
3	Mar-17	Audit cases similar to BB to check closure procedures followed.	Sally Hodges/ Rob Senior	Jun-17	
3	Apr-17	Update on complaints at the GIC in June	Amanda Hawke	Jun-17	
4	Apr-17	A report on the increase in incidents at Gloucester House to be provided	Amanda Hawke	Sep-17	
5	Apr-17	An update on the fall in recording of outcome measures to be included in the Chief Executive's report	Paul Jenkins	Jun-17	
6	Apr-17	An update on the delivery of the IM&T Strategy is to be provided to the July Board	David Wyndham-Lewis	Jul-17	
2	May-17	Review the approaches for other providers in training new staff in the gender identity service	Sally Hodges		
3	May-17	Update the Board on GIDS waiting times and activity, include a trajectory for when the waiting times will be within the target	Sally Hodges		
4	May-17	Undertake an audit of the quality data	Louise Lyon	Nov-17	
5	May-17	Include in the June Chief Executive's Report an action plan to address issues arising from the Quality Report	Paul Jenkins/Louise Lyon	Jun-17	
6	May-17	Identify when the planning permission for a temporary building housing the FNP wing needs to be renewed	Terry Noys	Jun-17	
7	May-17	Provide a schedule of courses on offer and student numbers	Brian Rock	Jun-17	
8	May-17	Allocation of tasks and priorities to the Non-Executive Directors to include leads for Unexpected deaths and Quality	Paul Burstow	Jul-17	
9	May-17	Confirm when the target for mandatory training with regard to clinical risk will be met.	Rob Senior	Jun-17	



## Board of Directors : July 2017

**Item :** 6

**Title :** : Family Nurse Partnership (National Unit: service line report

**Purpose:**

The purpose of this report is to update on the FNP National Unit's progress and to set out future priorities.

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**This report focuses on the following areas:**

- Quality
- Patient / User Experience
- Finance

**For :** Noting

**From :** Ailsa Swarbrick, Director, FNP National Unit

## Service Line Report – FNP National Unit, CYAF

### Executive Summary

#### 1. Introduction

1.1 This paper gives an update on Family Nurse Partnership (FNP) National Unit (NU) progress in 16/17 and outlook for 17/18. It summarises the commissioning position for FNP nationally and for the NU; progress and early learning from FNP Next Steps, our improvement and innovation programme; and future planning.

#### 2. Areas of Risk and/or Concern

2.1 Key areas of concern are:

- 2.1.1 Continued risk of decommissioning of local FNP services across the country;
- 2.1.2 Uncertainty over the future of the NU contract with Public Health England (PHE), due to expire on 31 March 2018;
- 2.1.3 That FNP Next Steps will fail to generate the improvement in outcomes, the efficiency and the flexibility commissioners are seeking.

#### 3. Proposed Action Plan

3.1 The NU has an ambitious and well defined work programme, which it is managing tightly using Agile DSDM project management methodology. Progress is overseen by an FNP Consortium Board, and by a PHE programme board. Further details of progress and plans are set out below.

## Main Report

### 4. Overview of the Service

- 4.1 The NU vision is that every baby, child and young parent can thrive, fulfil their aspirations and contribute to society.
- 4.2 FNP is a structured, evidence based, early years, public health home visiting service. Specially trained nurses work with disadvantaged first time parents and their babies, from early in pregnancy until the child is two. The service is commissioned and managed locally, currently in nearly 100 local authority areas.
- 4.3 The NU oversees the service nationally, providing strategic leadership, quality assurance and improvement, licensing and training. It comprises 23 staff. Its services are delivered under a five year contract with Public Health England (PHE), from 2013 – 2018. The Trust manages the Unit as part of a consortium arrangement with the Dartington Social Research Unit (SRU) and Impetus-PEF, who deliver services through sub contracts. The original contract value was approx. £17.5m.
- 4.4 In the early years of the contract, NU activity was focused on delivering against a Government expansion commitment (which it exceeded) and on successfully increasing the efficiency and reducing the cost of its core services, particularly delivery of FNP training to a cohort of over 700 family nurses.
- 4.5 The last two years have been dominated by responding to three significant pressures:
- 4.5.1 The publication in October 2015 of the Cardiff University “Building Blocks” RCT, which found no effect in relation to primary outcomes (smoking in pregnancy, subsequent pregnancies within two years, A&E attendance and birth weight) but was promising in relation to some important secondary outcomes, including early language and cognitive development, safeguarding and maternal self-efficacy;

4.5.2 The transfer of commissioning and funding responsibility for FNP along with other 0–5 public health services passed from NHS England to LAs; and

4.5.3 Severe local authority budget cuts.

4.6 This response has involved a refocus of NU activity with a consequent restructure; an ambitious improvement and innovation programme, FNP Next Steps; action to maintain the national commissioning footprint; and continued delivery of NU services in over 100 sites together with support for safe decommissioning in some areas.

### **Commissioning status**

5.1 Commissioning of FNP across the country has held up relatively well in the circumstances, although we remain alert to the risk of future decommissioning. Our current forecast of the places that will remain by the end of 17/18 is in the range of 9,000 – 11,000 (70–90 sites). Pressure to decommission continues to come mainly from financial pressures on LAs. Commissioners also tell us they need to be able to offer a service to all vulnerable families, not just young parents. Despite this, there remains a solid base of support and interest in FNP, particularly an adapted FNP. Currently, a total of 57 sites are contracted through to the end of 2018; with 50% of these having contracts in place beyond that, in some cases to 2024. So it appears that many LAs continue to believe that FNP is an important and viable component of local services.

5.2 We are currently discussing with PHE options for the future once the current NU contract expires.

### **FNP Next Steps**

6.1 FNP Next Steps is an ambitious programme of innovation and improvement which seeks to improve FNP outcomes, cost effectiveness

and flexibility and to share learning with other services. It comprises four main elements: 1) Universal improvements–changes we have been able to introduce relatively quickly); 2) Evidencing local impact – responding to commissioner wishes for clear local data, where possible; 3) Knowledge and Skills Exchange – sharing learning of FNP approaches and methods through training packs family nurses deliver for other local services; and 4) ADAPT – rapid cycle innovation and testing of more complex changes. Annex A sets out some further detail, and I summarise progress on ADAPT below.

6.2 We are jointly running ADAPT (Accelerated Design and Programme Testing) with the Dartington Social Research Unit (DSRU). This involves collaboration with 11 FNP sites to co–design and test more significant changes to FNP, using a methodology DSRU are developing called Rapid Cycle Innovation (RCI). Briefly, this seeks to combine good science with pragmatism, using robust evidence to inform the design of changes to FNP, develop logic models and implementation plans; and then testing and refining these iteratively, in cycles of about three months, using both quantitative and qualitative data about outcomes where possible, acceptability and implementation. Some of the methodology is drawn from QI/ Improvement Science principles.

6.3 Over the last year, 8 sites have designed six clinical adaptations which are now being tested, with a view to improving key outcomes in quitting smoking, breastfeeding, neglect, intimate partner violence, perinatal mental health and attachment. All 11 sites are testing greater personalisation of FNP, involving options: to change eligibility criteria; to flex content and intensity of visits; and to leave FNP (“graduate”) early. These decisions would be informed by a new assessment tool jointly completed by nurses and clients, called the New Mum Outcomes Star. Further details are in Annex B. We have reviewed initial lessons learned with DSRU, are already making changes to the adaptations based on preliminary data brought together in June, and are aiming to develop a comprehensive report in the Autumn, following the second data cycle. DSRU are also planning to develop a brief paper for publication, discussing the methodology.

## Communications

7.1 The refocus of NU activity also included a strengthening of our communications and stakeholder engagement functions, in order to engage well with the FNP community of sites and workforce; and to raise awareness of the work we do. A major focus this year is to mark the tenth anniversary of FNP being brought to the UK. This was launched with a successful reception in Parliament on 30 March, and we have since held regional engagement events June for all family nurses, provider leads and commissioners. We are currently planning an “FNP week” of local activities in the autumn, and a series of specialist thought leadership seminars in the second half of the financial year.

## Future strategy

8.1 While we hope FNP Next Steps and other work will ensure continued FNP sustainability, site feedback and other intelligence tells us that we can do more to use the assets and learning we have developed over the last ten years. The FNP Board have, therefore, agreed that we should develop and test the feasibility of a system-wide approach to widening the reach of FNP methods and learning. This could comprise a local offer of support for an adapted FNP for the most vulnerable, support for knowledge and skills development for other relevant local early help services, and possibly a new, lighter touch programme for parents who are less vulnerable than FNP clients but could still benefit from an enhanced service. Family nurses may be deployed for training, clinical supervision, and triaging, in addition to delivering FNP. Many areas are already considering similar approaches of their own, but are attracted by the additional rigour, data and infrastructure the NU might bring. We are currently scoping and consulting on this work, with a view to possibly starting development and testing with a small number of sites from the autumn.

Ailsa Swarbrick  
Director, FNP National Unit  
17 July 2017

# FNP Next Steps



Changing the world one baby at a time™

### Universal improvements

**Improve quality and efficiency across all sites to better meet local priorities.**

- New eligibility criteria
- Updated smoking cessation and nutrition guidance
- Revised FNP data dashboard

### Evidence impact

**Review data and new research to confirm effectiveness.** Look at where we can measure impact, do further research to determine impact.

- ASQ Impact & Improvement Tool
- Safeguarding tool
- Quality Improvement

### Knowledge & Skills Exchange

**Collaborate with other services to improve local systems overall through knowledge and skills exchange.** Sharing local FNP team's skills and knowledge to build capacity in their wider workforce and support quality improvement to benefit a wider local population

### ADAPT

**Work with 11 sites co-design clinical and personalisation adaptations to the current FNP.** Test these adaptations rapidly and roll-out positive improvements.

# Annex B

# ADAPT

## Sites

- Blackpool
- Bradford
- Cheshire East
- Derby City
- Dudley
- Lambeth
- Lewisham
- Nottingham
- Portsmouth
- Southend
- West Sussex

**Personalisation** – all areas

### **Clinical adaptations:**

Smoking cessation (Cheshire East, Dudley)  
Breastfeeding (Blackpool)  
Domestic violence (Lewisham, Lambeth)  
Perinatal mental health (Nottingham)  
Attachment (Bradford)  
Neglect (Portsmouth)

# ADAPT: data

## Quantitative data

- Data completeness
- Implementation data on
  - Eligibility
  - Flexing the content
  - Dialling
  - Early graduation
- Client throughput
- Nurse perspective of personalisation
- Client perspective of personalisation
- Nurse perspective of New Mum Star
- New Mum Star scores
- ASQ scores

## Qualitative data

- Impact of changes on programme delivery
- Impact of changes on relationships with clients
- Nurse confidence in decision-making and delivery
- Nurses experience of using New Mum Star, and effect on practice
- Client experience of New Mum Star and effect on experience of FNP



## Board of Directors : July 2017

**Item :** 8

**Title :** Chief Executive's Report

**Summary:** This report provides a summary of key issues affecting the Trust.

**For :** Discussion

**From :** Chief Executive

## Chief Executive's Report

### 1. Chalcot Estate

- 1.1 Staff from both our Camden CAMHS and TAP services have been proactive in offering support to families affected by the evacuation of tower blocks in the Chalcot Estate.
- 1.2 We have also offered support in respect of those affected by the Grenfell Tower fire and the attack at Borough market. Staff from our trauma service are holding a seminar on 28<sup>th</sup> July for front line staff involved in the response to traumatic events.

### 2. Data Quality

- 2.1 Following discussion at the last Board we have further developed a programme of work to strengthen our assurance on data quality. This will be led by David Wyndham-Lewis with support from Louise Lyon. We are looking to engage some outside assistance for the work to provide additional capacity and expertise.
- 2.2 The work will address three issues:
  - Review the main items of data collection across the Trust and the sources of assurance we have for each data item.
  - Use waiting times data as an exemplar for modelling best practice on data collection and validation.
  - Review the set of data available for external audit as part of the production of the 2017/8 Quality Account and carry out a health check of our systems for validation of these measures.
- 2.3 We will produce an initial report on this work for the October Audit Committee with a final report coming to the November Board.

### 3. Review of Strategic Plan

- 3.1 We have carried out a 6 monthly review of the Strategic Plan agreed by the Board in November 2016. A summary of progress against objectives is attached as an Annex to this report.
- 3.2 We are proposing to refresh the plan to reflect our increased focus on new income generation and wider changes in the external environment. We are also proposing to see to what extent we can better align the different objective setting processes we have in place for the Board, the Management Team and the wider organisation.

Paul Jenkins  
Chief Executive  
17<sup>th</sup> July 2017



A - SERVICE MODELS AND CONSULTANCY

Aim 1 - Contributing to the development of new models of care

<p><b>1a: Work with partners in the NCL STP to transform mental health services and support the development of integrated care closer to home PJ</b></p> <p><b>Success Criteria:</b></p> <ul style="list-style-type: none"> <li>- Strengthened model for care close to home for mental health</li> <li>- Progress against STP objectives for improving quality outcomes</li> </ul>	<p><b>Accountable Director:</b> Chief Executive</p> <ul style="list-style-type: none"> <li>- T&amp;P secures recognition for system leadership in reshaping models of care</li> <li>- Co-production embedded in approach to reshaping mental health services</li> </ul>
<p><b>Next Milestones</b></p>	
<p><b>Current Milestones and Progress</b></p> <ol style="list-style-type: none"> <li>1. STP plans embedded contracts for 2017/8 -2018/9 <b>Significant shortfall in funding of mental health plan due to overall financial pressures across the STP.</b></li> <li>2. Implementation plans agreed for STP MH priorities for 2017/8 <b>Plans in place for funded elements of the programme.</b></li> <li>3. Experts by Experience Reference Group up and running <b>Group established and contributing well to STP work</b></li> <li>4. Effective contribution to development of thinking on new delivery models in NCL <b>Ongoing contribution in particular to Care Closer to Home workstream</b></li> </ol>	<p><b>Overall Progress on Achieving Outcome</b></p>
<p><b>Progress in achieving milestones in last quarter</b></p>	<p><b>Overall Progress on Achieving Outcome</b></p>

**Aim 1 - Contributing to the development of new models of care**

<p><b>1b: Establish a leadership role for the Trust in the field of children and young people's mental health including promoting Thrive as the leading model for the provision of CAMHS services</b></p> <p><b>Success Criteria:</b></p> <ul style="list-style-type: none"> <li>- Thrive is central to transformation plans and commissioning intentions for an increasing number of CCG's &amp; STP's</li> <li>- T&amp;P takes system leadership role in development of CAMHS across NCL STP (<b>SH and RS are leading on various elements of the NCL CAMHS initiatives</b>)</li> <li>- Growth in Thrive Community of Practice and established evidence base for effectiveness of Thrive</li> </ul>	<p><b>Accountable Director:</b> Chief Executive &amp; Director CYAF</p> <ul style="list-style-type: none"> <li>- Sustainable funding model for i-Thrive Programme Team</li> <li>- T&amp;P leads introduction of local t4 commissioning across the STP area</li> </ul>
<p><b>Current Milestones and Progress</b></p> <ol style="list-style-type: none"> <li>1. Completion of commissioned modules for i-Thrive Academy including progress against HEE funded risk support workstream <b>Modules completed</b></li> <li>2. Agreement of strategy for sustainable funding of i-Thrive Programme <b>Work ongoing. Dependent on sustainable model for commercialising i-Thrive training and other support</b></li> <li>3. Agreed model for t4 commissioning in NCL ready for second wave bidding process <b>Model agreed, however BEH put in bid to lead. The bid was unsuccessful.</b></li> <li>4. Active T&amp;P involvement in all CAMHS workstreams in STP <b>SH taking a leadership role in the CAMHS subgroup</b></li> </ol>	<p><b>Next Milestones</b></p> <ol style="list-style-type: none"> <li>1. Complete and implement agreement on a sustainable model for i-Thrive programme with focus on commercialising and</li> <li>2. Refresh publicity for Thrive model and impact.</li> <li>3. Work with STP to develop alternative model for crisis and step up /step down care for T4, taking a leadership role in this process</li> <li>4. SH to take forward STP proposal to influence any bid for CAMHS in education funding post the publication of the green paper</li> </ol>
<p><b>Progress in achieving milestones in last quarter</b></p>	<p><b>Overall Progress on Achieving Outcome</b></p>
<p>A</p>	<p>A</p>

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**Aim 1 - Contributing to the development of new models of care**

<p><b>1c: Develop our contribution to models of problem solving justice and intervention for vulnerable children including securing sustainable funding model for FDAC and FNP</b></p> <p><b>Success Criteria</b></p> <ul style="list-style-type: none"> <li>- Sustainable funding model for FDAC and FDAC National Unit</li> <li>- Development of FDAC model to other areas of problem solving justice and work with vulnerable families</li> </ul>	<p><b>Accountable Director:</b> Chief Executive &amp; Director CYAF</p> <ul style="list-style-type: none"> <li>- T&amp;P secures reprocurd contract for FNP National Unit</li> <li>- Evidence from ADAPT programme of effectiveness of planned changes to FNP interventions</li> </ul>
<p><b>Current Milestones and Progress</b></p> <ol style="list-style-type: none"> <li>1. A programme of negotiations is in place with DfE &amp; DoJ, aim to secure funding for the gap year <b>Funding was agreed through DfE for the full year, and possibly a little further dependent on progress with the SIBs programme. DfE are very keen to ensure that FDAC can be made sustainable and understand that there will need to be bridging funding to ensure SIBs funding is given the best possible chance</b></li> <li>2. To continue lining up interested LA's for the SIBs programme, and to ensure a structure for these relationships as well as a model for the funding</li> <li>3. To secure the south London FDAC contract <b>Unfortunately this has been delayed owing to a concern about the possibility of legal challenge. A procurement process has now started and its unclear how much this will need to be followed given the EOJ stage responses.</b></li> <li>4. To continue negotiations and regular meetings with PHE To continue negotiations and regular meetings with PHE <b>PHE have now indicated they will extend the contract for two years and we are discussing terms with them.</b></li> </ol>	<p><b>Next Milestones</b></p> <ol style="list-style-type: none"> <li>1. To reach agreement on the FDAC SIBs structure, and to start to put this in place.</li> <li>2. To establish the mechanism for the FDAC SIBs in the LA's who are prepared to go forward with this</li> <li>3. The issue re procurement will become clearer over the course of the next month, however in the meantime, funding for the existing team is reduced considerably. We are likely to have to take some risk with unfunded posts in order to be able to maintain enough of a service when the final contract is awarded. Steve will be working closely with the team in order to maintain morale at this point.</li> <li>4. To agree the overall shape of funding model for FNP National Unit in 18/19 and 19/20 agreed with PHE.</li> <li>5. To continue to develop 'value added' aspects of the service as part of the sustainability programme</li> <li>6. That the first quarter data for ADAPT completed and reviewed</li> </ol>

- 5. To develop further the knowledge and skills exchange framework and collect feedback to ensure that it is well received. **On track – initial feedback positive; review of phase 1 and decision on phase 2 due by end May.**
- 6. That the ADAPT programme starts to generate positive data re outcomes and cost effectiveness **Not yet – we've not had a full data collection round (see below for timing)**

Progress in achieving milestones in last quarter

A



Overall Progress on Achieving Outcome

A



**Aim 1 - Contributing to the development of new models of care**

<p><b>1d: Establish a leadership role for the Trust in the field of primary care mental health</b></p> <p><b>Success Criteria:</b></p> <ul style="list-style-type: none"> <li>- MUS Summit held with CEO as Chair</li> </ul> <p><b>Current Milestones and Progress</b></p> <ol style="list-style-type: none"> <li>BR and JStE have met with key staff members (e.g. Tim Kent) to progress Primary Care Programme between DET &amp; clinical services to explore strategy for NTC programme. Further developments in progress , .w.r.t staffing, scope and reach of work</li> <li>Build on MUS conference with further meetings- Further MUS conference planned for early 2017; JStE to speak at National Integrated Care meeting Jan 2017 (UCLP) “Breaking barriers”</li> <li>Build on links with UCLP as per meeting in November 2016-including provision of educational resources with them</li> </ol> <p><b>Developments include:</b></p> <ul style="list-style-type: none"> <li>• DET and AFS working closely together to progress this ambition.</li> <li>• JS , CC and BR met, and BR has now met the key members of the primary care teams</li> <li>• 2 successful national MUS summits, with 3<sup>rd</sup> one planned</li> <li>• Progress towards commissioning a further health economics evaluation from Centre for Mental Health</li> </ul>	<p><b>Accountable Director:</b> Director AFS and Director Education &amp; Training</p> <ul style="list-style-type: none"> <li>- BR and JStE met with UCLP November 2016</li> </ul> <p><b>Next Milestones</b></p> <ul style="list-style-type: none"> <li>• <b>Progress:</b></li> <li>• Have now met with Michael Parsonage-Health economist-who is very keen to progress a further health economics evaluation from Centre for Mental Health</li> <li>• <b>DET and AFS close to a role descriptor for the Primary Care project lead role , and the staffing of such a project.</b></li> </ul> <p><b>Milestones:</b></p> <ul style="list-style-type: none"> <li>• To reach agreement on the strategy for NTC programme, staffing, scope and reach of work</li> <li>• To finalise the commissioning of a further health economics evaluation from Centre for Mental Health</li> <li>• To further build on the 2 successful MUS conferences</li> <li>• To continue to bid ,together with our commercial colleagues, for further clinical services in primary care</li> </ul>
<p><b>Progress in achieving milestones in last quarter</b></p> <p style="text-align: right;">A</p>	<p><b>Overall Progress on Achieving Outcome</b></p> <p style="text-align: right;">A</p>



**B MAINTAINING AND DEVELOPING THE REACH OF OUR CLINICAL SERVICES**

**Aim 2 – Maintaining and developing the quality and reach of our clinical services.**

<p><b>2a: To maintain and develop our existing portfolio of services for adults and children and support links with our work on education and training</b></p> <p><b>Success Criteria:</b></p> <ul style="list-style-type: none"> <li>- To ensure that our services maintain a distinctive quality that warrants them to be commissioned</li> <li>- More process of sustainability for our clinician trainer model</li> </ul>	<p><b>Accountable Director:</b> Director AFS &amp; Director CYAF</p> <ul style="list-style-type: none"> <li>- To ensure that where ever possible clinical staff have some exposure to providing training</li> <li>- To grow the clinical services from the current base via strong relationships with commissioners and local providers</li> </ul>
<p><b>Current Milestones and Progress</b></p> <ol style="list-style-type: none"> <li><b>1.</b> To support contracts through the current commissioning round. <b>This has gone relatively well with stable contracts and some minor gains in key contract areas</b></li> <li><b>2.</b> To work with DET to ensure clinical staff are being used for training, that this is equitable and sustainable across clinical services. <b>Many clinical staff are now in the working groups over the key possible training development areas for example vulnerable children, forensic and GIDs. DET have kept CYAF &amp; AFS abreast of where clinical staff are being asked to contribute to this work.</b></li> <li><b>3.</b> To engage with commissioners re CAMHS transformation plans locally (SH) <b>This has happened and has resulted in additional funding in both Haringey and Camden. Barnet CAMHS are likely to go our to tender soon.</b></li> <li><b>4.</b> To engage with the STP mental health workstream where ever possible. Both SH and JSte are sitting on the STP MH steering group now.</li> </ol>	<p><b>Next Milestones</b></p> <ol style="list-style-type: none"> <li><b>1.</b> To ensure that data quality and outcomes are prioritised in order to give commissioners feedback needed on services, which also ensures their stability</li> <li><b>2.</b> To continue to engage with DET to ensure that training contract priority areas are well supported from the clinical services. To make joint bids against training funding where ever possible.</li> <li><b>3.</b> To maintain close working relationships with all five NCL CAMHS Commissioners</li> <li><b>4.</b> To develop and maintain closer working relationships with Adult MH commissioners, both national (esp forensic) and local</li> <li><b>5.</b> To lead on NCL wide mental health initiatives where appropriate</li> <li><b>6.</b> To continue to work closely with our commercial colleagues in scoping and then competing for relevant bids to increase our level of activity/contribution. In AFS ,this is especially promising in forensic work</li> </ol>

**Aim 2 – Maintaining and developing the quality and reach of our clinical services.**

<p><b>2b: Agree and implement the Trust' clinical quality strategy including the delivery of current and future regulatory requirements</b></p>	<p><b>Accountable Director:</b> Director Quality and Patient Experience</p>	
<p><b>Success Criteria:</b></p> <ul style="list-style-type: none"> <li>- Maintain Good rating with CQC awaiting visit before end of November 2016</li> <li>- Establish and implement a clinical quality improvement programme</li> </ul>	<ul style="list-style-type: none"> <li>- Satisfactory progress on implementating clinical quality strategy 2015-7</li> </ul>	
<p><b>Current Milestones and Progress</b></p>	<p><b>Next Milestones</b></p>	
<ol style="list-style-type: none"> <li>1. Present clinical quality improvement strategy to the Board in January <b>Strategy presented to the Board in January and approved</b></li> <li>2. Review progress on clinical quality strategy <b>Progress reviewed through Quality Group and CQSGC</b></li> <li>3. Develop an agreed realistic action plan to progress clinical quality objectives for remained of 2016-7 period of the strategy <b>Outline action plan developed but further discussion of issues led to seeking external consultation to ensure that we had a clear vision of what success would look like and clarity about how best to lead QI in our Trust</b></li> <li>4. Establish a plan for engaging all staff in quality improvement <b>Plan not fully elaborated but opportunities for QI training regularly advertised, community of practice initiated, growing interest amongst staff but further work needed</b></li> </ol>	<ol style="list-style-type: none"> <li>1. Reducing the Burden project to produce priorities for action</li> <li>2. Scope QI training options and methodologies</li> <li>3. Develop CQC action plan for GIC and establish relationship with CQC for this service</li> <li>4. Ensure continued progress on CQC Action Plan for whole Trust</li> <li>5. Initiate project to implement systems for managing incidents, complaints, NICE guidance, audit and QI project logging and tracking</li> <li>6. Initiate consultation to develop a refreshed patient and public involvement strategy to support quality maintenance, QI and service development ( clinical directorates and DET)</li> </ol>	
<p><b>Progress in achieving milestones in last quarter</b>  <b>Progress has been slower than planned as the Quality Group has increasingly become aware of the need to prioritise and think through dilemmas on next steps. We are also learning from other organisations about the length of time needed to embed QI and the importance of tailoring our approach to our organisation. Additionally progress on Reducing the Burden should make for more capacity to focus on QI</b></p>	<p><b>Overall Progress on Achieving Outcome</b></p>	
<p>A</p>	<p>A</p>	

**Aim 2 – Maintaining and developing the quality and reach of our clinical services.**

<p><b>2c: To develop systems for capturing, analysing, reflecting upon and acting upon qualitative and quantitative data to support the implementation of the clinical quality strategy with a particular focus on capturing the experience of people who use our services.</b></p>	<p><b>Accountable Director:</b> Director of Quality and Patient Experience</p>
<p><b>Success Criteria:</b></p> <ul style="list-style-type: none"> <li>- Comprehensive, easy to assimilate data is available to internal and external stakeholders to provide assurance</li> <li>- Monitor performance and show where improvement is required or has successfully been achieved</li> </ul>	<ul style="list-style-type: none"> <li>- Evidence that we have a good understanding of how our service users experience our services.</li> </ul>
<p><b>Current Milestones and Progress</b></p> <ol style="list-style-type: none"> <li>1. Complete work with dashboard project to ensure that dashboards cover main areas of data capture relevant both to external and internal reporting <b>Not finalised due to delay in Dashboard Project due to Adult GIC implementation.</b></li> <li>2. Develop a proposal to share with Commissioners to reduce amount of data collected and to agree on which measures are most relevant to monitoring performance and providing assurance. <b>Delayed because of overall dashboard project put on hold temporarily</b></li> </ol>	<p><b>Next Milestones</b></p> <ol style="list-style-type: none"> <li>1. Establish clarity about responsibility for producing and validating data for each element of the EMT/Board dashboard</li> <li>2. Develop business case for dashboard and data quality project</li> </ol>
<p><b>Progress in achieving milestones in last quarter</b> Some relevant work has progressed eg ensuring clarity about which data is presented on the dashboard and which to commissioners etc</p>	<p><b>Overall Progress on Achieving Outcome</b></p>

**C- NATIONAL TRAINING CONTRACT**

**Aim 3: Growing and developing our training and education and delivering a remodelled National Training Contract**

<p><b>3A: Agree and implement changes to our National Training Contract including the establishment of National Workforce Skills Development Unit (NWSDU)</b></p>	<p><b>Accountable Director:</b> Director of Education and Training / Director of Nursing</p>
<p><b>Success Criteria</b> Fully engage with the opportunity afforded by the development of the NTC to extend the reach and the impact of our education and training offer for the development and transformation of the workforce</p>	<p>Establish successful partnerships and fully engage with collaborating organisations to develop, deliver and extend our contribution to mental health in line with the 5 year forward view</p>
<p><b>Current Milestones and Progress</b></p> <ol style="list-style-type: none"> <li>1. Establish the NWSDU and governance arrangements (incl. with HEE) <b>We have now established the National Workforce Skills Development Unit with a developing core staff. We are going out for recruitment again for the AD role though have interim arrangements in place. We are establishing clear governance arrangements – some significant changes at HEE which are being monitored and engaged with including new national MH &amp; LD lead (partial achievement)</b></li> <li>2. Identify and establish new programmes (incl. links with clinical services) <b>Programme briefs established for all four programmes – further clarity and focus to be worked on in the next quarter. Successful workshop with HEE held (partial achievement)</b></li> <li>3. Establish the Mental Health Workforce Development Collaborative and agree priorities for 17/18 <b>The Collaborative is gaining some traction – all Trusts have gone through required internal process for sign up - and will be meeting for the fourth time in July. Clear themes established (complete)</b></li> <li>4. Continue with Portfolio Review for course development and expansion <b>Considerable work has been done with identifying areas for further consideration for particular courses. It has been challenging to get further engagement from PMs and there have been some challenges around DET finance focus with competing objectives (partial achievement)</b></li> </ol> <p><b>Progress in achieving milestones in last quarter</b></p>	<p><b>Next Milestones</b></p> <ol style="list-style-type: none"> <li>1. Recruitment of the AD for the NWSDU and further engagement with the HEE national MH &amp; LD lead manager</li> <li>2. Continue to clarify and work up four programme areas</li> <li>3. Further engagement of Collaborative with the NWSDU programmes</li> <li>4. Establish the Collaborative as a conduit to HEE for intelligence gathering and sharing</li> <li>5. Continue with development of Portfolio Review and the establishment of productivity programme</li> <li>6. Establish the feasibility of the Associate Lecture role with programme for phased implementation</li> </ol>
<p><b>Overall Progress on Achieving Outcome</b></p>	<p><b>Overall Progress on Achieving Outcome</b></p>

**Aim 3: Growing and developing our training and education and delivering a remodelled National Training Contract**

<p><b>3B: Deliver targets for growth in student numbers and educational income including growth in student numbers across the country, through local delivery and/or TEL blended learning, and the development of plans for international recruitment.</b></p>	<p><b>Accountable Director:</b> Director of Education and Training</p>
<p><b>Success Criteria</b>          Achieve growth in the reputation and relevance of our approach to learning and development through increase in reach geographically and across different levels of the workforce in related sectors          Develop and deliver a credible and stretching TEL strategy that underpins growth and an increase in capacity to extend our contribution          Develop and deliver international strategy that will increase income to the Trust</p>	
<p><b>Current Milestones and Progress</b></p> <ol style="list-style-type: none"> <li>1. Setting targets for growth in student numbers (based on a better understanding of course level contribution and required national reach) <b>Targets have been set and better data monitoring at the individual course and portfolio level about the pipeline. Close monitoring by recruitment group with stronger links to faculty.</b></li> <li>2. Appointment of interim TC Lead and implementation of TC review <b>Successful appointment of TC Lead with completion of restructuring by 1 April 2017. Clear plan for reconfiguration and consolidation.</b></li> <li>3. Establish E&amp;T commercial strategy and focus of TEL development opportunities <b>Draft business plan agreed at April TEPMB. Dissemination with core operational teams and PMs. Work underway to have a more coherent and systemic approach to pipeline and contract management.</b></li> <li>4. Draft strategy for international development <b>Review of UK based international recruitment. Engagement and commencement of MBA consultancy project looking at e-learning and international. Development of proposal for</b></li> </ol>	<p><b>Next Milestones</b></p> <ol style="list-style-type: none"> <li>1. Close monitoring of pipeline to ensure that we understand which courses might need to be stopped (with staff redeployed) or delivered with increased provision (by addressing logistical issues) for exceeding targets</li> <li>2. Maximising the conversion of increased numbers of applications by deploying academic and other resources to best match demand for places</li> <li>3. Achieving overall student target numbers and income using timely planning to reduce or remove obstacles to success</li> <li>4. Close monitoring of possible obstacles to reaching student target numbers and timely planning to reduce or remove obstacles to success</li> <li>5. Further development and implementation of TC business development strategy</li> <li>6. Review of DET pipeline in relation to existing targets to identify possible areas where shortfalls and where opportunities for exceeding targets</li> </ol>

<p>engagement of external consultancy to assess and outline international strategy for transnational opportunities.</p>	<p>7. Review of overall marketing plan in line with above</p> <p>8. Establish key TEL projects for income generation over and above existing commitments to operational delivery</p> <p>9. Support and deliver consultancy projects on international development including engagement of external consultancy</p> <p>10. Establish plan for UK based international student recruitment in light of risk issues</p>	<p>A</p>	<p><b>Overall Progress on Achieving Outcome</b></p>	<p>A</p>
<p>Progress in achieving milestones in last quarter</p>	<p>A</p>	<p>A</p>	<p><b>Overall Progress on Achieving Outcome</b></p>	<p>A</p>

D- WELLBEING AND ENGAGEMENT OF STAFF

Aim 4 – Supporting the wellbeing and engagement of our staff

<p><b>4A. Agree and implement an Organisational Development and People Strategy that includes our commitment to enhancing staff health, wellbeing, diversity and inclusion.</b></p>	<p><b>Accountable Director:</b> Director of Human Resources</p>
<p><b>Original Key Success Criteria:</b></p> <ul style="list-style-type: none"> <li>- To deliver a comprehensive organisational development and people strategy that sets out the workforce priorities for the next two years.</li> <li>- Maintain and improve Trust performance against Trust survey</li> </ul>	<ul style="list-style-type: none"> <li>- Improve staff retention</li> </ul>
<p><b>Current Milestones and Progress</b></p> <ol style="list-style-type: none"> <li>1. Achieve Board approval of the organisational development and people strategy <b>Presented to the Trust board in March. Comments received were positive and it was requested that the delivery plan be worked up with timescales.</b></li> <li>2. Respond to the findings of the 2016 NHS Staff Survey <b>Results received in early March and reported to the Board in the same month.</b></li> <li>3. Review our recruitment, marketing and attraction processes <b>New e-recruitment solution implemented and work has commenced to start promoting our roles through new media channels.</b></li> <li>4. Launch the Trust's new management and leadership development programme <b>Two cohorts launched which will complete in Q1 2017/18.</b></li> </ol>	<p><b>Next Milestones</b></p> <ol style="list-style-type: none"> <li>1. Develop a comprehensive business plan to outline the activities required to deliver the organisational development and people strategy</li> <li>2. Support DET with the development of the Tavistock and Portman Academy</li> <li>3. Design, consult and implement the 2017/18 staff education programme</li> </ol>
<p><b>Progress in achieving milestones in last quarter</b></p>	<p><b>Overall Progress on Achieving Outcome</b></p>
<p>G</p>	<p>G</p>

**Aim 4 – Supporting the wellbeing and engagement of our staff**

<p><b>4B Progress towards seeing better implementation of diversity at all levels in the organisation.</b></p> <p><b>Success Criteria</b> Implement our four year diversity and inclusion objectives with a specific focus on recruiting, developing, retaining and providing promotional opportunities for our diverse staff and students.</p>	<p><b>Accountable Director:</b> Director of Human Resources, Director of Quality and Director of Education and Training</p> <ul style="list-style-type: none"> <li>- Ensure that we comply with our statutory obligations and deliver a comprehensive annual diversity and inclusion report with the appropriate equality delivery system (EDS) assessment.</li> </ul>
<p><b>Current Milestones and Progress</b></p> <ol style="list-style-type: none"> <li>1. Deliver the statutory diversity and inclusion annual report and objectives <b>Developed and reported to the January Trust board.</b></li> <li>2. Review and assess applications made to the management development programme <b>Diverse group of applications made to the leadership programme. The Trust also held a specific BAME career development and coaching seminar in March 2017.</b></li> <li>3. Finalise the scoping assessment of staff, service users and students with disabilities</li> <li>4. Assess the impact of senior HR professionals on interview panels for roles graded 8 and above <b>There has been a small shift in BAME representation in grades Band 8 and above.</b></li> </ol>	<p><b>Next Milestones</b></p> <ol style="list-style-type: none"> <li>1 Consult on and develop draft Race Equality Strategy for workforce, education and training and clinical services. Final draft to be presented to the Board in September 2017</li> <li>2 Present WRES to the Board July 2017</li> </ol>
<p><b>Progress in achieving milestones in last quarter</b></p>	<p><b>Overall Progress on Achieving Outcome</b></p>
<p>A</p>	<p>A</p>

**E- FINANCIAL FUTURE**

**Aim 5 – Delivering a sustainable financial future for the Trust**

<b>5A: To lead the development and updating of a Commercial Strategy for the Trust to generate growth in income across our activities including options for developments outside London and internationally.</b>		<b>Accountable Director: Director of Finance, Directors of CYAF, AFS, E&amp;T</b>	
<b>Success Criteria</b> <ul style="list-style-type: none"> <li>- Trust Income to increase by £1m in 2017/18 and £2m in 2018/19</li> </ul>			
<b>Current Milestones and Progress</b> <ol style="list-style-type: none"> <li>1. Training Commercial strategy in place March <b>2017 Progress made but not yet fully in place</b></li> <li>2. Secure £4m contract for Adult GIC if awarded host arrangement Jan 2017 <b>Achieved</b></li> <li>3. Conclude contract negotiations achieving a £0.5m increase in GIDS and £200k increase in CCG contracts <b>achieved</b></li> <li>4. Refresh Patient Services Commercial Strategy February 2017 <b>Progress made, growth areas being reviewed in April at Joint Boards and SCC</b></li> </ol>		<b>Next Milestones</b> <ol style="list-style-type: none"> <li>1. Presentation of potential new business opportunities to be made to April Strategic &amp; Commercial Committee</li> <li>2. Initiate consultancy work on international education and training</li> </ol>	
<b>Progress in achieving milestones in last quarter</b>	<input type="text" value="A"/>	<b>Overall Progress on Achieving Outcome</b>	<input type="text" value="A"/>

**Aim 5 – Delivering a sustainable financial future for the Trust**

<b>5B: Deliver the Trust's agreed control total</b>		<b>Accountable Director: Director of Finance</b>	
<b>Success Criteria</b> <ul style="list-style-type: none"> <li>- Control total of £800k in 2016/17 and £950k in each of 2017/18 and 2018/19</li> </ul>			

Current Milestones and Progress	Next Milestones
<ol style="list-style-type: none"> <li>Monthly forecasts reviewed by Management Team - <b>Achieved</b></li> <li>Decision regarding capitalisation of office refurbishment for GIDS - <b>Achieved</b></li> </ol>	<ol style="list-style-type: none"> <li>Review of full year CIPS by EMT in May</li> <li>Agreement with Deloitte's regarding degree of capitalisation of Relocation Project costs</li> <li>Identify income / efficiency gap – by end of June</li> </ol>
<b>Progress in achieving milestones in last quarter</b>	<b>Overall Progress on Achieving Outcome</b>
G	A

**Aim 5 – Delivering a sustainable financial future for the Trust**

<b>5C: To develop a 2017/8 budget for the Trust in line with our Control Total</b>	<b>Accountable Director:</b> Director of Finance
<b>Original Key Success Criteria:</b> <ul style="list-style-type: none"> <li>2017/18 Budget set to deliver a surplus of £950k</li> <li>Efficiencies to achieve Budget identified and agreed with Budget holders</li> </ul>	

<p><b>Current Milestones and Progress</b></p> <ol style="list-style-type: none"> <li>1. November 2016 Board agreement to confirm 2017/18 and 2018/19 Control Totals - <b>Complete</b></li> <li>2. Major contracts signed off by 23 December 2016 - <b>Complete</b></li> <li>3. Budget holders 'sign off' agreed efficiencies necessary to achieve Budget – <b>Complete (partial)</b></li> <li>4. Budget approved by March 2017 Board - <b>Complete</b></li> </ol>	<p><b>Next Milestones</b></p> <p>See 5b above</p>
<p><b>Progress in achieving milestones in last quarter</b></p>	<p><b>Overall Progress on Achieving Outcome</b></p>
<p>G</p>	<p>A</p>

F- PUBLIC DEBATE AND DISCLOSURE

**Aim 6 – Raising the Trust’s profile and its contribution to public debate and discourse**

<b>6A: To agree and implement the Trust’s Public Affairs Strategy</b>		<b>Accountable Director:</b> Director of Communications
<p><b>Success Criteria</b></p> <ul style="list-style-type: none"> <li>- Increased media profile and enhanced reputation as thought leader</li> </ul>		
<b>Current Milestones and Progress</b>		
<p><b>1.</b> Maximise reach and positive coverage of Kids on the Edge and kick start next major documentary project (probably FDAC). <b>This was done and a report was drawn up and circulated.</b></p> <p><b>2.</b> Successfully tender for an independent reputation audit. <b>This was done, though rather last minute as decision to fund was delayed.</b></p> <p><b>3.</b> Establish internal mechanisms to implement Public Affairs strategy. <b>This was not done. In light of going ahead with the reputation audit, the PA work was kicked slightly into the long grass but is being picked up now.</b></p> <p><b>4.</b> Secure positive coverage (proactively) and online content for Trust projects and services which illustrate one of the three areas of focus identified in the Public Affairs Strategy. <b>We have done this where possible, though a lot of our media work remains about GIDS. We did have some notable wins around FDAC.</b></p> <p><b>5.</b> Insightful and actionable reputation audit that informs our public affairs strategy. <b>Now under way.</b></p>	<p><b>Next Milestones</b></p> <ol style="list-style-type: none"> <li><b>1.</b> Kick-start reputation audit to inform communications and public affairs strategy.</li> <li><b>2.</b> Establish internal body to govern public affairs, alumni and centenary work.</li> <li><b>3.</b> Select preferred bidder for FDAC documentary, conduct initial scoping and research and pitch successfully to major TV channel.</li> <li><b>4.</b> Prepare communications strategy and stakeholder engagement plan for relocation project.</li> <li><b>5.</b> Refresh Tavistock Clinic Foundation website with view to fundraising event in September.</li> </ol>	<p style="text-align: center;">A</p>
<b>Progress in achieving milestones in last quarter</b>		A
<b>Overall Progress on Achieving Outcome</b>		
A		A

**Aim 6 – Raising the Trust’s profile and its contribution to public debate and discourse**

<p><b>6B: To develop, deliver and maintain an alumni function which creates a 'community of practice' and significantly reinforces the lifelong relationship between the Trust and its alumni.</b></p>	<p><b>Accountable Director:</b> Director of Communications and Director of Education</p>
<p><b>Success Criteria</b></p> <ul style="list-style-type: none"> <li>- Successful promotion campaign leading to a steady rise in alumni numbers</li> <li>- Relevant and popular series of events and opportunities</li> </ul>	<ul style="list-style-type: none"> <li>- Creating a real sense of community and connection for past students</li> <li>- Developing Tavi ambassadors</li> </ul>
<p><b>Current Milestones and Progress</b></p> <ol style="list-style-type: none"> <li>1. Continue to increase number of registered alumni and introduce cards.</li> <li>2. Develop a suite of events across 2017 following on from initial first event.</li> <li>3. Use alumni function to actively promote book launches, policy seminars and other activities that contribute to establishing the Trust as a thought leader.</li> <li>4. Create an alumni newsletter and identify contributors and ambassadors for the Trust.</li> </ol>	<p><b>Next Milestones</b></p> <ol style="list-style-type: none"> <li>1. See 6A 2. above.</li> <li>2. Review performance against alumni strategy and ensure all aspects of the function are established and in a manner informed experience and feedback from first year of operation.</li> <li>3. Continue to organise events and use alumni function to actively promote book launches, policy seminars and other activities that contribute to establishing the Trust as a thought leader.</li> <li>4. Create an alumni newsletter and identify contributors and ambassadors for the Trust. [carried over]</li> </ol>
<p><b>Progress in achieving milestones in last quarter</b></p>	<p><b>Overall Progress on Achieving Outcome</b></p>
<p>G</p>	<p>A</p>

**Aim 6 – Raising the Trust’s profile and its contribution to public debate and discourse**

<p><b>6C: To secure further prestigious external grant funding for research, contributing to raising the Trust’s profile as a leader nationally and internationally in the clinical and training domains</b></p>	<p><b>Accountable Director:</b> Medical Director</p>	
<p><b>Success Criteria</b></p> <ul style="list-style-type: none"> <li>- Achieve further grant funding</li> </ul>	<ul style="list-style-type: none"> <li>- Contribute visibly to research where funding is held by other organisations</li> </ul>	
<p><b>Current Milestones and Progress</b></p>	<p><b>Next Milestones</b></p>	
<p>1. Deliver successful recruitment on NIHR programme grant</p>	<p>RS and EK co-applicants on NIHR grant to evaluate VIPP-FC. Next milestone delivering screening and recruitment in First Step service.</p>	
<p>2. Develop relationships with potential co-applicants in HEIs, Trusts and Third sector</p>	<p>MOSAIC collaborating on EPPIC-ID (Parent Mediated Intervention for challenging behaviour in Pre-school children with Intellectual Disability). Again challenge is delivery of recruitment.</p>	
<p>3. Hold workshops with potential partners to shape applications</p>	<p>Recruitment site on DfE funded CYP MH research and evaluation in schools.</p>	
<p>4. Submit further research grant applications</p>	<p>Collaborations being built for NIHR HS&amp;DR themed call on gender identity services. Stage 1 submission September 2017</p>	
<p><b>Progress in achieving milestones in last quarter</b></p>	<p><b>Overall Progress on Achieving Outcome</b></p>	<p>G</p>

**G- INFRASTRUCTURE TO SUPPORT WORK**

**Aim 7- Develop our infrastructure to support our work**

<p><b>7B: To implement the IM&amp;T strategy for the Trust which better supports our work and staff</b></p>	<p><b>Accountable Director:</b> Director of Technology and Transformation</p>
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**Aim 7- Develop our infrastructure to support our work**

<p><b>7A: To agree a Full Business Case for the best long term accommodation for the Trust's businesses</b></p> <p><b>Accountable Director:</b> Director of Finance</p>	<ul style="list-style-type: none"> <li>- Full Business Case approved by Board and NHS England</li> <li>- Staff 'buy in' to preferred option</li> </ul>
<p><b>Success Criteria</b></p> <ul style="list-style-type: none"> <li>- Confirmation of preferred option</li> <li>- New site identified (if appropriate)</li> <li>- Required funding obtained</li> </ul>	<p><b>Next Milestones</b></p> <ol style="list-style-type: none"> <li>1. Heads of Terms with vendor of preferred site agreed by July 2017</li> <li>2. Bridging finance for project to be confirmed</li> <li>3. Brief for design competition agreed (June)</li> </ol>
<p><b>Current Milestones and Progress</b></p> <ol style="list-style-type: none"> <li>1. Revised costings / financial appraisal presented to the Council of Governors - <b>Complete</b></li> <li>2. If appropriate new site identified and Heads of Terms Agreed – <b>In progress</b></li> <li>3. If new site not appropriate, then outline plan for redevelopment agreed – <b>not relevant</b></li> </ol>	<p><b>Overall Progress on Achieving Outcome</b></p> <p style="text-align: right;">A</p>
<p><b>Progress in achieving milestones in last quarter</b></p>	<p style="text-align: right;">A</p>
<p><b>Success Criteria</b></p> <ul style="list-style-type: none"> <li>- Delivery of projects related to the Infrastructure IMT strategy theme</li> <li>- Delivery of projects related to the Information IMT strategy theme</li> </ul>	<ul style="list-style-type: none"> <li>- Delivery of projects related to the Services IMT strategy theme</li> </ul>
<p><b>Current Milestones and Progress</b></p>	<p><b>Next Milestones</b></p>

<ol style="list-style-type: none"> <li>1. Complete Network Refresh procurement and replace network hardware at the Tavistock Centre Reallocation of IMT resource to the delivery of Adult GIC project has resulted in a delay in all other IMT projects. The procurement exercise will not commence until Q1 2017/18.</li> <li>2. Complete migration of Trust email to modern platform and Office365 Complete. A follow on project to enable Office365 for patient data will be undertaken in Q3 2017/18.</li> <li>3. Complete eReferral, Data Warehouse and Analytics (Phase 1) &amp; GID Telemedicine projects Reallocation of IMT resource to the delivery of Adult GIC project has resulted in a delay in all other IMT projects. The projects will not commence until Q2 2017/18.</li> <li>4. Implement new Service Desk and PPM systems Procurements complete and technical implementation complete. Deployment delayed to Q1 2017/18</li> </ol>	<ol style="list-style-type: none"> <li>1. Develop a revised IMT programme for 2017/18 and agree at both IMT Steering Committee and Wider Management Team</li> <li>2. Complete the Network Refresh procurement exercise and select preferred bidder. Contract signature to be in Q2 2017/18</li> <li>3. Deploy the new Service Desk and Programme and Project Management systems</li> <li>4. Develop and present a business case for Trustwide Scheduling to Trust Board</li> <li>5. Develop and present a draft Transformation Strategy to Trust Board</li> </ol>
<p>Progress in achieving milestones in last quarter</p>	<p>Overall Progress on Achieving Outcome</p>
<p>A</p>	<p>A</p>

## Board of Directors : July 2017

**Item :** 9

**Title :** North London Partners in Health & Care  
Sustainability and Transformation Plan

**Summary:** Along with other organisations in the STP we are being asked to consider and approve the latest version of the STP for North Central London.

**For :** Discussion and approval

**From :** Chief Executive

## North London Partners in Health & Care Sustainability and Transformation Plan

### 1. Introduction

- 1.1 The *North London Partners in Health & Care Sustainability and Transformation Plan (STP)* has been produced by all the main healthcare organisations and local authorities within North Central London. It sets out plans to meet the challenges faced locally and to deliver high quality and sustainable health and care services in the years to come.

### 2. Background

- 2.1 Following publication of the *Case for Change* in September 2016, the draft STP was submitted to NHS England on 21<sup>st</sup> October 2016 and was published in November 2016. The draft plan was described as a ‘work in progress’ and we invited comments from the public and other stakeholders while we continued to develop the more detailed delivery plans.
- 2.2 An updated version of the draft STP was published in February 2017 to reflect the more detailed work that had taken place in advance of agreeing NHS contracts at the end of December 2016 for 2017/18 and 2018/19. A commitment was made to publish a more complete update of the STP, including an updated financial analysis by the end of April 2017.

### 3. Updated plan

- 3.1 The updated plan confirms the overall vision we put forward in October 2016 and reflects the detailed more granular planning which has been undertaken over the last six months. All comments received on the draft plan have been responded to and where applicable addressed in the updated plan.

### 3.2 The plan sets out:

- Our vision: A place where no-one gets left behind
- Our strategic framework for change covering prevention; service transformation; productivity; and enablers
- The programme governance to achieve the change
- Detailed plans for prevention; health & care closer to home; urgent & emergency care; planned care; mental health; cancer; maternity; children & young people; workforce; estates; and digital
- An updated financial analysis, including investment plans
- Our approach to communications and engagement
- Equalities analysis and impact assessment
- Conclusion and next steps

3.3 Although we are committed to publication of the STP as part of our commitment to openness and transparency, it remains a technical planning document. We will therefore also produce an updated plain English public facing summary of the plan.

3.4 In line with national thinking as set out in the *Next Steps on the Five Year NHS Forward View* document published at the end of March 2017, we have reframed the STP as a partnership of health & care organisations: *North London Partners in Health & Care*. Other London STPs have adopted a similar approach. The Communications & Engagement workstream proposed the move away from 'North Central London' as North London better reflects the identity of the area we cover. In the future we hope to be able to widen the partnership to include for example the voluntary and community sector.

## 4. Financial position

- 4.1 We have worked hard to identify opportunities to deliver efficiencies in the way in which we deliver health and care. This plan sets out the impact we believe we can achieve. However the plan does not yet balance the finances, either next year or by 2020/21. There are significant pressures on budgets particularly in 2017/18. We will continue to look for opportunities for further efficiencies, including one-off measures that can improve the financial position in the short run pending full implementation of the transformational changes which we plan to deliver over the next few years.
- 4.2 We know that this is probably not be enough to bring our plan into financial balance. To support our plan, we will continue to work with NHS England and NHS Improvement to help us to produce a set of affordable NHS plans 2017/18 as part of the *Capped Expenditure Process*. This aims to help us deliver the best possible clinical outcomes for local people within the funding available. Commissioners and providers will work together on this process through our existing STP partnership arrangements in agreeing plans, engagement, undertaking impact assessments and delivery.
- 4.3 Any proposals from the Capped Expenditure Process will be need to be fully assured they are consistent with constitutional rights for waiting times and patient choice and to ensure that patient safety and quality is safeguarded. If any proposals are developed in relation to service reconfiguration these will be subject to full public consultation in line with our legal duties. As proposals are developed we will ensure that patients and staff are engaged throughout the planning and implementation stages of CEP.

## 5. Next Steps

5.1 Bringing health and care together in a way that is sustainable, while also making improvements to how we deliver services is challenging. The environment in which we work is constantly changing and we must be ready to respond when it does. While we are fully committed to implement the STP as set out, we know our plan will continue to evolve. There may be new opportunities we can embrace, or decisions to be made about the viability of some of the things we currently do. We will work closely with local people and communities and our staff deciding what further changes are needed and in how we implement these changes. At the heart of every decision is our commitment to deliver the health and care the people of North London expect and deserve.

## 6. Recommendations

6.1 The Board is asked to:

- NOTE the reframing of the STP partnership of health & care organisations: *North London Partners in Health & Care*
- ENDORSE the *North London Partners in Health & Care* Sustainability and Transformation Plan
- NOTE the intention to produce a plain English public summary of the plan
- NOTE the commitment to continue to work with NHS England and NHS Improvement to produce a set of affordable NHS plans for 2017/18 as part of the Capped Expenditure Process
- DISCUSS the next steps

Paul Jenkins  
Chief Executive  
17<sup>th</sup> July 2017





**Working together for  
better health and care:  
our sustainability and  
transformation plan**



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## Foreword

Welcome to our plan for health and care in North London.

Health and social care services in North London have become 'partners in health and care' to improve the access and quality of services, and to make the system more efficient. As partners, we serve a population of more than 1.5 million people from the London boroughs of Barnet, Camden, Enfield, Haringey and Islington.

This is our plan for changing the way the health and social care services in North London work, to bring them together to provide the entire local population with access to the best possible health, care and wellbeing services, and to make North London a place where no-one is left behind.

We have a proud history of providing high quality health and care services. We have an important role to play in delivering the **NHS Five Year Forward View** and other national health and social care policy. We need to ensure our services can adapt to meet future needs and are financially sustainable against a backdrop of increasing demand. In particular, we need to support services work better together, both in hospital and the community, to keep people well and independent and to help them recover when they are unwell.

On 31 March, NHS released the **Five Year Forward View Next Steps**. This update provides us with an opportunity to relook at our local plan and to make some adjustments so that our focus remains aligned to the national priorities while delivering at local level.

Our current system is unsustainable. The health and social care needs of our local people are changing and the way we are currently organised means that waiting times for some services, as well as the health outcomes vary. As our population ages, we now need to consider how people will receive care and what that care may look like. We believe there is the scope to provide more services closer to people's homes. Working alongside local authorities, we can design and deliver the right care in the right setting so that everyone can live and age with dignity. We need to do more to recognise the mental health as well as the physical health needs of our population. We want the standard of care and people's experience of health and social services to be of the highest quality.

Our financial situation remains challenging as the demand for health and social care continues to grow year on year, exceeding any increase in funding.

We have worked hard to identify challenging but achievable opportunities to deliver efficiencies in the way in which we deliver health and care. This plan sets out the impact we believe we can make. However, the plan does not yet balance the finances, either next year or by 2020/21. There are significant pressures on budgets particularly in 2017/18. We will continue to look for opportunities for further efficiencies, including one-off measures that can improve the financial position in the short run pending full implementation of the transformational changes that we plan to deliver over the next few years.

We know that this is probably not be enough to bring our plan into financial balance. To support our need to achieve financial balance, we will continue to work with NHS England and NHS Improvement as part of the Capped Expenditure Process to help us to produce a set of affordable NHS plans 2017/18, which potentially includes difficult choices. This aims to help us deliver the best possible clinical outcomes for local people within the limited funding available.

Bringing health and care together in a way that is sustainable, while also making improvements to how we deliver services, is challenging. The environment in which we work is constantly changing and we must be ready to respond when it does. Our plan will continue to evolve. There may be new opportunities we can embrace, or decisions to be made about the viability of some of the things we currently do. We will work closely with local people, communities and our staff when deciding what further changes are needed and in how we implement these changes. At the heart of every decision is our commitment to deliver the health and care the people of North London expect and deserve.



## Executive summary

It has been over a year since we came together as a partnership of 21 health and social care organisations in North London. During this time, we have invested time, energy and resources into building strong relationships with each other and developing a shared vision for a health and care system that can deliver high quality services to our community where and when they need, while becoming more sustainable.

We have undertaken significant work to identify, articulate and quantify the specific gaps in health and wellbeing; care and quality; and our baseline financial position. We agree on the nature and scale of the challenge described in our **Case for Change** (published September 2016).

Creating a healthier population is at the heart of our plan. Our vision is for our community to be happier, healthier and to live longer in good health. To do this we must embrace the opportunities that working together can deliver. We must look to emerging technologies and finding new and better ways of working that can eliminate duplication and waste and we must develop and support a motivated, highly skilled and professional workforce to serve North London.

As partners we have a shared vision, a collective agenda and the commitment to transform the health and care services of North London.

Every day the media report on the pressure experienced by the health and social care system. We know that to meet the demands of our population now and into the future we must do things differently. We have already invested time and resources into finding new ways of working. Our community has told us they want a more joined up and integrated health and care system, they want care closer to where they live and work, delivered by professional and compassionate health and care workforce. Some of our boroughs, such as Islington and Haringey, already have a strong history of working together and we know there some similarities in the health and care profile of the North London populations. We want to use this collective knowledge to deliver better health and care services to the North London community and to ensure we have a system that is efficient, effective and sustainable.

To build a better health and care system we must also look at the social determinants of health and wellbeing. There are high levels of poverty, mental ill health and employment insecurity. In general, life expectancy is increasing, but for many people, the last 20 years of their life is lived in poor health. As a result, older people often require a lot of support from health and care services.

Working together presents an opportunity for our health and care services to focus on the people we commission and provide services for. We want to share the collective responsibility for meeting the mental and physical health and care needs of the North London community and to help make our community more resilient.

Our greatest aim is to help people to be, stay or regain good health and wellbeing. To do this we must take a preventative approach, build strong community services and improve health and care outcomes for people. Working together in this way will allow us to look across the system at how services are provided and identify opportunities to add value, improve outcomes and eliminate duplication and reduce costs.

Our vision is for North London to be a place where our people experience the best possible health and wellbeing. North London is a place where no-one is left behind.

To achieve our vision, this plan must result in real and demonstrable improved health and care outcomes for the people. Our community will experience the benefits of improved health and wellbeing, better services delivered within the available resources for our health and care system.

We currently project a financial deficit across the NHS organisations in North London of £234m in 2016/17. If we do nothing, by 2020/21 we project this financial deficit in health will rise to £811m plus a funding gap across North London councils on social care and public health of a further £247m. Our plans reduce this financial deficit across the NHS organisations to £75m by 2020/21 but we clearly need to continue to work to identify further opportunities for efficiencies to ensure that we have financially sustainable services.

In respect of the 2017/18 financial position specifically, current plans fall short of the 'control total' targets set by NHS England and NHS Improvement for the CCGs and NHS Trusts across North London. Currently North London CCGs and Trusts are assessed as c£60m away from delivering the 2017/18 target, with further risks of delivering already challenging savings plans on top of this

We will therefore continue to work to identify additional efficiencies that will help to reduce this residual gap and this includes working with NHS England and NHS Improvement as part of the Capped Expenditure Process to help the NHS produce a set of affordable plans for 2017/18.

We have in place a governance structure to enable NHS and local government organisations to work together in a new way to deliver our plan. It is crucial that whole system is aligned and committed to the delivery of this Sustainability and Transformation Plan (STP) and we have ensured the two year health contracts that are in place for 2017/18 - 2018/19 are consistent with the plan's strategic framework (outlined below).

Much work and effort has taken place to provide more detail about our proposals. We have begun to engage with those who use health and care services and we invite the public to work with us to test our thinking and validate that our plans truly reflect their needs.

We are committed to being innovative in our approach; to focusing on improving the health and wellbeing of our community and delivering the best care not only in London, but nationally. Local people deserve to be supported to live happier, healthier and longer lives, and we are fully committed to making this vision a reality.



## Our vision: A place where no-one is left behind

We want to transform North London into a place where no-one is left behind. We are united in our commitment to transforming care to deliver the best possible health outcomes for our local population. This will be done by shifting our model of care so that more people are cared for in 'out of hospital' settings, and through prevention, more proactive care, and new models of care delivery, we can reduce the reliance on secondary care and improve the way people access and receive care.

To deliver on our bold vision, we have designed a programme of transformation with four fundamental elements:

- **Prevention:** We know that many of the health challenges facing our population arise from preventable conditions. We will increase our efforts on prevention and early intervention to improve health and wellbeing outcomes for our whole population;
- **Service transformation:** We know that there are emerging technologies and new and better ways to deliver services. To meet the changing needs of our population we will transform the way that we deliver services;
- **Productivity:** We know that there is duplication and waste that can be eliminated by working together. We will focus on identifying areas to drive down unit costs, remove unnecessary costs and achieve efficiencies, including working together across organisations to identify opportunities to deliver better productivity at scale;
- **Enablers:** We know that there may be untapped resources that can be put to work to improve our capacity. We will build capacity in digital, workforce, estates and new commissioning and delivery models to enable transformation.

Developing our vision in North London has taken time. We have harnessed high quality clinical and practitioner leadership at every stage of the process. The vision for North London initially drew on existing local engagement work which was underway before the STP process started – putting the needs and expectations of the public at the heart of the plan. Leaders across the system agreed the vision in September 2016. This process, alongside more local engagement events, has ensured that our vision is collectively owned across the health and care partnership. We will continue to engage with our population and develop the plan with them throughout the process.

By establishing North London 'Partners in health and care' we will work together to deliver our Sustainability and Transformation Plan (STP) and realise our vision for North London. Our core principles to support our ambition are:

### Our core principles

- We will put the health and wellbeing of our population at the heart of our plan;
- We will work in a new way as a whole system; sharing risk, resources and reward. Health and social care will be integrated as a critical enabler to the delivery of seamless, joined-up care;
- We will move from pilots and projects to interventions for whole populations built around communities, people and their needs. This will be underpinned by research-based delivery models that move innovation in laboratories to frontline delivery as quickly as possible;
- We will make the best the standard for everyone, by reducing variation across North London;
- In terms of health, we will give children the best start in life and work with people to help them

- remain independent and manage their own health and wellbeing;
- In terms of care we will work together to improve outcomes, provide care closer to home, and people will only need to go to hospital when it is clinically essential or economically sensible;
  - We will ensure value for tax payers' money through increasing efficiency and productivity, and consolidating services where appropriate;
  - To do all of this we will do things radically differently through optimising the use of technology;
  - This will be delivered by a unified, high quality workforce for North London.

We are continuing to include staff and residents in the development of our plan. We will continue to engage with people and groups throughout the process so that our conversation with our local community continues to develop and mature alongside our proposals. Each organisation in the partnership is committed to delivering the right service, at the right time, in the right place.

Further detail about how we plan to engage with our patients and residents can be found in the [Communications and Engagement](#) section of this document.



# Our Strategic Framework

To deliver on our vision and achieve an increase in health and wellbeing; meet the highest standards of care and quality; and improve productivity and efficiency, we have designed our five year programme of transformation with four elements:

- Prevention:** Much of the burden of ill health, poor quality of life and health inequalities in North London is preventable. We will increase our efforts on prevention and early intervention to improve both the physical and mental health and wellbeing of our whole population. This will reduce health inequalities, and help reduce the demand for more expensive health and care services in the longer term. Best of all, we can improve the quality of life of our residents and build a more resilient community;
- Service transformation:** To meet the changing needs of our population and to respond to what people have told us they want from health and care services, we will transform the way that we deliver services. This involves taking a “population health” approach: giving children the best possible start in life; strengthening the offers and provision in the local community to ensure that where possible care can be provided out of hospital and closer to home – reducing pressure on hospital services; rethinking the relationships between physical and mental health to ensure that mental health care is holistic and person-centred; and, reducing variation in services provided in hospital. Working in partnership with local authorities, together we can provide a better health and care experience for people when they need it, and in a place that more conducive to recovery or longer term care, supported by caring and compassionate professionals;
- Productivity:** In order to ensure sustainability, we will focus on identifying areas to drive down unit costs, remove unnecessary costs and achieve efficiencies. For providers, this includes implementing recommendations from the **Carter Review** and working together across organisations to identify opportunities to deliver better productivity at scale;
- Enablers:** To increase our ability to provide health and care services for the future we have identified key areas that will support the delivery of transformed care across North London. To do this we must have the necessary architecture in place. This includes digital, workforce, estates, and new commissioning and delivery models.

**Exhibit 1: The North London STP strategic framework**

<b>Social Care</b>	<p><b>Service Transformation</b>  <b>Improves population health outcomes; reduces demand; improves the quality of services</b></p> <ul style="list-style-type: none"> <li>Health and Care closer to home</li> <li>Urgent and Emergency Care</li> <li>Children and Young People</li> <li>Specialised Commissioning</li> <li>Planned Care</li> <li>Mental Health</li> <li>Maternity</li> <li>Cancer</li> </ul>	<p><b>Productivity</b>  <b>Reduces non value-adding costs</b></p> <ul style="list-style-type: none"> <li>Commissioner savings</li> <li>Provider savings</li> <li>System-wide productivity</li> </ul>	<b>Prevention</b>
	<p><b>Enablers</b>  <b>Facilitates the delivery of key workstreams</b></p> <ul style="list-style-type: none"> <li>Digital</li> <li>Workforce</li> <li>Estates</li> <li>New Commissioning and delivery models</li> </ul>		



## Programme governance to deliver the plan

In coming together as a collaborative, we have developed a governance structure, which enables NHS and local government partners to work together in new ways. The objectives of the North London STP governance arrangements are to:

- Support effective collaboration and trust between commissioners, providers, political leaders and the general public to work together to deliver improved health and care outcomes more effectively and reduce health inequalities across the North London system;
- Provide a robust framework for system level decision making, and clarity on where and how decisions are made on the development and implementation of the North London STP;
- Provide greater clarity on system level accountabilities and responsibilities for the North London STP;
- Enable opportunities to innovate, share best practice and maximise sharing of resources across organisations in North London; and
- Enable collaboration between partner organisations to achieve system level financial balance over the remaining 3 years of the Five Year Forward View timeframe and deliver the agreed system control total, while safeguarding the autonomy of organisations.

A detailed governance handbook including the terms of reference for all of the governance groups is available [here](#). A summary of the programme governance is provided below.

The delivery of the plan is overseen by the North London Programme Delivery Board. This is an executive steering group made up of a cross section of representatives from across North London. This group is specifically responsible for providing accountability for the implementation of the workstream plans. Membership includes the Senior Responsible Officers (SRO) of each workstream and SRO leads for CCGs, Providers and Local Authorities. Two subgroups provide advice to the Programme Delivery Board: the Health and Care Cabinet (formerly the Clinical Cabinet) and the Finance and Activity Modelling Group.

The Health and Care Cabinet meets monthly to provide clinical and professional steer, input and challenge to each of the workstreams as they develop. Membership consists of the five CCG Chairs, the eight Medical Directors, clinical leads from across the workstreams, three nursing representatives from across the footprint, Pharmacy and Allied Health Professions representatives, a representative for the Directors of Public Health and representatives for the Directors of Adult Social Services and the Directors of Children's Services respectively.

The Finance and Activity Modelling Group is attended by the Finance Directors from all organisations (commissioners and providers). This group currently meets fortnightly, to oversee the finance and activity modelling of the workstream plans as they develop.

The component workstreams feed into the overarching governance framework. The workstreams are responsible for developing proposals and delivery plans in the core priority areas. Every workstream has its own governance arrangements and meeting cycles which have been designed to meet their respective specific requirements, depending on the core stakeholders involved.

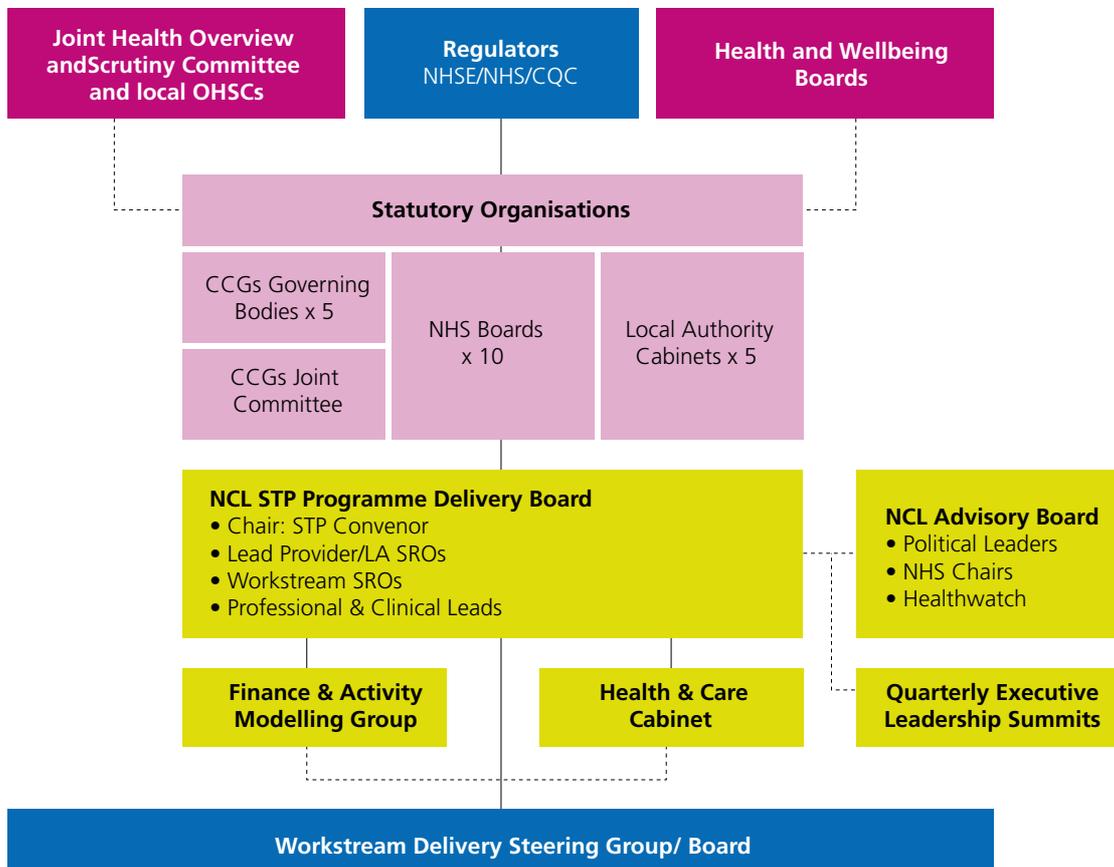
A new STP Advisory Board was established established in June 2017. This group will have an advisory role, enable a collective partnership approach, and act as the 'sounding board' for the implementation of the STP plans. The membership of this group includes Local Authority leaders, NHS Chairs, and Healthwatch. This will go some way to address the democratic deficit and representation of views of the local population, and ensure a better connection with the independent members of NHS boards/governing bodies, local authority leadership, patients, and residents. This group will meet quarterly and a decision whether or not to appoint an Independent Chair will be discussed in due course.

In addition to the above governance groups, CEOs and other relevant executive directors and stakeholder representatives will meet quarterly for executive leadership events to enable continued engagement and momentum, regular communication, and to assist with resolving any programme delivery issues identified by the programme delivery board.

There has been the appointment of a single Accountable Officer for the five CCGs across North London. This will ensure a more collaborative commissioning approach across North London. The Governing Bodies of the five CCGs agree to establish a Joint Committee for some elements of commissioning in North London including:

- All acute services core contracts and other out of sector acute commissioning
- All learning disabilities contracting associated with the Transforming Care programme
- All integrated urgent care (through the Urgent & Emergency Care Boards including NHS 111/ GP Out-of-Hours services)

**Exhibit 2: Agreed programme governance structure**



## Programme resourcing

The implementation of the STP is regarded as business as usual, so the majority of the capacity required to implement the plan will be found from within existing management and clinical capacity within the health & care organisations in North London. In addition we have established a Project Management Office (PMO) which facilitates and coordinates the meetings of the main governance groups, liaises with each of the workstreams to monitor and track delivery plans, as well as delivering communications and engagement support to the programme.

Each workstream has a Senior Responsible Officer (SRO). Some workstreams have shared leadership, where a mixed skillset is required. All of these individuals are senior Executive level - Chief Executives, Medical Directors or Finance Directors - ensuring leadership of the highest quality.

## Health and wellbeing boards

CCGs are required to involve their local Health and Wellbeing Board (HWB) when preparing their commissioning plan so that HWBs can consider whether their draft plans take proper account of the local health and wellbeing strategy. As CCG commissioning plans will be set within the context of the STP, CCGs have engaged with HWBs as we developed the plan and will continue to do so as it is implemented.

## Overview and scrutiny committees

Local authorities have a role in reviewing and scrutinising matters relating to the planning, provision and operation of health and care services in their local area. Local authorities themselves are scrutinised on the delivery of health and social care services for which they are directly responsible and accountable, but commissioners and providers of NHS services must also consult the local authority where they are considering any proposal for a substantial development or variation of the health service in the area. Providers of public health services commissioned by the local authority are also required to consult the local authority in the same way as commissioners and providers of NHS services.

The local authority may scrutinise such proposals and make reports and recommendations to NHS England and the Secretary of State for Health. Legislation provides for exemptions from the duty to consult in certain circumstances, for example where the decision must be taken without allowing time for consultation because of a risk to safety or welfare of patients or staff. As part of the overview and scrutiny process, the local authority will invite comment from interested parties and take into account relevant information available, including that from Healthwatch.

We have a Joint Health Overview and Scrutiny Committee (JHOSC) in place for North London. The JHOSC undertook a review of the draft STP during November and December 2016. The JHOSC heard verbal and written evidence from local residents and a range of other stakeholders at specially convened meetings. This review has generated a report from the JHOSC setting out a number of key principles and recommendations across eight themes, which aim to support and inform the further development and delivery of the STP going forward. The JHOSC also reviewed governance and communications & engagement proposals in March 2017. We continue to work constructively with the JHOSC as the proposals are developed so we can plan ahead for any potential public consultation. In addition, we will discuss plans with any relevant local authority overview and scrutiny committees as we move towards local implementation.

To meet the changing needs of our population we must transform the way that we deliver services and shift the nature of care from reactive to proactive. We will embed prevention in everything we do. This starts with giving children the best start in life and helping people stay healthy and well throughout their lives. We will develop our care closer to home model, and we will create a holistic approach to mental health services. We will improve urgent and emergency care, optimise the planned care pathway, consolidate specialties where appropriate and transform cancer services to improve the treatment and care experience for patients and their families.

## **Implementing our plans**

This work began as an NHS directive. However, we are all committed to ensuring integrated health and social care is what we provide our population. Now health and social care are working together to join up the system. Our collaboration means more joined up health and social care services, this integration is a key success factor in the realisation of our plan.

A robust delivery plan has been developed for each of our workstreams, setting out the scope; objectives; financial and non-financial impact with trajectories; any investment requirements, communication and engagement plans and the key risks to successful delivery.

The delivery plans are live documents and will continue to be reviewed and revised as the programme develops. Each workstream has developed a detailed delivery plan which will provide a reference point for the relevant governance structures and the central PMO to keep planned delivery on track, and to support the effective management of interdependencies between workstreams.

## **Social Care**

Social care plays a crucial role in our plan and is reflected throughout this document. Sufficient, high quality and sustainable social care delivered directly by local authorities (e.g. via social workers) or commissioned through external providers (e.g. in the residential, nursing and home care markets) can deliver excellent outcomes for residents in North London and reduce the burden on health and care services.

However, adult social care faces similar funding challenges to the NHS, as the ageing population with more long term conditions begin to draw on adult social services in the same way they do the NHS. Put together with recruitment and retention issues and a social care provider market under significant pressure, it is important that we invest time and effort in social care and the NHS in equal measure.

Recent measures announced by the Government have begun to ease the financial pressure, but a significant financial gap remains.. In the 2017 Spring Budget, the Chancellor of the Exchequer announced an additional £2bn investment into adult social care from 2017/18 to 2019/20. This is on top of the £2.4bn announced as part of an improved Better Care Fund in the 2015 Spending Review and separately, powers for Councils to raise additional revenue for adult social care through applying a precept of up to 6% over the next three years. The additional £2bn investment equates to £28m for North London Councils in 2017/18 and £55.5m by the end of 2019/20. This is to be spent specifically on adult social care for the purposes of meeting adult social care needs, reducing pressures on the

NHS, including supporting more people to be discharged from hospital when they are ready, and stabilising the social care provider market. North London Councils will be working closely with NHS organisations to implement these measures during 2017/18, using guidance in the new Better Care Fund Policy Framework and Planning Requirements 2017-19. More detail on the financial position of local authorities on adult social care is reflected in the 'Addressing the financial gap' chapter.

Since the publication of the draft plan in October 2016 NHS organisations and local authorities in North London have continued to work together to ensure the STP addresses the challenges across health and social care. As such, many workstream delivery plans now seek to deliver benefits and outcomes from both a health and social care perspective. Directors of Children's Services (DCS) and Directors of Adults Services (DASS) across all five North London Councils have been contributing to the development of the delivery plans where there is an opportunity to work as a system across health and social care.

We have also undertaken some further analysis across North London to understand the nature and scale of the local social economy and pinpoint areas where the NHS and local authorities need to work together closely to deliver better health and care. These areas are summarised below.

### **Hospital admission avoidance and discharge**

Councils' ability to arrange social care packages for adults in North London is a major contributing factor to delays in hospital discharge, albeit it is not the biggest cause. Latest data from NHS Digital shows that 55% of delays are caused by the NHS, 42% by social care and the remainder attributable to both parts of the system. Each Council in North London has a different approach to arranging packages of care and ensuring timely discharge from hospital, therefore there are variations in the length of wait to be discharged from hospital depending on where you live in North London. There are similar variations in the way each Council supports people to avoid unnecessary admission to hospital.

We will be working closely with NHS colleagues as part of the Urgent and Emergency Care workstream to ensure variation is minimised across North London.

### **The social care 'market'**

Under the Care Act 2014, upper tier local authorities have a responsibility to manage and shape their local social care market to ensure the needs of users and carers are met. A significant proportion of social care packages are purchased from an external marketplace of large and small, profit-making and not-for-profit organisations some of which operate nationally and/or locally. Analysis shows that the 42% of delays transfers of care attributable to social care, the majority of these relate to difficulties in sourcing a suitable package of care in a residential or nursing home or in the person's own home with homecare. Analysis of 2016 data from NHS Digital suggests a growing trend in delays attributable to the sourcing of suitable home care vs bedded care, suggesting pressure on homecare market capacity. Local authorities in North London also pay different prices for residential, nursing and home care, even when purchasing the same package of care from the same provider.

High quality, sustainable capacity in these markets are critical to achieving the aims of the STP, both in order to prevent admission to hospital and help with timely discharge, but also in ensuring care can be delivered closer to home and in the community. North London local authorities will be working together to shape and manage the market, working closely with NHS colleagues to ensure shared ambitions are achieved.

## The social care workforce

The social care workforce ranges from social workers directly employed by Councils to care workers employed in the independent sector and family carers who provide care on a paid for or voluntary basis. A study by Skills for Care in 2016 showed that 78% of employed carers in North London worked in the independent sector. Employment terms and conditions can be challenging, with care workers being paid near the National Minimum Wage or London Living Wage (depending on the terms and conditions of the Council in North London) with variances in their contractual terms. Whilst many new starters (73%) in the independent care sector have previous experience of working in adult social care in North London (suggesting we retain our workforce well), the average turnover rate in the region is 21% with some boroughs seeing as many new starters as those leaving the sector. The care sector in North London also employs a large number of non-British nationals (42%), with some boroughs seeing more non-British national employed vs British nationals. Uncertainty on the future of non-British workforce creates additional pressure and anxiety in the marketplace, which is a challenge shared in other public services including the NHS.

North London Councils will be working together with NHS colleagues under the STP workforce workstream to develop capacity and skills in the care workforce.

## Prevention

Much of the burden of ill health, poor quality of life, and health inequalities in North London is preventable. Between 2012 and 2014, an estimated 20% (4,628) of deaths in our community were from preventable causes. By focusing on helping people to stay well we will improve health and wellbeing outcomes for our whole population, reduce health inequalities, and help manage demand for health and care services in both the immediate and longer term.

We will embed evidence-based prevention and early intervention across the whole health and care system. This will include council services, social care and the voluntary and community sector. We will build upon on the individual strengths that each part of the public sector in North London can bring to preventing disease and ill health. As well as traditional 'health professionals' this also means working with local authority housing officers and other organisations such as the London Fire Brigade in preventing falls.

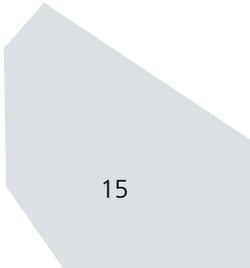
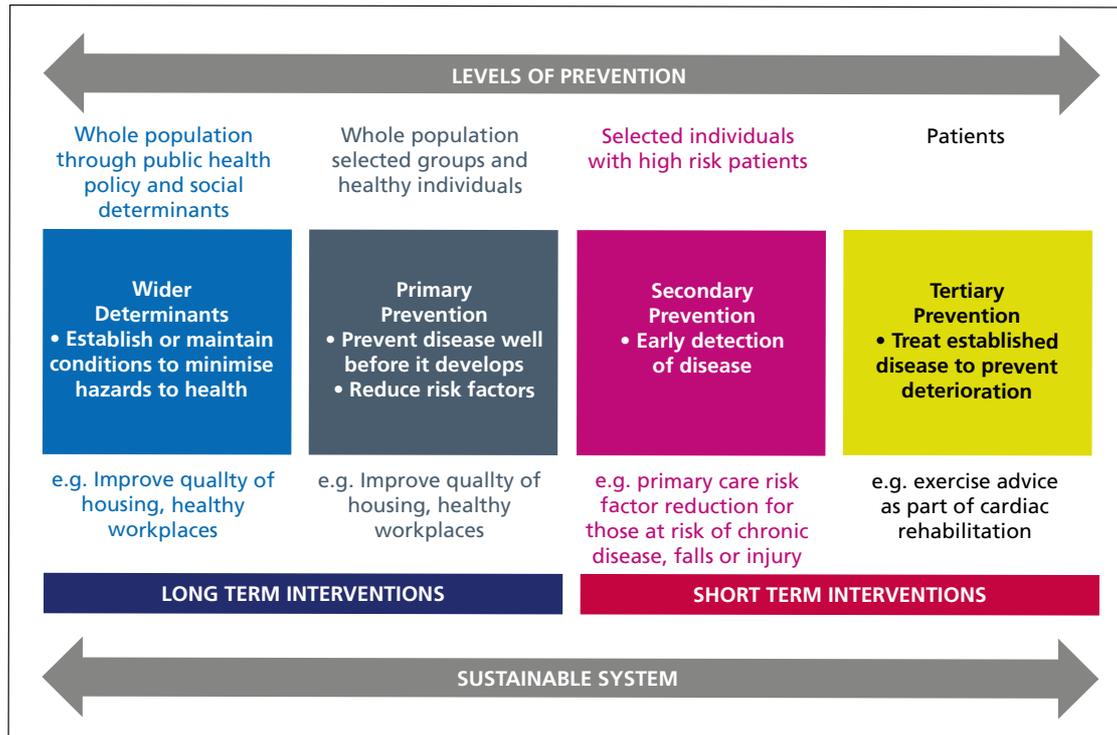
Afrin lives in hostel accommodation and is dependent on alcohol. He experiences seizures almost daily. Afrin has in the past, with support from treatment, managed to gain abstinence but had a relapse which is due to depression brought on by unstable housing and economic circumstances. Afrin has had many unscheduled hospital admissions in the last 6 months. In future, on admission to hospital Afrin will be referred to an alcohol assertive outreach worker by the hospital alcohol liaison worker. This support will enable him to put in place foundations that will help him towards abstinence alcohol assertive outreach worker and recovery. Afrin will be supported to give up drinking, with input from an addictions doctor at a community alcohol service. A slow reduction plan, that is achievable and minimises the risk of seizures, which in the past have led to hospital admission, will be put in place. Afrin will have regular 1-2-1 appointments with his alcohol assertive outreach worker, which will include psychological help.

We also recognise the important contribution that voluntary and community sector organisations can make in achieving disproportionately greater improvements in health for residents with mental ill

health and learning disabilities, specific BME groups, and those in the most deprived communities, and we are committed to working more collaboratively with these organisations.

Our prevention plan focuses on interventions and system change across the whole spectrum of prevention (exhibit 3), where there is strong evidence of effectiveness. We have identified opportunities where we could quickly build upon successful local initiatives across North London to achieve economies of scale.

**Exhibit 3: Approach to prevention**



We will concentrate our efforts on three priority areas with different initiatives:

Workstream	Initiative	Description	Deliverable
Workforce for prevention	Making Every Contact Count (MECC)	Residents will be appropriately directed to services that might be of benefit to them, including lifestyle interventions and those addressing the social determinants of health e.g. debt, employment, housing. The 'brief advice' and signposting given as part of the MECC programmes will increase the numbers of referrals into preventative services.  Residents with mental health issues, including dementia, will be identified more quickly and guided towards the right support service to address their needs.	Increase the number of staff across the health and care system and the wider public sector participating in online MECC training.  Increase the number of frontline health and care staff participating in face-to-face MECC training.
	Mental Health First Aid (MHFA)		Increase the number of non-medical frontline staff (NHS and LA) trained in MHFA.
	Dementia awareness		Increase the number of NHS and social care staff trained in basic dementia awareness.  Commence training for dementia friendly GP practices.
Healthy environments	Haringey devolution pilot	Pioneer new approaches to tackling problem gambling, alcohol misuse and smoking to secure the sustainability of the NHS, and reduce demand on social care by creating a supportive environment where it is easier to make healthy choices.  Prevent people with mental health difficulties from becoming long-term unemployed and claiming ESA benefits by providing effective early help and job retention support.	Rapid application of learning across North London.
	Child Obesity	Reduce levels of childhood obesity, reduce the negative impacts on children's physical and mental health over the short and longer term through ensuring that the settings where children spend their time are recognised as healthy, and promote healthy eating and physical activity.  Reduce the health and wellbeing gap by targeting settings in our most deprived communities and those with a high proportion of children from some BAME groups who are more likely to be overweight / obese.	Increase the number of early years' settings and schools in North London accredited as healthy schools or early years settings.
	Workplace Wellbeing	Build on existing momentum and commitment to promote a culture that improves health and wellbeing of employees, by working with the North London Health Education England lead, North London healthy workplace leads and Healthy London Partnerships to promote a culture that improves health and wellbeing of employees and leads to healthy and productive workplaces.	All North London NHS and local government organisations sign up to and attain at least achievement standard of the Healthy Workplace Charter.

Healthier choices	Obesity	Develop and up-scale the delivery of weight management programmes which include integrated physical and wellbeing activities. Specifically reduce the health and wellbeing gap by targeting those living with a mental illness and a physical condition and those from Black and South Asian minority ethnic groups living in the most deprived areas.	Increase the percentage of overweight/obese residents accessing support. Increase the number of overweight and obese residents losing $\geq 3\%$ of their body weight
	Smoking	Radically up-scale the delivery of smoking cessation activities across North London, and in all parts of the system, as well as increasing the options available to residents who want to quit smoking. This includes: the use of digital (smartphone) apps being developed at a pan London level; increasing community support through the use of the voluntary and community sector; and providing more specialist addiction support for those with highly addictive behaviours.  To reduce the detrimental health impacts on fetuses and young children, there will also be additional support for pregnant women to quit smoking, including the expansion of CO monitoring.  To specifically close the health and wellbeing gap, we will target disadvantaged groups for intervention, including people with serious mental health problems, learning disabilities, specific BAME groups, and those from the most deprived communities.	Reduce smoking prevalence Increase the number of 4-week smoking quitters per year. Reduce smoking related hospital admissions
	Alcohol	Increase in the capacity and reach of alcohol liaison teams, alcohol outreach teams, as well as an increase in alcohol screening rates across North London, to identify and proactively manage via and intensive support programme a complex cohort of high risk and dependent drinkers so that their health needs are stabilised. This will reduce the number of people in crisis and help to avoid repeat hospital admissions and call-outs for blue light services. To reduce the health and wellbeing gap, interventions will be targeting high risk and dependent drinkers who are disproportionately from the most deprived communities.	Reduce alcohol-related hospital admissions  Increase in alcohol screening rates
	Falls	Falls-related hospital admissions will be reduced through the use of a multifactorial intervention combining regular exercise (including strength and balance), modifications to people's homes and regular review of medications, delivered in collaboration across the local public sector organisations and with the voluntary and community sector. This will include collaboration with London Fire Brigade (in Camden and Islington initially) as part of their 'Safe and Well' initiative, as well as identifying people who have had minor falls for early intervention.	Reduce falls-related hospital admissions
	Sexual health - contraception	There will be an increase in the offer and uptake of long acting reversible contraceptives to achieve national average expenditure. Residents will have increased choice and convenience of access of contraceptive methods, including via primary care, maternity, abortion, and early pregnancy loss services. There will also be training and skills development for health professionals and awareness raising and outreach in the community.	Increase the offer and uptake of long acting reversible contraceptives to achieve national average expenditure.  Reduce unwanted pregnancies
	Sexual health – late HIV diagnoses	There will be an increase in the offer and uptake of HIV testing to diagnose people with HIV earlier across the system. New regional on-line services will also help increase access to HIV testing, as will outreach and promotion with higher risk and more vulnerable groups.	Reduce late HIV diagnoses.

We will know we have been successful when:

- Every member of the public sector workforce in North London is a champion for prevention and taking proactive steps to close the health and wellbeing gap;
- Our residents, families and communities are supported to look after their health: smoking and drinking less, eating more healthily, and being more active, as well as looking after their sexual health and mental health wellbeing;
- There are fewer hospital admissions from preventable causes such as smoking, alcohol, and falls, and reductions in associated ill health and early deaths;
- We close the health inequalities gap, through disproportionately greater improvements in health for people with mental health problems and learning disabilities, specific BAME groups, and those in the most deprived communities;
- We start to reverse the trend in childhood obesity, by proactively working across different settings to promote healthier eating and more physical activity among children and young people, as well as using our regulatory powers;
- Those working in North London become healthier, through increased levels of active travel, supporting positive mental health wellbeing, supporting employees to quit smoking and to eat more healthily, leading to reduced absences and increased productivity.

**In 2017/18 we will:**

- Ensure that a prevention focus is effectively embedded in all the other clinical workstreams in the plan.
- Seek to identify investment funding to take forward early implementation of the prevention priorities set out in the plan.

## **Health and care closer to home**

Working closely with all system partners, including hospitals, GPs, Community and Social Care, as well as with Patients/Residents and the voluntary sector, we will deliver the right care at the right time to the whole population.

Health and care will be available closer to home for all, ensuring that people receive care in the best possible setting at a local level and with local accountability. At the heart of the care closer to home model is a 'place-based' population health system of care delivery which draws together social, community, primary and specialist services underpinned by a systematic focus on prevention and supported self-care, with the aim of reducing demand on the system over time. Social care and the voluntary sector will play a key role in the design, development and expansion of the future model.

Ms Sahni is 87 and has four chronic health problems. Previously, she had to book separate appointments with different primary care professionals to have all of the relevant check-ups and appointments that she required. In future, Ms Sahni will be in a special "stream" of patients who will have all of their care co-ordinated by a very experienced GP. This will allow her to see the specialist heart or diabetic nurses at the Integrated Care Centre located at her GP surgery. There will also be a care navigator in the team who can help to sort things out for her at home, including community support when she needs it.

North London has good services, the health and care closer to home model will focus on scaling these services up, reducing variation and making the care closer to home integrated network model the default approach to care and place based commissioning of services. We will address the sustainability and quality of general practice, including workforce and workload issues. It is recognised that for

some people, health and care being delivered closer to their home is not always the best choice, and therefore high quality hospital-based and care home services will continue to be available when needed. The model will make sure services are focused on the care of people within neighbourhoods.

Achieving care closer to home will need to be underpinned by more resilient communities that are able to support residents live independently at home, where that support is needed. The support may be provided by families, carers, neighbours or from voluntary and community groups, all of whom have central roles to play.

Specific interventions that make up the scope of the care closer to home model include:

- **Developing 'Care Closer to Home Integrated Networks'** (CHINs<sup>1</sup>): These may be virtual or physical, and will potentially cover a population of c.50,000 people. They will be home to a number of services including the voluntary and community sector to provide a more integrated and holistic, person-centred community model, including health and social care integrated multi-disciplinary teams (MDTs), care planning and care coordination for identified patients;
- **Quality Improvement Support Teams** (QIST) will also operate from CHINs, to reduce unwarranted variation by providing hands-on practical help for individual GP practices to ensure a consistent quality standard and offer to all patients which will include support for case finding and proactive management of high blood pressure, atrial fibrillation and diabetes;
- **Extended Access:** Patients will be able to access consultations with GPs or other primary care professionals in their local area for pre-bookable and unscheduled care appointments between 8am and 8pm 7 days a week. Telephone triage, virtual consultations and online booking systems will be available for all patients;
- **Social Prescribing:** In line with our prevention agenda, the care closer to home model will include upscaling our smoking cessation activities by nine-fold to reduce prevalence and hospital admissions; increasing alcohol screening and the capacity of alcohol liaison services and alcohol assertive outreach teams across North London; scaling up weight management programmes with integrated physical and wellbeing activities; reducing unplanned pregnancies by increasing the offer and uptake of long acting reversible contraception. The care closer to home model will include a greater emphasis on social prescribing and patient education. Support will be available for patients, carers and professionals to be confident users of information and IT solutions that enable self-management and care, as well as care navigation support to direct patients to the right services.

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<sup>1</sup> CHINS is a working title only – name to be co-designed with patients and residents

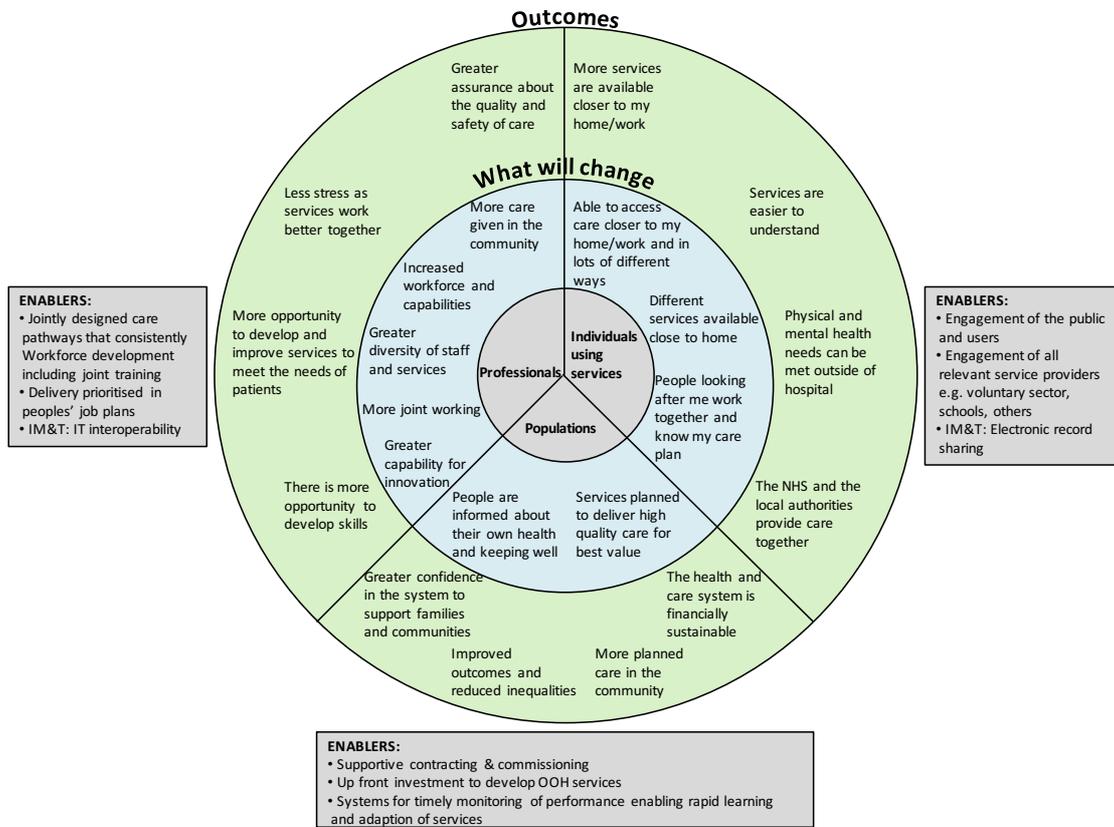
The impacts of three main strands of this workstream are detailed below:

Initiative	Description	Deliverable
<b>Improved access</b>	Patients will be able to access consultations with GPs or other primary care professionals in their local area for pre-bookable and unscheduled care appointments between 8am and 8pm 7 days a week. Patients will be able to access a GP through a variety of different methods such as telephone and e-consultations as well as book appointments and access their records online.	<ul style="list-style-type: none"> <li>• Improved patient satisfaction with access to primary care</li> <li>• Reduced number of patients with a primary care appropriate problem seen in A&amp;E or Urgent Care</li> <li>• A health and care system that is more resilient</li> </ul>
<b>Quality Improvement Support Teams</b>	Improving quality in primary care; and reducing unwarranted variation will also operate from CHINs, including Quality Improvement Support Teams (QIST) to provide hands-on practical help for individual GP practices to ensure a consistent quality standard and offer to all patients. This will include support for case finding and proactive management of high blood pressure, atrial fibrillation and diabetes.	<ul style="list-style-type: none"> <li>• Reduction in unwarranted clinical variation</li> <li>• Reduction in activity and cost of secondary care services</li> <li>• Preventing people from dying prematurely</li> <li>• Enhancing quality of life for people with long-term conditions</li> <li>• Reduction in inequalities in health</li> <li>• Ensuring people have a positive experience of care</li> </ul>
<b>Care closer to Home Integrated Networks (CHINs)</b>	CHINs may be virtual or physical, and will most likely cover a population of c.50,000 people. They will be home to a number of services including the voluntary and community sector to provide a more integrated and holistic, person-centred community model, including health and social care integrated multi-disciplinary teams (MDTs), care planning and care coordination for identified patients. Interventions focused on the strengths of residents, families and communities	<ul style="list-style-type: none"> <li>• Reduction in clinical variation</li> <li>• Reduction in activity and cost of secondary care services</li> <li>• Preventing people from dying prematurely</li> <li>• Enhancing quality of life for people with long-term conditions</li> <li>• Reduction in inequalities in health</li> <li>• Ensuring people have a positive experience of care</li> </ul>

Improving outcomes will be the crucial measure of success of the care closer to home model. The benefits of our health and care closer to home model include:

- Improved patient satisfaction with access to primary care
- Reduced unwarranted clinical variation
- Prevention of people from dying prematurely
- Reduced inequalities in health
- Enhanced quality of life for people with long-term conditions
- More people have a positive experience of care and support to self-care
- Shared learning across CHINs and QISTs and ability to roll out best practice, new technology and new ways of working more quickly across North London

**Exhibit 4: Delivery of the Better Health for London outcomes through the health and care closer to home model**

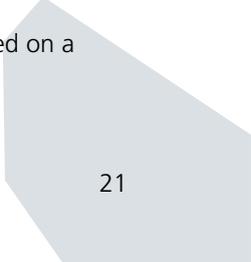


We plan to bring together the funding currently used for Locally Commissioned Services (LCS) and the premium spent on Personal Medical Services (over and above GMS) to establish a single LCS contract framework for the whole of North London. This LCS contract will have agreed outcomes which are shared with the Health and Care Closer to Home Networks (CHINs) and the Quality Improvement Support Teams (QISTs) so that local GPs are provided with the necessary funding and incentives to fully engage with these vital components of the health and care closer to home work. Delivery of this whole system alignment is partly dependent on NHS England (London) delegating commissioning of the PMS premium to the CCGs which is currently under discussion with all key parties.

In support of delivering our health and care closer to home model, Islington CCG has expressed an interest in becoming an Integrated Personal Commissioning (IPC) site to improve health and wellbeing outcomes through personalised commissioning, improved care and support planning and developing an asset based approach to support solutions.

The Integrated Personal Commissioning site will:

- improve outcomes for patients with care delivered closer to home, and aim to reduce unplanned admissions;
- realign service provision in light of new service developments related to IPC and Personal Health Budgets;
- review existing contracts to assess impact and identify opportunities for realignment based on a number of other developments such as New Care Models and IPC.



### **In 2017/18 we will:**

- Offer improved access to Primary Care across the whole of North London: Patients will be able to access consultations with GPs or other primary care professionals in their local area for pre-bookable and unscheduled care appointments between 8am and 8pm 7 days a week.
- Implement the first wave of 'Care Closer to Home Integrated Networks' (CHINs) in each of the boroughs and invest in the corresponding Quality Improvement Support Teams. We aim to achieve comprehensive coverage of these networks during 2018/19

### **Urgent and emergency care<sup>2</sup>**

We are all aware of the pressures faced in A&E departments throughout the country. Every year we hear about breaches of waiting times and ever-increasing the winter pressures. We know the system is overburdened and cannot meet expectations for performance and patient experience.

Over the next five years, we will deliver urgent and emergency care (UEC) services that are reliable, work well together and are easily understood. Our services will be consistent and inspire confidence in patients and professionals; supported by the use of an integrated digital care record that can be accessed across organisations.

The Health and Social Care services within our five boroughs will be working collectively to solve problems that affect a person's care. We will explore new ways of delivering our services to provide the best quality services for the resources we have available. This will span from the moment somebody identifies that they have an urgent or emergency need through to when they return home.

The focus on urgent and emergency care services will reduce confusion about which service people should access, will reduce the number of unplanned admissions to hospital and will support people to return home from hospital as soon as possible. This will improve people's experience of the care they receive when unwell or in crisis and make sure that people have their care on a planned basis wherever possible.

Mary is 83 years old and lives at home with her husband. Mary had a fall at home and injured her ankle. Her husband was unable to help her get up so he called 999 for an ambulance. Mary was taken to the nearest A&E and admitted to hospital, where she is diagnosed with a urinary tract infection (UTI). She was reviewed by the consultant: a plan was put in place for treatment of her UTI and physiotherapy was recommended for her ankle. Over the weekend, Mary's UTI improved, but there was no consultant to review her condition or physiotherapist to provide her care, so Mary was unable to go home. When going to the toilet in the night, Mary fell again and stayed in hospital for a further 2 weeks. Mary became increasingly less mobile and more frail and dependent.

In the future when Mary falls, her husband will dial 999, and a paramedic will be dispatched. When the clinical assessment does not suggest any fractures, the crew will access the local directory of services whilst on scene and electronically refer Mary to the falls response part of the community based admission avoidance team. Mary will then be visited at home by the falls team on the same day, who will design a package of care to support Mary to stay at home. The falls team will be able to make a rapid appointment with her GP or a hospital specialist if they think that Mary would benefit from a medical opinion. Mary will then get the treatment and support that she needs, quickly, to help support her.

<sup>2</sup> This workflow includes all aspects of Urgent and Emergency Care provision delivered in the acute setting, including support for people to leave hospital. Also in scope is the development of a high quality, integrated urgent care system

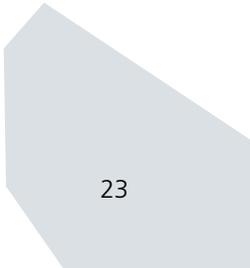
To do this we need to work with local people to understand the urgent and emergency care services that they need and would choose to access. We will work with local people in designing our services to better understand the way they want to use services for an urgent or emergency need.

**Our top priorities are:**

- To create a consistent and reliable Urgent and Emergency Care service by 2021 that is accessible to the public and easy to navigate, inspires confidence, promotes consistent standards in clinical practice and leads to a reduction in variation of patient outcomes
- To review current Urgent and Emergency Care services and compare them against the defined national and London-wide standards
- To implement a high quality Integrated Urgent Care model which complies with IUC ‘top 8’ requirements set nationally
- To develop high quality, responsive 7 day community services, enabling more care to be provided closer to a person’s home
- To develop an enhanced community based, admission avoidance model to support care being provided closer to a person’s home and to reduce the number of avoidable hospital admissions
- To develop high quality ambulatory care services across North London, supporting people to receive acute care on an outpatient/ day case basis and thereby reducing the number of avoidable hospital admissions

The projects that we will be starting with first will focus on:

Workstream	Description	Initiatives	Impact
<b>Enhanced Community Based Admission Avoidance &amp; Ambulatory Emergency Care</b>	Developing high quality, responsive community-based services that work 7 days a week, and support someone to have their care closer to home and therefore not requiring admission to hospital or the need to attend an emergency department.	This focuses on: <ul style="list-style-type: none"> <li>• joining up of all community-based admission avoidance services to support patients to receive their acute care at home, supported by a single point of access ;</li> <li>• developing services in acute trusts to provide same day emergency care to patients to support assessment, diagnosis and treatment; and</li> <li>• developing admission avoidance models to support ambulatory / short stay community based care for paediatrics.</li> </ul>	Key benefits to be achieved include reductions in admissions and readmissions and improved patient experience



Workstream	Description	Initiatives	Impact
<b>Acute Frailty Pathway</b>	Developing the care we provide for frail older people who become unwell to support them to be assessed and treated quickly, so they can remain in their home for as long as possible	This focuses on: <ol style="list-style-type: none"> <li>1. enabling rapid, early, risk-based assessments of elderly people by senior geriatricians and the provision of diagnostic support, therapy, mental health teams, access to care in the community 7 days a week and access to rehabilitation teams through a single point of access;</li> <li>2. enabling rapid treatment of frail older people by standardising services, processes and pathways across North London to ensure that only those requiring admission are admitted to hospital;</li> <li>3. enabling rapid discharge of medically optimised frailty patients.</li> </ol>	Key benefits to be achieved include reducing variation, improving patient outcomes and improving patient flow
<b>Last Phase of Life</b>	Improving the quality of peoples' care within the last phase of their life, to support them to die in their place of choice	This focuses on: <ol style="list-style-type: none"> <li>1. improving the care of care home patients in the last 12 months of life by embedding practice facilitators / case finders in the relevant local community palliative care service to identify, support and record care planning information for care and nursing home residents in their last year of life;</li> <li>2. Specialist Palliative Care (SPC) services working together to reorganise services around two hubs (north and south) to provide SPC advice 7/7 a week, enable Single Points of Access and to reduce inequity of provision;</li> <li>3. Telemedicine - remote Band 7 nurses will support 3-5 Band 5 nurses who visit patients and provide care in community and 'eSHIFT' technology will provide remote access to electronic patient records, enabling Band 5 nurses to communicate key clinical findings centrally, and be given expert advice on next steps.</li> </ol>	Key benefits to be achieved include reducing A&E admissions and non-elective activity, improving end of life care, improving patient experience, and improving the knowledge and care of the social care workforce.

Workstream	Description	Initiatives	Impact
<b>Integrated Urgent Care</b>	Improving and standardising access to Urgent Care across North London to avoid the need to attend an emergency department	This focuses on implementing a high quality Integrated Urgent Care model which brings together current urgent care services such as 111, GP out of hours, Pharmacy, Urgent Care Centres and Minor Injury Units to create a single, unified approach to urgent care in line with the London UEC designation standards	Key benefits to be achieved include a reduction in A&E activity and an increase access to a locality GP/ Primary Care clinician
<b>Simplified Discharge</b>	Addressing the multiple different reasons that mean somebody's discharge from hospital back to their home is delayed	This involves: <ol style="list-style-type: none"> <li>1. establishing a Trusted Assessor Model wherein health and social care professionals complete a single assessment of patients' needs, which can be shared, reducing duplication;</li> <li>2. developing 7 day community services to support discharge processes through the development of single access points, including a North London discharge referral form;</li> <li>3. improving patient flow through the hospital, ensuring the right care can be delivered at the right place at the right time through the implementation of the 'SAFER' patient flow rules;</li> <li>4. supporting shorter hospital stays by ensuring that, where appropriate, an assessment of on-going care and community support needs takes place in an environment familiar to an individual, either at home or using 'step down' beds;</li> <li>5. stroke - transformation of service delivery to implement a consistent approach to the management and delivery of stroke pathways across North London.</li> </ol>	Key expected benefits include reduction in delayed transfers of care, improved patient flow, reduction in readmissions, reduction in excess bed days and improved patient experience results.

**In 2017/18 we will:**

- Join up all community based admission avoidance services to support patients to receive their acute care at home, supported by a single point of access
- Develop services in all acute trusts to provide same day emergency care to patients to support assessment, diagnosis and treatment on a same day basis with no overnight stay
- Develop admission avoidance models to support ambulatory/ short stay/ community based care for Paediatrics

- Implement simplified discharge for stroke patients
- Begin design work to improve and standardise access to Urgent Care across North London to avoid the need to attend an emergency department

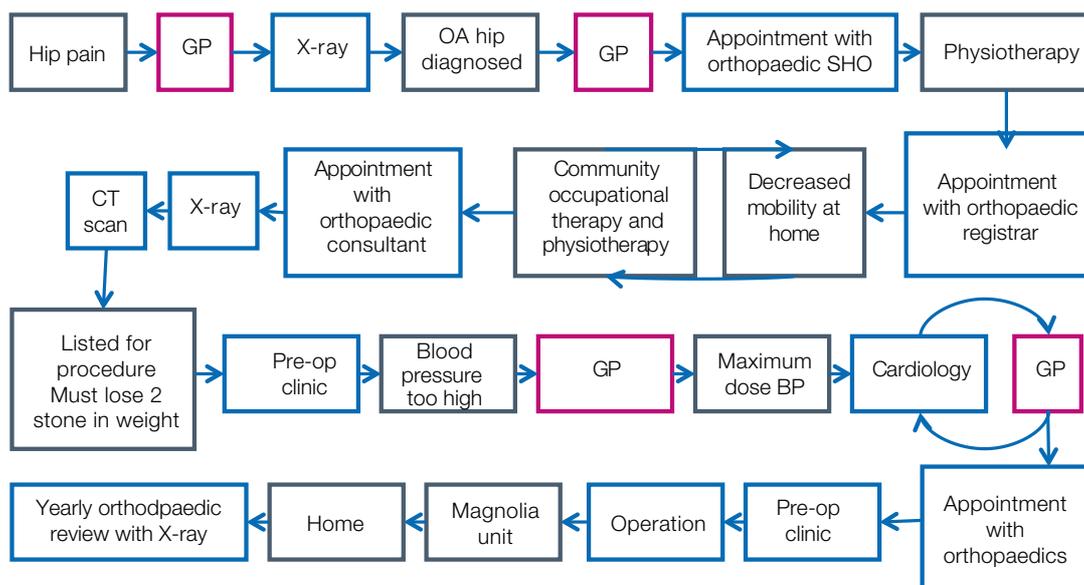
## Planned care

Building on the opportunities identified through RightCare<sup>3</sup>, we will deliver the best value planned care services across North London to reduce unwarranted variation in planned care across providers in North London. This will include;

- Reducing variation in the length of stay in hospital
- Reducing variation in the number of outpatient appointments received by patients with similar needs.
- Optimising pathways to ensure patient safety, quality and outcomes, and efficient care delivery.
- Standardising Procedures of Limited Clinical Effectiveness (PoLCE), consultant to consultant (C2C) referrals and referral threshold policy across North London to ensure parity of care regardless of patient's postcode.

Below is an example of a journey from a patient who was suffering from hip pain. Due to handoffs, inefficiencies and suboptimal advice and information transfers, this patient's pathway continued for more than three years.

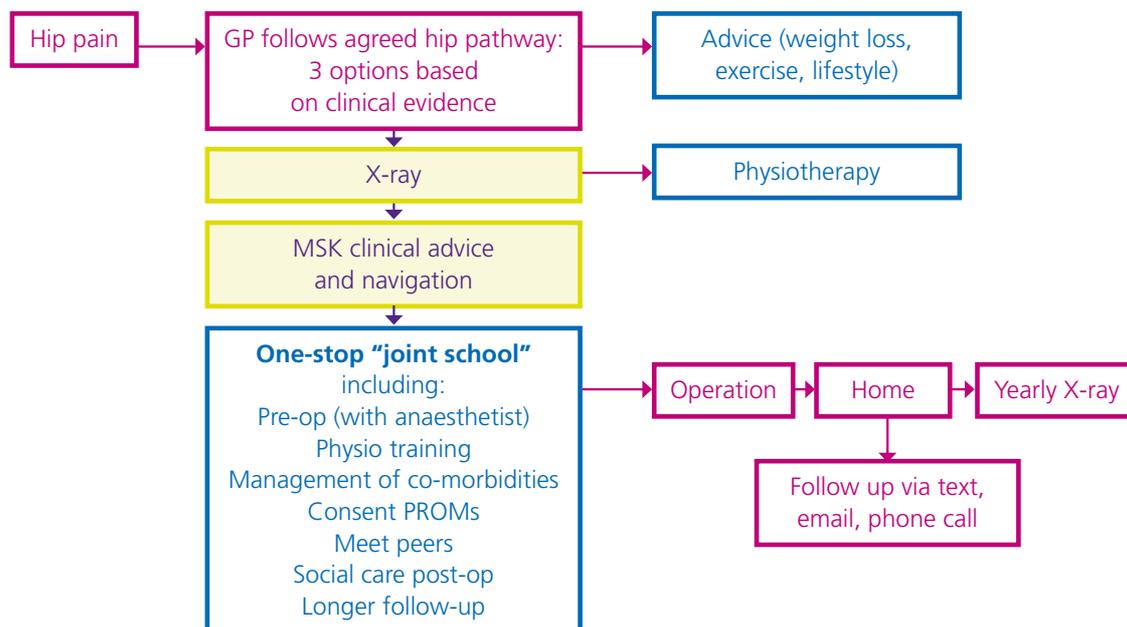
**Exhibit 5: Example of previous patient journey**



Moving forward the planned care workstream will seek to create a system where patient journeys are as efficient, safe and well managed as possible. As a result the new pathway will look more like the below and last a much shorter amount of time.

<sup>3</sup> RightCare Atlas of Variation in Healthcare, September 2015

## Exhibit 6: Example of revised patient journey



As well as delivering efficiency savings, reducing variation in planned care will improve patient outcomes and experience. In order to deliver this the workstream will adopt the following principles:

- Standardised approach to pathway delivery across CCGs and hospitals
- Senior clinical triage and advice with access to multidisciplinary triage where appropriate
- Majority of outpatients managed within a community or primary care based service
- Community services supervised by senior clinicians
- Diagnostics ordered once and only when clinically necessary – reduce over ordering
- One stop service/co-location to improve patient experience
- Follow-up once, and only when necessary
- Patient centred, safe services
- Payment mechanism based on whole system management and clinical outcomes
- Quality of GP referrals and clinical thresholds improved – protocol driven
- Educational support for primary care through training and development led by senior clinicians
- Provision of health and advice telephone lines for clinicians
- Integrated IT/information portal
- Use of technology to deliver virtual services
- Standardised approach to Procedures of Limited Clinical Effectiveness (POLCEs)
- Standardised approach to consultant to consultant referrals

Drawing on local and global examples of best practice and building on the evidence, we will redesign pathways with local clinicians and patients, responding to local needs and opportunities. We will initially focus on areas with high volume or high variability, where there is opportunity to achieve high impact by making changes, such as orthopaedics. A key enabler to the work will be the provision of enhanced advice, based on competency to make sure everyone within the system, including patients, have the right access in order to manage their conditions.

We will leverage the following opportunities for improvement to planned care pathways:

- clinical advice and navigation: ensuring competency based advice and navigation for patients so they are managed in the most optimal way for their condition
- standardised POLCE and consultant to consultant policies: ensuring parity of care and reduction in

handoffs and unnecessary procedures

- expert first point of contact: making sure people have access to the right expertise from their first appointment in primary care
- one-stop services: so that people do not need to attend multiple outpatient appointments before their procedure
- efficient surgical pathways: to ensure maximum use of staff and theatres
- timely discharge planning: to reduce unnecessary time in hospital

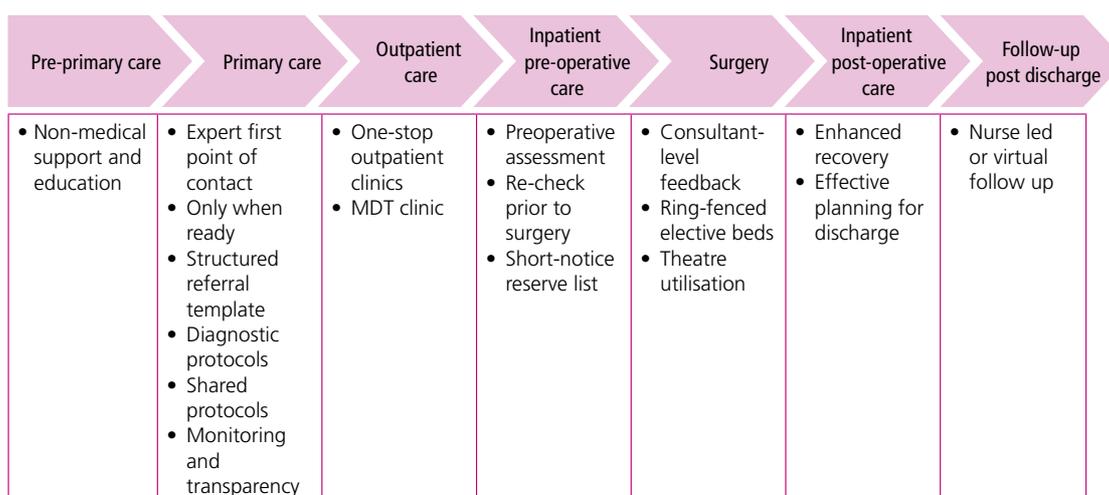
Below is an outline of the eight areas of focus and the resulting benefits for the system:

Workstream	Initiatives	Description	Impact
<b>Group 1 'High volume'</b>	MSK	High volume referrer where extensive work is already being undertaken across North London	<ul style="list-style-type: none"> <li>• Improved patient experience</li> <li>• Improved staff experience</li> <li>• Delivery of associated financial savings with the workstream</li> <li>• Reduction in the number of secondary care attendances</li> <li>• Improved utilisation of inpatient services</li> </ul>
	Dermatology		
<b>Group 2 'Integrated CAN'</b>	Clinical Advice and Navigation	Single point of access for advice and navigation and referral management	<ul style="list-style-type: none"> <li>• Improved patient experience</li> <li>• Improved staff experience</li> <li>• Delivery of associated financial savings with the workstream</li> <li>• Reduction in the number of secondary care attendances</li> </ul>
<b>Group 3 'Work in train'</b>	Neurology	Service that already has work being done within North London that could be adopted using 'follow the fastest' principle	<ul style="list-style-type: none"> <li>• Improved patient experience</li> <li>• Improved staff experience</li> <li>• Delivery of associated financial savings with the workstream</li> <li>• Reduction in the number of secondary care attendances</li> <li>• Improved utilisation of inpatient services</li> </ul>
	Urology		
	Ophthalmology		
<b>Group 4 'Fastest First'</b>	Gynaecology	Service that already has work being done within North London that could be adopted using 'follow the fastest' principle	<ul style="list-style-type: none"> <li>• Improved patient experience</li> <li>• Improved staff experience</li> <li>• Delivery of associated financial savings with the workstream</li> <li>• Reduction in the number of secondary care attendances</li> </ul>
	Gastroenterology		
	Colorectal Surgery	High volume service, identified as priority through stocktake and/or Right Care data	<ul style="list-style-type: none"> <li>• Improved utilisation of inpatient services</li> </ul>
<b>Group 5 'Avoiding the postcode lottery'</b>	PoLCE	Standardisation of thresholds and policy across North London to ensure parity of care provision.	<ul style="list-style-type: none"> <li>• Improved patient experience</li> <li>• Improved staff experience</li> </ul>
	Consultant to consultant referral		
<b>Group 6</b>	Diagnostics	Standardisation of diagnostics thresholds and ordering across North London	<ul style="list-style-type: none"> <li>• Improved patient experience</li> <li>• Improved staff experience</li> <li>• Improved utilisation of diagnostics</li> </ul>

Workstream	Initiatives	Description	Impact
Group 7 'Phase 2'	Vascular Surgery	High volume service, identified as priority through stocktake and/or Right Care data	<ul style="list-style-type: none"> <li>• Integrated pathways and services</li> <li>• Reduction in variation in length of stay</li> <li>• Standardisation of service and pathways across North London</li> <li>• New financial models based on whole system design</li> <li>• Improved patient experience</li> </ul>
	Breast Surgery		
	Hepatobiliary & pancreatic surgery, Upper GI surgery		
	General Surgery		
	ENT	Service that already has work being done within North London that could be adopted using 'follow the fastest' principle	
Group 8 'Local schemes'	Local Schemes	Local CCG specific schemes that do display any initial benefit to North London level work	<ul style="list-style-type: none"> <li>• New local models based on the need of borough or area specific population</li> </ul>

To deliver on the above, a series of interventions will be put in place at each stage of the planned care pathway. These are illustrated and detailed below.

**Exhibit 7: Interventions that support optimised planned care pathways**



Implementation of these high level interventions includes:

- **Better use of non-medical support and education:** promoting non-medical support staff as the first line for minor concerns (e.g. at gyms), greater use of pharmacists, and giving patients access to more information online.
- **Expert first point of contact:** the first person the patient comes into contact with would be a GP with special interest or experienced physiotherapist, who would know the full range of treatment options available. As a consequence of this, more outpatient referrals would have diagnostics already performed and patients would be supported by the right information when they are making decisions about onward treatment.
- **Use of a structured referral template:** allowing all information to be available at the

first clinic appointment. Ideally, this would be an electronic form which would reduce the risk of unnecessary follow up appointments as all relevant diagnostics and information are readily available to clinicians at the initial appointment. Structured referral templates are currently used by some providers and commissioners in North London to good effect, but would be used more widely as part of the optimised planned care pathway.

- **Improved diagnostic protocols:** administrative protocols would be ordered to ensure that the appropriate tests are being conducted to diagnose patients. This would limit repetitive tests being ordered, which is better for patients and optimises resource use.
- **Use of NCL-wide shared protocols:** would ensure that patients are being managed in a consistent way. It would build relationships and teams across the whole system, fostering trust and reducing duplication in tests, appointments and treatments as a result.
- **Only when ready:** patients are only referred when they are ready and available for treatment. This avoids a second GP appointment and re-referral.
- **Better monitoring and transparency:** peer review and support would be established to ensure referrals are appropriate, enabling clinicians to have an open dialogue regarding the quality of referrals and continuously improve their own referral practices.
- **One-stop outpatient clinics:** access to simultaneous pre-assessment and additional diagnostics in a single place, reducing the need for unnecessary follow ups.
- **Multi-disciplinary team (MDT) clinics:** clinics which consist of multiple different people working together to triage to the most appropriate clinician. Consultants, extended scope physiotherapists and GPs with special interests would all working together in a single setting to form the MDT.
- **Pre-operative assessments conducted at the first outpatient appointment:** if patients are not found to be fit, then their plan is reviewed the same day. This would be supported by greater use of e-self assessment by patients in their home. Rehab and post-operative packages of care would be arranged prior to referral, enabling patients who are at risk of staying for long lengths of time in hospital to be proactively identified.
- **Re-check prior to surgery:** patients will be contacted 48-72 hours before their surgery to reduce the risk of late cancellations. This check will ensure patients are still well enough for surgery, and want to go ahead with the planned procedure.
- **Short-notice reserve list:** to ensure that gaps caused by late cancellation can be filled by patients who are ready for treatment which allows theatres to be used most efficiently.
- **Consultant-level feedback:** transparency of list utilisation and case volumes per list. This allows for peer challenge to take place between consultants, to ensure the highest quality and most efficient practices are being maintained.
- **More effective planning for discharge:** discharge planning services will be offered earlier in the process, before patients are admitted to hospital. This will give greater access to community support services, and reduce delays in discharge.
- **Enhanced recovery pathways will be consistently applied:** patients will have a greater understanding of their expected length of stay when they are admitted, and be advised on the best course of action to avoid staying for longer.
- **Ring fenced planned care beds will be available:** to reduce wasted theatre time, and diminish the risk of infection for planned care patients.
- **Theatre utilisation will be optimised:** by scheduling cases and ensuring that critical equipment is properly scheduled to maintain the order and running of lists.

**In 2017/18 we will:**

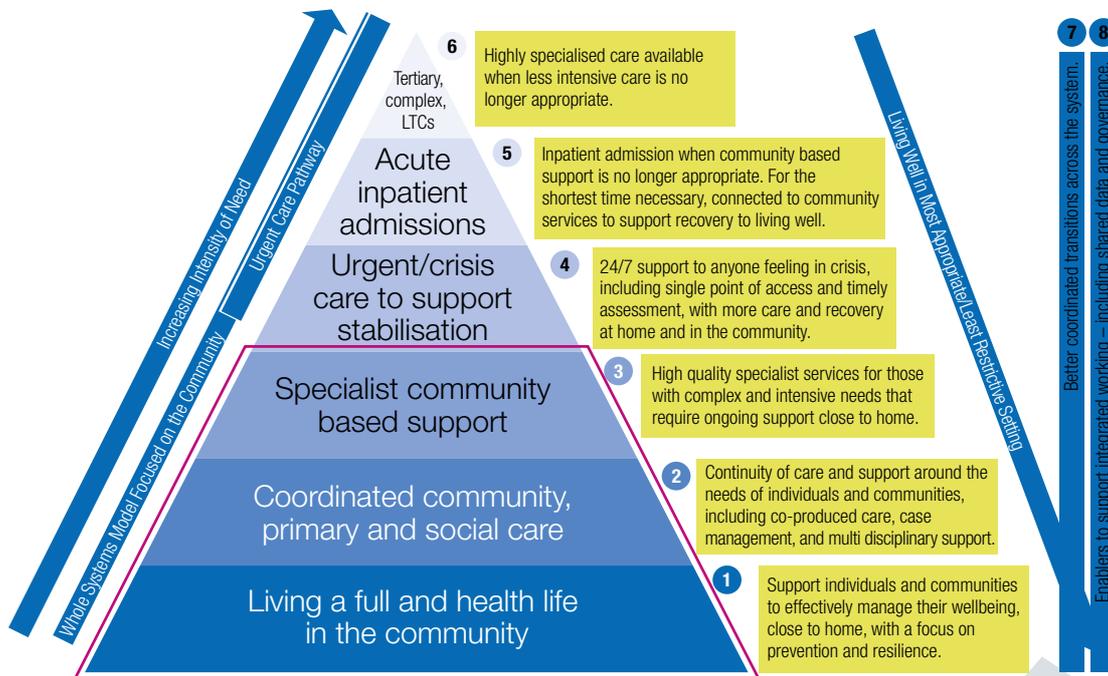
- Work with local clinicians and patients, responding to local needs and opportunities to redesign pathways in:
  - > MSK and Dermatology
  - > Urology, Neurology and Ophthalmology
  - > Gynaecology, Gastroenterology and Colorectal Surgery
- Design a single point of access for advice and navigation and referral management
- Standardise thresholds and policy across North London to ensure parity of care provision through a review of Policies of Limited Clinical Effectiveness and Consultant to Consultant referrals
- Standardise diagnostics thresholds and ordering across North London

**Mental health**

Our ambition is that unless someone requires highly specialised care, they will be able to receive the care they need with North London, and not require an out of area placement. By investing in community based care, we aim to reduce demand on the acute sector and mitigate the need for additional mental health inpatient beds.

We will develop a ‘stepped’ model of care supporting people with mental ill health to live well, enabling them to receive care in the least restrictive setting for their needs. The provision of appropriate social care is a key success factor for people with long-standing mental ill health and this will be central to the success of the stepped model.

**Exhibit 8: The mental health ‘stepped’ model of care**



We aim to reduce demand on the acute sector and mitigate the need for additional mental health inpatient beds. We want to improve overall mental health outcomes across North London and reduce

inequalities for those with mental ill health, enable more people to live well and receive services closer to home and ensure that we are treating both physical and mental ill health equally. We will work towards achieving the key mental health access standards:

- more than 50% of people experiencing a first episode of psychosis will commence treatment with a NICE approved care package within two weeks of referral
- 75% of people with common mental health conditions referred to the Improved Access to Psychological Therapies (IAPT) programme will be treated within six weeks of referral, with 95% treated within 18 weeks.

Through this work we aim to bring all of North London up to the same level of care quality. No matter where in North London you live, you can expect to receive the same high quality care. This includes:

- increase mental health basic awareness, reduce stigma and increase mental health self-awareness
- support at risk population to stay well
- provide more accessible mental health support delivered at locality level
- increased alternatives to admission and support for discharge to enable more people to live well in the community, with better crisis support
- eliminate the need for out of area placement for female service users who require psychiatric intensive care via the female PICU initiative
- give more women access to specialist perinatal mental health services
- make sure more children have access to mental health support and unless highly specialised care is required, eliminate out of area placements for children requiring inpatient support
- more people in A&E and on physical health inpatient wards to have their mental health needs supported
- support more people to spend more time at home, rather than in hospital
- For North London to become more dementia friendly

Maisie suffers from dementia, and is cared for by her husband Albert. Previously, after falling at home, Maisie was admitted to hospital. Due to the accident and change of surroundings, Maisie was agitated and more confused than normal. In future, the hospital will have Core 24 liaison psychiatry meaning that the liaison team will be able to help the hospital support both Maisie's physical and mental health needs. As Maisie will receive holistic care it will mean that she is ready to be discharged sooner than if only her physical health needs were supported. Maisie's husband Albert will also be supported by the dementia service, allowing him to continue to care for Maisie at home.

Broadly the programme covers mental health support for all age groups and the current identified initiatives include:

- Community resilience
- Primary care mental health
- Acute pathway – including Health Based Place of Safety, S136, alternatives to admission
- Female psychiatric intensive care unit (PICU)
- Child and adolescent mental health services (CAMHS) and Perinatal mental health
- Mental health liaison
- Dementia

Over time other areas may be identified which have the potential to deliver savings. Currently out of scope are specialist commissioned mental health services (excluding Tier 4 CAMHS) although this may be reviewed over time.

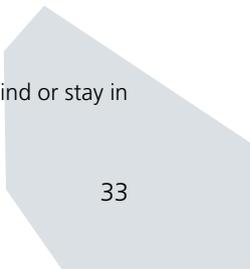
In the development of this model of care we are committed to coproducing with those who have lived experience. We have established an 'experts by experience' group, the EbyE Board, with representation from across our 5 boroughs. The group formed in December 2016, and going forward will be involved in all of our areas of work, and support us in further engagement and coproduction across North London.

Initiatives will cover mental health support for all age groups and include:

Workstream	Description	Impact
<p><b>Improving Community Resilience</b></p>	<p>Both for the general population, and those at risk of developing mental ill health or of becoming more severe.</p> <p>For the general population this includes a health promotion campaign aimed at increasing basic mental health awareness including self-awareness, normalising mental health needs and reducing stigma.</p> <p>For the at-risk population focus will be given to improving access and support through training of non-mental health specialists to recognise mental ill health symptoms, improving service navigation, development of open resources, and provision of individual and group therapies; employment support to help people to maintain and get back into work including through Individual Placement Support<sup>4</sup>; and suicide prevention work to strengthen referral pathways for those in crisis, linked to the local multiagency suicide prevention strategies<sup>5</sup>. This will be delivered in conjunction with other regional and national schemes such as the London digital wellbeing platform. We will continue to build upon current work; for example Barnet CCG and local authority are already working towards a dementia friendly borough by providing lunch clubs, reminiscence therapy and engaging with local shops to raise awareness.</p>	<ul style="list-style-type: none"> <li>• 3% reduction sick days</li> <li>• 165 new jobs via IPS scheme</li> <li>• Reduction in suicide rate</li> <li>• Improved well-being for the general and at-risk population</li> </ul>

<sup>4</sup> Five Year Forward View - 29,000 more people living with mental ill health should be supported to find or stay in work (~725 within North London)

<sup>5</sup> Five Year Forward View - Reduce suicide by 10%



Workstream	Description	Impact
<b>Increasing access to primary care mental health services</b>	Ensuring more accessible and extensive mental health support is delivered locally within primary care services. This will be developed as part of the Care and Health Integrated Networks ; enabling physical health and mental health needs to be treated and supported together <sup>6</sup> . We will offer support directly to patients and support to GPs and other professionals; enabling more people to access evidenced based mental health services <sup>7</sup> , with more care to be offered through Care and Health Integrated Networks rather than requiring referral to secondary care mental health services. Services will include increasing the IAPT offer to reach 25% of need <sup>8</sup> with a focus on supporting people with long term conditions. In 2017/18 the Primary Care Based Mental Health service is being rolled out to all Islington CCG practices. This service provides assessment and support within primary care, as well as training for GPs, so that more people can have their mental health supported in primary care rather than secondary care.	<ul style="list-style-type: none"> <li>• 30% reduction in secondary care MH referrals</li> <li>• Delivery of national IAPT targets</li> </ul>
<b>Improving the acute mental health pathway</b>	Building community capacity to enable people to stay well and reduce acute presentations. This includes developing alternatives to hospital admission by strengthening crisis and home treatment teams; reviewing Health Based Place of Safety (HBPoS) provision with the view to reduce the number of units and to have a sector wide provision that meets all requirements; and investing in longer term supported living arrangements to provide more effective discharge, enabling people to live well in the community. In the southern part of North London a plan is being developed to close the A&E HBPoSs, and move to a purpose built suite at Highgate Centre for Mental Health, this is expected to open in 18/19. In the north section of North London there is the potential to develop a complex rehab ward.	<ul style="list-style-type: none"> <li>• Improved patient experience</li> <li>• Improved stakeholder satisfaction</li> <li>• Reduced LoS</li> <li>• Avoidance of need for additional inpatient beds.</li> <li>• Bed occupancy maintained at 95%</li> <li>• HBPoS provision to meet North London needs</li> </ul>
<b>Developing a female Psychiatric Intensive Care Unit (PICU):</b>	It is important to facilitate local provision of inpatient services to female patients requiring psychiatric intensive care. There is currently none available in North London. Patients will be able to remain close to their communities, with a more streamlined and effective pathway with the focus on recovery. A potential site within North London has been identified, and work is underway to develop the plan further.	<ul style="list-style-type: none"> <li>• Eliminate out of area placements</li> <li>• Improved quality of provision and patient experience</li> <li>• Reduced LoS</li> <li>• Financial savings.</li> </ul>

6 FYFV – at least 280,000 people with severe mental ill health have their physical health needs met (~7,000 within North London)

7 Five Year Forward View - more adults with anxiety and depression have access to evidence based psychological therapies (~15,000 within North London)

8 Five Year Forward View – increased IAPT to reach 25% of need by 2020/21

Workstream		Description	Impact
<b>Investing in mental health liaison services</b>		By scaling up 24/7 all-age comprehensive liaison to more wards and Emergency Departments (EDs), we can ensure more people in Emergency Departments and on inpatient wards being treated for their physical health problems will also have their mental health needs assessed and supported.	<ul style="list-style-type: none"> <li>• Improved patient experience</li> <li>• Improved A&amp;E performance</li> <li>• Average of 1 day reduction in length of stay</li> <li>• Reduction in readmissions</li> </ul>
<b>Investing in a dementia friendly North London</b>		Looking at prevention and early intervention, supporting people to remain at home longer and supporting carers. This will be delivered in line with national standards around dementia.	<ul style="list-style-type: none"> <li>• A dementia diagnosis rate of at least two-thirds of the estimated number of people with dementia.</li> </ul>
<b>Focusing on perinatal and child and adolescent mental health services (CAMHS)</b>	Shared dataset	Develop shared dataset to enable comparison and shared learning across North London	<ul style="list-style-type: none"> <li>• 32% of children with a diagnosable condition being able to access evidence-based services by April 2019</li> <li>• Reduction in LoS and admissions</li> <li>• Elimination of OOA placements</li> <li>• Investment in outreach offer</li> </ul>
	Eating Disorders	Invest in eating disorders	
	Workforce	Planning for a workforce that meets the mental health and psychological well-being needs of children and young people in North London, including CYP IAPT workforce capability programme	
	Transforming Care	Supporting children and young people with challenging behaviour in the community, preventing the need for residential admission	
	Perinatal	Develop a specialist community perinatal mental health team so that more women have access to evidence based specialist perinatal mental health care	
	Child House Model	Following best practice to support abused children in North London	
	Crisis Pathway	Develop an North London crisis pathway that includes 24/7 urgent and emergency mental health service for children and young people with care delivered as close to home as possible for children in crisis, this includes local commissioning of Tier 4 CAMHS, and review of S136 provision	
	Youth Justice	Work with NHS England to develop co-commissioning model for youth justice	

**Focusing on perinatal and child and adolescent mental health services (CAMHS):**

We know 50% of all mental illness in adults begins before 14 years of age and 75% by 18<sup>9</sup>. There is significant financial cost associated with perinatal mental ill health along with negative social/emotional impacts on a child's life, health and wellbeing<sup>10</sup>, Focusing on children and young peoples' mental health and wellbeing and perinatal mental health as key priorities we can improve the long term mental health outcomes for our population. The eight priority areas identified above form

9 Cavendish Square Group

10 Centre for Mental Health and London School of Economics

the joint aspect of the North London Children and Young People (CYP) Transformation Plans. The principles of THRIVE<sup>11</sup> will be used as an overarching approach with the aim of at least 32% of children with a diagnosable condition being able to access evidence-based services by April 2019 as set out in the Mental Health Taskforce.

There are a number of interdependencies across the North London mental health workstream and the other elements of our programme of work. Other areas of work such as workforce are crucial in identifying the future workforce we need in order to deliver these initiatives, which includes new roles and developing new skills.

The Estates workstream is another important enabler of a number of our initiatives. This includes the redevelopment of the Barnet, Enfield and Haringey Mental Health Trust, St Ann's site and the Camden and Islington Foundation Trust St Pancras site in conjunction with the proposed relocation of Moorfields Eye Hospital Foundation Trust to the St Pancras site.

The proposed developments of the St Ann's and St Pancras sites would:

- Transform the current inadequate acute mental health inpatient environments on both sites
- Provide more therapeutic and recovery focussed surroundings for patients and staff
- Improve clinical efficiency and greater integration of physical and mental health care
- Release estates across the trusts, to enable development of community-based integrated physical and mental health facilities
- Develop world class research facilities for mental health and ophthalmology enabling practice to reflect the best evidence
- Provide land for both private and affordable housing, as well as supported housing for service users and housing for key workers.

The delivery of these initiatives, and the realisation of the proposed benefits, is critically dependent on increased investment. For 2017/18 to date we have identified investment of an additional £1.3m and have succeeded in accessing a further £2.5m from national transformation funding.

Priorities for mental health are being taken forward in line with available funding at this stage and with a focus on the ability to test new models of provision and strengthen the evidence base for effectiveness. The STP remains committed to expanding the pace of transformation in mental health care as resources, including national transformation funding become available.

**In 2017/18 we will:**

- Roll out primary care mental health services in Islington
- Establish integrated IAPT capacity in Haringey and Islington
- Map and design the acute care pathway
- Establish a specialist community perinatal mental health team Bid for local commissioning of Tier 4 CAMHS
- Develop core 24 hour mental health liaison services at UCLH and North Middlesex
- Plan the development of a local female PICU to be put in place in 2018/19
- Seek to identify further investment funding to take forward implementation of other priorities in line with the plan

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<sup>11</sup> THRIVE is a population approach to children and young people's mental health developed by the Tavistock and Portman Foundation Trust and Anna Freud Centre which aims to replace the traditional tiered model with one which tailors the response of services to the presenting needs and expressed preferences of young people.

## Cancer

Working in partnership as the UCLH Cancer Collaborative, Commissioners and providers across north central and north east London and west Essex joined together in late 2015 to form the national Cancer Vanguard, in partnership with Manchester Cancer and Royal Marsden Partners, under the auspices of NHS England's new care models programme.

We aim to save lives and improve patient outcomes and experience for those with cancer in North London and beyond by driving changes in delivery of cancer care across a whole health system that will save hundreds of lives, reduce variation and improve quality of care.

Previously Margaret, aged 60, went to see her GP with persistent epigastric pain for several weeks. She was otherwise well, and did not have reflux, diarrhoea, vomiting or weight loss. Over the course of next 3 weeks, Margaret's GP organised tests and ruled out any inflammation, heart problem, or gallstones that could cause the pain. He also started Margaret on a tablet (lansoprazole) to try to reduce inflammation from the acid on her stomach lining. However, Margaret's pain was more persistent this time and she was still worried.

In the new system, Margaret's GP will be able to refer her to the Multidisciplinary Diagnostic Centre at UCLH despite the fact that her symptoms are not considered "red flag". Here, Margaret will be assessed for vague abdominal symptoms. A clinical nurse specialist will see her 4 days after referral. The team will identify that Margaret has early stage pancreatic cancer and because it is picked up early she will be able to access potentially curative keyhole surgery.

Our top priorities are to:

- **Improve survival:** through earlier diagnosis, implementation of best practice and improved access to novel diagnostics and therapeutics
- **Improve patient experience:** by reducing pathway delays (sustainable delivery of 62 day standard), supporting care closer to home and developing integrated patient pathways across primary and secondary care, physical and mental health, health and social care
- **Reduce cost:** using new models of care, reducing variation in pathways and closer integration between providers and across the commissioning landscape
- **Generate new income:** by capitalising on our position of natural competitive advantage in translational and clinical cancer research

Faster diagnosis will be delivered at pace and scale through a range of approaches including the use of decision support tools mobilising primary care in the early detection of cancer, driving the straight to test agenda and effective modelling to focus diagnostic capacity most efficiently on areas of need. Quality of care, variation in treatment and outcomes and improved cancer waits will be tackled through implementing agreed whole pathways of care through diagnosis and treatment to living with and beyond cancer and end of life care. Efficiencies can be further consolidated through innovative service delivery models and partnerships to deliver personalised cancer care from diagnosis to living with cancer and beyond.

Our cancer workstream builds on the platform established by the National Cancer Vanguard and encompasses a breadth of priorities, primarily the recommendations from the National Cancer Taskforce. The key areas of focus include:

- **Early diagnosis:** to address impact of late diagnosis on survival outcomes across North London, we will target specific causes of late diagnosis and poor detection rates. Targeting colorectal and lung pathways are a particular focus given the high percentage of patients receiving late stage diagnoses, often in Emergency Departments. We will roll out the Multi-disciplinary Diagnostic Clinic model for vague abdominal symptoms, promote adoption of straight to test models, implement interventions to increase screening uptake rates, lead innovation in cancer diagnostics and deliver a programme to improve awareness of cancer symptoms in primary care.
- **Pathway improvement:** across the region there is an on-going challenge to ensure that patient' rights under the NHS constitution concerning waiting times for cancer diagnostics and treatments are consistently realised. We are working together as a whole system to understand where the 'pinch points' are that cause delays in pathways, and to be able to 'flex' diagnostic capacity and workforce. We have already enabled reconfiguration of some small volume MDTs to improve diagnostic pathway and workforce efficiency and resilience.
- **Living with and beyond cancer:** working with patients, hospitals and GP practices to support long term self-management, increase care in community settings and improve both understanding and communication of patients' holistic needs between healthcare professionals and with patients.
- **End of life care:** evidence indicates a need for service improvement to ensure that patients are better supported to choose the location for their last days of life. There is also growing evidence indicating a need for better informed clinical and patient decision making concerning the value of therapeutic interventions in the last days of life.
- **New models of care:** we are developing the case for a single provider model for radiotherapy in North London, to help achieve financial sustainability, reduce variation in clinical protocols and improve patient access to research and clinical innovations. This is being explored between the North Middlesex University Hospitals NHS Trust, the Royal Free NHS Foundation Trust and University College London Hospitals NHS Foundation Trust and links the hospital chains Vanguard led by the Royal Free. We will increase provision of chemotherapy closer to home, establishing a quality standard for chemotherapy and supporting self-management. The first patient treatment in the home for breast cancer took place in September 2016.
- **Centre for Cancer Outcomes (CCO):** to deliver robust outcomes data, improve pathway intelligence and address important population health research questions we are developing balanced scorecards which can made available to MDTs, providers and commissioners through a free to access web-based platform. A project on interventions in the last three months of life is about to launch in conjunction with PHE.
- **Cancer Academy:** a new Academy is being launched to provide infrastructure and expertise to develop programmes for patients, primary care, multidisciplinary teams, cancer professionals and staff working in cancer clinical research. The Academy is working closely with partners across London as well as with UCL to collaborate effectively in programme design and delivery.
- **Research and commercialisation:** we will leverage our unique position nationally in cancer to improve care for people with cancer, generate additional revenues across the system, and generate efficiencies by avoiding unnecessary interventions.

We are focused on achieving a step change in key patient outcomes including:

- Deliver Cancer Taskforce aspiration for proportion stage 1 & 2 diagnoses by 2020
- Reduce to the national average or below the proportion of patients diagnosed in an emergency setting
- Achieve and sustain delivery of the 62 day access standard from the 2nd quarter of 2017/18
- Improve patient experience to achieve or exceed national average performance
- Reduce variation in these outcomes across NCEL and close the gap with the best performing regions, aiming for no CCG to be in the lowest quartile for any of these outcomes by the end of 2018/19

- Aiming to improve overall one year survival rate and reduce the current large variation seen across North and East London

**In 2017/18 we will:**

- Achieve a shift in the stage at which patients receive a cancer diagnosis, through a range of access and awareness improvements.
- Agree new care models in chemotherapy and radiotherapy to reduce variation in quality, improve financial sustainability and support care closer to home
- Work to define and capture the outcomes that matter to patients along their pathway from diagnosis to living with and beyond cancer so that this information can be fed back to patients, clinicians, providers and commissioners
- Undertake analysis that will improve patient experience and informed decision on therapeutic interventions during the last days of life.
- Define and implement best practice cancer pathways and service delivery models.
- Reduce wastage and improve value for money from cancer drugs spend

**Maternity**

In 2014-15 there were approximately 20,000 babies born to North London residents and 24,000 births delivered by the local Trusts. In North London there are specialist maternity services centred on a single tertiary level neonatal unit, as well as obstetric, midwifery led-units and home births taking place. The population is diverse and growing and experiences significant fluctuations as people using health and care services move in and out of the city. North London has significant areas of deprivation as well as older women, more likely to be overweight or obese and likely to experience medical complications in pregnancy such as gestational diabetes, when compared with the national averages.

Across North London, fewer women access services in midwifery-led settings, within birth centres and at home than would be clinically indicated. While community midwifery antenatal care is offered by all providers, more care can be provided close to home or work. Women are not being offered choice of care setting or receiving continuity of antenatal or postnatal care. There is a lower than national average score for experience during the antenatal, intrapartum and postnatal periods and perinatal mental health support is varied.

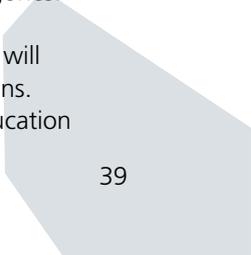
In November 2016, North London was successful in a bid to become an early adopter of the National Maternity Transformation Programme. This programme sets out to achieve the ambitions of the Better Births report - the output from the National Maternity Review conducted earlier in 2016.

Based on the Better Births report, the primary objectives for their Maternity Programme are:

- To improve the experience of women accessing maternity services in North London
- To provide increased community-based choice across the pathway of care and greater access to midwifery-led care within birth centres and for home birth
- To improve continuity of maternity care, including continuity of carer
- To improve the safety of maternity care provided to women
- To improve the quality of information offered during pregnancy so that women can be supported to make choices that are most appropriate for their needs
- To develop a single point of access or centralised booking service

The key areas of transformation have been identified and summarised into three main categories:

**Personalisation** – We will redesign maternity provision so that women and their families will be able to choose maternity care in a variety of settings and by the most appropriate clinicians. This will be achieved through the development of innovative models of care, advice and education



which, where possible, will take place outside of the acute hospital setting. This will require staff development, process improvement and the development of appropriate early information around risk to choice and continuity. The gap between the actual and desired place of care will be reduced and births in midwifery-led settings (where appropriate) will be increased. Women will have an engaged professional advocate (usually their midwife) to provide unbiased support and advice. Maternity teams will work closely with the emerging perinatal mental health services to develop improved services for women affected by mental ill health.

**Continuity** - The majority of care will be provided in community hubs by midwives working in partnership with other agencies including:

- Social Services
- Health Visiting
- Family Nurse Partnership
- Housing
- Contraception
- Mental health
- Neonatal outreach with classes offered to all (antenatal, breastfeeding, parenting, pre-conceptual care for next pregnancies)

Autonomous teams of midwives will be supported by named obstetricians with the governance, training, protocols and processes to work in any facility within the North London system. There will be continuity from the initial booking visit through the availability of a centralised booking service offering appointments, information and advice. Maternity information will be shared across North London organisations through the implementation of electronic medical records. Continuity of postnatal care will be improved through revised models of care and care plans.

**Safer Care** – Governance and training will be centralised so the system becomes more responsive and learns from events. Duplication will be reduced with prompt response to abnormal results achieved through equal access to all systems partners (with a woman's permission). We will continue to reduce perinatal deaths through the Still Birth Care Bundle, investigating deaths using a standardised review process, increasing utero transfers to L3 units, reviewing capacity and escalating 'red' outcomes for peer review. Benchmarking and driving improvement plus ensuring the Maternity Services dataset is completed by all providers. Care will be delivered by a multi-profession workforce which is able to work across organisations to support new models of care and improve staff safety levels.

The programme will be delivered through four workstreams, which address different elements of the transformation plan. However, because of the interdependencies between the workstreams, the working groups will need to be cross cutting. For example, the work on improving community care through the establishment of community hubs is dependent on the work to establish systems for collaborative working. The establishment of a single point of access is dependent upon the work on choice.

Those elements of work on safer care, which don't fall specifically into one of the four workstreams, will be picked up within a Quality and Safety Subgroup of the Local Maternity Services Board.

Furthermore, given the considerable body of research suggesting that foetal exposure to an adverse environment in-utero sets the trajectory for child and adult health in terms of congenital malformations, obesity, diabetes and cardiovascular disease, the Partnership will explore ways to link primary care, public health and maternity services to optimise maternal health before, during and after pregnancy.

In particular, smoking cessation, weight reduction, optimisation of blood sugar control in diabetics and improving the diet of women of reproductive age has the potential to reduce the health needs of both women and children in the longer term.

Below is an outline of our plans in more detail:

Workstream	Initiative	Description/Deliverable	Impact
<b>Ensuring equality of choice for all North London women regarding place and type of care</b>	Identify current birth settings and which are chosen at present	Detailed mapping of current offer for birth, antenatal and postnatal care by each Trust has been completed.	<ul style="list-style-type: none"> <li>• Improvement in patient satisfaction in relation to choice and information offered.</li> <li>• Increased score within CQC survey relating to choice questions. More women say they are offered choice of place of antenatal, birth and postnatal care.</li> <li>• Improved and streamlined systems for clinical staff.</li> </ul>
	Determine factors impacting choice of birth setting	Engage service users to understand the factors that impact choice.	
	Identify current antenatal and postnatal settings and which are chosen	Map key blockers to ensuring choice is offered and perceived as such by women. Map the current processes and how staff and women perceive them.	
	Determine factors impacting choice of antenatal and postnatal settings	Engage women to understand what choice means to them.	
	Standardise the process for offering choice of care setting at referral	Engage staff to understand how these systems could improve.	
	Ensure women have equal access to a range of antenatal, birth and postnatal settings whichever Trust they choose	Review information available and standardise. Consider a North London wide website for information. Produce standardised decision making tools, linking to single point of access work. Review guidelines, milestones and workforce to ensure able to implement new models of care.	

Workstream	Initiative	Description/Deliverable	Impact
<b>Improving community services</b>	Mapping of existing community services	Detailed mapping of current service locations and activity has been completed. Further mapping to identify other co-located services to follow.	<ul style="list-style-type: none"> <li>• More care available closer to home or work for women outside an acute setting.</li> <li>• Clear pathways of care across geographical boundaries.</li> <li>• Improved continuity of carer for women.</li> <li>• Improved satisfaction for staff in being able to provide continuity.</li> <li>• Improved postnatal care, demonstrated through improved CQC survey scores and London continuity audits.</li> <li>• Reduced blood spot screening Sis.</li> </ul>
	Identification of maternity activity at community sites		
	Mapping of existing processes underpinning services	Detailed mapping of antenatal and postnatal pathways including for out of area women and those from in area who birth outside to be completed.	
	Development of North London wide community model of care	A new vision for community services, including models of care and pathways to be developed in conjunction with stakeholders.	
	Development of North London wide antenatal pathway	Develop a plan for the configuration of hubs and other locations, including staffing, IT etc.	
	Development of North London wide postnatal pathway		
	Implementation of community hubs	Develop policies, a training plan and materials.	
	Reconfiguration and training of North London workforce		
Communication of change			
<b>Implementation of single point of access</b>	Determine existing access models	Mapping to identify current booking patterns is complete.	<ul style="list-style-type: none"> <li>• Increased level of informed choice about type and location of care at beginning of pregnancy.</li> <li>• Increased rates of early booking to meet screening target at 10+0 weeks.</li> <li>• Reduced levels of DNAs, reduced levels of multiple appointments and bookings.</li> <li>• Streamlined systems within maternity services.</li> </ul>
	Determine preferred future model	In-depth review of referral processes to be undertaken.	
	Ensure staff equipped to transition to new model	Work with women and families to map factors, which shape choices made at booking.	
	Refine literature offered to women	<p>Develop vision for new model by examining what is available elsewhere and engaging with stakeholders to determine the most appropriate for North London.</p> <p>Review and refine current information in conjunction with choice and community work streams.</p>	

Workstream	Initiative	Description/Deliverable	Impact
<b>Implementation of collaborative working approach</b>	Implementation of shared processes and procedures	Working closely with work stream 2 this work stream is about enabling the establishment of community hubs and the ability for staff to work across the system.	<ul style="list-style-type: none"> <li>• A mobile workforce that can be flexed across the system.</li> <li>• Improved demand management at times of increased activity.</li> <li>• More efficient use of maternity services across North London.</li> <li>• Improved continuity of care for women with the greatest medical and social need.</li> </ul>
	Implementation of shared communication approach	Governance and indemnity systems and processes will be reviewed and changes required enabling staff to work across the system.	
	Implementation of a mobile workforce	Pathways and models of care into and out of acute care to the community will need to be mapped.	
	Enabling shared access to patient data / IT	Along with current training systems and materials so that a new models of education and training can be developed (As per work stream 2).	

**In 2017/18 we will:**

- Standardise the process for offering women a choice of care setting at referral in North London
- Ensure women have equal access to the different birth settings and antenatal care/postnatal care settings at whichever North London Trust they book with
- Improve Community Services through a review of current pathways and provision that will lead to the design of community hubs
- Work with relevant partners to design a single point of access for maternity services

**Children and Young People**

Children and young people are a significant proportion of the total population of North London (approximately 25% to 30%).The health and wellbeing of our children and young people today will determine the health and wellbeing of all future generations. Our service transformation therefore must include a specific focus on our younger population.

Our simple aim is to ensure children and young people are as happy, safe and healthy as possible and have access to opportunities that allow them to achieve their full potential.

We are committed to reducing health inequalities with a focus on prevention and early intervention. We believe that we need to work across health, education and social care in North London to do this, particularly maximising the potential of nurseries and schools to improve health and wellbeing of our children and young people.

We know that poverty, deprivation and inadequate housing are the greatest determinants of poor health and wellbeing outcomes in children and young people and we face significant demographic challenges. We also know that issues such as domestic violence can impact negatively on the mental

health and wellbeing of children. Our case for change demonstrated that 30% of local children grow up in child poverty, with 6% living in households where no one works. Four of our five boroughs are in the top 10% of areas in England for the number of homeless households with a priority need, and all five are in the top 10% or number of households in temporary accommodation.

In response to these challenges, we have established a North London-wide Children and Young People's Network which will champion children and young people's service development and drive up quality and efficiency. Our priority areas are:

**Paediatric elective and emergency surgery** - Children & Young people should have equal access to surgery based on clinical need. Surgery should be undertaken as close to home as possible by staff with the requisite training and skills. There is opportunity to commission and deliver surgery differently across the footprint to achieve high quality care whilst at the same time realising economic benefits.

**School readiness by five** - Supporting children to have the very best start in life is very important to their future health and life opportunities. However, we know a third of our children in North London do not reach a good level of development in preparation for school. We will explore how to work together to have the biggest impact on this area, in particular by improving oral health of children (tooth extraction is the biggest cause of hospital admission nationally in school aged children five to nine years of age) and by improving children and young people's speech, language and communication.

**Long term conditions** - Asthma is the most common long term condition in the UK and, on average, affects three pupils in every school classroom. We will draw on the London paediatric asthma standards to ensure children and young people are routinely followed up by their GP practice after an asthma related A&E attendance or admission; to ensure every registered asthmatic has a written asthma management plan and an annual health review, which will include correct inhaler technique and medication review; and to extend the Asthma Friendly Schools Initiative successfully piloted in Islington.

**Reducing emergency attendances and admissions** - The network will play a pivotal role in supporting the delivery of reduced paediatric A&E attendances and emergency hospital admissions by 20% by March 2021. This will mean new models of care will be tested and developed across the footprint.

In addition to the areas above, the network will promote an all age, life course approach across all other workstreams within this plan.

To tackle obesity and the number of children who are overweight, we will promote active travel, sport and play for children in schools, encouraging schools to deliver the Take 10, Active 15, Walk a daily mile initiatives that have been successfully adopted in other parts of the country. By 2020/21, our aim is that four out of five early years' settings and schools in North London will be accredited as part of the healthy schools, healthy early years or similarly accredited programme for promoting healthy lives.

Working with the Mental Health workstream of this plan, we will address mental ill health in children as early as possible: developing antenatal and postnatal interventions for mothers with mental ill health; improving services for parenting support, health visiting, and signposting; and creating targeted services that focus on vulnerable high risk families.

We will capitalise on the universal services of MIND, Place2Be and established voluntary sector initiatives like **Hope Tottenham** that are already working directly with families and young people.

Tai, 14, suffers from severe depression. With the involvement of Tai, his family, and his CAMHS practitioners, Tai has been admitted into a Tier 4 unit on a planner basis. Previously, it was likely that Tai would have been placed far from home. In future, with the local commissioning of Tier 4 he will be able to be placed close to home. This will enable better linkage with the local CAMHS community team, which will have also been enhanced. Together, these factors will mean Tai has a better experience of care and stays in hospital for a shorter length of time. When Tai is discharged back into the community, he will have an enhanced care plan to support him to keep well.

We will work collaboratively with the mental health workstream to deliver the Child and Adolescent Mental Health Services (CAMHS) and perinatal initiatives as detailed above. We will explore ways to develop the Partnership and link primary care, public health and maternity services to optimise maternal health before, during and after pregnancy and to reduce the health needs of children in the longer term.

#### **In 2017/18 we will:**

- Engage with the other workstreams in the partnership to support the delivery of their plans to improve the lives of children
- Develop a more detailed delivery plan for work that falls outside of the remit of the other workstreams ready to implement in 2018/19

### **Specialised commissioning**

The London Specialist Planning Board has set out the scope of its work, and established four workstreams on clinical pathways, in Renal, Cardiovascular, Cancer and Paediatrics. We are actively participating in the groups which held their first meetings at the end of January: it is too early to know how these workstreams will impact on North London which has already undertaken significant reconfiguration in three of these. We also understand that NHS England is driving a number of initiatives through commissioning, to control expenditure on high cost drugs and devices. We will incorporate information on these, together with further refinement of additional priorities and North London-driven activity in due course.

### **New commissioning and delivery models**

As part of the development process of this plan, and in response to the changing healthcare landscape in North London, the five CCGs have agreed to establish new ways of working more collaboratively together whilst also seeking to strengthen joint commissioning with local authorities. The establishment of a more formalised degree of cooperation between the five CCGs will improve health commissioning, particularly in response to:

- the development of new models of care, including larger provider organisations such the Royal Free Group model which aims to bring together a network of hospital providers
- increasing financial risk
- stretched capability and capacity

We have agreed to establish a joint committee across the five CCGs to enable joint governance of some key commissioning decisions; the development of a common commissioning strategy and financial strategy; and the establishment of some shared CCG management arrangements, with a view to shaping new ways of commissioning. With a focus on population health systems and

outcomes and the transition to new models to deliver these, our objective is to further strengthen strategic commissioning over the next two years. We have agreed that any new commissioning arrangements need to balance the importance of local relationships and existing programmes of work with the need to commission at scale.

The governing bodies of each of the CCGs have agreed to the need for new executive management arrangements including shared roles across the CCGs: an Accountable Officer; a Chief Finance Officer; a Director of Strategy; and, a Director of Performance. Additionally, in order to ensure the continued role of each CCG in respect to its local commissioning and joint work with local government, local Directors with responsibility for local functions and services have been proposed.

These new leadership positions will work with each of the CCGs, as well as the new shared governance structure described above, to ensure that health commissioning in North London delivers the best possible health and wellbeing for the local population whilst ensuring value for money. The arrangements were agreed by governing bodies in November 2016 and a single Accountable Officer is now in place. The remaining new post holders will start early in 2017/18.

In parallel, commissioners and providers across the system have been working together to define our direction of travel in terms of new delivery models. We already have significant work we can build on relating to this, including the Haringey & Islington Wellbeing Partnership, the Royal Free London's provider chain model; the UCLH Cancer Vanguard; the Moorfields Eye Hospital ophthalmology specialty chain; and, the Royal National Orthopaedic Hospital NHS Trust chain of orthopaedic providers.

We have consulted with the leaders of organisations across the system to get their views on the different options for new delivery models, and the broad consensus includes moving over time towards:

- whole system working with a population rather than individual organisational focus
- a deeper level of provider collaboration, including collaboration between primary care, community services, acute services, mental health services and social care services
- the establishment of some form of 'new delivery vehicle' or 'new delivery system' to support this provider collaboration
- a transfer over time of some elements of what we currently consider commissioning functions (for example, pathway redesign) into these new delivery vehicles
- a move towards some sort of population based capitated budget for the new delivery vehicles
- the retention of a strategic commissioning function responsible for holding the delivery vehicles to account, with accountability for outcomes rather than inputs based on principles of commissioning for value

We recognise that the health & care landscape in London is particularly complicated, so we do not expect to implement any significant changes in the short term but will keep our approach under review.

## **Consolidation of specialties**

We will identify clinical areas that would benefit from being organised differently (e.g. managing multiple services as a single service), networking across providers, or providers collaborating and / or configuring in a new way in order to deliver high impact changes to major services. While changes of this sort can be challenging to implement and controversial with the public, we cannot shy away from making changes where we are sure that significant improvements in the quality of care can be achieved.

We are not starting from scratch in this area: considerable service consolidation and specialisation has already taken place in North London. We have successfully done this across:

- Cardiac / cancer (see case example box)
- Neurosurgery
- Pathology Joint Venture
- Renal medicine
- Hepatology and hepatobiliary surgery
- Neurosurgery
- Vascular surgery
- Ear, Nose and Throat (ENT)
- Bone Marrow transplantation
- Upper gastrointestinal
- Malignant gynaecology
- Cardiology
- Major trauma services
- Stroke services
- Plastic surgery
- Respiratory sub-specialties
- Cancer services including: pancreatic cancer, renal cancer, skin cancer, prostate cancer, head and neck cancer

We recognise that there are other service areas which are currently or may become vulnerable in the future. There are many reasons why consolidation of services might be considered as a possible opportunity for improvement. We agree that improving quality should always be the key driver for exploring consolidation, particularly where there is clear evidence of patients achieving better outcomes.

This work is at an early stage. No decisions have been made. Over the next year we will review whether these or any other services would benefit from consolidation or networking. Consideration of any requirements for consolidation of services will be undertaken within each of our clinical workstreams as they develop more detailed delivery plans. The Health and Care Cabinet will retain oversight of this work to maintain a whole system perspective.

### Enablers

As well as making the changes outlined above in prevention and service transformation, we need to ensure the infrastructure and resources we have are redesigned and aligned to deliver these transformed services - these workstreams are known as enablers. To achieve this, we will work as a sector to share and transform the vehicles that underpin delivery.

### Workforce

Our vision is to support North London health and social care organisations to be excellent employers, committed to supporting the wellbeing of staff whilst also preparing them to deliver the new care models in a range of settings. We will work with North London organisations across all health and care settings to support their collaborative efforts to achieve this whilst ensuring that everything we do contributes to the following aims:

1. Improve patient experience and outcomes through improved staff experience and engagement
2. Define and adopt new ways of working, including working across health and care settings
3. Maximise workforce efficiency and productivity
4. Create a reputation where North London is recognised as a great place to work aiding recruitment and retention
5. Promote and provide an excellent learning environment
6. Develop, implement and embed a systematic approach to leadership development.

To support these aims we are committed to co-creating, communicating and collaboratively delivering plans to address capacity, quality, cost and capability of our workforce. As leaders, we will encourage a culture of networking, collaborating and educational asset sharing, as we believe that strong relationships between our staff are the best way of achieving change. The 'Breaking Down the Barriers' programme (a collaboration between Health Education England, UCL Partners and a number of our Trusts that aims to improve mental and physical health through education and training) is a positive example of an initiative which will be taken forward through developing such a culture.

We will achieve efficiencies in employment by:

- connecting employment services and processes collectively across the footprint
- enabling North London organisations to recruit and retain staff, particularly where employee turnover rates are high or where there are staff shortages
- facilitating the implementation of new models of care, providing a framework for the deployment of staff to new settings and areas of greatest need

We will develop initiatives to equip the existing workforce with new skills and ways of working, ensuring that our people are working to the best of their ability as well as adapting roles to meet the changing requirements of our services. We will implement plans emerging from the workstreams to equip people currently working in hospital settings with the skills and confidence to work across the care pathway, reaching out into community care settings and delivering the care closer to home model.

Since the inception of the STP, we have commissioned 446 postgraduate career development programmes and rotations for our nurses to develop the skills required to fulfil our vision of an agile, highly skilled, North London workforce. This work will continue over the life of the plan through initiatives such as the Capital Nurse programme (for which we have already affirmed our commitment to deliver) and through a single implementation plan for the sector, boroughs and organisations.

We have five successful Community Education Provider Networks (CEPNs) in North London who are starting to focus their work to the following core themes:

- Retention
- Clinical skills
- Widening participation
- Carers and communities
- New ways of working and new roles
- Building a stronger interface with secondary care to enable skills transfer

Our CEPNs are an example of a network/asset sharing based approach to improvement. Delivering improvements to primary and community care through initiatives such as Care Closer to Home Integrated Networks (CHINs) is fundamental to achieving the service ambitions set out in our plan.

**A note on mitigating the potential risks of Brexit: We do not currently know how the process of the UK leaving the EU will impact on health and care services but we do know North London is a cosmopolitan area with many people from the EU settled here as workers and residents. We know Brexit it is a real concern to staff, patients and residents – both in terms of who will provide their care, who will run their services and what it will mean for the livelihoods of friends and family. In the current political and economic climate, a safe supply of workers to meet the needs of our patients in North London. Our retention strategies are aimed at continuing to attract and retain the right people, thus reducing the reliance on overseas staff. Our HR community is working closely with the Mayor of London to ensure that overseas workers, who are vital to our health economy, remain part of our health economy.**

Health, social care and public health delivery is not limited to employees of our traditional employers, and our notion of working with the 'wider workforce' extends to the numerous carers, volunteers and citizens who improve the life of our population but are employed outside of the public sector, including home care workers and personal assistants. In order to improve the general wellbeing of our population and make use of the substantial social capital across our footprint, we will educate and support patients, carers and those in their communities in areas such as self-care, self-management, dementia and mental health awareness.

We will implement initiatives to equip existing and future staff with motivational and coaching skills, competence in promoting self-care and prevention, and enhancing emotional resilience in themselves, their teams and their patients. We have developed a health coaching competency framework which has now been rolled out across each of our Trusts, with each Trust now leading a specific person-centred conversation initiative.

We will support the Prevention workstream in training all frontline NHS and social care staff in Making Every Contact Count (MECC). Similar work will be undertaken to ensure that all non-medical frontline staff receive training in Mental Health First Aid (MHFA) and basic dementia awareness. We have created a Dementia Awareness programme in North London, which we will continue to develop and ramp-up to focus on Tiers 1, 2 and 3. This programme, developed by Health Education England and UCL Partners, has been nationally acclaimed.

While most of the people who will be engaged in delivering the North London vision are already with us, working in roles which will need to adapt or change in some way, we will also help to establish a number of new roles such as physician associates, care navigators and advanced clinical practitioners. We will support strategic workforce planning and redesign and commission training for skill enhancement, role diversification and new role implementation. Much of this work has begun, but others will be contingent on the definition of new clinical models.

To enable transformation, we will deliver system-level organisational development, supporting leaders and teams through the transformation journey. In addition, we will train everyone in a single approach to continuous quality improvement to deliver sustained clinical excellence and high quality care.

As part of our Delivery Plan we have brought together the health and social care workforce community under the strategic leadership of the LWAB (Local Workforce Action Board) and initiated a programme of work in the following areas that help deliver the six aims outlined earlier:

- Resourcing and integrated employment (aim 4)
- Learning and development (aim 5)
- Enabling new models of care (aim 2)
- Enabling productivity and back office rationalisation (aim 3)

We have launched collaborative work programmes to improve staff retention, manage temporary staff rates of pay, procure a shared bank and reduce levels of agency expenditure. We have already identified significant savings against these initiatives which we are committed to achieving. Building the brand of North London as a place of choice to train and work is a pivotal enabler to these ambitions; where permanent or temporary employment is deemed much more attractive than agency work; whilst remaining flexible.

We recognise the benefits of collaborating on learning and development and our delivery plan includes work on shared leadership, Organisational Development programmes and a review of Learning and Development capacity and delivery, as well as a joint approach to new arrangements for apprenticeships.

These initiatives, together with work on creating common employment policies and procedures, will improve employment portability and further the aim of achieving more integrated employment across North London.

**Exhibit 9: Integrated model of employment**



The Workforce workstream is a key enabler for the new models of care emerging from the workstreams. We will lead workshops and task and finish projects to facilitate agreed workforce plans. The NHS provider HR community is also collaborating on a review of back-office HR processes; shared HR systems and policies will facilitate this work.

For the next stage of the Workforce workstream, we will turn our focus to the clinical workstreams to accelerate the pace at which they develop new service models and define the workforce they require.

Engagement and the development of close working with the clinical workstreams has been a key element of our initial work and this now needs to progress into the delivery of workforce plans to transform services. We will support scenario modelling to assess the financial benefits of the new models and the impact of new roles and changing settings for providing care.

Below is an outline of the different areas we are working on:

Work package	Initiative	Description	Deliverable
<b>New Models of Care (Workforce as an enabler)</b>	Package of work for each of the clinical work streams	Support the new models of care leads in understanding changes to workforce resulting from the new models of care covering capacity changes, new roles, changed roles, skills, training, competencies, recruitment and professional and career development. Bring together professional expertise in pathway designers with HR expertise to ensure credible plans for implementation	<ul style="list-style-type: none"> <li>• Workforce modelling and analysis</li> <li>• Workforce design</li> <li>• Education &amp; Training design and delivery</li> <li>• Develop change management skills and capacity to support new models of care</li> </ul>
<b>Primary Care</b>	Recruitment & Retention  Training & Development  New Roles	Review and re-alignment of GP Training across London/ North London. Implementation of new role programme.  Implementation of retention schemes and training of existing workforce	<ul style="list-style-type: none"> <li>• Workforce design to take place concurrently with CHIN development timelines</li> <li>• Delivery of workforce aspects of the GP Forward View</li> </ul>
<b>Resourcing</b>	Recruitment & Retention  Temporary Staffing  Bank	To reduce turnover across North London and retain existing skills  To consolidate temporary resourcing activity across North London and to provide attractive and comparable rates and reduce agency spend  Single procurement for a shared bank platform/service	<ul style="list-style-type: none"> <li>• Stage one qualitative “deep dive” assessment</li> <li>• Reward Assessment</li> <li>• Common Recruitment Policy and Processes</li> <li>• Pay data report to LWAB</li> <li>• Platform for one provider that enables Trusts to join the bank</li> </ul>
<b>Learning &amp; Development</b>	Statutory and Mandatory  Shared provision  Apprenticeships	Standardise and streamline and extend one approach to statutory and mandatory training  Pooling resources across North London and developing shared capabilities for in house delivery of education, training and workforce development  Collaborative approach to apprenticeships	<ul style="list-style-type: none"> <li>• Standard common approach , content, topics and standards implemented to delivery models for statutory training</li> <li>• Initial phase provides an in depth review of learning centres, e-learning platforms, library services, simulation facilities and current provision</li> <li>• Shared policies including pay, terms and conditions</li> <li>• Co-ordinated approach to capabilities</li> <li>• Joint procurement of providers</li> <li>• Joint planning of shared cohorts</li> </ul>

Work package	Initiative	Description	Deliverable
<b>Integrated Employment Model</b>	Branding Employment portability Career frameworks	To encourage employment flexibility across the health and social care system. To implement employment portability and career frameworks that supports the new models of care.	<ul style="list-style-type: none"> <li>• Employment Concordat</li> <li>• Shared Vision</li> <li>• Programme of work</li> </ul>
<b>Productivity</b>	HR Administration	Future HR operating models that consolidates HR transactional activity	<ul style="list-style-type: none"> <li>• Standardisation and streamlining of policies and processes and procedures and an operating model for future delivery</li> </ul>

Our Local Workforce Action Board has matured into a dynamic forum for improvement, bringing together the workforce community from across all our stakeholders as a key vehicle for developing, approving and assuring our plans. It will continue to provide oversight and challenge to current programmes, ensuring that benefits are realised while extending the reach of these programmes and bringing new ones on-stream.

Key challenges for 2017/18 will be to support the service in:

- Breaking down the boundaries that exist between hospitals and primary care, health and social care and between generalists and specialists
- Building the future workforce to tie in with the implementation of new service models, where there is a significant lead time in training new staff
- Investing, developing and deploying support staff to become a more flexible and cost-effective resource that reduces pressure on highly qualified staff
- Extending skills of registered professionals and training advanced practitioners to fill gaps in the medical workforce, provide rewarding clinical career options and mentoring for less experienced staff

#### **In 2017/18 we will:**

- Work with the Care Closer to Home workstream to ensure the required staffing mix is available
- Work with Primary Care colleagues to support the transformation of access to Primary Care seven days a week
- Work to reduce turnover across North London and retain existing skills to support delivery of the above
- Roll out a collaborative approach to learning and development and apprenticeships

## **Estates**

Our vision is to provide a fit for purpose, cost-effective, integrated, accessible estate which enables the delivery of high quality health and social care services for our local population.

The priorities for development of our estates strategy are:

- to respond to clinical requirements and changes in demand by putting in place a fit for purpose estate
- to increase the operational efficiency of the estate
- to enhance delivery capability and
- to enable the delivery of a portfolio of estates transformation projects that support the implementation of clinical change in the Partnership

There are a number of barriers to achieving this including:

- in North London, there are a significant number of organisations and the differences in governance, objectives and incentives between each organisation, can result in organisations working in silos
- misaligned incentives, which do not encourage optimal behaviour
- lack of affordability, specifically the inability for non- foundation trusts to retain capital receipts, budget “annuality” and the difficulty of accessing capital investment for re-provision, especially in the constrained fiscal environment for the NHS
- the complexity of developing business cases in terms of getting the right balance of speed and rigour, and the different approvals processes facing different organisation types (for example, there are different capital approval regimes operating across the NHS and local government)
- the primary and community estate requires development to create ‘care closer to home’, improved access and to meet the needs of significant population growth. Capital funding to develop this estate is scarce and significant proportion of the community and primary estate is not owned by the partners in the Partnership

We are working as part of the London devolution programme to pilot devolved powers in relation to the health and care estate. As part of this, we are asking for:

- local prioritisation and investment of capital receipts, including those that would otherwise be retained nationally
- NHS capital business case approval to be accelerated and consolidated through the implementation of a jointly owned and collaborative North London / national process (or devolved to sub-regional or London-level)
- developing local flexibilities in terms and conditions for the primary and community health estate to improve quality and utilisation

It is anticipated that the London devolution agreement for health and care will be agreed in Spring 2017. In the currently agreed London timetable, North London expects to be able to use devolved powers in shadow form initially, moving to full use of devolved powers after 2017/18. We want to use devolution as an opportunity to accelerate the development of the estate needed for care closer to home, securing greater utilisation of community estate and capital for redevelopment from disposals of surplus estate. We also want to ensure that devolved powers enable us to address the need for better quality mental health in-patient facilities at greater pace.

A London Estates Board has been established to oversee the implementation of estates devolution in London. An early priority for North London in 2017/18 is to develop its legally constituted governance for devolved powers.

We anticipate the following benefits from the estates workstream and devolution:

- a whole system approach to estates development across North London, with different partners working together on projects and developing a shared view of the required investment and development to support clinical change
- the ability to undertake better local health economy planning, including establishing estates requirements
- increased affordability of estates change across North London
- greater incentives to dispose of surplus property, releasing land for housing
- focused action on the development of the estates requirements to deliver care closer to home
- greater efficiency and flexibility in the estate, reducing voids and improving utilisation and co-location which will support financial savings

Across the sites of Moorfields, St Pancras, St Ann’s we are beginning to evidence qualitative benefits of working together to deliver estates value and improvement. The sector for a number of years has had unresolved estates issues relating to poor mental health inpatient accommodation and potentially saleable and high value estate at St Pancras Hospital. The three providers are working together on this strategic estates project which aligns estates priorities between all three trusts.

The proposed programme, which is still subject to consultation, would see sales proceeds from surplus assets used to deliver new purpose built mental health accommodation, and the potential relocation of Moorfields Eye Hospital to the St Pancras site. Clinical improvements would be prioritised through the building of a new Institute of Mental Health and an integrated Eye Hospital and Institute of Ophthalmology at the current St Pancras Hospital site.

The three trusts are currently refining their outline business cases, with outputs due mid-2017. Subject to consultation, further testing of economic viability and planning permission, the specific benefits of the work will include:

- development of a new world class research, education and clinical care facility housing an integrated Moorfields Eye Hospital and UCLH's Institute of Ophthalmology, transforming ophthalmology facilities that are at present a constraint on continuous improvement
- improvements to the estate to meet CQC "must dos" including new mental health inpatients facilities for Camden and Islington NHS Foundation Trust (including the integration of physical and mental health and social care through an integrated practice unit at St Pancras). Also, new facilities for Barnet, Enfield & Haringey Mental Health Trust at St Ann's Hospital, Tottenham
- a world class UCLH Institute of Mental Health and associated patient care and educational facilities at St Pancras Hospital
- potential to deliver c.1,500 new housing units in London, significantly contributing to the NHS target for release of land for residential development
- improvements to environmental sustainability, as the new builds will deliver a balance between BREEAM ratings for 'green' initiatives, the cost of the capital build requirements to deliver them and the whole life cycle benefits in terms of costs and a more sustainable future for our planet. We will design, build and operate in a manner that supports recycling and use of low carbon technology.

The schemes are planned at a total capital cost of c. £400m with joint provider engagement under the umbrella of the estates devolution pilot driving completion of the final scheme by 2023. It is planned that around £325m of this is financed by sale proceeds with the remainder funded from a variety of sources, including philanthropy.

Progression on this scheme may lead to a platform for sector wide capital prioritisation and create an improved incentive framework for asset disposal and enhanced utilisation, which will give rise to a locally originated capital funding stream.

In line with the findings of Healthcare for London in 2014, our analysis shows that significant capital work is required across North London to improve the primary care estate. The primary and community estate needs improvement in a number of areas:

- development of CHINs to enable the delivery of the care closer to home model
- expansion and development of primary care facilities to ensure registration for a significantly expanding population and extended hours access
- our modelling indicates that development of the estate required for care closer to home will need capital investment of circa £111m. North London has been successful in securing some investment from NHS England's Estates and Technology Transformation Fund and an allocation from the NHS Information Governance Fund. However, the funding secured, in common with other STP footprints, will not meet the full cost of development.

**In 2017/18 we will:**

- develop detailed business cases for the care closer to home estate to support the developing CHIN framework by working closely with the Care Closer to Home and the Planned Care workstreams
- use devolved powers and other avenues to secure capital to deliver these much needed improvements and reduce the running costs of this estate

## Digital

We will use digital technologies and information to move from our current models of care to deliver proactive, predictive, participatory, person-centred care for the North London population.

There is significant and immediate opportunity for digital to transform our current delivery models and seed completely new, integrated models of health and social care. We recognise the strength of both the clinical and financial case for digital and its potential impact in strengthening productivity, providing ease of access to our services, minimising waste and improving care. Our ambition is to become a national leader in population health management enabled by informatics, to reduce variation and cost and improve care.

We will prioritise and increase pace of appropriate digital technology adoption within our organisations, realigning the demand on our services by reducing the emphasis on traditional face to face care models. We will explore new digital alternatives that will transform our services, with the aim of moving care closer to home, enabling virtual consultations and providing our patients with the information and resources to self-manage effectively, facilitating co-ordinated and effective out of hospital care. We will utilise opportunities for real-time, fully interoperable information exchanges to provide new, flexible and responsive digital services that deliver integrated, proactive care that improves outcomes for our patients.

Our digital programme proposes the creation of a North London Population Health Management System (exhibit 10) which supports prevention, service transformation and productivity, and would assist in meeting the national mandate of operating paper free at the point of care by 2020. Through this system we will move from a landscape of diversity and variation to one of shared principles, consolidation and joint working for the benefit of the population.

**Exhibit 10: North London Population Health System Management**

<b>Activate</b>	<b>Digitally activated population</b> Personal Health Record; Self management; remote monitoring; digital transactions	<b>Information Governance</b>	<b>Data Quality and Validation</b>	<b>NCL Digital Delivery Model</b>
<b>Analyse</b>	<b>Insights driven health system</b> Health system benchmarking; cohort stratification; patient tracking; case management; whole pathway decision support; predictive modelling			
<b>Share</b>	<b>Integrated care</b> Shared health and care records; care plans			
<b>Link</b>	<b>Integration and messaging</b> Health Information Exchange; information and messaging standards; document, image and data exchange			
<b>Digitise</b>	<b>Applications</b> Electronic health records; clinical documentation; ePrescribing and closed loop medication management; orders and results; device integration; alerts and decision support	<ul style="list-style-type: none"> <li>• CCGs</li> <li>• Primary care Social care</li> <li>• Acute, community, mental health and specialist providers</li> <li>• Care homes</li> </ul>		
<b>Enable</b>	<b>Infrastructure</b> Network; wifi; unified comms; email; collaboration tools; end user technology; virtual care services			

The six elements that make up our digital strategy are:

- **Activate:** We will provide our citizens with the ability to transact with healthcare services digitally, giving them access to their personal health and care information and equipping them with tools which enable them to actively manage their own health and wellbeing.



- **Analyse:** We will use data collected at the point of care to identify populations at risk, monitor the effectiveness of interventions on patients with established disease and deliver whole systems intelligence so that the needs of our entire population can be predicted and met.
- **Link:** We will enable information to be shared across the health and care systems seamlessly.
- **Share:** We will create and share care records and plans that enable integrated care delivery across organisations.
- **Digitise:** We will support our providers to move away from paper to fully digital care processes; including documentation, ordering, prescribing and decision support tools that help to make care safer.
- **Enable:** We will provide infrastructure which enables our care professionals to work and communicate effectively, anywhere at any time, and facilitate new and enhanced models of care closer to home.

To deliver on our digital strategy we will need to invest £159m, with a further £21m in 2020/21.

**In 2017/18 we will:**

- Develop and adopt a common Information Sharing Agreement
- Develop a connectivity strategy for North London
- Develop a system-wide approach for Integration and Data Platform
- Review the opportunities for the consolidation of the ICT services across providers
- Identify digital maturity investment objectives across providers
- Scope of Universal Capabilities reporting



## Addressing the financial gap

Not only do we aspire to provide the best services that improve outcomes and reduce inequalities, we need to make the system financially sustainable.

The financial analysis that we have undertaken (exhibit 11) shows the significant gap between anticipated growth in demand (and therefore cost growth) for the NHS in North London and the growth in funding that the NHS expects to receive over the five years of the STP.

**Exhibit 11: The 'do nothing' financial gap for North London**

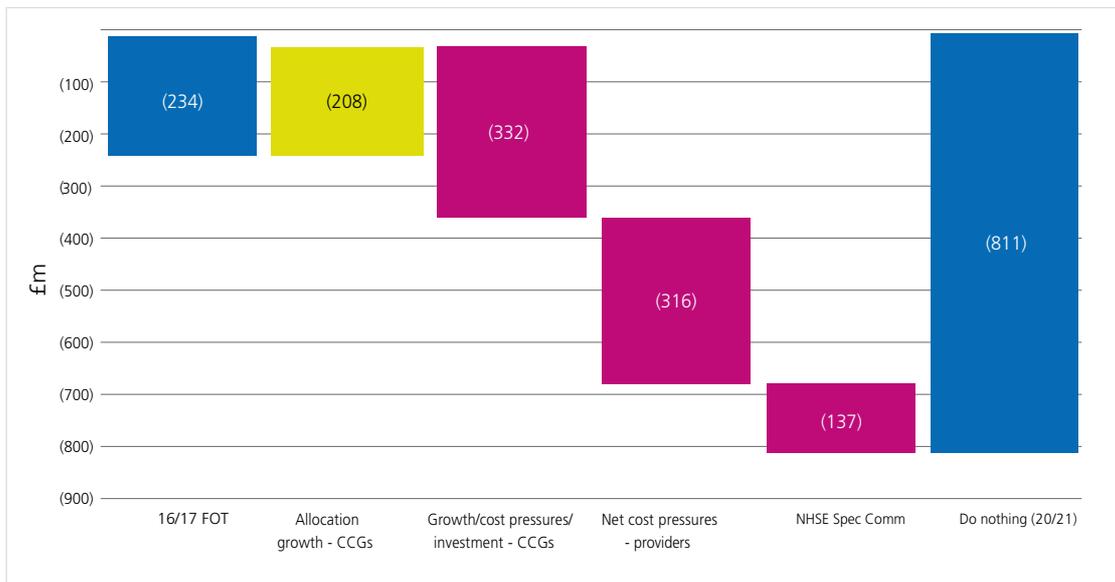
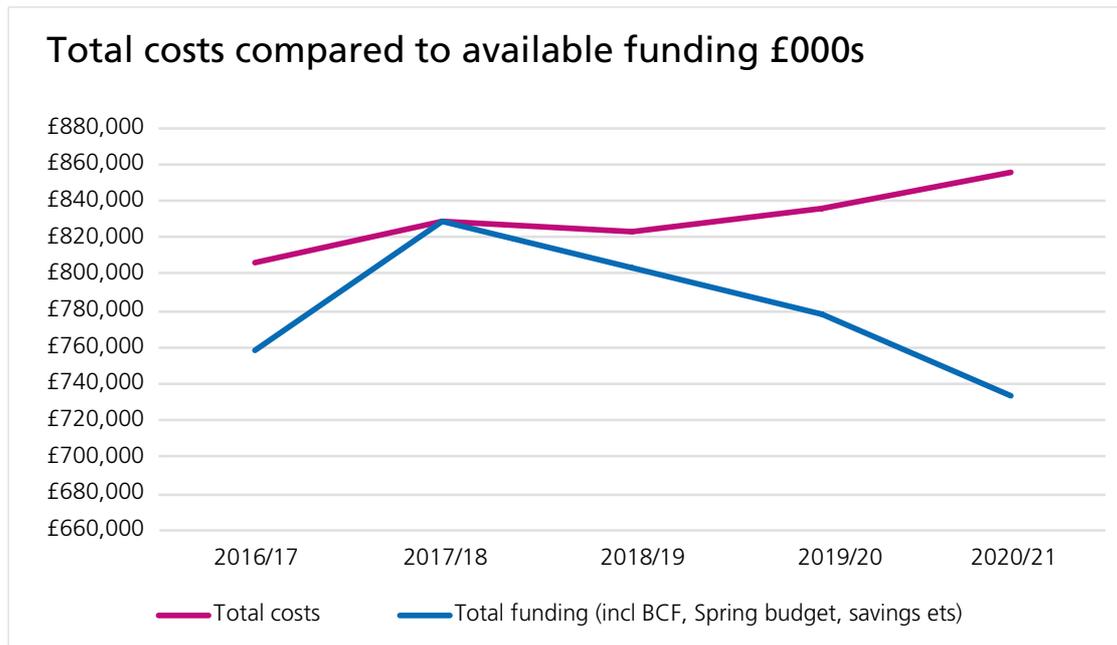


Exhibit 12 shows the financial pressure facing Councils in North London (for children's and adult social care and public health), which includes additional funding announced in the 2015 Spending Review, 2016 Autumn Statement and 2017 Spring Budget.

**Exhibit 12 – North London Council pressure budget pressure 2016/17 – 2020/21**



Without changing the way that we work together as a system to provide a more efficient, joined up service across organisations, we will have an estimated £811m deficit across the NHS in North London in 2020/2021. North London Councils will face a budget pressure of £247m for social care and public health by 2020/21, even when all additional funding announced by the Government has been taken into account. Local government finance legislation states that Councils must deliver a balanced budget each year, so North London Councils are using a variety of measures to offset this financial pressure, including increasing the pace on the delivery of transformation programmes, using savings from elsewhere in the organisation, and drawing from financial reserves accrued in previous years.

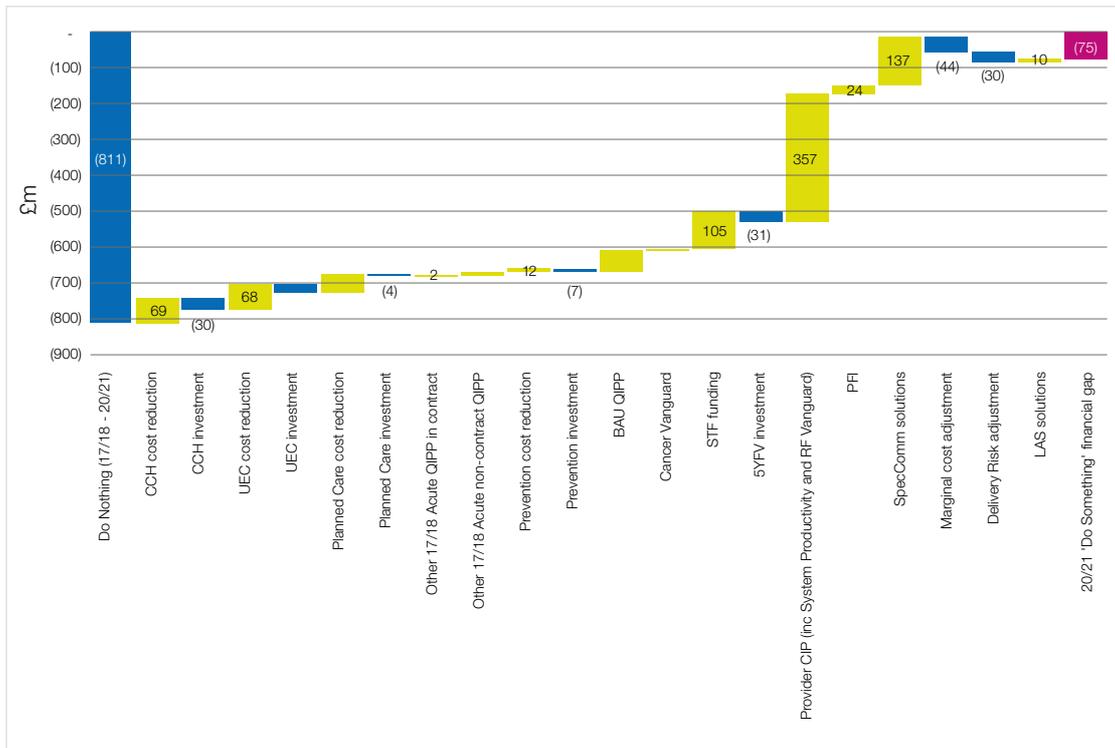
Further work is being undertaken to develop a full understanding of the financial pressures on North London Councils, particularly in adult social care, with a view to working closely together in 2017/18 to understand how we can jointly address the financial gap we face as a system. In particular, the NHS within North London is seeking to learn from local authority colleagues’ best practice in relation to reducing cost whilst improving the experience of service users and the public.

As such, the rest of this section refers to plans to address the financial gap across the NHS in North London.

This ‘do-nothing’ financial gap has been calculated on a normalised recurrent basis (i.e. excluding one-off items) in accordance with NHS England and NHS Improvement guidance. The main drivers of the financial gap are the increased projected demands on the NHS as a result of the increasing population, and within this the demographic changes of an increasing elderly population in particular, as well as the increasing costs of providing healthcare, e.g. due to inflation. Although the NHS in North London is receiving additional resources, the combined impact of the projected increase in demand and cost increases are forecast to be greater than the increase in resources. This therefore results in the ‘do-nothing’ recurrent projected deficit in 2020/21 increasing to £811m, from the forecast 2016/17 outturn of £234m.

The STP in North London has brought together organisations across health and social care to jointly discuss how we can address this financial challenge as well as making progress in improving the quality of, and access, to services. Based on the plans and analysis set out in this STP, which have been developed with and by local clinical experts, we will reduce the annual deficit over the next five years to £75m (exhibit 13) whilst this addresses more than 90% of the financial gap, we recognise that further work is needed to close it entirely.

**Exhibit 13: The 'Do something' financial gap to 2020/21**



The key elements of the plan are set out in detail earlier in this document. Exhibit 13 shows how these contribute to the improvement in the annual financial position of the North London system over 5 years. The savings that will be delivered from the key areas of transformation are:

- **Care closer to home:** savings of £69m have been estimated from improving access to primary care and providing community-based care (with £30m of investment);
- **Urgent and Emergency care:** savings of £68m (with £20m of investment) to proactively identify early intervention to avoid crisis; rapid response to urgent needs to prevent hospital admissions; provide ambulatory-based care; and reducing delays to discharge.
- **Optimising the planned care pathway:** savings of £49m (with £4m of investment) through redesigning outpatient and planned care pathways.
- **Prevention and the support of healthier choices:** this is estimated to result in savings of £12m, with £7m investment.
- **UCLH Cancer Vanguard,** savings of £4m and Royal Free Hospital Chain Vanguard, included in the provider CIP section below.
- **Productivity** savings are planned to be achieved, including both 'business as usual' cost

improvements across providers, and wider system savings through working together of £357m in total. Business as usual QIPP schemes (non-acute) total £57m. Further details of the productivity savings projected are set out below.

## **BAU productivity**

Significantly improving provider productivity is an essential part of the work to address our financial challenge. Our plans assume significant delivery of CIP (Cost Improvement Programmes), improving provider productivity. Lord Carter's report on hospital productivity has shown that there is variation in how productive different NHS services are, and provides a "model hospital" website to help providers to understand where productivity improvements can be made. In addition to specific Carter initiatives within providers, each organisation will also have an intensive programme of cost improvement opportunities. The assumed levels of provider CIP in each year for 2017/18 and 2018/19 are based upon providers' detailed operating plans. Beyond this, a general assumption of 2% per year productivity improvement is made – this is a "net" figure as trusts usually experience additional external cost pressures each year (for example, PFI charges, rates increases and education funding losses) which must be offset with new savings first, before delivering an overall productivity improvement.

Analysis by NHS Improvement, provided by an independent firm, has indicated that a figure of around 2% per year is a reasonable maximum expectation in relation to annual productivity improvement for NHS providers. In an environment of reducing activity growth, for example as a result of the STP's work to provide patient care in more appropriate and less acute settings, it becomes more challenging to deliver a higher level productivity improvement.

## **System-wide productivity**

Notwithstanding the above, we know from the Carter work that we have opportunities to improve productivity further without detriment to the service we provide our patients and service users. Much of this comes from working more closely across different organisations within the STP in addition to work within organisations. North London has already consolidated many services across organisations, both clinically (such as cardiac, cancer and neurosurgery) and non-clinically (such as payroll, pathology laboratory services and procurement) which means there are fewer opportunities remaining.

However, we have identified a number of additional opportunities for system productivity (defined as those areas where CIP delivery is dependent on trusts working together rather than in isolation) to deliver financial savings whilst maintaining or improving quality. Our plans also assume savings from more efficient contracting between CCGs and trusts. As the STP has developed, it has become the norm for organisations to work together in realising savings, and these savings are incorporated within the CIP plans of each provider.

Specific initiatives to improve productivity are described in the sections below.

### **Workforce**

The Delivery Plan for Workforce includes a range of initiatives that have the effect of sharing back office workforce activity. These include:

- Standardising and streamlining statutory and mandatory training to deliver a standard common approach
- Pooling training resources across North London and developing shared capabilities in the delivery of education, training and workforce development

- Developing a common approach to Apprenticeships including joint procurement of providers with the aim of maximising the benefit from the levy
- Reviewing and standardising rates of pay for temporary staff across North London with an initial focus on locum medical pay
- A integrated review on workforce supply and reward to inform a new North London specific pay and non-pay benefit strategy for our permanent workforce
- Developing a platform for one staff bank which enables trusts to join at a time of their choosing. UCLH is leading a collaborative procurement to appoint a new provider not just for UCLH but for all other provider organisations within the STP who wish to join. This will reduce administrative costs and increase the number of temporary staff that are paid through a “staff bank” rather than through more expensive agency arrangements

These initiatives will help improve the efficiency of our HR functions as well as improving retention of current staff and upskilling the health and social care workforce to enable delivery of new models of care. We also commit to complying with the maximum total agency spend and hourly rates set out by NHS Improvement.

### Digital and ICT Consolidation

There are two main themes in relation to the use of digital technology across the STP – firstly the transformational ICT initiatives that will help improve the way in which organisations communicate with each other and their patients (which is described elsewhere in this document), and secondly reducing the costs of providing existing technology such as PCs, telephony, networks and other IT infrastructure. This second area is being addressed through a new digital technology partnership with Atos, a large IT company, which has the potential to significantly reduce costs across STP organisations by consolidating expenditure whilst also improving the resilience and quality of services. UCLH have already signed a contract with Atos that will reduce costs by c. £30m over ten years, and this was procured in such a way that other STP organisations can readily join.

### Other Workstreams for System-wide Productivity Improvement

- **Procurement:** we will reduce purchasing unit costs with increased volume and scale across all providers by reducing clinical variation in product choice and undertaking joint action on drugs and medicines management. This will be driven through the procurement shared service that already exists for 5 of our North London providers, with further collaborative work across the Shelford Group and the London Mental Health network augmenting this work.
- **Back office:** We have worked over the last 4 months to review opportunities for back office consolidation, centralisation and outsourcing, supported by external consultancy and internal project management. Although in many areas the external work suggested limited opportunities for further productivity improvement in the short term, we are actively seeking to reduce our overheads and improve service resilience across the footprint and are progressing with the following key workstreams in addition to those highlighted above:
  - o Enhance and extend the existing shared procurement arrangements (which serve most NHS providers within North London) to reduce non-pay costs; maximise use of wider procurement networks for large teaching trusts and mental health trusts.
  - o Review with HR Directors and our workforce workstream the opportunities and enthusiasm for HR transaction consolidation.
  - o Review with Finance Directors opportunities for process alignment, resource sharing and cost reduction across organisations’ finance directorates.
  - o Progress further outsourcing of payroll functions and take opportunities to consolidate contracts where feasible to do so.

- **Contract and transaction costs:** Releasing savings from streamlining transactions and contracting. This will be delivered through implementing new commissioning arrangements (which may facilitate joint procurement of services from the Commissioning Support Unit (CSU), for example) and leveraging the opportunities associated with joint commissioning between local authorities and CCGs.
- **Other:** Additional existing provider productivity schemes: estates, clinical admin redesign, service transformation, income etc.
- **Operational and clinical variation:** all acute providers are actively progressing plans in relation to the Carter productivity work. Reducing variation is a key part of the Royal Free's Group model, and we will also be working collectively to reduce average length of stay, maximise theatre utilisation and streamline clinical processes, in addition to the changes proposed through the planned care workstream.

### **Commissioner business as usual efficiencies (QIPP)**

We will continue to deliver significant “business as usual” efficiencies throughout the 5 year period. Business as usual (BAU) QIPP (Quality, Innovation, Productivity and Prevention) comprises savings commissioners expect to deliver as part of their normal activities. These are efficiencies in areas of CCG spend not covered by our other workstreams and include opportunities in the following areas:

- **Mental health:** this includes ongoing non-transformational efficiencies, consistent with parity of esteem requirements. Examples of mental health QIPP are the management of out of sector placements and streamlining the pathways with specialist commissioning across forensic and mental health services.
- **Community:** spend on community services includes an assumption of increased efficiency equivalent supported by benchmarking work and transition to new models of care.
- **Continuing care:** spend on continuing care assumes increased efficiency supported by existing framework agreements.
- **Primary care prescribing:** spend on primary care prescribing assumes increased efficiency including the adoption of generic drugs where possible, the adoption of local quality schemes to improve consistency and effectiveness.
- **Programme costs (including estates):** this includes measures to reduce void costs and better alignment of health and care services to reduce the overall estate footprint whilst maintaining and improving service quality.
- **Private Finance Initiatives (PFIs)** – whilst we recognise the role that PFI projects have had on modernising the NHS's buildings, we also believe that they don't represent value for money for individual NHS Trusts. We have modelled a conservative estimate of the saving (£24m per year) that could be made from terminating these contracts and bringing management of these facilities back within the public sector. We will continue to work with the Department of Health and others to develop these plans, or alternatively to seek additional central funding for these schemes if terminating them is not possible, recognising that there are a number of constraints.
- **Other** - Although detailed plans have not yet been developed, we have been advised by NHS England to assume that the North London proportion of the **London Ambulance Service (LAS)** financial gap of £10m and the estimated **specialised commissioning** pressure of £137m will be fully addressed by LAS and NHS England respectively. North London hospitals provide a very significant amount of specialist care and it is therefore essential that NHS England works together with the STP on how these services can flourish whilst also addressing the financial pressures associated with the growth in specialist activity (which in most developed economies is higher than growth in other services due to new technologies, drugs and clinical interventions).

These improvements cannot be achieved without investment. The plan is based on investment of £20m in urgent and emergency care, £7m in prevention, £30m in care closer to home, and £4m in planned care. We have also assumed that £31m of our indicative £105m share of the Sustainability and Transformation Fund will be required to fund national policy priorities over and above these investments, in addition to that already assumed within the 'do nothing' scenario.

The savings set out above are predicated strongly upon reducing significant activity in acute hospitals, in particular reducing demand for inpatient care. We know that realising such savings can be difficult in practice and are contingent upon removing or re-purposing capacity within acute hospitals. As such, through working with the Health and Care Cabinet within North London we have assumed that the cost savings that will be realised from each avoided day of acute hospital care will be significantly lower than the average tariff that is currently paid to providers by commissioners for this care. This is reflected in a £44m marginal cost (i.e. stranded costs) and £30m 'delivery risk adjustment' in the financial analysis.

## Delivery through 2 year contracts in North London

Delivering the STP is a priority for health and care commissioners and providers in North London - and our commissioning intentions, operating plans and contracts reflect this. All NHS contracts within the STP incorporate the impact of the STP's planned initiatives, particularly those that seek to provide care to our patients in a more appropriate, less acute setting. This strategic alignment, working as a system, will help support delivery. Whilst we recognise that implementation will look different in different local areas, we know that it will only be possible to deliver on the STP if we are all pulling in the same direction. Having two year contracts based around our STP delivery plans will help these plans to be implemented quickly, as well as supporting a longer term move to new relationships between commissioners and providers, reducing transactional costs and building the foundation for working more closely as a system between commissioners and providers in the future.

We have also ensured that organisations' operating plans are strategically consistent with the STP. In the current context of the financial position and management capacity across the system, we will ensure in the first 2 years of the STP that we are prioritising our efforts in the areas which will add the most value in terms of increasing health and wellbeing for people; improving the quality of care people receive; and ensuring value for tax payers' money.

Recognising that we have still not achieved financial balance in the current plan to 2020/21, we will continue to look for further opportunities for further efficiencies, in line with the Five Year Forward View Next Steps document, published recently by NHS England.

## 2017/18 position

In respect of the 2017/18 financial position specifically, current plans fall short of the 'control total' targets set by NHS England and NHS Improvement for the CCGs and NHS Trusts across North London.

Although there are plans in place to reduce the recurrent deficit in 2017/18, the targets set for 2017/18 are for an in-year surplus. Currently North London CCGs and Trusts are assessed as c£60m away from delivering the 2017/18 target, with further risks of delivering already challenging savings plans on top of this. Recognising this, we are continuing to work on reducing the risks of delivering existing plans for 2017/18, as well as looking for further immediate opportunities for further efficiencies, beyond those set out above, including one-off non-recurrent measures that could improve the financial position in 2017/18, pending the full implementation of the transformational changes planned over the period to 2020/21.

To support our plan, NHS England and NHS Improvement have initiated a Capped Expenditure Process, to help the NHS produce a set of affordable plans for 2017/18. This aims to help us deliver the best possible clinical outcomes for local people within the funding available.

## Capital expenditure

We recognise that the national capital budget for the NHS is highly constrained over the course of this parliament, and will continue to work hard to minimise the need for significant capital investment unless there is a strong return on investment. North London also has a number of creative proposals that will seek to maximise disposal proceeds from sites no longer required, and use these to reinvest in the priority areas of the STP as well as the potential to provide additional, much-needed housing for the residents of North London.

There are a number of large capital schemes that are already approved and underway within the STP and, whilst far from being “business as usual” these are included in the ‘do nothing’ scenario as their approval pre-dates the STP work. Total capital, before specific STP-related investment, is £1.2bn over the 5 years. This includes:

- UCLH new clinical facilities: haematology-oncology and short stay surgery – (£137m); Proton-beam therapy (£130m), ENT and dental facility to consolidate two existing hospitals onto the main University College Hospital campus (£98m) and other more minor schemes. UCLH have approved DH funding of £278m (£51m public dividend capital (PDC) and £227m DH Loan) as well as anticipated, ring-fenced disposal proceeds to finance these developments;
- Royal Free - Chase Farm redevelopment (£183m), which includes £93m of approved DH funding (£80m PDC and £13m DH Loan)

In addition to these major developments there is of course significant business as usual capital investment such as equipment replacement and building maintenance, funded through depreciation, cash reserves and other sources of funding (including disposals).

The additional gross capital requirements to implement the transformation programme set out in the STP totals £542m, with a much smaller net investment requirement after taking into account disposals, donations and grants:

- Estates redevelopment relating to our St Pancras/St Ann’s/Moorfields proposals - £404m, assumed to be funded through disposals (£326m), DH loans (£39m and Donations (£37m), of which £272m (including short term bridging loans and repayments) occur within the period covered by this STP (i.e. before 2020/21) and is included above;
- Primary Care for Care Closer to Home and Five Year Forward View investment (£111m – assumed to be funded predominantly through ETTF (£60m – all bids submitted), s106/CIL/GP contributions (£26m), grants and other sources.
- IT investment (£159m with a further £21m in 2021/22) – all assumed to be funded by ETTF (circa £10m – bids submitted for the Person Held Record/IDCR) or through the central Digital Transformation fund.

We recognise that further work is needed to develop full business cases for the above, and at present these figures are estimated - particularly in relation to primary care and digital investment. In developing these schemes we will seek to maximise the use of existing buildings and other assets, and minimise the need for new capital investment, together with applying a robust requirement for return on investment for each scheme. However, we fundamentally believe that investment in primary care and digital technology is central to the transformation of services that is needed in North London to address the gaps in service quality, access and finance, and wholly consistent with the Five Year Forward View and requirement to be paper-free at the point of care by 2023. It would be wrong to

assume that such investment is not required and won't deliver value simply because of the stage in development of these plans that North London is currently in.

The estates redevelopment relating to St Pancras, St Ann's and Moorfields, and the estates devolution work, offers an exciting and compelling vision as to how existing assets, disposals, redevelopment and construction of new facilities can be financially efficient as well as delivering significant benefits to patients, service users and the wider population.

In addition, we will continue to engage with the work being led by Sir Robert Naylor in relation to property strategy across the NHS, to further understand how being a pilot area in this can help North London make best use of its current assets to support the delivery of our vision.



## Communications and Engagement

Since November 2016, we have been working with the NCL Joint health oversight and scrutiny committee (JHOSC). We have presented at the JHOSC and shared with the committee and members of the public our draft plan and introduced some of the areas of work. In January, the committee presented a report which included a number of recommendations to the NCL STP. We have responded to these recommendations and will continue to attend the JHOSC meetings to share our progress and respond to questions and feedback with a commitment to transparency and collaboration. As part of our work with the JHOSC, we have agreed a number of principles to guide the NCL process:

- Put the needs of individual patients, carers, residents and communities truly at the centre;
- Recognise that local patients, carers, residents and communities themselves are a resource for knowledge, for information, for understanding and for change; work with patients, residents and communities to harness their strengths;
- Trust and empower local patients, carers, residents and communities to drive change and deliver sustainable improvements;
- Co-design, co-produce and co-deliver services and programmes with local patients, carers, residents and communities;
- Focus on building resilient patients, carers, residents and communities -and on where resources can have the biggest sustainable impact.

The full report responding to the JHOSC recommendations can be found at <http://democracy.camden.gov.uk/documents/s57037/response%20to%20JHOSC%20report%20January%202017%20-%20final.pdf>

We have come a long way since being asked to come together as 21 health and social care organisations with disparate views in December 2015. It takes time to build trust and develop shared a shared vision of the future between people and organisations, and to get everyone working towards the same goals. We are now all aligned behind a collective agenda and are ready to share it more widely, seeking input and feedback on our draft plans to date.

The most important people we need to engage with are those who use our services – the residents of NCL. We have specifically created a shared core narrative for this purpose – ensuring it is in patient-focused and accessible in language to begin to involve people in the process. Now that we are in a position to communicate our collective thoughts effectively, our intention is to engage residents, local Councillors, our workforce and other key stakeholders to get feedback on our plans. We have held initial public meetings in each of the five boroughs to begin the process of co-design with patients, people who use services, carers, families and Healthwatch.

Our approach going forward will be to collaborate more extensively with people who use services and carers, local political stakeholders as well as members of the public, to ensure that our residents help inform our decisions. This approach is guided by the following core principles (often called the “Ladder of Citizen Participation”). We will undertake different types of engagement as set out on the ladder as appropriate:

1. ‘inform’ stakeholders
2. ‘engage’ with stakeholders in open discussions
3. ‘co-design/ co-produce’ services with stakeholders

Feedback from our local residents will be fundamental to our decision making and will help us shape the way the final plan is implemented.

## Our future plans

To help us meet our communication and engagement commitments we have formed a communications and engagement workstream. Membership of this group includes representatives from the 21 partner organisations, Healthwatch, voluntary sector representatives and lay people.

Working together as partners, we have established an evidence based engagement model and drawn of the expertise of communications leads from our CCG's, local authorities and provider organisations. We have identified key population groups and those members of your community that can at times be hard to reach. Working alongside Healthwatch and the voluntary sector we are now taking our proposals to the community for input and advice.

- In partnership with CCGs and Healthwatch we will participate in pan-NCL events on the overall plan and any specific issues that may arise at pan North London or individual borough level.
- Each workstream area has an engagement plan and will hosting meetings and events with patients, service users, carers and with the public on focussed topics such as urgent and emergency care, primary care, and mental health. This will help us to get more in-depth input from the community about their needs and how they expect services to be delivered.
- Our website will provide opportunities for online surveys and an online FAQ which will be kept current
- Our website will feature animations, infographics and relevant resources that will help people better understand the plan.
- We will link our website to social media and to promote our public engagement programmes and share information. We will also use these channels push residents and stakeholders to our website to test ideas and share progress on local priorities.

### To do this, we will:

- Work alongside Healthwatch and the voluntary sector, to identify representative groups, resident associations and other interest groups, local authority engagement networks and the many other networks available to the 21 partner organisations to reach out to the public and share proposals.
- We work in partnership with the communications and engagement teams across North London health and care organisations and together access their community activities and channels to share information about our proposals and progress and invite feedback and participation when appropriate.
- We will use existing online engagement tools used by partners to engage specific audiences and reach those who may be unable to attend our events.

We recognise it is crucial to ensure our local political stakeholders are actively involved in the oversight of the plans as they develop. We are planning on doing this by:

- planning regular face to face meetings between the STP leadership team and local councillors and MPs, along with Ministers in the Department for Health if required to seek their regular advice on all proposed changes
- continuing to submit our work to the Joint Health Overview and Scrutiny Committee (JHOSC) ensuring that all political channels through CCGs, local authorities and providers are kept fully briefed on the STP as it develops and any public concerns for the regular engagement they undertake with elected leaders
- logging all FOI requests, public enquiries, media stories and providing an update to the Transformation Board and meeting with elected members.

The health and care workforce is a significant stakeholder in the STP process. We have been providing a weekly update from the convenor of news and important meeting dates.

To engage more fully with our health and care workforce we are developing a staff engagement strategy in partnership with the workforce workstream. This will include identifying and training workplace champions, well versed in the priority areas of work who can speak at staff forums and events on the STP programme and articulate the implications and benefits of a more sustainable health and care system.

- the weekly STP newsletter that we have set up for those working within the organisations of the STP
- providing people working within our organisations with regular updates on progress through internal newsletters and bulletins, weekly / monthly updates from Chief Executives
- face-to-face meetings with professional organisations (e.g. Royal College of Physicians) to seek advice on communicating and engaging with specific cohorts within the health and care workforce and the most relevant issues.
- participating in or hosting sessions with a wider set of clinicians and social care practitioners to get their input into the priorities and delivery areas. This includes joint commissioners and working with our GP Federations to engage primary care providers to ensure our workforce is a driver and owner of change
- working with membership organisations to showcase the range of work which is happening across North London and share with staff the proposals and what the future health and care workforce will look like and how changes to how health and care is delivered may affect them.

We will continue to build our communications and engagement capabilities across the system. The Communications and engagement workstream meets monthly to develop and co-design the communications and engagement strategy. This forum is designed to build skills and expertise in engagement and brings together communication and engagement practitioners, clinical expertise, Healthwatch, voluntary sector and layperson representative in one room with a commitment to best practice in engagement.

There are many stakeholders in this programme of work. The most important is the residents of the five North London boroughs. Communicating with such a large and diverse audience is challenging. We will utilise the existing communications channels available through the 21 partner organisations and our network of voluntary sector organisations, Healthwatch and professional colleges and bodies.

The workstreams will identify specific key audiences appropriate to their proposals and engage with these groups of patients, service users, carers and other interested parties. It is through this work we can make sure that services meet the needs of people rather than the current system that is often disparate and disjointed for the person accessing.

## **Public consultation**

A formal public consultation is not needed for every service change. However, it is likely to be needed should substantial changes to the configuration of health services in a local area be proposed as our plans develop and we are committed to ensuring we consult widely and effectively.

Each of the partner organisations has conducted numerous engagement activities over past two years. This has included events, resident and staff surveys, forums, public meetings as well as input and feedback via organisational channels.

This data has helped us build a comprehensive picture of local views and concerns about health and care services. We know that people expect:

- People want more joined up health and care services

- People want health and care closer to where they live or work
- Services that are flexible, that adapt to people's differing needs
- People want to tell their story once
- Good signposting and information
- Access to services for a diverse population including interpreting services
- Simple, effective admin process which support patients to access the right service
- Compassionate healthcare professionals
- Access to a wide range of community support
- To not forget about carers and family

The launch of our North London Partners in health and care website (July 2017) will provide a single platform for information of the STP for residents, staff and other stakeholders.

On the website we will provide the most up to date information about our plan and the progress we are making to improve the health and wellbeing of the people of North London.

It is on our website where we will share stories of real local people and how the changes we are proposing make a difference to how they access care but also improving their health and care outcomes. It will also be our platform for inviting local people to participate in activities and events to help as co-design and co-produce services.



# Equalities analysis and impact assessment

Under the Equality Act 2010, we are required to analyse the effect and impact of our plans in relation to equality. We have carried out an equality impact assessment to ensure our plan does not discriminate against disadvantaged or vulnerable people, or other protected groups.

The analysis has considered the effect on different groups protected from discrimination by the Equality Act to ensure any changes are fully effective for all target groups and mitigate any unintended consequences for some groups. The analysis of the plans to date found that no groups will suffer a negative impact from the plan, rather the plans will have a broadly positive impact on health inequalities. Exhibit 11 summarises these impacts, indicating for each workstream, what is the expected impact on health inequalities for each protected characteristic. Detailed impact assessments for each workstream and each protected characteristic are available by emailing us at [nclstppmo@nhs.net](mailto:nclstppmo@nhs.net).

**Exhibit 11: summary of impacts by workstream**

Protected characteristic \ Workstream	Disability	Sex	Race	Age	Gender reassignment	Sexual orientation	Religion or belief	Pregnancy and maternity	Other groups
Care closer to home	Positive	Positive	Positive	Positive	Positive	Positive	Positive	Positive	Positive
Urgent & Emergency Care	Positive	Positive	Positive	Positive	Positive	Positive	Positive	Positive	Positive
Mental Health	Positive	Positive	Positive	Positive	No impact	No impact	No impact	Positive	Positive
Cancer	Positive	No impact	Positive	No impact	No impact	No impact	No impact	Positive	Positive
Planned Care	Positive	No impact	Positive	No impact	No impact	No impact	No impact	Positive	Positive
Productivity	Positive	No impact	No impact	No impact	No impact	No impact	No impact	Positive	Positive
Prevention	Positive	Positive	Positive	Positive	No impact	No impact	No impact	Positive	Positive
Digital	No impact	No impact	No impact	No impact	No impact	No impact	No impact	Positive	Positive
Estates	Positive	No impact	No impact	Positive	No impact	No impact	No impact	Positive	No impact
Workforce	Positive	Positive	Positive	Positive	No impact	Positive	No impact	Positive	Positive
Maternity	Positive	Positive	Positive	Positive	Positive	No impact	No impact	Positive	Positive
Communications and Engagement	Positive	Positive	Positive	Positive	Positive	Positive	No impact	Positive	Positive

No impact Positive impact

## Disability

Most workstreams will have a positive impact on inequalities associated with disabilities, which include physical, visual, and sensory impairment, and mental health problems or learning difficulties.

Some workstreams specifically aim to reduce health inequalities experienced by residents with disabilities. For example, the **Prevention workstream** will develop smoking cessation services that specifically target people with learning disabilities, including a payment to incentivise providers to

target this population group.

Patients with disabilities and their carers frequently experience disjointed health and care provision that fails to consider their needs in the round, or put the patient at the centre. Multiple workstreams, such as **Urgent and Emergency Care**, **Planned Care**, and **Care Closer to Home**, will seek to develop better integrated care to enable people with complex needs to have their needs more proactively assessed and met and to experience more joined up care.

Physical access to facilities and the availability of suitable equipment to meet the specific needs of people with different disabilities also figures prominently as a concern. The work by the **Estates workstream** is particularly relevant for this, as the review, re-purposing and reinvestment in estate will be done in the context of ensuring access for residents and patients with disabilities, e.g. in terms of level access/ramps, and in terms of ensuring premises are located at places that are most accessible by public transport etc. The work of the **Communications and Engagement workstream** will also aim to ensure that all venues used for events are assessed for accessibility for people with disabilities. Additionally, the review of office space and flexible working arrangements planned by the **Productivity workstream** and enabled by the **Digital workstream** may result in encouraging more flexible working opportunities for staff with disabilities.

As an overarching programme, the **Mental Health workstream** will have a positive impact for people suffering from mental ill health. For example, building community resilience will increase mental health basic awareness, reduce stigma, and increase mental health self-awareness. The **Workforce workstream** will also contribute to reducing stigma by ensuring that staff recruitment, training and retention practices are fully compliant with best practice.

Some ways of delivery of these projects will further facilitate access to services for people with disabilities. For example, the new care model proposed by the **Cancer workstream** has a strong emphasis on care closer to home, which has the potential to improve access for patients with disabilities. The **Workforce workstream** will also contribute to facilitating access by promoting a workforce that is better able to deliver care in appropriate settings, closer to home.

The **Maternity workstream** expects to have a positive impact on inequalities related to disability. Specific work is being planned to engage service users and community organisations to help ensure the needs of residents with disabilities are firmly built into workstream plans and implementation.

## Sex

Men and women do experience different health outcomes. However, these differences are difficult to isolate as being caused by gender alone, as gender interacts with other characteristics such as ethnicity and age, leading to considerable differences in the determinants of health for each population group.

However, some differences can be identified. For example, men are typically underserved by mental health services. The **Mental Health workstream** will target men in its community resilience, primary care mental health, and acute pathway projects, in order to address this inequality. Men may also be less likely to engage with preventive services delivered in 'traditional' healthcare services and settings, e.g. general practices. The **Prevention workstream** will use voluntary and community sector organisations to provide services to harder to reach groups, hopefully increasing the uptake of those services by men.

Some workstreams have identified other differences between men and women that will be addressed during the implementation phase. For example, men are generally more likely to die prematurely from

chronic diseases than women. In the **Care Closer to Home workstream**, the Care Closer to Home Integrated Networks (CHINs) will need to redesign services to make them more accessible to men and to find ways of engaging them earlier and to build resilience and self-care more effectively. Additionally, data from the recent Urgent and Emergency Care stocktake demonstrates that women use some services, such as walk-in centres, more than men. Resident engagement work by the **Urgent and Emergency Care workstream** will ensure that both genders are engaged in the design of Urgent and Emergency Care services across North London.

Men and women still carry significantly different burdens of work, caring, and other responsibilities. The **Workforce workstream** will seek to improve access to flexible employment arrangements, providing North London workers with a wider variety of work options.

The **Maternity workstream** also expects to have a positive impact on male partners as well as on women, although this needs to be further explored as these plans develop.

## Race

Language and cultural factors can determine health inequalities in groups defined by race and ethnicity.

The focus on healthier environments and settings as part of the **Prevention workstream** is fundamental to the reduction of health inequalities. By promoting positive changes in the settings where people grow, live, and work, we will be positively impacting on equality of opportunities, helping to reduce the health inequalities experienced by groups with certain characteristics, such as race and ethnicity.

One important determinant of different health outcomes between ethnic groups is differences in health service use. Greater involvement of and working with voluntary and community sector services and organisations at a local level in the planning and delivery of care and support should help professionals to become more responsive to the diverse needs of the communities they serve. This should enable more people to access advice and services that they might otherwise not access or use. The focus on working with and engaging the community is an important focus of the work of the **Prevention, Care Closer to Home, Cancer, Planned Care, and Mental Health workstreams**.

The investment and strengthening of primary care, expected through the **Care Closer to Home workstream**, should impact positively on inequalities in health and in particular improve the health of people from ethnic minorities.

The **Urgent and Emergency Care workstream** aims to improve the monitoring of ethnicity data within Urgent and Emergency Care services and is working alongside Healthwatch to develop a co-production strategy to engage harder to reach communities. Ensuring services are accessible and reach key population groups, including recognising language as a key determinant of access, will be a key consideration for this workstream.

The population served by maternity services is diverse, with high immigrant populations and in particular those who do not have English as their first language. Services can be difficult to navigate, with greater choice available to those best able to work their way through the system. The **Maternity workstream** aims to improve information regarding women's choices and the services that are available, and will equip staff to better signpost and guide women and their families through their maternity journey.

The **Workforce workstream** will ensure the recruitment, retention and development of underrepresented groups in North London, thus improving equality of opportunities.

The **Communications and Engagement workstream** will ensure opportunities for engagement are accessible to people from different cultural or ethnic groups, and will ensure all communication are made available in easy read or key community language.

## Age

Age is a major determinant of health and care needs, health outcomes, and service utilisation. The services provided by each workstream will seek to benefit different age groups and tackle age-related inequalities.

A major goal of the **Care Closer to Home workstream** is to provide better integrated care. This will enable frail older people to have their needs more proactively and holistically assessed and met, and to experience more joined up care.

There is a growing population of older people in North London. The **Urgent and Emergency Care workstream** has developed a frailty pathway project to address the specific needs of an ageing population. This will be considered in a range of areas, such as relationships with staff, accessibility of buildings, accessibility and cost of transport, and their overall experience of local healthcare. Additionally, future service design within this workstream will consider accessibility to specific facilities by target age group.

The **Prevention workstream** will maintain a focus on supporting children and young people to have healthy lives, ensuring that the settings in which they spend much of their time – early years' childcare and nurseries, and schools – give them the opportunity to be healthy. Additionally, it will make use of digital technologies and analytics to deliver interventions (e.g. apps), in order to promote access to services to young people. This workstream will also ensure that working age adults have the best chance to be healthy at work, by ensuring that the North London workforce (in its widest sense) is supported by organisational environments and opportunities that encourage and enable them to lead healthy lives and make choices that support their wellbeing.

The **Mental Health workstream** also includes projects that target specific population age groups, such as developments in children and adolescent mental health services, to better meet the needs of children and young people with mental health needs. This workstream will also invest in developing a dementia friendly North London, to better support older people living with dementia.

Experiences of maternity services can be very different according to maternal age. The **Maternity workstream** will link into existing services for young people under twenty. There are greater numbers of women over forty having babies in London than in other parts of the country. This workstream will examine the specific needs of this group and will create appropriate pathways of care for them.

The **Estates workstream** will ensure that the transformation of services and premises will be carried out in such a way as to consider the needs of the old and young, and target improvements in service provision. The **Workforce workstream** will guarantee that staff recruitment, training and retention practices would be fully compliant with best practice. The **Communications and Engagement workstream** will look to ensure that venues for engagement events are accessible for older people, who more frequently have mobility needs.

## Transgender

People who experience their body to be different from their assigned gender at birth remain a vulnerable group that suffers from an array of health inequalities. Some people may choose not to access services because their assigned gender on clinical records does not match how they personally experience their gender, which could cause distress and anxiety for the individual having to explain this to staff.

The **Care Closer to Home workstream** will aim to provide this group with the same quality and accessibility of services as for the rest of the population: improved access to more proactive and integrated care and the services better tailored to the needs of diverse local communities.

Under the **Urgent and Emergency Care workstream**, each service will develop its own policy regarding transgender and transsexual service users to ensure there is no discrimination and they are treated considerately and with respect. Regional or national organisations that represent individuals who are / have undergone gender reassignment will be invited to share their perspective within the formal consultation process.

Although the potential impact is not fully known, greater personalisation of care and improved choice provided by the **Maternity workstream** should have a positive impact on this population group.

The **Communications and Engagement workstream** will ensure all communications and engagement activities use inclusive language and venues are welcoming and consider the needs of all, including bathroom facilities that are trans-friendly.

## Sexual Orientation

There are clear differences in health outcomes between people of different sexual orientations. These differences will be addressed by the **Care Closer to Home** and **Urgent and Emergency Care workstreams** by improved access to more proactive and integrated care, by providing adequate training for all staff and by gathering further evidence and insight from local residents, organisations and groups to better understand their experiences of services and care. The **Workforce workstream** will further contribute by guaranteeing adequate staffing and skill mix, which should promote positive outcomes for all patients. Staff recruitment, training and retention practices will be fully compliant with best practice. The **Communications and Engagement workstream** will ensure all communications and engagement activities use inclusive language.

Furthermore, several workstreams plan to use voluntary and community sector organisations to deliver their interventions. This approach is intended to facilitate access to services by groups of people who are traditionally harder to reach.

## Religion or belief

The **Care Closer to Home** and the **Urgent and Emergency Care** workstreams will ensure there is no discrimination of service users according to their religion or belief, by providing improved access to more proactive and integrated care, delivering services that are better tailored to the needs of diverse local communities, and giving consideration to physical, cultural or behavioural barriers in the design of new services. The **Communications and Engagement workstream** will consider days of worship and cultural holidays or festivities.

The use of voluntary and community sector organisations to deliver interventions by several workstreams will also further facilitate access to and engagement in services by groups of people who are typically harder to reach.

## Pregnancy and Maternity

The **Care Closer to Home** and the **Urgent and Emergency Care** workstreams will ensure that, when designing new services, access and mobility issues will be considered for visitors and the ability for mothers to breastfeed and for parents to change babies as part of providers' consideration of service use.

The **Mental Health workstream**, through greater mental health support in primary care, will raise awareness of mental ill health in the perinatal period. Additionally, through the perinatal mental health programme, this workstream will support more women with their mental health in the perinatal period.

The **Productivity, Estates, Communications and Engagement, and Workforce workstreams** will all contribute to increasing opportunities for pregnant women and people with parental duties by reviewing flexible and remote working arrangements, encouraging more flexible working opportunities.

The **Prevention workstream** will develop projects with a specific focus on pregnant women. For example, smoking cessation services will specifically target pregnant women, including a payment to incentivise providers to target this particular population group. This will ensure that appropriate treatment is available to pregnant women, as traditionally not all services offer support for this group.

This is a particularly important group for the **Maternity workstream**, whose major impact is likely to be on pregnant women and parents. In terms of women and families using the services, increased access to care closer to home, improved choice and personalised care should improve access during pregnancy.

## Other Groups

The eight protected characteristics defined by the 2010 Equality Act do not exhaust all determinants that can lead to health inequalities. One major determinant is socioeconomic circumstance – income, education, employment, occupation, among others, can have significant impacts on an individual's health. Several workstreams will have an impact on socioeconomic health inequalities.

The **Prevention workstream** aspires to follow a model of proportionate universalism, which seeks to offer a universal service that is accessible to all but also target communities and groups where additional needs exist. Accordingly, it is not anticipated that a specific group of residents would be discriminated against, and this active approach will likely lead to a decrease in health inequalities. Some actions that will be suggested to guarantee this include:

- Setting specific targets for communities that carry a disproportionate weight of ill-health, in order to guarantee that their increased need is met with adequate services;
- Working with a variety of organizations, such as public, voluntary, and community sector, will allow a wider reach, ensuring residents of many social groups have the opportunity to be involved;
- Working in a variety of formats, such as the better use digital technologies, will facilitate this wide reach of North London residents;
- Maintaining a focus on contextual determinants – such as opportunities to eat a balanced diet, to exercise, or to work in a health-promoting environment – as key to guaranteeing equality

of opportunities, absence of discrimination, and promotion of good relationships between communities.

The **Care Closer to Home workstream** also explicitly seeks to address inequalities. Each Care Closer to Home Integrated Network (CHIN) will be provided with public health information showing where there are inequalities in health in their population which need to be addressed and they will be monitored on how effectively they deliver this outcome. Investing in primary care services is shown to reduce inequalities in health, reduce costs, improve access to more appropriate services, reduce in-hospital mortality, and reduce hospital admission rates. This is particularly important in North London, as there are high levels of A&E attendances across North London compared to national and peer averages, and also very high levels of first outpatient attendances.

Homelessness is of particular interest to the **Urgent and Emergency Care workstream**, as homeless people attend A&E more often than the general population, are admitted more often, and once admitted tend to stay longer. These and other issues regarding other vulnerable groups will be taken into consideration and addressed through local engagement groups and the co-production of Urgent and Emergency services.

The prevalence of severe mental illness varies amongst the North London boroughs, but is high across all areas. North London lies in the bottom quartile nationally, with varying outcomes across the boroughs. The **Mental Health workstream** will aim to reduce inequalities across the five boroughs so that no matter where someone lives in North London they can expect to receive the same high quality of care.

The **Cancer** and **Maternity workstreams** will also support work to understand where inequalities to access exist and will look to build evidence based solutions to address these. For example, the Cancer Vanguard includes a project to review the relative effectiveness of different types of invite to participate in screening.

The **Productivity** and the **Workforce workstreams** will also contribute to reducing health inequalities by encouraging more flexible working opportunities.

The **Communications and Engagement workstream** will seek to have a positive impact by ensuring that all communications and engagement activities use inclusive language.

Based on work previously done by the Islington CCG in building their personal health record, the **Digital workstream** will consult extensively with the public and patients to ensure that design, data presentation and access mechanisms are inclusive and support accessibility good practice.

We will continue to build on local regular equality audits of residents, patients and staff to ensure good engagement with protected groups and others, so that we can better understand the actual or potential effect of changes to functions, policies or decisions of the plan. This will help us to identify practical steps to tackle any negative effects or discrimination, to advance equality and to foster good relations.

Throughout our engagement to date, and building on the insight above, we have taken advice on best practice to ensure that all our public facing work is as fully accessible as possible, including sharing information in a variety of formats to ensure we are able to engage all our residents, using interpreters or Easy Read material where required. We will continue to hold events and meetings in accessible locations (accessible for people with disabilities and easily reached on public transport, with adaptations made for attendees' communication needs). Our aim is to enable different groups to be fully involved as the plans progress.



## Conclusion and next steps

We have made significant progress in developing our specific ideas for how we will achieve this. We have worked hard over the last few months to further develop our thinking, building on the evidence and by involving hundreds of members of staff from each of the provider and commissioning organisations and local authorities within North London. We held public meetings in each of the boroughs in September 2016 as the starting point to an ongoing conversation with the local community. We recognise there is more work to be done to engage with the community in the months ahead.

We have also worked proactively with the Joint Health Overview & Scrutiny Committee in North London to ensure that our developing plans are scrutinised and the robustness of our plan is challenged.

The STP has been developed to deliver the vision we have set out, the vision that the public has told us they want. As a sector, we have committed to the development and implementation of the delivery plans within each of the areas outlined above that can achieve the much wanted and much needed change. At the same time, we are clear that we will not lose focus on the longer term transformation and prevention work that will support sustainability.

Our work to April 2018 will focus on:

- taking steps to stabilise our financial position
- implementing our priorities as set out in this document in to ensure that we focus initially on the improvements which will make the most impact on our triple aims most quickly
- build on the early engagement with the public and staff

There remain issues to resolve and we know we do not have all the answers. But we are determined to succeed and will continue to work with people who use services, the public and our staff to find solutions in the months and years ahead.

For further information or to contact us please email [nclstppmo@nhs.net](mailto:nclstppmo@nhs.net).



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## Board of Directors: July 2017

**Item :** 10

**Title :** Board Assurance Framework

**Summary :**

The Assurance Framework identifies key risks to achieving the Trust's strategic objectives as set out in the Medium Term Strategy.

It was updated in January, April, July and November 2016 and February 2017.

The Framework was reviewed by the Management Team on 4<sup>th</sup> July 2017 and 13<sup>th</sup> July 2017. It was updated with two new risks (14 and 15) relating to the provision of good quality data and the medium and long-term planning for the Trust. Amendments were made to the wording of Risks 5, 7, 12 and 13. Risks 2 and 4 were combined with Risk 13 to improve clarity.

Risks 10 and 15, management capacity and longer term risk to the sustainability of the Trust (new risk) remain our most significant.

The BAF is brought to the Board in July as part of the quarterly reporting timings.

The **current** risk has been reviewed and updated and is presented on a Dashboard to provide a visual representation on a single page of all BAF risks.

If any major changes to the Trust's strategic risks are identified between these months, they will be reported to the Board at the next available opportunity.

The risks will be reviewed again in the autumn. This will inform the implementation of the Risk Register module of the new electronic Quality system, due at the end of the calendar year.

Amendments to individual risks are highlighted in **red**.

**For :** Approval

**From :** Deputy Chief Executive & Finance Director;  
Associate Director of Quality and Governance

## BOARD ASSURANCE FRAMEWORK

### 1. INTRODUCTION

- 1.1. The Board Assurance Framework (“BAF”) seeks to identify the key risks that could prevent the Trust from achieving its strategic objectives.
- 1.2. The following Framework and approach are in line with the Risk Management Policy and Strategy, and Risk Management Procedure both approved in May. The new approach is outlined below.
- 1.3. The BAF Heatmap presents all BAF risks on a single page as an overview of the current position. The direction of travel for each risk from last assessment is also included.

### 2. APPROACH TO RISK SCORING

- 2.1. Significant risks are identified by the Executive Management Team after discussion with each other, with their direct reports and with the Board. In identifying significant risks, various factors are taken into account including, amongst other factors, both the local and general environments for health and social care; the Trust’s current and future operational performance; the current and future availability of resources.
- 2.2. Each significant risk is then given a score for the:
  - 2.2.1. **initial risk**: the risk level assessed at the time of initial identification.
  - 2.2.2. **current risk**: the risk at a point in time, taking in account completed actions / mitigating factors.
  - 2.2.3. **target risk**: this is a new addition to the BAF and is the level of risk which the Board is expected / willing to accept after all necessary planned measures have been applied.
- 2.3. Scoring is based on the Trust’s Risk Management Policy, as follows:

1 – 4	Green
5 – 8	Yellow
9 – 12	Amber
15 – 25	Red
- 2.4. The risks have been numbered for easier referencing (although the number does not imply a higher or lower level of inherent or residual risk).
- 2.5. The **initial risks** were taken from the July 2015 BAF when the new BAF format was introduced.

- 2.6. Assurances are defined as (+) or (-) as per internal audit recommendations and controls map against at least one source of assurance (evidence).
- 2.7. Directors have reviewed and updated their sections of the BAF including confirming the **target risk**, updating the **current risk** scores for each risk and updating the strategic objective(s) affected by the risk with the relevant 'Aim(s)'.
- 2.8. The BAF has also been reviewed by the Executive Management Team.

### 3. SUMMARY

- 3.1. Risks 10 and 15, management capacity and longer term risk to the sustainability of the Trust (new risk) remain our most significant.
- 3.2. Risk 5, Delivery of the National Training Contract (reworded to focus on delivery of the contract), has reduced from 15 to 10.
- 3.3. All other risks have remained unchanged from the previous quarter.

### 4. CONCLUSION

- 4.1. The Board is invited to approve this update to the Board Assurance Framework; and to comment whether, with the action plans as set out, the risks are tolerated.

**CURRENT BAF HEAT MAP**

<b>Likelihood</b>	Almost certain to occur	5					
	Likely to occur	4				R10	
	Could occur	3			R3	R1, R6, R8, R9, R13, R14	R15
	Unlikely to occur	2				R7, R11	R5
	Very unlikely to occur	1				R12	
<b>Risk Matrix</b>			1	2	3	4	5
			Negligible	Minor	Moderate	Severe	Extreme
		<b>Consequence</b>					

**FEBRUARY 2017 BAF HEAT MAP**

<b>Likelihood</b>	Almost certain to occur	5					
	Likely to occur	4				R10,	
	Could occur	3			R3, R4	R1, R2, R6, R8, R9, R13	R5
	Unlikely to occur	2				R7, R11	
	Very unlikely to occur	1				R12	
<b>Risk Matrix</b>			1	2	3	4	5
			Negligible	Minor	Moderate	Severe	Extreme
		<b>Consequence</b>					

See next page for risk numbers and headings.



**Risk headings, reference numbers.**

**Arrows denote direction of travel from risk level from last assessment**

<b>Risk 1</b>	Clinical quality or governance failures	
<b>Risk 2</b>	Clinical growth targets not achieved [risk combined with 13]	N/A
<b>Risk 3</b>	Education and training quality failures	
<b>Risk 4</b>	Training course numbers reduced [risk combined with 13]	N/A
<b>Risk 5</b>	Delivery of National Training contract [reworded]	
<b>Risk 6</b>	Loss of workforce engagement and morale	
<b>Risk 7</b>	Failure to recruit or retain skilled workforce [reworded]	
<b>Risk 8</b>	Unable to agree or fund relocation/ redevelopment plans	
<b>Risk 9</b>	Loss of access to critical systems (IT)	
<b>Risk 10</b>	Insufficient management capacity	
<b>Risk 11</b>	Failure to raise the profile of current Trust work and relevance to mental health may damage the Trust's reputation and brand [reworded]	
<b>Risk 12</b>	Failure to comply with regulatory requirements [reworded]	
<b>Risk 13</b>	Failure to deliver savings and growth contribution [reworded]	
<b>Risk 14</b>	Failure to provide good quality data impacting on Trust work	New
<b>Risk 15</b>	Longer term risk to the sustainability of the Trust	New

## Board Assurance Framework 2017/18 – Summary –

	Risk	Owner	Strategic Aim	Current Risk Score				Target Risk <small>C = consequence L = likelihood Risk = C x L</small>	Current v Target Risk Score
				Oct 16	Jan 17	July 17	* 17		
10	Insufficient management capacity	Paul Jenkins	ALL	Red 16	Red 16	Red 16		Amber 4x3	Adverse
15 <small>New</small>	Longer term risk to the sustainability of the Trust	Paul Jenkins	5			Red 15		Amber 5x2	Adverse
13	Failure to deliver savings and growth contribution	Terry Noys	5	Red 16	Amber 12	Amber 12		Yellow 4x2	Adverse
2	Clinical growth targets not achieved	Terry Noys	5	Red 15	Amber 12	Moved to Risk 13		Amber 3x3	Moved to Risk 13
1	Clinical quality or governance failures in context of elevated risk of serious incidents	Rob Senior	2	Amber 12	Amber 12	Amber 12		Yellow 4x2	Adverse
6	Loss of workforce engagement / morale / commitment	Paul Jenkins	4	Amber 12	Amber 12	Amber 12		Yellow 4x2	Adverse
8	Unable to agree or fund relocation / redevelopment plans	Terry Noys	7	Amber 12	Amber 12	Amber 12		Yellow	Adverse

		<u>Current Risk Score</u>							
	<u>Risk</u>	<u>Owner</u>	<u>Strategic Aim</u>	<u>Oct 16</u>	<u>Jan 17</u>	<u>July 17</u>	<u>* 17</u>	<u>Target Risk</u> C= consequence L = likelihood Risk = C x L	<u>Current v Target Risk Score</u>
9	IT applications and hardware do not sufficiently support Trust objectives. Loss of access to critical systems	David Wyndham Lewis	7	Amber 12	Amber 12	Amber 12		Yellow 4x2	Adverse
14	Failure to provide good quality data impacting on Trust work	David Wyndham Lewis	2,12			Amber 12		Yellow 3x1	Adverse
4	Training course numbers reduced, or growth targets not achieved	Brian Rock	3	Amber 9	Amber 9	Moved to Risk 13		Yellow 3x2	Moved to Risk 13
5	Delivery of National Training contract	Brian Rock	3	Red 15	Red 15	Amber 10		Amber 4x3	Meets
3	Education and Training quality failures	Brian Rock	3	Yellow 8	Amber 9	Amber 9		Green 4x1	Adverse
7	Failure to recruit or retain skilled workforce	Craig De Sousa	4	Yellow 8	Yellow 8	Yellow 8		Green 4x1	Adverse
11	Failure to raise the profile of current Trust work and relevance to mental	Paul Jenkins	6	Yellow 8	Yellow 8	Yellow 8		Yellow 4x2	Meets

		<u>Current Risk Score</u>							
	<u>Risk</u>	<u>Owner</u>	<u>Strategic Aim</u>	<u>Oct 16</u>	<u>Jan 17</u>	<u>July 17</u>	<u>* 17</u>	<u>Target Risk</u> C= consequence L = likelihood Risk = C x L	<u>Current v Target Risk Score</u>
	health may damage the Trust's reputation and brand								
12	Regulatory failure	Paul Jenkins	2, 5	Yellow 5	Green 4	Green 4		Green 4x1	Meets

**STRATEGIC AIMS**

- 1) Contributing to the development of new models of care (PJ /SH/ JSt /BR)
- 2) Maintaining & developing the quality & reach of our clinical services (JSt/SH /LL)
- 3) Growing and developing our training and education and delivering a remodelled National Training Contract (BR)
- 4) Supporting the wellbeing and engagement of our staff (Cds / LL / BR)
- 5) Delivering a sustainable financial future for the Trust (TN / JS)
- 6) Raising Trust's profile & its contribution to public debate & discourse (LT/BR /RS)
- 7) Develop our infrastructure to support our work (TN /DWL)

<b>RISK 1): Clinical quality or governance failures – including the risk of serious incidents</b>	
<u>Risk Owner:</u> Medical Director	Date last reviewed: July 2017
<u>Strategic Objective(s) affected by this risk:</u> Aim 2: Maintaining and developing the quality and reach for our clinical services	<u>INITIAL risk rating (at identification):</u> Consequence 4 x Likelihood 2 <b>8</b> <u>CURRENT risk rating (after mitigation):</u> Consequence 4 x Likelihood 3 <b>12</b>
<u>Rationale for current score:</u> The consequence of a serious clinical incident attributable to a failure to comply with appropriate standards of quality or safety is high and the likelihood of incidents has risen because of increased risk in some services and populations. There are well-embedded systems in place to provide governance and early warning of system failures. Evidence of learning from incidents has improved. New GIC contract to be taken up April 2017 with unknown risk level.	
<u>Controls/Influences (what are we currently doing about this risk?):</u> Director of Quality and Patient Experience leads Quality work-stream reporting to CQSG Committee. Continuing development of staff training programmes. Associate Medical Director leads Patient Safety and Risk work-stream. CQC report discussed at MT, CQSGC and Board. Full action plan approved and being implemented. CareNotes now more fully embedded in clinical practice. Individual action plans arising from the investigation of incidents GIC clinical governance meetings set up	<u>Assurances received (independent reports on processes; when; conclusions):</u> CQC inspection report published in May: Good rating overall and in 4/5 domains (+) Quality Reports and Accounts externally audited: Risks attributable to reduced capacity of other providers including Social Care and Voluntary Sector are difficult to mitigate. Investigations including SCR and coroner's inquest have not identified failures by Trust practitioners. Clinical Governance Leads appointed CYAF and AFS (+) <b>CQC inspection report updated February 2017 rated 'good' all KLOes (+)</b> <b>GIC clinical governance meeting ToR agreed (+)</b>

<p><u>Gaps in controls/influences:</u> Some aspects of poor data quality have potential to impact on clinical quality and safety Acquisition of GIC service associated with some new risks</p>	<p><u>Action plans in response to gaps identified:</u> <i>(with lead and target date)</i> Review risk in light of new GIC contract. See action plan in relation to Risk 14</p>
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<p><b>RISK 3): Education and Training quality failures</b></p> <p>This includes failure to deliver a quality learning experience to students that is fundamental to our position in the sector.</p>	
<p><u>Risk Owner:</u> Director of Education and Training.</p> <p><u>Strategic Objective(s) affected by this risk:</u></p> <p>Aim 3: Growing and developing our training and education and delivering a remodelled National Training Contract</p> <p>Aim 5: Delivering a sustainable financial future for the Trust</p> <p><u>Rationale for current score:</u></p> <p>The Trust is a leading quality provider of education and training. Any actual or perceived loss of quality in delivery through the expansion of numbers, courses, sites of delivery and teaching formats would potentially have a serious impact. <b>Course content and approach in delivery of programmes remains of a high quality. Embedding of new staff and new processes following restructuring continues and is well progressed. Pressure on operational teams from MyTap implementation and on faculty from pressure and increased workloads continues.</b></p>	<p>Date last reviewed: July 2017</p> <p><u>INITIAL risk rating (at identification):</u></p> <p>Consequence 4 x Likelihood 2 <b>8</b></p> <p><u>CURRENT risk rating (after mitigation):</u></p> <p>Consequence 3 x Likelihood 3 <b>9</b></p>
<p><u>Controls/Influences (what are we currently doing about this risk?):</u></p> <p>Robust Academic Governance and Quality Assurance arrangements in place, supported and monitored by university partners.</p> <p><b>Curriculum Quality Group / Partnership Management Board Learning &amp; Teaching Committee focus with HR Director on people development and succession through the establishment of an academy linked to organisation's people strategy and CPD fellowship opportunities for all staff with Higher Education Academy.</b></p> <p>Portfolio Manager Group</p>	<p><u>Assurances received (independent reports on processes; when; conclusions):</u></p> <p>QAA monitoring report was extremely positive about progress on action plan arising from review in April 2016. Report published July 2017 (+)</p> <p>Annual student survey results in keeping with previous high levels of satisfaction (June 2016). <b>Awaiting current AY survey results (Sept 2017) with higher level of engagement than previous year (+)</b></p> <p><b>Project brief and action plan for establishment of T&amp;P academy presented and agreed at TEPMB with focus on identifying new talent (June 2017) (+)</b></p>

<p>Establishment of Standard Operating Procedures to create clarity of roles and responsibilities to support students across DET functions and course teams.</p> <p>Strategic plan for assessment of national centres (alternative &amp; Associate).</p> <p>Development of complaints procedure in line with membership of OIA.</p> <p>Implementation of new student information management system (release 4 underway).</p> <p><u>Gaps in controls/influences:</u></p> <p>Ongoing embedding of professional support services with clearer processes across roles.</p> <ol style="list-style-type: none"> <li>1) New staffing arrangements in core administrative team.</li> <li>2) Implementation of SITS involves sustained input from operational team.</li> </ol>	<p><b>National Centres baseline requirements agreed at TEPMB (May 2017) (+)</b></p> <p><u>Action plans in response to gaps identified:</u> <i>(with lead and target date)</i></p> <ol style="list-style-type: none"> <li>1) Workshops established to work with professional support staff and faculty to further develop and embed SOPs (Nov 2016 – ongoing / Associate Deans).</li> <li>2) Weekly Rapid Response Group established by Deputy Director to work closely with key operational staff members to monitor and address issues that impact student experience (Sept 2016 – ongoing).</li> </ol>
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<p><b>RISK 5): Delivery of National Training Contract [reworded July 2017]</b>                  Significant changes to HEE funding &amp; focus with active review of our National Training Contract has now been finalised. This is the initial period in which significant changes come into effect. Continuing to deliver and develop our existing portfolio alongside the establishment of the National Workforce Skills Development Unit will present both challenges and opportunities.</p>	
<p><u>Risk Owner</u>: Director of Education and Training.</p>	<p>Date last reviewed: July 2017</p>
<p><u>Strategic Objective(s) affected by this risk</u>:</p> <p>Aim 3: Growing and developing our training and education and delivering a remodelled National Training Contract</p> <p>Aim 5: Delivering a sustainable financial future for the Trust</p>	<p><u>INITIAL risk rating (at identification)</u>:</p> <p>Consequence 5 x Likelihood 3 <b>15</b></p> <p><u>CURRENT risk rating (after mitigation)</u>:</p> <p>Consequence 5 x Likelihood 2 <b>10</b></p>
<p><u>Rationale for current score</u>:</p> <p>National Training Contract has been significantly reshaped through a lengthy and extensive process of discussion and negotiation with HEE. A key focus is on the continued development of the NWSDU and the delivery of tangible outcomes. Notwithstanding significant changes in HEE, continued positive engagement and support from local office, relevant national team and responsible DEQ.</p>	<p><u>Assurances received (independent reports on processes; when; conclusions)</u>:</p> <p>Significantly improved quality of reporting (+)                  Ongoing engagement with key HEE colleagues in an active process including presentation to key stakeholders at HEE (+)                  Positive initial response to programme briefs (+)</p>
<p><u>Controls/Influences (what are we currently doing about this risk?)</u>:</p> <p>Active portfolio review and alignment of portfolio provision with HEE priorities and broader policy drivers.</p> <p>Establishment of productivity board to further develop work in reviewing cost base of course provision.</p> <p>Focus on identifying new income streams via BDG.</p> <p>Establishment of a steering group for NTC activity with T&amp;P and HEE membership.</p> <p>Active engagement of key HEE personnel in the development of new activity and on reporting and contract monitoring.</p>	

<p>Formal establishment of the NWSDU with agreement of key lines of accountability in the Trust involving Director of Nursing and DET Director.</p> <p>Development of the Workforce Development Collaborative.</p> <p>Interim leadership arrangements with core team formation.</p>	
<p><u>Gaps in controls/influences:</u></p> <p>Personnel changes at the national team level and significant flux in the commissioning organisation.</p> <p>Appointing AD for the NWSDU to lead this area of activity.</p> <p>Project leadership and the pace of delivery.</p>	<p><u>Action plans in response to gaps identified:</u> <i>(with lead and target date)</i></p> <p>Collaboration with HEE has fruitfully continued and engagement with new leadership team is underway with positive early signs (CC 9/2017).</p> <p>Second recruitment round successfully underway (CC 7/2017).</p>

<b>RISK 6): Loss of workforce engagement and morale</b>	
Risk Owner: Chief Executive	Date last reviewed: July 2017
<u>Strategic Objective(s) affected by this risk:</u> Aim 4: Supporting the wellbeing and engagement of our staff	<u>INITIAL risk rating (at identification):</u> Consequence 4 x Likelihood 2 <b>8</b> <u>CURRENT risk rating (after mitigation):</u> Consequence 4 x Likelihood 3 <b>12</b>
<p><u>Rationale for current score:</u> Staff survey consistently shows strong commitment to the Trust and its work. Evidence form a number of sources indicates growing pressure on staff as resources reduced and workload increases.</p>	
<p><u>Controls/Influences (what are we currently doing about this risk?):</u> Organisational Development and People Strategy agreed by Board in April with important focus on staff engagement and wellbeing. Continuing programmes of consultation and communication with staff including monthly CE Question Time. New intranet launched to support improved staff communications. Reducing the burden project launched to reduce burden of data collection. Support development of team managers as a key level for staff support/engagement.</p>	<p><u>Assurances received (independent reports on processes; when; conclusions):</u> 2016 NHS Staff survey demonstrates overall engagement holding up but includes clear evidence of continuing pressure on staff (+/-) Organisational Development and People Strategy (+)</p>
<p><u>Gaps in controls/influences:</u> Level of external pressure to generate financial savings. Uncertainty of current external environment.</p>	<p><u>Action plans in response to gaps identified: (with lead and target date)</u> People Strategy being implemented with specific recommendations on staff wellbeing and engagement and the development of middle managers. (CdS 03/2020)</p>

	<p>Further development of intranet to support staff communications. (LT)</p> <p>Follow through of Reducing the Burden project to reduce the burden of data collection. (LL 11 /2017)</p>
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<b>RISK 7): Failure to recruit or retain skilled workforce [reworded]</b>	
<u>Risk Owner:</u> Director of HR	Date last reviewed: July 2017
<u>Strategic Objective(s) affected by this risk:</u> Aim 4: Supporting the wellbeing and engagement of our staff	<u>INITIAL risk rating (at identification):</u> Consequence 4 x Likelihood 3 <b>12</b> <u>CURRENT risk rating (after mitigation):</u> Consequence 4 x Likelihood 2 <b>8</b>
<p><u>Rationale for current score:</u> Skills and experience levels remain high within the organisation, however, there are signs of growing pressure. Results from the annual Staff Survey and from the Friends and Family Test remain generally good.</p> <p><u>Controls/Influences (what are we currently doing about this risk?):</u> Employee engagement and employee satisfaction is assessed annually through national survey and four times a year through the Staff Friends and Family Test. The findings of these surveys and any arising concerns are discussed and addressed with the management team and our trade union colleagues. For example, the helpline for staff to raise concerns helpline has been introduced. We have also implemented a localised action planning process. The Trust Board approved a new organisational development and people strategy which has four overarching aims. The strategic priorities are to recruit and attract talent in to the organisation; ensure we retain and develop our existing staff; we protect the health and wellbeing of our workforce; and to value and respect our diverse group of staff. The Trust has developed a much more strategic approach to learning and development commissioning. Through the annual</p>	
<p><u>Assurances received (independent reports on processes; when; conclusions):</u> <b>Organisational Development and People Strategy (+)</b> Quarterly reports to the Board (+) (-) <b>Results of the quarterly friends and family tests and staff survey results - via the dashboard (+) (-)</b> <b>Trust developed action plan to respond to recent staff survey findings (+) (-)</b> <b>Staff development and leadership programmes (+)</b></p>	

<p>appraisal process a comprehensive development programme has been developed and approved by the Staff Training Committee. In addition to this the Trust also continues to make provision for flexible, multi-professional, continuous professional development funding.</p> <p>The process for succession planning within Directorates is encouraged and a framework will be delivered as part of the people strategy to support a consistent approach.</p> <p>Organisational values: Our Trust values have been developed.</p> <p>Job Descriptions: Managers and trade union colleagues are engaged by HR to assess the future skills requirements in job descriptions that cater to the current and future Trust needs.</p>	<p><u>Action plans in response to gaps identified:</u> <i>(with lead and target date)</i></p> <p>The people strategy delivery plan details a number of actions required to maintain staff engagements and to protect the health and wellbeing of our staff. Implementation of the OD and People Strategy (Cds 3/2020)</p> <p>Directorate succession planning framework will be delivered as part of the people strategy (Cds 3/2020)</p> <p>Managers tasked to address hot spots within their directorates relating to the localised staff survey action plan. (KM 9/2017)</p> <p>Flexible, multi-professional, CPD funding refreshed annually (KB 3/2018)</p> <p>Develop a behavioural framework to be applied to recruitment and appraisal processes. (Cds 3/2018)</p>
<p><u>Gaps in controls/influences:</u></p> <p>Increasing levels of sickness absence</p> <p>Delivery of People Strategy Delivery Plan</p> <p>Local implementation of staff survey action plan</p> <p>Ongoing CPD funding</p> <p>Behavioural framework including Trust values required for recruitment and appraisal processes</p>	

<b>RISK 8): Unable to agree or fund relocation / redevelopment plans</b>	
<u>Risk Owner:</u> Deputy Chief Executive	Date last reviewed: July 2017
<u>Strategic Objectives affected by this risk:</u> Aim 7. Develop our infrastructure to support our work	<u>INITIAL risk rating (at identification):</u> Consequence 4 x Likelihood 3 <b>12</b> <u>CURRENT risk rating (after mitigation):</u> Consequence 4 x Likelihood 3 <b>12</b>
<u>Rationale for current score:</u> Currently in exclusive negotiations with vendor regarding new site. Funding agreed in principal (in 2016), however, further work required in order to secure drawdown. Financial parameters of Relocation have changed since Outline Business Case. Property markets are volatile.	
<u>Controls/Influences (what are we currently doing about this risk?):</u> <ul style="list-style-type: none"> <li>Ongoing updated review of costs and potential proceeds</li> <li>Meetings with funding agency, ITFF (last meeting in July)</li> <li>Exclusive negotiations with vendor towards Heads of Terms</li> </ul>	<u>Assurances received (independent reports on processes; when; conclusions):</u> <ul style="list-style-type: none"> <li>Updated review of costs by Currie and Brown (June 2017) (+) (-)</li> <li>Updated valuation of potential proceeds from sale of assets by Montagu Evans (July 2017) (+) (-)</li> <li>Ongoing conversations with senior management of vendor (+)</li> <li>Meeting with ITFF (+)</li> </ul>
<u>Gaps in controls/influences:</u> <ul style="list-style-type: none"> <li>Future movements in property values (for both sale and purchase) uncertain</li> <li>Requirements to draw down funding unclear</li> </ul>	<u>Action plans in response to gaps identified: (with lead and target date)</u> <ul style="list-style-type: none"> <li>Ongoing updated review of costs and potential proceeds (TN)</li> <li>Further meeting with ITFF planned for August 2017 (TN)</li> <li>Aiming for Heads of Terms by no later than end August 2017 (TN)</li> </ul>



<b>RISK 9): IT applications and hardware do not sufficiently support Trust objectives. Loss of access to critical systems (IT)</b>	
<b>Risk Owner:</b> Director Technology and Transformation	<b>Date last reviewed:</b> July 2017
<u>Strategic Objectives affected by this risk:</u> Aim 7: Develop our infrastructure to support our work	<u>INITIAL risk rating (at identification):</u> Consequence 4 x Likelihood 3 <b>12</b> <u>CURRENT risk rating (after mitigation):</u> Consequence 4 x Likelihood 3 <b>12</b>
<p><u>Rationale for current score:</u>  <b>IMT Strategy (January 2016) implementation is now well progressed but with certain key projects outstanding. Recent incidents across the NHS have highlighted the need for improved business continuity planning across the Trust even following the introduction for more resilient infrastructure. Cyber security threats are evolving swiftly with recent attack impacting other NHS Trusts over the last months.</b></p> <p><u>Controls/Influences (what are we currently doing about this risk?):</u>            CareNotes Optimisation Work is complete with most issues related to the resilience of the CareNotes system itself now resolved. This has however highlighted weaknesses in other aspects of our infrastructure, notably in IMT provision at remote sites. These issues will be addressed in the main through the Network Replacement Project <b>with procurement completing in July 2017.</b> Procurement includes network replacement, network security and ongoing support contract that will collectively increase uptime and performance of network. Improvements to electrical provision and security and physical environment for network cabinets has been started with levels 1, 3 and 4 complete. <b>The remaining works require a significant planned downtime for the Trust network to allow for migration to resilient power sources. This has therefore been deliberately</b></p>	
<p><u>Assurances received (independent reports on processes; when; conclusions):</u>  <b>Penetration testing against the network in 2016/17 yielded broadly positive results with all output issues from the report now addressed. (+)</b>   <b>The Trust's avoidance of any impact from the WannaCry ransomware has highlighted the good standard of our processes related to cyber security, although with no room for complacency given the speed with which this threat evolves. (+)</b></p>	

<p>delayed until the Network Replacement Project so as to avoid duplication of this downtime.</p> <p><u>Gaps in controls/influences:</u></p> <p>Final implementation of the replacement network along with its improved technical protections, and proactive automated cyber security controls.</p>	<p><u>Action plans in response to gaps identified:</u> <i>(with lead and target date)</i></p> <p>Network replacement to be implemented in Q4 2017. Action plans for security and continuity are being implemented alongside this. (DWL 31/12/17))</p> <p>New student records system in implementation during 2016/17. (BR 30/11/17)</p> <p>Email system replacement is underway with Phase 1 and 2 now complete. Phase 3 (secure send of patient data without NHSMail) due in Q4. (DWL 31/12/17)</p>
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<b>RISK 10): Insufficient management capacity</b>	
<u>Risk Owner:</u> Chief Executive	Date last reviewed: July 2017
<u>Strategic Objective(s) affected by this risk:</u> ALL	<u>INITIAL risk rating (at identification):</u> Consequence 4 x Likelihood 3 <b>12</b> <u>CURRENT risk rating (after mitigation):</u> Consequence 4 x Likelihood 4 <b>16</b>
<p><u>Rationale for current score:</u> As a small and diverse Trust management resources are spread thinly. Need to support growth alongside savings agenda. Considerable growth in external pressure from STP and regulators.</p>	
<p><u>Controls/Influences (what are we currently doing about this risk?):</u> Use strategic plan to focus priorities and manage trade-offs. <b>Review of Business Development capacity to strengthen capacity.</b> <b>Use strategic opportunities for additional investment, in particular focused on new income development.</b></p>	<p><u>Assurances received (independent reports on processes; when; conclusions):</u> Quarterly review of progress against strategic objectives by the Strategic and Commercial Committee (+)</p>
<p><u>Gaps in controls/influences</u> Uncertainty of external environment and impact on internal capacity. <b>Pressure to deliver Trust Control Total reduces capacity for additional investment.</b></p>	<p><u>Action plans in response to gaps identified: (with lead and target date)</u> Continue to use strategic plan on a quarterly basis to review pressures and resolve tensions over priorities. <b>Identify opportunities for additional investment to support income generation.</b></p>

<b>RISK 1 1): Failure to raise the profile of current Trust work and relevance to mental health may damage the Trust's reputation and brand [reworded]</b>	
<u>Risk Owner:</u> Chief Executive	Date last reviewed: July 2017
<u>Strategic Objectives affected by this risk:</u> Aim 6: Raising the Trust's profile and its contribution to public debate and discourse	<u>INITIAL risk rating (at identification):</u> Consequence 4 x Likelihood 2 <b>8</b> <u>CURRENT risk rating (after mitigation):</u> Consequence 4 x Likelihood 2 <b>8</b>
<u>Rationale for current score:</u> Generally positive reputation in wider mental health world. Positive impact of Kids on the Edge. <b>However danger that, in constrained financial environment, the Trust's priorities are not prioritised.</b>	
<u>Controls/Influences (what are we currently doing about this risk?):</u> <b>Commissioned reputation audit</b> Public Affairs Strategy	<u>Assurances received (independent reports on processes; when; conclusions):</u> Media monitoring (+) Communications team fully staffed (+)
<u>Gaps in controls/influences:</u> Change in external environment	<u>Action plans in response to gaps identified: (with lead and target date)</u> <b>Review results of Reputation Audit – September 2017 (PJ)</b> Public Affairs Strategy due to the Board in <b>September 2017 (LT)</b> Planned follow up to Century Films (LT)

<b>RISK 12): Failure to comply with regulatory requirements [Reworded]</b>	
<u>Risk Owner:</u> Chief Executive	Date last reviewed: July 2017
<u>Strategic Objectives affected by this risk:</u> Aim 2: Maintaining and developing the quality and reach of our clinical services	<u>INITIAL risk rating (at identification):</u> Consequence 5 x Likelihood 1 <b>5</b> <u>CURRENT risk rating (after mitigation):</u> Consequence 4 x Likelihood 1 <b>4</b>
<u>Rationale for current score:</u> Strong current performance but needs to keep under review. Positive rating for CQC and QAA in the last year. Currently in top rating for NHS Improvement	
<u>Controls/Influences (what are we currently doing about this risk?):</u> Range of governance processes in place. CQC Good rating. QAA Fully meet UK requirement and positive follow up visit May 2017 Trust in receipt of rating of 1 for NHS Improvement Single Oversight Framework	<u>Assurances received (independent reports on processes; when; conclusions):</u> CQC rating (+) QAA rating (+) Clean external audit opinion, May 2017 (+) NHS Improvement Single oversight framework (+)
<u>Gaps in controls/influences:</u> Ongoing pressure for efficiency savings impact on management capacity.	<u>Action plans in response to gaps identified: (with lead and target date)</u> CQC action plan agreed and being implemented. (LL) QAA action plan developed and being implemented (BR 3/2018) Implementation of Clinical Quality Strategy (LL)

<b>RISK 13): Failure to deliver savings and growth contribution [Reworded. Risks 2 and 4 included July 2017]</b>	
<u>Risk Owner:</u> Deputy Chief Executive	Date last reviewed: July 2017
<u>Strategic Objectives affected by this risk:</u> Aim 5. Delivering a sustainable financial future for the Trust	<u>INITIAL risk rating (at identification):</u> Consequence 4 x Likelihood 4 <b>16</b> <u>CURRENT risk rating (after mitigation):</u> Consequence 4 x Likelihood 4 <b>12</b>
<u>Rationale for current score:</u> It is likely required savings and growth targets will be met for 2017/18. The major risk relates to 2018/19, where achievability of the Control Target is currently less certain and not yet supported by detailed delivery plans	
<u>Controls/Influences (what are we currently doing about this risk?):</u> <ul style="list-style-type: none"> <li>Active and regular Executive Management Team consideration of the issues (including monthly management accounts)</li> <li>Projections and targets (including Directorate-specific plans) for 2017-18 agreed. Growth targets and action plans reviewed regularly by Business Development Group, Strategic and Commercial Committee, Education and Training programme Board and Trust Board</li> </ul>	<u>Assurances received (independent reports on processes; when; conclusions):</u> <ul style="list-style-type: none"> <li>2017/18 and 2018/19 Operating / Financial Plans submitted and accepted to NHSI (+)</li> <li>Management accounts to end May 2017 show Trust on track to meet Budget / Control Total (+)</li> </ul>
<u>Gaps in controls/influences:</u> <ul style="list-style-type: none"> <li>Directorate targets need to be agreed for 2018/19</li> </ul>	<u>Action plans in response to gaps identified: (with lead and target date)</u> <ul style="list-style-type: none"> <li>Detailed reforecast of 2017/18 to be completed in July 2017 (TN 7/17)</li> <li>Review of 'ask' for 2018/19 to be undertaken in July, with detailed discussions to follow in order to develop a 2018/19 Operational Plan in the early Autumn (TN 10/17)</li> </ul>

<b>RISK 14): Failure to provide good quality data impacting on Trust work [New Risk]</b>	
<u>Risk Owner:</u> Director Technology and Transformation	First review: July 2017
<u>Strategic Objectives affected by this risk:</u> Aim 2: Maintaining and developing the quality and reach of our clinical services Aim 7: Develop our infrastructure to support our work	<u>INITIAL risk rating (at identification):</u> Consequence 4 x Likelihood 3 <b>12</b> <u>CURRENT risk rating (after mitigation):</u> Consequence 4 x Likelihood 3 <b>12</b>
<p><u>Rationale for current score:</u> Challenges in achieving local indicators in 2016/17 Apparent inconsistency between data provided to local teams and third parties Reported high level of manual process required to validate this data before use Reported high level of burden in operation of the clinical and education systems by Trust staff</p>	
<u>Controls/Influences (what are we currently doing about this risk?):</u> The governance and management structures are already in place to address these issues in the form of DARC and CDQRC and procedures.	<u>Assurances received (independent reports on processes; when; conclusions):</u> Terms of reference for DARC, CDQRC (+) Clinical Data Quality Procedure (+)
<u>Gaps in controls/influences:</u> An action plan is required to handle immediate “backlog” and achieve a stable working position on which the existing structures can then iteratively build. A project brief is being developed to consider the scope of improvements to be made. This will closely interact with a number of other projects proposed as part of the upcoming Transformation Strategy, such as Trustwide Scheduling	<u>Action plans in response to gaps identified: (with lead and target date)</u>  Action plan for immediate support (DWL 10/8/17) A project brief is being developed (DWL 31/8/17)

<b>RISK 15): Longer term risk to the sustainability of the Trust [New Risk]</b>	
<u>Risk Owner:</u> Chief Executive	First review: July 2017
<u>Strategic Objectives affected by this risk:</u> Aim 5. Delivering a sustainable financial future for the Trust	<u>INITIAL risk rating (at identification):</u> Consequence 5 x Likelihood 3 <b>15</b> <u>CURRENT risk rating (after mitigation):</u> Consequence 5 x Likelihood 3 <b>15</b>
<u>Rationale for current score:</u> Trust faces gap of £3.6m over the next 3 years to be filled by savings or contribution from new income. Requirement for step change in income generation with ability to enter new markets.	
<u>Controls/Influences (what are we currently doing about this risk?):</u> <ul style="list-style-type: none"> <li>Established new organisational focus on income generation through BDC and SCC.</li> <li>Developing strategies for development of new markets.</li> <li>Revisit strategic plan during the autumn</li> <li>Develop response to the development of Accountable Care Systems in London</li> </ul>	<u>Assurances received (independent reports on processes; when; conclusions):</u> <ul style="list-style-type: none"> <li>BDC/SCC review of current and future pipelines (+)</li> <li>Revised strategic plan (+)</li> </ul>
<u>Gaps in controls/influences:</u> <ul style="list-style-type: none"> <li>Ability to create sufficient capacity to address future growth agenda</li> <li>Wider system developments beyond the Trust's control</li> </ul>	<u>Action plans in response to gaps identified: (with lead and target date)</u> <ul style="list-style-type: none"> <li>Quarterly SCC review of pipeline (TN)</li> <li>Revised strategic plan – (PJ/TN 11/17)</li> </ul>



## Board of Directors : July 2017

**Item** : 10

**Title** : Operational Risk Register

### **Summary:**

The full Operational Risk Register has traditionally been presented to the Board annually for review in conjunction with the Board Assurance Framework. The Board is asked to consider whether the register provides adequate assurance that risks are accurately described, controlled and rated.

Risks rated 9+ are reviewed via the relevant governance workstreams and within the updated Risk Management Procedure directorate risks must be reviewed by an agreed directorate forum. For the clinical services this will be the AFS and CYAF clinical governance groups.

Risks rated 9+ have been reviewed by the following workstreams:

Patient Safety – Clinical Risk (10 July 2017)

Corporate Governance and Risk (12<sup>th</sup> July 2017)

IG Work stream (11<sup>th</sup> July 2017)

Wider Management Team (13<sup>th</sup> July 2017)

The updated Risk Management Procedure approved in May 2017 confirms the frequency of reviewing entries as follows:

Risks 15-25 Monthly

Risks 9-12 Quarterly

It is proposed that rather than the full Trust operational risk register going to the Board, that this is limited to those risks rated 9+.

### **This report focuses on the following areas:**

*(delete where not applicable)*

- Quality
- Risk
- Finance

**For** : Approval

**From** : Associate Director of Quality and Governance





3	IT	2012	Financial, new business and business continuity risks	<p>In the event of a Major Incident the Trust is unable to deliver services - Business Continuity Plans .</p> <p>Emergency Preparedness response and Recovery ( EPRR )</p>	<p>Business Continuity Plan in place with action cards for Gold, Silver and Bronze Commands</p> <p>IT Recovery Plan added to the Business Continuity Plan and Major Incident Plan</p> <p>Directorate specific Business Continuity Risk Assessments, annually reviewed</p> <p>Annual Table top exercise with Management team, lessons learnt and actions recorded</p>	<p>Annual revision of published plans and submission to NHS England Q3</p> <p>EPRR Assurance of 'Substantial' (RAG rated Green ) approved by the Board , presented by Dr Rob Senior</p> <p>Published risk assessments</p> <p>Record of annual table top exercise.</p>	<p>Service / Site specific Business Continuity Risk Assessments to be converted to Business Continuity Plans for all services 2017-18</p>	3	1	3	No	No Change July 2017	quarterly review	IM&T Director and H&S Manager	Corporate Governance and Risk work stream & CQSG	<p>Work plan for EPRR for the Assurance of the EPRR Core Standards for NHS England for 2017-18</p> <p>Service specific to BCPs to be identified and compiled with service managers on site visits through 2017-18</p>	3	1	3
				<p>Risks: Reputational risk, patient and commissioner dissatisfaction, failure to maximize business opportunity</p> <p><b>Background</b></p> <p>Background the demand has increased with a growth in referrals especially with regard to recent London incidents and historic child sexual abuse agenda.</p> <p>20 new referrals in 3/12 cf &lt;30 for the previous year. In addition, new links with commissioners who are wishing to refer DID cases (Dissociation Identity disorder) , choice agenda, DET priorities, and higher profile of the service all suggest the trend will continue.</p>	<p>Case by case review of high risk patients</p>				3	3	9	Updated July 2017	JSte	Director of AFS	Service Director	<p>Have increased staff 0.2 WTE and working with commmerical team to procure a viable strategy 2017-18</p> <p>JSte Working with Michael Mercer (Cx Needs lead), Dr Jo Stubble and Amy Le Good and Rachel Surtees</p>	3	3	9



8	All services	Sep-15	Reputation	<p>Risk to registration and reputation from failing to achieve a 'good' or above rating from the CQC</p> <p>Updated CQC project Board and draft action plan in place</p> <p>Updated CQSG reporting arrangements</p> <p>Demonstrating Quality Campaign launched to embed long term sustainable change.</p> <p>Appropriate staff in post to lead to CQC work</p> <p>Specific communications support for CQC period</p> <p>Trust evidence benchmarked against CQC requirements.</p>	<p>progress against plan</p> <p>From November 2015 - CQSG minutes and papers</p> <p>Comms action plan and progress reports (this outlines the trust Quality campaign including quality events, regular dissemination of quality news together with information on Moodle and the internet)</p> <p>Educational materials and record of education sessions carried out.</p> <p>Associate Director Quality and Governance in post Sept 2015 with administration support.</p> <p>Interim appointment to Communications was in place in advance of the CQC inspection</p> <p>Documented evidence recorded . Action plans to respond to gaps identified</p>	<p>3</p> <p>1</p> <p>3</p>	<p>Risk reduced from a 9 to a 3</p> <p>CQC inspection reports rated the Trust 'Green' overall and for each of the service inspected.</p> <p>An Action plan is in place to address 3 'Must Do' recommendations and a number of 'Should Do's'</p>	<p>3</p> <p>1</p> <p>3</p>	<p>Yes, Damage to the Trust's reputation and brand and Regulatory failure</p>	<p>No Change June 2017</p> <p>quarterly review</p> <p>Director of Quality and Patient Experience</p> <p>CQSG</p>	<p>3</p> <p>1</p> <p>3</p>	<p>Operational</p>
9	All services		Operational	<p>agreed SMART action plan to address deficits</p> <p>HR follow up all non attendance at induction and offer second date, if not attended then matter escalated to Director</p> <p>Introduction of sanctions for failure to complete mandatory training</p> <p>separate induction letter issued at appointment</p> <p>Use of spread sheets to identify staff due to attend INSET</p>	<p>quarterly progress report to CQSG via work stream</p> <p>quarterly performance report to CGRWS</p> <p>Practice now embedded</p> <p>internal HR check of process</p> <p>quarterly data report to Corporate Governance and Risk Work stream</p>	<p>3</p> <p>1</p> <p>3</p>	<p>continue with rolling programme</p>	<p>No</p>	<p>No change June 2017</p> <p>Ongoing review</p> <p>Director HR</p> <p>Corporate Governance and Risk work stream and CQSG</p>	<p>3</p> <p>1</p> <p>3</p>	<p>Operational</p>	

10	All clinical services	Operational and reputation	Inaccurate data capture on Carenotes due to failures of Trust checking data accuracy and validity resulting in inaccurate representation of Trust performance to COC and other assessors and potential loss of business	EPR teaching (CareNotes) Handbook to support accurate upload of data local audits of data quality (e.g. waiting times and DNAs) built into annual audit programme Carenotes User group Assurance to IG and CPQE workstreams <a href="#">Clinical data quality review group (CDQRG)</a> established <a href="#">relevant policies and plans approved</a>	Clinical Governance handbook online for clinical staff, contains clear instructions and screen shots to show how data is to be entered action plan arising from audits designed to improve data quality action tracker from IG workstream meeting Quality and Informatics staff produce reports and provide training IG and CPQE workstream minutes and papers <a href="#">Data Quality Policy</a> <a href="#">Clinical Data Quality Management Procedure</a> <a href="#">CDQRG ToRs and minutes go to EMT</a>	2 2 2 2 4	Implement EMT report recommendations Implement internal Audit recommendations <a href="#">Administration SOPs relating to data quality checks to be developed (31 August 2017)</a>	Information Governance work stream & CQSG	Associate Director of Quality Governance	quarterly review	Updated June 2017	No	2 1 2
11	IG	All clinical services	Breach of confidential information resulting in harm to patient and/or investigation by the Information Commissioner	Attendance at induction which includes training on confidentiality. Availability of Caldicott Guardian and IG Lead for advice. Confidentiality Code of Conduct Procedure on sending person-identifiable information by e-mail requires the use of nhsmail accounts (not Trust e-mail), with restrictions on the recipients' accounts. Alternative (Cryptshare) is provided where this is not possible. Incident reporting and investigation. information governance e-learning assessment	Attendance at induction and inset records held by HR. Feedback from Caldicott Guardian Staff sign for policy issued on employment. Procedure publicised frequently. Trust e-mail has a block to prevent data in certain formats being sent. IG workstream review of incidents, Board and external review of SUI reports <b>Pass rate for IG on line learning at 98% in 2016/17</b>	3 3 3 3 9	Maintain IG training and promotion of relevant Trust policies and procedures Plan to move to Office 365 approved July 2016.	Information Governance workstream & CQSG	Deputy SIRO	quarterly review	Update July 2017	No	3 2 6
12	Clinical	All clinical services	Risk to child due to Trust's inability to identify files of children with CP concerns on Carenotes	audit of CP files by CP named professional CP field on Carenotes revised forms for assessment review and closure forms has detailed section to record CP plan information	Audit showed difficulty in identifying CP files from Carenotes audit did not include non Carenotes sites e.g. MALT (expected higher level of compliance as Soc Serv data base prompts detailed record keeping on CP concerns)	2 3 6	Rolling audit in place	Patient Safety Clinical Risk workstream & CQSG	Medical Director	quarterly review	No change July 2016	No	

13	Clinical	Clinical and reputation	Failure to comply with Child protection training requirements for clinical staff resulting in impact on CQC and Ofsted assessment	Level 1 training needs met via INSET and local training. quarterly monitoring of performance by CGR workstream and CQSG Training dates in place on rolling basis for Level 2 and Level 3 training. Those required training are targeted by HR.	Records held by HR report from HR data base to work stream Invitations and attendance records held by HR.	no gaps current identified	3	2	6	Corporate Governance and Risk workstream & CQSG	Medical Director	quarterly review	Updated July 2016	No
14	Clinical	Clinical and reputation	Failure to follow Trust procedures for informing parents when raising a child protection concern with Social Services	case supervision child protection training	record of supervision child protection training records	no gaps current identified	3	2	6	Patient Safety Clinical Risk work stream & CQSG	Medical Director	quarterly review	Updated July 2016	No
15	All clinical services	Clinical	Inability to provide appropriate clinical treatment due to incomplete case record (rewarded risk)	Rolling case note audit programme training on case notes at induction and via team meetings following audits Promotion of good practice via team leaders and via supervision. Trust wide agreed standards for Carenotes records	Results of case note audit and action planning reported to CG committee. case note audit appraisal Case note standards available via intranet.	no gaps currently identified	3	2	6	Patient Safety work stream & CQSG	Medical Director	quarterly review	Updated July 2016	No
16	Clinical	Staff	Risk of physical and/or psychological harm to clinical staff due to violence or aggression by patient at Tavistock and Portman Estate (outside of Gloucester House Day Unit)	Clinical on call rota for immediate senior support. Emergency number 3333 for access to support for Tavistock /Portman Personal Safety training available for high risk groups/teams by H&S Manager On-going clinical risk assessment of patients to anticipate problems and take appropriate action.	Incident report following need to use 'on call' support Incident reports are followed up when 3333 used in these circumstances. delivery of training in response to request and/or incident analysis identifying 'risk' areas of practice Records of Personal Safety training provided by H&S manager Records audit to show compliance.	Updated patient clinical risk assessments	3	2	6	Corporate Governance and Risk work stream & CQSG	Medical Director	quarterly review	No Change June 2017	No

17	Clinical	Staff	<p>All Trust sites and services are part of a rolling annual risk assessment process, which includes lone worker assessments</p> <p>Lone worker procedure and incident reporting procedures presented at induction and INSET, this promotes requirement for case by case risk assessment.</p> <p>Staff are reminded to report 'near misses' and the 'raising concerns' with Gill Rusbridger</p> <p>Lone working procedures checked and updated at each outreach service by H&amp;S Manager</p>	<p>Risk assessment report for each site in place, which is reviewed quarterly CGR workstream. Reports schedule reviewed quarterly</p> <p>Induction and INSET programmes.</p> <p>Annual site visits and Manager assurance of Lone working procedures embedded in service lines</p>	<p>All new staff at initial induction to be briefed in local lone working procedures and given a mobile phone and if needed a personal alarm.</p>	3	2	6	<p>Continue to offer Personal Safety training to all staff, this will be managed by H&amp;S manager and service leads, and ad hoc training is provided if any concerns are raised by staff or from an incident report/s that the H&amp;S Manager is concerned with.</p> <p>Amend Trust local Induction sheet to include lone working procedures (31 July 2017)</p>	Corporate Governance and Risk work stream & CQSG	Clinical Directors and Health and Safety Manager	quarterly review	Updated June 2017	Yes, Loss of workforce engagement / morale / commitment	2	6
18	Clinical	All clinical services	<p>Rapid transfer procedure and quick check list available for staff (Caroline McKenna reviewing procedures)</p> <p>Risk assessment during clinical sessions, to support identification of patients 'at risk' of self harm.</p>	<p>incident review each time rapid transfer occurs, with local follow up by risk team if practice does not meet procedure</p> <p>Records audit include assessment of completion of risk assessment during contact with Trust.</p>	No gaps currently identified.	3	2	6	<p>Remains under review on a case by case basis and Rapid transfer procedure to be finalised</p>	Patient Safety Clinical Risk work stream & CQSG	Clinical Directors	quarterly review	Updated June 2016	Yes, Clinical quality or governance failures, including risk of serious incidents		
19	CYAF	Clinical	<p>It is expected that children too young to attend the centre on their own will be with a carer and/or therapist at all times</p> <p>lock down procedure in place for Tavistock Centre, which is promoted to staff and practiced by facilities staff</p>	<p>incident reporting following all requests for lockdown</p> <p>incident reporting</p> <p>incident report of events on each occasion when lock down occurs, shared with the Director of CYAF to prompt local case by case review if required</p>	<p>All Staff email promoting the Lockdown procedures - handsets installed on each floor in the lift lobbies to call 3333</p>	3	1	4	<p>To continue to promote 'lock down' process and ensure all children and vulnerable young people are escorted by staff or carers at all times.</p>	Patient Safety Clinical Risk work stream & CQSG	Director of CYAF	quarterly review	No change Sept 2016	Yes, Clinical quality or governance failures, including risk of serious incidents		

20	CYAF	Staff	Child causes member of staff physical or psychological harm at Gloucester House	<p>Pre intake assessment to plan and provide for child's behaviour management needs.</p> <p>Daily planning and behaviour review meetings.</p> <p>Incident reporting</p> <p>Regular support and updates for all staff in contact with children</p> <p>specialist nurse added to staff team to support TA's and teachers in behaviour management of children</p> <p>Team Teach approach to children's behaviour which provides staff with strategies and techniques to avoid danger.</p>	<p>Written pre intake plans and risk assessments.</p> <p>Daily debriefs and constant review of Positive Handling Plans (PHPs)</p> <p>Written behaviour management plans for each child.</p> <p>Incident analysis and review</p> <p>supervision of staff member, participation in team discussions, analysis of incident data over time</p> <p>Team Teach records</p>	<p>None currently identified, this is constantly monitored by Gloucester House Head Teacher and other senior staff, including regular reports to CYAF Director and CGR work stream</p>	2	3	6	<p>Incidents to continue to be monitored and reviewed on a case by case basis.</p>	<p>Corporate Governance and Risk work stream &amp; CQSG</p> <p>Director of CYAF</p> <p>Ongoing review (daily)</p> <p>01 June 2016</p> <p>Yes, Loss of workforce engagement / morale / commitment</p>
21	CYAF	Patient Safety	Harm to a child who absconds from Gloucester House	<p>Individual assessment for the children which includes consideration of risk of absconding</p> <p>Audible alarms on all secure exits, fire exit and front door. In the event of a child leaving the site there is a local emergency procedure in place which includes rapid call to the police</p> <p>Children closely monitored by staff at all times</p> <p>Contingency Procedure to be activated if child absconds to minimise risk (includes early involvement of police), a and incident reporting</p> <p>In the event of a Gloucester House child coming into the Tavistock centre, front of house staff will initiate the 'lock down' procedures</p>	<p>Recorded risk assessments and plans for each child.</p> <p>Alarm test schedules. Activation of procedure reviewed in detail on each occasion it is used</p> <p>Detailed review on each occasion that a child absconds to learn lessons.</p> <p>incident review and local feedback each time this occurs</p>	<p>None currently identified.</p>	3	2	6	<p>To maintain vigilance of staff observation, review in detail each occasion that a child leaves the unit and make local adjustments to procedure based on case by case learning .</p> <p>Consider risk of absconding when reviewing potential new premises.</p> <p>New Risk Assessments for children attending out of school activities (ie, Swiss Cottage leisure Centre)</p> <p>New swipe access for clinicians corridor to prevent children using fire escape in remote area of the building</p>	<p>Corporate Governance and Risk work stream &amp; CQSG</p> <p>Director of CYAF</p> <p>Ongoing review (daily)</p> <p>No Change Sept 2016</p> <p>Yes, Clinical quality or governance failures, including risk of serious incidents</p>

22	Portman	Patient Safety	Breach of confidentiality of Portman patient resulting in media interest, formal complaint and/or referral to the Data Commissioner	Records are securely stored in the Portman building and records are returned to the admin office at the end of each to be locked away  Strict local practices re responding to information requests about patients. All external requests are handled to a local protocol under the direction of the Portman Director  Protocol of strict confidentiality for patients in waiting room, phone calls conducted in private spaces and in groups strict rules about confidentiality and use of first name only  Local induction of staff and discussion about confidentiality at team meetings (which include admin and clinical staff)	IG tool kit returns. Records audit and reports  Case by case review and evidence of seeking e.g. legal/ Caldicott Guardian advice for complex requests  Evidence of management of cases on a case by case basis (e.g. if patient breaches group protocol they will be removed from the group and an alternative treatment plan instigated)  Induction record and team meeting notes	no gaps currently identified	4	1	4	Yes, Damage to the Trust's reputation and brand	Yes, Clinical quality or governance failures, including risk of serious incidents	No Change July 2017	risk to be reviewed annually	Director Portman	IG work stream and CQSG	To ensure that any breach or near miss is investigated promptly on a case by case basis and changes to local procedures made if indicated (on going)	4
23	Portman	Patient Safety	Portman patient causes physical or psychological harm to another person (patient/staff member/member of the public) whilst in the Portman clinic	Clinical risk assessment as part of assessment with relevant management plan, each patient has a clinician and a case consultant so more than one clinician considering patient risks and treatment.  All patients selected to be treated in groups are carefully selected and prepared for the group, they must abide by clear rules of behaviour and respect for others, if there is any breach then they will be removed from the group and an alternative plan implemented  Strict rota of on duty staff so that a clinician is never alone in the building with a patient  Written protocol for reception managed, reception staff on duty when patients are in the building  Escalation arrangements and rapid transfer procedures in place	Case records audit  Clinical meetings where patient issues are discussed  Incident reports in the event of a behaviour issue, with local review and follow up  Work schedules to show presence of more than one clinician.  Management supervision of admin staff to ensure protocols are followed  Protocols found to be followed on incident review on a case by case basis	no gaps currently identified	2	2	4	Yes, Clinical quality or governance failures, including risk of serious incidents	No Change July 2017	risk to be reviewed annually	Director Portman	Patient Safety Clinical Risk work stream and CQSG	To ensure that any incident or 'near miss' of a patient causing harm to another is investigated promptly on a case by case basis and changes to local procedures made if indicated (on going)  Revised SoP for the waiting room at the Portman and Risk assessment for Portman patients in the Tavistock Centre  Adult and Child waiting rooms have been separated. Children are accompanied by an adult at all times.	4	

24	DET	We fail to comply with Home Office UK Border Agencies requirements for overseas students which could result in loss of Tier 4 sponsorship status and inability to recruit overseas students	We were successful in being granted a renewed licence in 2017. All overseas applicants must present passports, qualifications and other forms of ID. We require evidence of adequate funding. Once satisfied, DET issue a CAS letter which the student submits for a VISA. Once in training attendance is monitored, and action taken if 2+ absences occur. Absences are reported to the UK Visas and Immigration Service.	The Head of Academic Governance and Quality Assurance has developed an action plan in this area. We have also entered into discussions with the University of Essex with regards to devising specific international versions of courses that can be amended and therefore advertised as full time. Advice has been received from immigration lawyers and we have taken decisions about specific courses as a result	There needs to be clear guidance in place to both students and staff about intermissions and breaks for students with Tier 4 visas. We also need clarity as to whether students can work while on these visas and if the clinical components of courses would be viewed as work.	4	3	12	Monitor compliance to the action plan and ensure regular updates to AGQA and TEPMB	On going	Jul-17		4	1	4
25	DET	That the new student records system will not be ready for roll out in the next academic year as expected	The project team are closely monitoring progress and regularly updating the Education and Training Executive. Standard Operating procedures are in place that will streamline current processes and will be updated in line with procedural changes introduced through the use of the new student record system SITS (MYTAP).	Gained in monthly project board meetings and weekly team meetings. The first releases have been delivered on schedule and the project is progressing as planned. Project board has risk register	There are gaps in staffing for the systems team. There is also considerable pressure on the operations team at this time.	3	2	6	Keep under review and continue regular updates	On Going	May-17		1	1	1
26	DET and Research	Research data collected by students on Trust courses may not be held securely, and may include person-identifiable information is not held in line with DPA	Students are aware of their responsibilities for safeguarding such data. The Trust had a procedure to provide a solution for holding such data, and to require all students to use it if they undertake research involving person-identifiable information.	We are currently using my private files on moodle. All students now do IG training.	Process is awaiting agreement and sign off. Video files cannot be saved as they are too large and we are implementing an encrypted drive system for these	4	2	8	Students on Research Degrees with registered Thesis have active accounts. All to undertake IG training	On Going	May-17		4	1	4
27	DET AND RESEARCH	Sponsorship for student research. UEL did this and indemnified in the past. Change of University partner has exposed a gap in this area in that Essex will not take this on. The HRA states that student research should be sponsored either by the university or by the trust. The trust is not at present in a position to undertake this role until a number of governance issues are resolved.	The Trust has agreed to sponsor student research, interim arrangements have been made pending confirmation of final processes and procedures.	ERS has been in contact with Claire Nixon at the University of Essex to write and implement a robust and transparent policy that would enable the Trust to undertake the role of sponsor. ERS has convened meetings with our governance manager Jonathan McKee, Manager of NOCLOR, Elish Kennedy and herself. They have agreed that they needed to work with NOCLOR and Essex in order to establish clear and robust policies and procedures.	Questions remain as to how this will be funded. There is potentially a need to review the contract with the University of Essex.	2	2	4	Continue discussions with the University of Essex, NOCLOR and the Trust Governance Manager	On Going	May-17		1	1	1
Assocaitate Dean for Academic Governance and Quality Assurance										Director of Education and Training	Associate Dean AGQA	Associate Dean AGQA			
AGQA Committee										ICT Project Board	IG workstream	DET AGQA			

28	DET & Research	DET	DET	DET and Clinical Services	Students undertaking clinical placements may not have completed all necessary governance training before beginning to see patients	A governance passport has been introduced. This must be completed before an honorary contract is issued and this is required before patients are seen. Completion of Governance training is now centrally coordinated.	DET regularly reports on outstanding governance training to the monthly Training and Education Programme Management Board	Some students still have training outstanding.	3	2	6	Continue to update and liaise with clinical teams with regards to outstanding training. Ensure that this process is part of welcome week next year so both students and staff are well aware of the requirements and have time to complete them.	DET Quality Assurance Committee,	Associate Dean, Academic Quality	Ongoing	May-17		3	2	6
29	DET	DET	DET		A group of visiting lecturers have threatened to bring a claim at an employment tribunal contesting that they are employees. There are also further complaints from VLS regarding access to computers and the demands on them.	A review is underway into our use of VLS and how we will develop this going forward. Human Resources have reviewed the contract to make all rights and responsibilities clear. A new contract has been agreed to be implemented in 2017/18.	Review is time consuming and no immediate action can be taken. There is increasing discontent among the VL group which could potentially increase the risk of a claim being brought.		4	1	4	Continue review and monitor the situation	DET Executive	Deputy Director	On Going	May-17		4	1	4
30	All services	DET	DET		Student placements are not adequately recorded in the department.	Student placements will be recorded within the new student record system to ensure a central, consistent record will be available of all placements.	A process of checking the quality of placements, inviting feedback from students and the placement providers on their experience, is required.		3	3	9	Ensure data is provided by all relevant course teams to be entered into the student record system SITS (MyTAP), within two months of the system "Go Live"	DET Executive	Associate Dean for AGQA	On going	Jun-17		3	2	6
31	DET	DET	DET		Terms and Conditions have not been reviewed for some time and may not be fully compliant with consumer rights legislation	A review group will be established to identify further issues with the terms and information we provide to students before they commence a programme. Legal advice will be sought if required	This is yet to be completed for our short courses. Our terms of admission expired in December 2016 and are awaiting review		2	2	4	FH will establish a working group to take forward the amendments and ensure adequate changing for all involved in recruitment.	DET Executive	Dean's Office Manager	On Going	Jun-17		1	1	1
32	DET	DET	DET		The current CPD online application system has no IT support since the departure of Feras Dib and Priyesh Patel. If the system is down students cannot apply for any CPD courses or conferences and the CPD team cannot access data in the system	SITS will alleviate this issue as a SITS developer is in post. This will take place in Autumn 2017	ICT staff unable to support management of this system		3	4	12	Contact DWL for assurance as to how support is to be provided.	Portfolio Development and Events Manager	Associate Dean for AGQA	On going	Jun-17		2	2	4

33	DET	01/07/2017	DET & AFS	<p>With the introduction of Carenotes coupled with supervision being provided by Visiting Lecturers there is insufficient oversight from the Trust with regards to clinical and IG governance for clinical trainees within AFS</p>	<p>The Maresfield unit is in place to support the governance of clinical trainees within the unit and support external supervisors with clinical managements. Students who see a Trust patient and their supervisors are required to attend these meetings to present cases and to enable the unit head to have oversight of the management of the case.</p>	<p>The governance for clinical trainees policy will be revised as will the guidance given to students to ensure they are aware of their rights and responsibilities in relation to supervision and record keeping</p>	<p>All supervisors need access to Carenotes. Tracking systems need to be in place to ensure attendance at team meetings</p>	<p>DET and AFS will meet to discuss these issues. Governance passport will be amended to include sections on supervision. All those with supervisor responsibilities will be trained in Carenotes. Annual audits will "close" completed students within DET halting access to systems. Students should present at team meetings in a regular and systematic manner and this will be monitored by the head of the unit</p>	<p>DET Executive and AFS Management</p>	<p>Julian Stern</p>	<p>On going</p>	<p>Jul-17</p>	<p>Updated July 2017</p>	<p>quarterly review</p>	<p>Deputy SIRO</p>	<p>Patient Safety Clinical Risk work stream &amp; CQSG</p>	<p>Complete tasks to demonstrate compliance with IGT 400s and 500s to level 3 Implementation of network replacement</p>	<p>No</p>	<p>3</p>	<p>2</p>	<p>6</p>
34	IG	Sep-15	All clinical services	<p>Failure to include IG clauses in some contracts exposes the Trust to risk of penalties, especially in the event of an information loss incident with such a contractor or commissioner</p>	<p>Note also that our commissioners (NHS, LA and private) also have their own IG requirements and processes. The risk of an information loss incident should be relatively small; but in the event of one, the lack of a clause in our contract could be penalised.</p>	<p>In case any contract were not covered in 2014/15, all contracts should be reviewed again for 2016/17, to ensure that the IG clauses are included.</p>	<p>Audit of contracts for 2016-17 to ensure clause is included</p>	<p>Yes, Damage to Trust's reputation and brand</p>	<p>Finance Director</p>	<p>Contract Manager</p>	<p>ongoing review</p>	<p>Updated June 2016</p>	<p>Updated July 2017</p>	<p>quarterly review</p>	<p>Director of Education and training</p>	<p>Patient Safety Clinical Risk work stream &amp; CQSG</p>	<p>Spot check implementation of IG and technical training for students (SK 30.09.2017) Clinical Governance 'passport' in place, updated with IG training requirement (SK 30.09.2017)</p>	<p>Yes, Clinical quality or governance failures, including risk of serious incidents</p>	<p>4</p>	<p>1</p>	<p>4</p>
35	DET	Sep-15	All clinical services	<p>Procedure is in place - Obtaining consent to record patient sessions procedure Incidents are monitored Encryption is available Staff have personal log ins and password protection to access Carenotes</p>	<p>Procedures in place - 'Secure storage of Doctoral students electronic research data procedure' 'Information managements and technology security procedure' INSET and Induction IG training .</p>	<p>Student IG training gap and minimal implementation of procedures</p>	<p>Student IG training gap and minimal implementation of procedures</p>	<p>That electronic recording and data of patient sessions by students for training purposes may be lost by students and used by third parties</p>	<p>IT systems blocks notify user that downloading and administration rights held by IT staff only Information Asset acceptance and registration procedure</p>	<p>Restriction of downloading ICT applications , 'apps', through the Servers firewalls Relevant IT purchasing procedure</p>	<p>Partial compliance with IGT 400s and 500s to level 3</p>	<p>9</p>	<p>3</p>	<p>3</p>	<p>3</p>	<p>9</p>	<p>3</p>	<p>3</p>	<p>9</p>		
36	IT	Sep-15	IT	<p>The Trust fails to comply with Principle 4 of the Data Protection Act - Keeping personal information accurate and up to date.</p>	<p>IT systems blocks notify user that downloading and administration rights held by IT staff only Information Asset acceptance and registration procedure</p>	<p>IT systems blocks notify user that downloading and administration rights held by IT staff only Information Asset acceptance and registration procedure</p>	<p>Complete tasks to demonstrate compliance with IGT 400s and 500s to level 3 Implementation of network replacement</p>	<p>Complete tasks to demonstrate compliance with IGT 400s and 500s to level 3 Implementation of network replacement</p>	<p>Patient Safety Clinical Risk work stream &amp; CQSG</p>	<p>Deputy SIRO</p>	<p>quarterly review</p>	<p>Updated July 2017</p>	<p>Updated July 2017</p>	<p>quarterly review</p>	<p>Director of Education and training</p>	<p>Patient Safety Clinical Risk work stream &amp; CQSG</p>	<p>Complete tasks to demonstrate compliance with IGT 400s and 500s to level 3 Implementation of network replacement</p>	<p>No</p>	<p>3</p>	<p>2</p>	<p>6</p>

37	Facilities	2012	Facilities	Risk of food poisoning or other environmental hazard from on site kitchen	Contracted service with detailed risk arrangements in contract. Regular internal and external inspections, certificates in place.	Contract records held by Facilities Directorate. External inspection reports (Camden Council)	Procedure is not well known or followed by staff.	2	1	2	No	July 2017- nochange	annual review	Director of Transformation	Corporate Governance work stream	To continue to monitor standards.	2	1	2
38	DET	Sep-15	DET	Permanent loss of data uploaded externally to website resulting in loss of information, service continuity and reputational damage;	National IT standards for NHS websites System standards Firewall on secure web server and server encryption Hardware resilience e.g. more than one connection available Minimal data on website through auto delete once transferred to internal server Back-up copies of website are maintained which minimises loss	Asset manager reviews against standards inspection of system spot checks to ensure no data held	Data transfer from ULCC not secure No disclaimer re data transfer for individuals who add data	2	2	4	Yes, IT applications and hardware not sufficient to support Trust objectives.	01 June 2016	quarterly review	Head of Communications/IM&T	IG work stream	Ensure means of data transmission from ULCC to Trust is secure Consider adding disclaimer to website re 'if delay in response please resend'	2	2	4
39	IT	Sep-15	DET	Loss of business continuity due to temporary unavailability of website	National IT standards for NHS websites System standards Firewall on secure web server and server encryption Hardware resilience e.g. more than one connection available Minimal data on website through auto delete once transferred to internal server Telephone, post, email and in-person communication channels remain open Waiting list monitored Case by case review for high risk patients Close working relationship maintained with referring GPs	Asset manager reviews against standards inspection of system spot checks to ensure no data held Waiting list data GP/Commissioner feedback	Implement advanced server protection	2	2	4	Yes, Loss of access to critical systems	July 2017- no change	quarterly review	Head of Communications/IM&T	DET	Use of proxy server with DDOS protection to be implemented by service provider	2	2	4

40	PCPCS	Risk added Dec 2015	Clinical and Reputation	Waiting lists still above desired levels	Waiting list monitored Case by case review for high risk patients Close working relationship maintained with referring GPs	Waiting list data GP/Commissioner feedback	Not sufficient skilled staff to meet the service demands. However we have recruited some additional temporary staff	4	12	We have done a great deal to address these issues in the last 2 quarters and the waiting list has reduced. We have agreed a refined intake criteria which effectively narrows the gaps between other services criteria that we are open to. These are now MUS and Frequent attenders. We are now working with most local NHS MH partners in the Psychological Therapies Alliance such that gaps in provision, demand and supply are thought about by a multi-agency group and risks therein are held by the group	Service Director	Director Adult and Forensic Services	On-going with monthly reviews	Updated July 2017	Yes, savings and growth contribution insufficient
41	GIDS	Risk added Dec 2015	Clinical and Reputation	Length of waiting list results increase risk to patients and risk to future referrals from GP's and/or changes to referral requirements of Commissioners. Breach of waiting list targets could have financial impact on income.	Employed new staff to support development of new systems for managing referrals System put in place to phone all seventeen years olds to discuss needs and direct referral to adult services if appropriate and preferred by service user. System put in place to telephone all young people on the waiting list to: Ensure that associated difficulties/risk are being supported locally. Signpost to appropriate local support groups Identify needs and urgency of referral	Close monitoring of waiting list and processes Record of calls and outcome of calls Evidence of escalation of higher risk cases	Not sufficient skilled staff to meet the service demands	4	12	Consider either: Increasing resource management approximately 33% over performing contract. OR Close waiting list OR cap referral numbers from surgeries	Service Director	Director Adult and Forensic Services	On-going with monthly reviews	new Risk added Dec 2015	Yes, savings and growth contribution insufficient





## Board of Directors: 25 July 2017

**Item :** 12a

**Title :** Workforce Race Equality Standard (WRES) Report

**Purpose:**

The WRES was introduced in 2014 as a supportive framework to assist NHS organisations address inequality in career progression, development and staff experience amongst Black, Asian and minority ethnic (BAME) staff.

This is the Trust's third WRES report and details the statistical data about our staff across a number of workforce domains and how these have changed in the last two years.

The statistics are accompanied by the draft race equality strategy which sets out our ambitions and the actions we plan to take to address areas there are issues.

**This report focuses on the following areas:**

*(delete where not applicable)*

- Workforce

**For :** Approval

**From :** Craig de Sousa, Director of Human Resources  
Louise Lyon, Director of Quality and Patient Experience



# Workforce Race Equality Standard

## REPORTING TEMPLATE (Revised 2016)



Template for completion

Name of organisation

Date of report: month/year

Name and title of Board lead for the Workforce Race Equality Standard

Name and contact details of lead manager compiling this report

Names of commissioners this report has been sent to (complete as applicable)

Name and contact details of co-ordinating commissioner this report has been sent to (complete as applicable)

Unique URL link on which this Report and associated Action Plan will be found

This report has been signed off by on behalf of the Board on (insert name and date)

Publications Gateway Reference Number: 05067

## Report on the WRES indicators

- 1. Background narrative**
  - a. Any issues of completeness of data**
  - b. Any matters relating to reliability of comparisons with previous years**
- 2. Total numbers of staff**
  - a. Employed within this organisation at the date of the report**
  - b. Proportion of BME staff employed within this organisation at the date of the report**

## Report on the WRES indicators, continued

3. Self reporting
  - a. The proportion of total staff who have self-reported their ethnicity
  - b. Have any steps been taken in the last reporting period to improve the level of self-reporting by ethnicity
  - c. Are any steps planned during the current reporting period to improve the level of self reporting by ethnicity
4. Workforce data
  - a. What period does the organisation's workforce data refer to?

## Report on the WRES indicators, continued

### 5. Workforce Race Equality Indicators

Please note that only high level summary points should be provided in the text boxes below – the detail should be contained in accompanying WRES Action Plans.

Indicator	Data for reporting year	Data for previous year	Narrative – the implications of the data and any additional background explanatory narrative	Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective
<b>For each of these four workforce indicators, compare the data for White and BME staff</b>				
1 Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce. Organisations should undertake this calculation separately for non-clinical and for clinical staff.				
2 Relative likelihood of staff being appointed from shortlisting across all posts.				
3 Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation. This indicator will be based on data from a two year rolling average of the current year and the previous year.				
4 Relative likelihood of staff accessing non-mandatory training and CPD.				

## Report on the WRES indicators, continued

Indicator	Data for reporting year	Data for previous year	Narrative – the implications of the data and any additional background explanatory narrative	Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective
<b>National NHS Staff Survey indicators (or equivalent)</b> For each of the four staff survey indicators, compare the outcomes of the responses for White and BME staff.				
5 KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.	White BME	White BME		
6 KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months.	White BME	White BME		
7 KF 21. Percentage believing that trust provides equal opportunities for career progression or promotion.	White BME	White BME		
8 Q17. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues	White BME	White BME		
<b>Board representation indicator</b> For this indicator, compare the difference for White and BME staff.				
9 Percentage difference between the organisations' Board voting membership and its overall workforce.				

**Note 1.** All provider organisations to whom the NHS Standard Contract applies are required to conduct the NHS Staff Survey. Those organisations that do not undertake the NHS Staff Survey are recommended to do so, or to undertake an equivalent.

**Note 2.** Please refer to the WRES Technical Guidance for clarification on the precise means for implementing each indicator.

## Report on the WRES indicators, continued

6. Are there any other factors or data which should be taken into consideration in assessing progress?
7. Organisations should produce a detailed WRES Action Plan, agreed by its Board. Such a Plan would normally elaborate on the actions summarised in section 5, setting out the next steps with milestones for expected progress against the WRES indicators. It may also identify the links with other work streams agreed at Board level, such as EDS2. You are asked to attach the WRES Action Plan or provide a link to it.

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and prevent future editing

## Board of Directors : July 2017

**Item :** 12b

**Title:** Draft Race Equality Strategy

**Purpose:** To provide the Board with the opportunity to review the Draft Race Equality Strategy.

This draft has been developed through extensive consultation. Draft versions of the strategy have been discussed in meetings between the CEO and Chair and BAME staff, the Executive Management Team, the Equality, Diversity and Inclusion Committee and the Professional Clinical Advisory Group in June 2017.

All staff have been invited to provide feedback on the draft by September 4<sup>th</sup> 2017.

Directors and managers have been asked to ensure the draft is discussed within their teams.

A revised draft will be presented to the Board for approval in September 2017.

**This report focuses on the following areas:**

- Quality

**For :** Discussion

**From :** Louise Lyon, Director of Quality and Patient Experience, Chair, Equality, Diversity and Inclusion Committee

## Draft Race Equality Strategy 2017–2020

### 1 Introduction

Discrimination on the basis of ethnicity is widespread within the NHS (see eg West et al 2015) with black staff groups being the most likely to experience discrimination. Our organisation is no exception.

We have heard from staff and seen from the NHS staff survey results over consecutive years that staff in our organisation have experienced discrimination, been bullied and feel our approaches to development and progression are not fair. Below are the statistics from the recent staff survey specifically focusing on the experiences of black, Asian and minority ethnic (BAME) staff.

KF25	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	White	22%
		BME	18%
KF26	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	White	22%
		BME	27%
KF21	Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	White	91%
		BME	45%
Q17b	In the 12 last months have you personally experienced discrimination at work from manager/team leader or other colleagues?	White	7%
		BME	22%

These statistics are disappointing and provide a clear call to action; as an organisation we make a firm commitment to changing them.

There is an overriding ethical case for addressing inequality in our organisation. In addition there is increasing evidence for the benefits for an organisation in promoting equality, diversity and inclusion. Diverse and inclusive organisations are more creative, productive and successful. Fair, respectful, non-discriminatory treatment of staff leads to better, more compassionate patient care in NHS organisations.

We deliver many of our clinical services and education programmes across a number of diverse London communities yet the profile of our leadership, clinical and teaching staff does not mirror the service users and students we serve. This may mean that we are less effective in helping certain communities through our clinical services and less capable of training the workforce for the future of our increasingly diverse communities. We can all benefit from a more inclusive organisation and we can all play our part in working towards this.

We recognise that strategic documents are good at detailing our intent but it is our actions that speak volumes and really make cultural change happen. Throughout the lifetime of this strategy we will commit to taking a number of actions that are intended to change our organisational culture and eradicate work place discrimination.

We can learn from organisations which have successfully tackled racial discrimination. Key lessons include the importance of leadership; investing in development for staff across all levels of an organisation; setting out a plan of action; producing data to measure and stories to demonstrate progress; and clear accountability for putting plans in place and revising those plans where they are failing to achieve our aims. The voice of BAME staff is crucial to setting out the areas to address. In many organisations a formal and fully supported and resourced BAME network has been effective in providing a safe forum for discussion, raising issues and holding the organisation to account for delivery of an effective strategy. We already have an informal network within the Trust and staff support for setting up a formal network with clear lines of authority, drawing on examples from other organisations. However, it should be clear that the strategy can only be truly effective if those currently in leadership positions at every level, predominantly white staff, accept and act on the need for change. In order to promote ownership and engagement with the strategy across the Trust, the draft strategy will be discussed at management meetings in all directorates and in the clinical disciplines through their discipline meetings or other means of promoting consultation and discussion.

White staff have an important role to play in recognising their role in perpetuating discrimination and in challenging inappropriate behaviour. As West et al (2015) point out, whilst we have moved away from overt expressions of discrimination, subtler forms remain which require recognition and challenge.

Our strategy recognises that we need to foster cultural change to ensure that we achieve our aims. To support this we will engage Frank Lowe, Consultant Social Worker and Psychotherapist, to lead a programme of Thinking Space events to address the difficult aspects of our culture in relation to race. Bringing awareness of discrimination to the fore is recognised as potentially uncomfortable for everyone for different reasons. We expect all staff members to take the opportunity to attend these events. Everyone, white and BAME, at every level of seniority, will have something to contribute and something to discover through these thoughtfully-led exploratory events. As an organisation there is much that we hold in common in terms of our commitment to our work in mental health and social care and to our compassionate and thoughtful approaches. We may use these commonalities to support us as we explore painful areas of difference and unfairness.

We will find ways of using what we know but do not fully acknowledge within our organisation. For example our regular Group Relations events frequently bring to the fore issues relating to race but this potentially powerful knowledge and reflection on how race affects us all does not effectively find its way into the thinking within the wider organisation. Our staff group contains experts in models of thinking about race and discrimination within systems and organisations but we have yet to make full use of this knowledge as applied to our own organisation.

In addition to our Board level race equality strategy sponsor, Prof Bhugra, we will engage an external sponsor as a critical friend to help us maintain focus and to bring in an external view. We will also invite external speakers to help us recognise and think through issues. We will arrange regular events, with external and internal contributors,

aimed at encouraging joint ownership of our strategy and a positive experience of working together.

## 2 Aims

Our aim is to end racial discrimination at the Tavistock and Portman and to do all we can to ensure that all staff are confident that they are valued, that they will be treated fairly and supported to fulfil their potential.

One of the four main themes of our organisational development and people strategy, approved by the Board in April 2017, is respecting, developing and supporting our diverse workforce. The race equality strategy amplifies but does not replace this strategy which was in turn developed through wide consultation with staff and other stakeholders.

This strategy focusses on race equality in our workforce and sets out the steps required to develop a strategy for our education and training services and briefly outlines our approach to equality, diversity and inclusion in our clinical services. More detailed strategies for education and training and clinical services will follow. All three areas, workforce, education and training and clinical services, are closely linked and progress in each will be dependent on the others. A more diverse and fairly treated workforce will enhance our clinical work, our research and our education, training and consultancy services. Our specific approach to training relies on clinician-trainers and therefore progress in race equality for all staff will impact positively in all key service areas.

The Board of Directors and the Management Team are entirely committed to supporting our race equality strategy to put right the historic experience of discrimination and inequality. As an NHS organisation it is our duty to do so and we will be held to account externally. Both the Public Sector Equality Duty and the Workforce Race Equality Standard (WRES) are publicly reported and our performance on

the WRES contributes to the Care Quality Commission's assessment of our achievement of the well-led standard.

Over the three year (2017– 2020) life time of this strategy we aim:

- To achieve a reduction in bullying and harassment which places the Trust in the top 10 NHS organisations as measured by staff survey results
- To achieve equal rates of appointment following shortlisting for BAME and white staff
- To achieve an improved level of confidence amongst BAME staff that all staff will be treated fairly as reported in the staff survey
- To achieve an equal level of confidence that all staff, irrespective of grade, will have access to training and development opportunities as reported in the staff survey.
- We will invest in developing our more junior staff by determining their needs through robust appraisals, reviewing personal development plans (PDPs), feedback from ongoing discussions and commissioning education and training that will create our future leaders. Each year we will audit our PDPs across all staff levels to ensure that agreed development is implemented and track progress through the annual NHS staff survey.
- To increase the proportion of BAME staff in 8a posts and above, to place the Trust in the top 10 NHS organisations
- To increase BAME representation in both Executive Director and Non-Executive Director roles on the Board of Directors by AT LEAST 7% (at least 1 more BAME Board member, at least 2 out of 14 members in all) to reflect the communities we serve.
- To collect and report on data to identify areas where change is required and/or where it has been achieved. This means having

more detailed information available about each area of the Trust and involving each discipline and profession in reporting on the profile of their discipline or profession and any barriers to race equality specific to these areas.

Each of these aims should be achieved within the three year life of the strategy and all have been designed to be measurable so that we can see if we are making adequate progress. The table in section 7 sets out how the actions proposed within this strategy link with the aims. Further work will be required to translate this into a detailed action plan with clear accountability, responsibility, milestones and to establish the most effective ways of communicating progress throughout the Trust.

### **3 Putting our plans into practice and holding to account**

Putting our plans in place requires clear leadership at all levels including the Board, the Management Team, and all those who are in line management positions. Each manager will have agreed objectives to support the race equality strategy. They will be supported by appropriate training, mentoring and coaching as part of the overall organisational development strategy.

Overall progress on implementing the race equality strategy will be reported to the Equality Diversity and Inclusion Committee on which Prof Bhugra sits. The Chair of the Equality, Diversity and Inclusion Committee, Louise Lyon, is also Board member and will keep the Board informed of progress.

It is important that both formal and informal channels of communication remain open between staff as well as between staff and the Management Team and Board of Directors. As we put our plans in place, we may discover better ways of supporting progress, or staff may feel enabled to speak up about areas for change which are not yet addressed in the current strategy. Communication may take place through many channels including the proposed Diversity

Champion and the continued meetings of BAME staff with the Chief Executive and the Chair of the Trust Board of Directors.

#### **4. Respecting, developing and supporting our diverse workforce**

This section sets out the actions we will take in support of our workforce.

##### *4.1 Providing visible and authentic leadership*

In recent months we have reflected carefully about what we have done in the past and what more we need to do. We recently revised our terms of reference for what was once the equalities committee and broadened its title to be the equality, diversity and inclusion committee. With that change we also reviewed the membership and our Trust Board chair has now joined this important committee to demonstrate the Board's commitment to this agenda.

In addition to the above both the chair and chief executive have established a BAME network meeting where staff can come and share their experiences and help shape where we should be focusing our attention. This strategy was informed by the contributions and has helped us set what we should prioritise in the short, medium and long term.

##### *4.2 Having difficult conversations*

We recognise that tackling discrimination is not easy and often there are many layers to how it manifests in organisations. What we are clear about, though, is that discrimination is unacceptable in whatever shape or form it takes. As an organisation we make a strong and firm commitment that we will not shy away from having difficult conversations about what is less positive about working in our organisation and that we will take steps to address inappropriate behaviour.

The Trust has many well worded policies and procedures but often using formal channels to get a resolution when discrimination manifests is daunting for a member of staff, and often results in a more destructive outcome than intended. We commit to developing ways in which staff can speak, confidentially, about behaviour they feel is inappropriate and that managers are empowered to take action that stops it.

**Action:** We will look at methods in addition to those resources already available by identifying a number of people in our organisation who can listen to staff and help them address concerns or inappropriate behaviour.

Where there are themes of inappropriate behaviour alleged against one member of staff, irrespective of their actual or perceived seniority, we will support managers to have a difficult conversation, and support an individual to improve whilst being clear that if the issues continue then we will take action.

#### *4.3 Developing cultural intelligence*

We live in a diverse society and being placed in the capital our workforce is made up by a wealth of different cultures, nationalities and ethnic backgrounds. We will commit to widening our understanding of the differences amongst different cultures to facilitate better conversations about how we best work together and ensure that we embrace the benefit that diversity can bring to our organisation.

Research has shown that whilst an organisation is made up by diverse people we often expect staff to behave like a white British person and when they do not they can begin to be treated differently or with animosity. Examples can include that some cultures are perceived to be overly direct in their communication and can be perceived to lack empathy or appear to be confrontational. This can result in them being spoken down to, being made to feel they are not respected or them being excluded. Likewise, white British cultures often take a more

circumspect approach to difficult situations and where they are unclear about cultural difference they avoid talking about the challenge and opt to distance themselves so as not to create conflict. This in turn can be perceived as being duplicitous or excluding people from different backgrounds.

**Action:** We will develop training for managers and staff in how to recognise differences and adapt working styles to address potential for work place inequality drawing on insights from the theory of cultural intelligence.

We will embed all learning in to our induction, appraisal, mandatory training and leadership development programmes. Training will only go so far, though, and our intention is to make this agenda a living conversation where staff feel free to talk about cultural difference and engage in meaningful dialogue about how diverse teams best work together.

#### *4.4 Recruiting a Diversity Champion*

There are a number of best practice examples from our NHS neighbours of where taking proactive action to address discrimination has worked well. Having spoken to other organisations we have learned that seeking out willing and capable individuals who can champion our work and also help us to understand what our staff need often results in making change happen effectively.

We have already started to recruit Equality Champions to our clinical teams and now plan to extend this to our training portfolios to ensure that in our clinical and training services there are staff members authorised to raise issues of equality, diversity and inclusion particularly as they relate to the services they deliver. In addition staff not in clinical or education and training directorates may also wish to nominate Equality Champions.

**Action:** We will appoint a Diversity Champion with protected time to work with the Equality, Diversity and Inclusion committee. A

comprehensive role specification will be developed and expressions of interest will be invited from across the Trust. The post-holder will be provided with training for the role.

The post-holder will report directly to the Chair of the Equality, Diversity and Inclusion Committee and will have direct access to the Board of Directors through Prof Bhugra, the Board sponsor for our race equality strategy. The Diversity Champion will work with the existing equality, diversity and inclusion leads in our clinical directorates and the Department of Education and Training, and will open up clear channels of communication with the clinical team and portfolio level champions so as to provide support and guidance to help normalise discussions of the relevant issues.

It is also recognised that not all staff feel comfortable sharing their experiences in a committee or to a more senior manager in the organisation. The Diversity Champion will need to be an individual staff can relate to, and also feel that their suggestions or concerns will be taken seriously and given the support to seek resolution, where this is needed.

#### *4.5 Improving fairness in recruitment and promotion*

Our statistics have proven that fewer BAME staff are successful at interview and to address this we enforced that all posts graded band 8 and above should have an HR business partner on the appointment panel to challenge interviewers where potential unconscious bias may arise. For the most senior posts in the organisation our HR director fulfils this role. We know that this has had some small impact in the first year and we have seen an increase in our BAME staff in higher graded roles, but we do also need to focus on positions in the lower tiers of the organisation. We commit to replicating the approach we have adopted for senior roles and apply this to more junior posts in our organisation.

We do know, however, that there are more deep rooted issues about recruitment practice in the organisation.

4.5.1 The first being that staff from minority backgrounds have lacked investment in their own career development skills and some lack the confidence to apply for promotional opportunities. In March 2017 we held a well-reviewed half day seminar on career skills and personal impact, and this was just the start of our developmental offerings. Over the lifetime of this strategy we will ensure that we commission further, more focused, programmes and embed coaching in to our everyday practice.

4.5.2 In addition to the above we want to ensure that if we invest in staff to undertake development programmes that they should be the first to be able to access promotional or secondment opportunities. To do this we will ensure that we robustly track participants on management and leadership programmes and ensure that they get the first opportunity to apply for progression in our organisation.

4.5.2 We will ensure that leaders and line managers at all levels of the organisation are tasked with clear objectives in relation to the achievement of the aims of our race equality strategy.

Our objective through this work is to ensure staff, regardless of their race, have the same recruitment and promotional experience and that they are assessed on merit and potential.

**Action:** To support managers at each level, training will be provided which will address issues such as fair recruitment, how to support staff development, address performance, tackle inappropriate behaviour and address the impact of unconscious bias in the manager and amongst those managed.

#### *4.6. Developing and supporting our diverse staff*

Over the last twelve months we have taken a much more strategic approach to personal, management and leadership development. However, historically we have lacked robust data to evidence who is

accessing our development opportunities, where in the organisation they are and how this links to their personal and professional progression.

In 2016/17 we launched our first internal leadership development programme which has seen 20 participants from a range of backgrounds start a leadership journey to build the skills to be an effective leader, understand their personal impact, how they lead within their team, and their leadership role across the organisation and in the wider healthcare system. We will continue to offer these opportunities and flex the content to ensure it remains relevant to our organisational priorities and that it is fully inclusive.

We also recognise that developing future leaders starts early in a person's career and that we need to focus greater attention on developing programmes that support our more junior staff to develop in their roles and throughout their career.

Staff, mainly our more junior staff, have also explained to us that they need encouragement from their line manager to apply for development programmes. Through this strategy we actively advertise our development programmes to senior managers and ensure that they encourage applications from BAME staff.

**Action:** We will commit to implementing robust and formalised non-mandatory training data collection and reporting on this through the Workforce Race Equality Standard.

#### *4.7 Reporting and sharing progress*

We have heard that often messages do not cascade well within the organisation and that often some of the good work that we do does not reach staff working in operational roles. The Trust's new intranet will provide one vehicle for sharing messages and the work that we do. We will consider carefully how we communicate important messages,

for example through making sure that they find their way in to a team meeting, or in a way that works best.

There are a number of corporate publications that we will continue to use such as our annual integrated equality, diversity and inclusion report, published every January, which draws together data about our service users, staff and students and reflects on what we have done in the previous year and progress we make against our priorities.

There is also the workforce race equality standard (WRES) report which we share with staff towards the end of every July which gives a specific focus on what we have done to address inequality for our BAME staff.

#### *4.8 Partnership working*

We have a long history of working in partnership with our trade unions through the Joint Staff Consultative Committee. Recognising their important they are members on a number of committees, including the Equality, Diversity and Inclusion Committee and its sub-groups. Union representatives are crucial to ensuring that workers are involved in the development of policy and strategy. Traditionally, BAME staff join trade unions because they feel that they are more likely to be better protected and listened to when they raise a concern. The Staff Side Chair meets regularly with the Director of Human Resources, with HR senior managers, with the Freedom to Speak Up Guardian as well as less regularly with the CEO, Trust Chair and other Trust Directors and senior managers. Good, effective and transparent partnership working and consultation can ensure that the Trust is alerted to any areas across the organisation where engagement or communication could be more effective and which can further improve equality of access, experience, opportunity and wellbeing for those working in all of our services.

**Action** – to promote diversity and inclusion across all areas of our working experience by promoting and further developing good partnership working and consultation between the Trust and the trade unions around race equality.

#### *4.9 Exit interviews*

HR will provide the opportunity for exit interviews for all staff to gain a better understanding of reasons for leaving.

### **5 Developing a race equality strategy in Education and Training.**

This section of the strategy sets out the areas on which the Department of Education and Training (DET) propose to focus, and the process through which DET will develop its strategy. DET has a key role to play in training future care professionals, clinicians, researchers and leaders in the NHS, social care and education and training. It therefore has an important role to play not only within our organisation but in contributing to ensuring that the future workforce is capable and confident in handling issues of race and difference where ever they work.

#### **5.1 Introduction**

Work is underway in DET to contribute to the development of an overarching race equality strategy for the Trust.

Currently we are engaged in a scoping exercise including:

- Meetings with BAME staff in faculty to understand developments in DET, specific issues and concerns, areas of good practice, and recommendations of focus areas to make the most impact.
- Development of an equalities questionnaire for students. A decision was taken to launch this survey after the completion of the internal student survey (June 2017) so that it could be given sole focus.
- Review of regular course evaluation feedback to gain information about how students and trainees experience the Trust

- Literature review to contribute to setting standards and identifying good practice where it exists in similar organisations in the Higher Education sector.
- Review of relevant policy documents and sector thought leadership.

## 5.2 Areas of focus

There are a number of clear areas under consideration, including:

- access to training for students from minority backgrounds.
- the extent to which race and culture is addressed in the curriculum.
- the broader experience for BAME students while studying on our programmes and the support available for them.
- the diversity of our own staff group.

## 5.3 Background : Studies on BAME students in Higher Education

In a study by the National Union of Students<sup>i</sup> (n938) the student perceptions of the black, Asian and ethnic minority (BAME) student participants were that BAME students are not getting an education equal to that of their white peers. The data suggests that BAME students are not satisfied with their learning environment and that inequalities are perpetuated by institutional practices. The data identified a complex interplay between previous educational experiences, wider societal factors, and the Higher Education (HE) experience of BAME students.

A recurring theme in many studies is the lack of support and isolation many BAME students feel. Research into the achievement and retention of BAME students found a lack of staff support and isolation due to a lack of cultural diversity (including lack of BAME staff as role models and mentors) and opportunities to integrate with other students.

## 5.4 Current profile of students at Tavistock & Portman

There are 6 courses at the Tavistock & Portman where BAME students represent half the students on the course. In 15 courses they represent one third of the students. A single summary chart of self-declared ethnicity of students by portfolio can be found in Appendix A [Please note these figures are approximations as the question about ethnicity is optional]. More detailed intelligence is available although this can be difficult to display readily in graphic form.

A breakdown of the BAME backgrounds of students:

Classification	Population by number
Asian or Asian British – Pakistani	9
Asian or Asian British – Bangladeshi	8
Asian or Asian British – Indian	27
Black or Black British – African	44
Black or Black British – Caribbean	48
Chinese	19
Mixed White/Asian	15
Mixed White/African	8
Mixed White/Black Caribbean	11
Other Asian	20
Other Black	4
Other ethnic background	38
Other mixed background	33
White	898
	1182

Proportion of ethnicities by percentage among students

Classification	Population by %
Asian/mixed Asian	6.7%
African/mixed African	4.4%

Caribbean/mixed Caribbean	5%
Chinese	1.6%
White	76%

This data does not include those students/participants engaged in short courses.

## 5. 5 Examples of initiatives in comparable HE institutions

5.5.1 King’s College London, which has the Institute of Psychiatry, Psychology and Neuroscience, has an intention to provide ‘unconscious bias training’ as part of their priority to have all staff trained.

5.5.2 The Race Equality Charter Mark is an initiative run by the Equality Challenge Unit, which aims to inspire a strategic approach to making cultural and systemic changes that will make a real difference to minority ethnic staff and students. It covers professional and support staff, academic staff, student attainment, diversity of the curriculum and progression of students into academia. King’s College were one of only 8 institutions that achieved the bronze award<sup>ii</sup>.

5.5.3 At University College London, the ‘Equality, Diversity and Inclusion Strategy 2015–2020’ aims to reduce the student attainment gap, increase student applications, and enrolment, especially from under–represented BME backgrounds. The aim is to achieve a 5% increase in the diversity of senior staff by 2019<sup>iii</sup>.

5.5.4 In its ‘Equality and Diversity Objectives 2014–2016’ Imperial College London has a diversity specific network for race equality – ‘Imperial As One’ – whose members are represented on the overarching Equality and Diversity Committee. Members are consulted and the Provost’s Board has executive sponsors, one of whom is a champion of race equality.

## 5.6 Initial themes for the Tavistock and Portman DET

### 5.6.1 Data

The BAME average in higher education in 2015–6 is 22.3%. On Tavistock & Portman NHS FT courses it is 25%. The proportion of BAME students is, therefore, in line with national trends. However, this comparison needs to be viewed with caution, and interrogated more robustly going forward. For one, the figures might include undergraduate recruitment.

We also know there is a particular issue with regard to significant under-representation of BAME professionals working in the professions in general. Certain programmes of ours recruit a very diverse group of students, while others less so. Within the core mental health and social care professions there are differential rates of BAME students accessing qualifying professional training. We deliver training to professional qualification in some core disciplines but not all, although we deliver post-graduate training to the majority through our multi-disciplinary post qualification programmes and CPD. The Trust-wide heads of clinical disciplines will have a role in advising on how best to achieve impact in their disciplines which will in most cases involve linking with wider professional bodies and their initiatives in relation to race equality.

### 5.6.2 Complexity

It is clear that this is a complex area. From the staff discussions so far, it is clear that efforts have been made to address issues here, notably with the employment of race consultants and the establishment of the race and equity group facilitated by Britt Krause.

### 5.6.3 Inconsistency of practice

Certain courses engage particularly well with the issues of difference, including race.

There are examples of good practice but there does seem to be an issue of consistent practice across all programmes.

#### **5.6.4 Emerging sector leadership**

The Higher Education Academy research study emphasises the need for HE to develop a more holistic approach to ‘race’ equality policies, whereby the whole student cycle receives attention, from recruitment through to progression/retention, achievement and employability. Resources are available in the sector to draw upon and learn from where appropriate.

To make successful changes it is important to have institutional leadership that emphasises the importance of race equality to all staff, provides mechanisms for supporting academics in implementing race equality, and ensures mechanisms exist to integrate and align race equality into all activities.

### **6. Clinical Services**

A comprehensive race equality strategy for clinical services will be developed in consultation with staff, patients and families, community groups, commissioners and other relevant stakeholders. At this stage, we can provide an outline of work already in hand which is briefly described below.

Our figures on the ethnicity of patients accessing our services show that certain groups of patients are under-represented in some of our services in comparison with national and local demographic data.

We have a positive track record of developing services with and for specific groups in the communities we serve but we need to extend this work on the basis of the currently available data.

We will review access to our services according to demographic profiles of the areas we serve and differential levels of need as we are aware that experiences of discrimination and other associated experiences, can adversely affect mental health. We will assess the

helpfulness and responsiveness of our services for patients from BAME backgrounds. One of our four Quality Priorities for 2017–8 sets out our plans to collect more comprehensive data on the ethnicity of those accessing our services, including their experience of our services, to ensure that directors, service and line and team managers are aware of the data and to consult with patients and relevant communities group to find ways in which we can improve our services where needed.

Over the last few months we have been recruiting Equalities leads to our clinical teams. Their role is to speak up about equalities issues, including race, in team discussions. For this to work, Team Managers need to ensure that time is set aside in team meetings for discussion of the relevant issues as they arise in clinical work.

In order to provide high quality services for BAME groups, all staff, white and BAME should be supported to engage in discussion of issues that arise in their work with people from a different race or culture than their own in order to develop confidence and capability to work with difference. Prof Bhugra, Frank Lowe and colleagues have held initial discussions about setting up a Race and Culture Consultation Group for clinical staff.

## 7. Action plan

In this section, actions are set out against each of the aims of the strategy

- To achieve a reduction in bullying and harassment which places the Trust in the top 10 NHS organisations as measured by staff survey results

*Action: Bullying and Harassment procedure developed and implemented that learns from best practice. This will be based less on HR procedure and focus more on promoting safe conversations and useful discussions with those whose behaviour is unacceptable*

- To achieve equal rates of appointment following shortlisting for BAME and white staff for lower and higher banded posts

*Action: HR Business partner observers on interview panels, currently this is in place for 8a posts and above but will be rolled out for lower banded posts*

*Training for managers to promote fairer recruitment*

*Personal Development Plans for lower banded staff focused on staff development and progression*

- To achieve an improved level of confidence amongst BAME staff that all staff will be treated fairly as reported in the staff survey

*Action: Implementing the strategy with engagement from all staff, BAME and non BAME*

*Effective communication of actions taken and celebration of success where this has been achieved*

*Promotion of safe discussion and raising of issues through the formal BAME network and Trust Diversity Champion in addition to already existing channels , HR , Freedom to Speak Up champion, staff side representatives*

- To achieve an equal level of confidence that all staff, irrespective of grade, will have access to training and development opportunities as reported in the staff survey.

*Action: Training for line managers in effective appraisals*

*Follow up on Personal Development Plans and monitoring of access to training and development opportunities*

*Line managers holding to account those managers reporting to them for the PDPs agreed with staff*

- We will invest in developing our more junior staff by determining their needs through robust appraisals, reviewing personal development plans (PDPs), feedback from ongoing discussions and commissioning education and training that will create our future leaders. Each year we will audit our PDPs across all staff

levels to ensure that agreed development is implemented and track progress through the annual NHS staff survey.

- *Action: training for managers in appraisals, commissioning training and education and encouragement to more junior staff to apply for training or development opportunities*
- To increase the proportion of BAME staff in 8a posts and above, to place the Trust in the top 10 NHS organisations

*Action: Staff development at lower bands*

*Fairer recruitment process including observers on panels*

- To increase BAME representation in both Executive Director and Non-Executive Director roles on the Board of Directors by AT LEAST 7% (at least 1 more BAME Board member, at least 2 out of 14 members in all) to reflect the communities we serve.

*Action: Increase BAME recruitment to high banded posts to increase the pool of BAME candidates prepared to progress into Director level posts*

*Follow best practice and learn from other organisations*

- To collect and report on data to identify areas where change is required and/or where it has been achieved. This means having more detailed information available about each area of the Trust and involving each discipline and profession in reporting on the profile of their discipline or profession and any barriers to race equality specific to these areas.

*Action: Develop set of metrics and provide resources to analyse and report*

This action plan outline below sets out the main actions proposed to support the strategy and when they are planned for initial implementation. Once the strategy is agreed a detailed delivery plan will be developed which will include accountability, responsibility and timescales. Planning work will commence before these dates. Much of

the work will be ongoing and developing over the lifetime of the strategy, 2017 to 2020

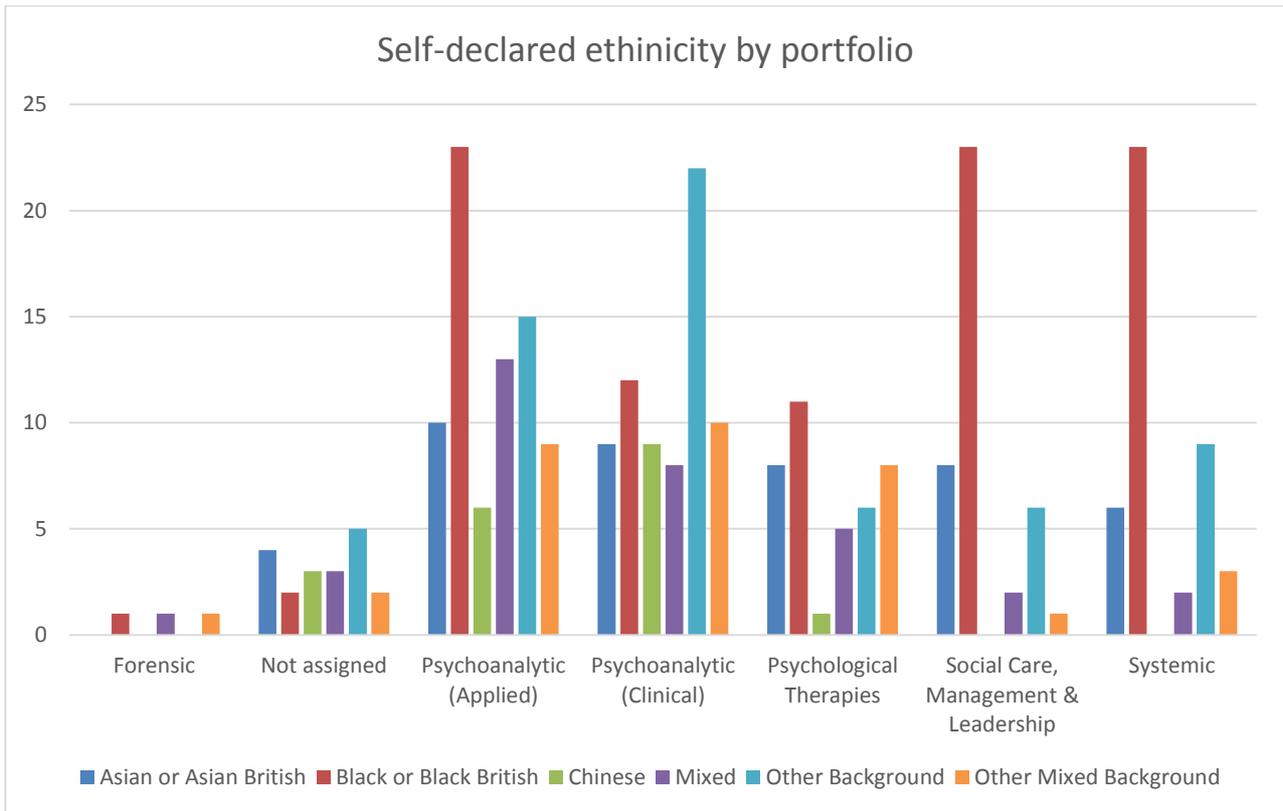
	Action:	Leads	Completion
<b>Engage all staff in discussion in support of cultural change</b>	Lead a programme of Thinking Space events to address the difficult aspects of culture.	Frank Lowe	Ongoing
<b>Having difficult conversations</b>	Identify individuals in the Trust who can listen to staff and help them address concerns or inappropriate behaviour. Support managers to have these conversations. Support individuals who report concerns/inappropriate behaviour.	HR	April 2018
<b>Developing cultural intelligence</b>	Explore cultural intelligence further, and develop training for managers and staff to recognise differences and adapt working styles. Embed learning in to induction, appraisal, mandatory training, and leadership development programmes.	HR	April 2018

<p><b>Recruiting a Diversity Champion</b></p>	<p>Appoint Diversity Champions with protected time to work with the Equality, Diversity and Inclusion Committee. Develop a comprehensive role specification and invite expressions of interest for this from across the Trust. Provide training for this role.</p>	<p>HR and Chair of EDI Committee</p>	<p>September 2017</p>
<p><b>Improving fairness in recruitment and promotion</b></p>	<p>Provide training to address fair recruitment, supporting staff development, addressing performance, tackling inappropriate behaviour, and addressing the impact of unconscious bias.</p>	<p>HR</p>	<p>Autumn 2017</p>
<p><b>Developing and supporting our diverse staff</b></p>	<p>Implement robust and formalised non-mandatory training data collection, and report on this through the workforce equality standard.</p>	<p>HR</p>	<p>Autumn 2017</p>
<p><b>Developing the DET race equality strategy as part of the</b></p>	<p>Complete scoping exercise and produce draft race equality strategy for DET</p>	<p>Director of DET</p>	<p>Autumn 2017</p>

<b>overall Trust strategy</b>			
<b>Developing strategy for clinical services</b>	Enhance collection of data on ethnicity and experience of service and review to establish areas for improvement	Director of Quality and Patient Experience	April 2018

Louise Lyon  
 Chair, Equality, Diversity and Inclusion Committee  
 June 19<sup>th</sup> 2017

## Appendix A



This graph give a view of the self-assigned race categories by portfolio.



## Board of Directors : July 2017

**Item :** 13

**Title:** Quality and Performance reports- Overview Quarter 1  
2017-18

**Purpose:**

The purpose of this report is to provide the Board with an overview of areas of good performance and areas of concern reflected in the quality and performance reports.

This report has been reviewed by the Executive Management Team on July 18<sup>th</sup> 2017

**This report focuses on the following areas:**

- Quality
- Patient / User Safety
- Risk

**For :** Approval

**From :** Louise Lyon, Director of Quality and Patient Experience

## Quality and performance reports

### Quarter 1 2017-18 overview

- 1 The overall numbers of patients seen in this quarter demonstrates an increase in comparison with last year. In Q1 we have already seen more than half the number of patients seen in the full year last year. This is largely due to our taking on the Charing Cross Gender Identity Clinic in April 2017.
- 2 Overall performance on waiting times in clinical services has been good with some decreases in waiting times maintained. Areas where waiting times remain an issue are the Gender Identity Service (GIDS) and the Charing Cross Gender Identity Clinic (GIC) where the volume of referrals exceeds the capacity on which the service has been modelled.
- 3 There has been some increase in from 10% to 10.3%. in our rate of DNAs . The reasons for the increase are not yet clear but DNA rates will be monitored and Q2 data will establish whether this is temporary variation or a trend.
- 4 Overall we are on track with our performance on CQUINs and quality priorities but need to be aware that much of the work remains to be achieved later in the financial year.
- 5 The elements of MHSDS which are reported as part of the Single Oversight Framework are a cause of concern. The picture of good or poor performance is not uniform across services. GIC does well in terms of ethnicity data but to date has poor returns on accommodation and employment. Substantial improvement on this may be hard to achieve given the large number of open cases in this service. Across other services, there has been improvement in collection of accommodation and employment data for over 18s with plans in place to achieve further improvement through piloting a new system for collecting the data in Adult and Forensic Services. All services apart from GIC need to improve the collection of ethnicity data.
- 6 Safeguarding alerts have increased due to a new system for collecting this information.
- 7 There has been a reduction in incidents at Gloucester House due to a range of factors including staff changes. The rate of incidents is closely linked to the academic year and it can be anticipated that the number of incidents will rise once children return to school in September and should fall as they settle.

- 8 In Q2, DET data will feature more prominently as results from the student survey will be available along with updated student numbers.



## Board of Directors: July 2017

**Item :** 13b

**Title :** Quality Report Commentary Quarter 1 2017/18

**Purpose:**

The purpose of this report is to provide commentary on key quarter 1 quality metrics where targets have not been met or the trajectory shows a worsening or improving position. Actions taken to address identified issues are included.

The Board of Directors is asked to confirm whether this paper is accepted as adequate assurance, and where not, whether the Board of Directors is satisfied with the action plans that have been put in place. The detailed Q1 Quality Report is available on request.

This report has been reviewed by the following Committees:

- Executive Management Team,

**This report focuses on the following areas:**

- Quality
- Patient / User Experience
- Patient / User Safety
- Risk
- Productivity

**For :** Noting

**From :** Louise Lyon, Director of Clinical Quality and Patient Experience  
Kerri Johnson-Walker, Data Quality Manager

## Quality Report Q1 2017/18

### 1. Introduction

1.1 As requested by the Board of Directors the following paper provides a summary and narrative for quarter 1 quality metrics currently within the Quality Report. This report specifically covers those metrics where we are not meeting targets or where the trajectory suggests a worsening position. Service level updates and actions are provided by the Service Leads. Some significant improvements are also highlighted. Please note the data in this report is for Trust wide, with the exception of CQUINS that apply to London Contracting only.

1.2 The following metrics are summarised below:

1.2.1 Waiting times

1.2.2 Did not attend (DNAs)

1.2.3 MHSDS data

1.2.4 Quality Priorities

1.2.5 Outcome monitoring

1.2.6 Physical Health KPI Targets and Living Well CQUIN programme

1.2.7 Safe and Timely Discharge CQUIN

### 2. Summary

2.1 Data is validated by services and is as accurate as possible. Standard operating procedures (SOPs) /Validation and reliability of the data have improved due to new checklists being implemented and new processes within the Quality Team. The Quality Team has a Data Quality SOP to streamline validation, and a Clinical Data Quality Validation Plan has been approved. A Data Quality Policy and a Clinical Data Quality Management Procedure were approved in quarter 4 2016/17.

2.2 Waiting times have been reported differently in the financial year 2017–18 to be brought in line with how it is reported internally to board. RTT (Referral to Treatment) times are now also recorded, treatment being defined as the second attended appointment. Adult teams: Overall Adult Complex Needs Service has improved their waiting times. Their breaches are well under the 10% Trust target, which had been exceeded

in Q4 2016/17. City and Hackney have reduced their breaches a significant amount whilst also keeping their RTT (Referral to Treatment) waiting times low. Portman have seen less people in Q1 2017/18 however only 1 person has breached the target waiting times of 11 weeks. Camden CAMHS has performed consistently well throughout 2016/17 which has continued in to Q1 of 2017/18, with such a high volume of patients. Although the adolescent service has exceeded the Trust breach target of 10% they have improved significantly from Q4 of 2016/17, similarly with the Other CAMHS. GIDS still displays a high number of breaches above the 18 week, even though they have seen less people off of the waiting list in the quarter. This is the first quarter the trust has reported on GIC waiting times an extremely low number of patients were seen with in the target waiting time of 18 weeks.

- 2.3 DNA rates are an average and expected to be no larger than 10%. The definition used for DNA figures is **Numerator:** Total DNA / **Denominator:** Total Appointments (Total Attended + Total DNA appointments). CYAF, GIDS and City ad Hackney PCPCS all just breached the 10% DNA trust target, whilst Adult and Forensic Services and Westminster FAS were well within the target. GIC reported a high level of DNA rates around 15%.
- 2.4 The trust has decided to now report on MHSDS (Mental Health Service Data Set) on a quarterly basis to see where demographics of patients are not collected. MHSDS is submitted twice for each month the analysis that you will see is for February, March and April. The reason for this is that it is the refreshed data that is sent nationally. For many of the categories, including gender, date of birth, referral information, GP information, contract information, marital status and current postcode targets were met. However areas of concern were completion of ethnicity (79% complete), accommodation status (25%) and employment status (25%).

\*due to the dates of this data, it does not include that from GIC as their data will be included from Mays refreshed submission.

## 2.5 Quality Priorities

### 2.5.1 Quality Priority 1: Improve the Physical Health of Patients Receiving Treatment

The trust is in the process of developing this programme, an online survey has been sent out to staff members, students, Trust members and members of the public, which aims to understand what individuals would like to see within a Living Well Programme. Steps have been taken to make physical health champions a priority to raise awareness conversations have been held with existing physical health champions to develop a greater understanding of what work has been done, what has been a challenge, and to hear their thoughts about the development of the physical health service within the Trust. A formal meeting has been set up with the physical health champions in July to further develop this role. A comprehensive training programme is currently being developed by the PHSP to be delivered across various teams, with the aim of 'training the trainer' through utilising the Physical Health Champions. An evidence-based set of workbooks, addressing key topics such as smoking, alcohol use, substance use, weight management, sleep and stress are currently being developed by the Physical Health Specialist Practitioner to increase individual support around physical health issues.

### 2.5.2 Quality Priority 2: Improve the Identification and Management of High Risk Patients :

To increase clinician's knowledge and awareness of the clinical risk assessment and management of self-harm and suicide a Risk Assessment Skills workshop is held once a quarter in the CYAF Directorate. The lead for patient safety together with the clinical governance lead for AFS will be running a risk assessment training in September 2017. Risk assessment and risk management is also included in the Trust INSET days. Three policies and procedures related to risk assessment, self-harm and prevention of suicide are currently being updated. A re-audit of the completion of risk assessment and risk management forms on the electronic patient record system will be completed at the end of July and an action plan drafted in response to the findings.

**2.5.3 Quality Priority 3: Embed meaningful use of outcome monitoring in services.**

Patient views are being collected with regards to the outcome measures used by the trust; after this information has been collated a review of outcome measures will take place. An audit has taken place to ensure that forms are entered on the CareNotes within a week of patient completion, it found that there are some delays in the outcome monitoring forms being sent to the Data Entry Clerk with in the Quality Team for entry, these findings will now be addressed. To improve access to patient level data a dashboard scoping exercise is being carried out by the IM&T department to develop a business case for the requirements and funding of a dashboard system.

**2.5.4 Quality Priority 4: Improve the use of equalities information to ensure clinical services are responsive to the needs of patients, carers and families.**

Establish reference group(s) from staff, patients, and other stakeholders to develop and oversee the priority work plan gaps will be addressed from findings in Q3. This has not yet taken place. Revised equalities forms have been prepared and implementation is imminent.

2.6 Outcome monitoring KPI CORE target is 70% of the eligible cohort showing improvement on the measure. In Q1 7 patients were eligible with 7 improving (100%). Please note that this data is cumulative. Goal Base Measure: Please note that Goal Base Measure is not recorded in Q1 as the form is generated once every 3 months and patients need to have a Time 1 and Time 2 to be included in the cohort.

2.7 The Living Well CQUIN includes completion of the physical health form this has been amended from the past financial year to include all patients from 13 years rather than from 14 years. There have been Quarterly targets set for each quarter throughout this financial year for Q1 the target was 50% which has been met. Two consultations were carried out to assess what forms of intervention would be helpful within the physical health service.

- 2.8 The Safe and Timely Discharge CQUIN for Portman requires an audit to be taken place for reporting in September CQRG, this audit is scheduled for the 28<sup>th</sup> July 2017 and actions will be shared in the Clinical Data Quality Review Group (CDQRG).
- 2.9 The Transitions out of Children and Young People's Mental Health Services CQUIN in under way, a meeting was convened on the 11<sup>th</sup> of May 2017 with other CCGs that serve Camden, an audit plan was agreed and is now implemented.
- 2.10 GIDS Telemedicine CQUIN is behind schedule, the implementation of training for staff should have started, however, now a telemedicine provider and the project board will be setting up a demo in Q2 and this will be classed as the first of the staff training. A monthly project board has been set up with the service and IM&T to ensure the feasibility and success of implementation.
- 2.11 GIDS Transfer arrangements across the Gender Identity Pathway CQUIN I often grouped with the GIC Transfer arrangements across the Gender Identity Pathway CQUIN. To satisfy both CQUINS service managers from both services have identified outstanding items from 2016/17 from the GID Service and put actions in to place to ensure they are satisfied when patients transfer from GIDS to GIC.
- 2.12 GIC 7 pt implementation plan CQUIN has been satisfied by appointing a Clinical Governance Lead for the service with a Clinical Governance meeting being appointed for July 2017. There is a staff survey being created by HR to measure staff moral after joining the Tavistock and Portman NHS Foundation Trust, new ideas on service improvement and development.

### **3. Data commentary**

#### **3.1 Waiting Times**

Waiting time targets, from receipt of referral, vary according to service contract agreements from 8 – 18 weeks. Targets are on the basis of internal breaches only and have a threshold of 10% for 8 and 18-week

referrals, and 5% for 11-weeks referrals. Please note GIC is a new service so trajectory cannot be monitored.

### 3.1.1 Improvements

Other CAMHS waiting times are being met with a slight improvement of 0.1% in Q4 to Q1.

Adult Complex need Service has just missed their under 5% target for 11 week waiting times, but have seen huge improvements from 14.6% in Q4 to only 5.5% of patients breaching in Q1.

GIDS have continued to improve in Q4 only 16.1% of patients were seen with in the 18 week waiting time target however in Q1 25.8% met the target time, however are still a little way off the 10% threshold for their 18 week waiting times target, with the new recourses in place it has been predicted that waiting times should be in line with this target by September 2017 given that referrals stay the same. This look unlikely as the waiting list has grown significantly.

City and Hackney have made improvement in their waiting time target of 18weeks, with 1.7% of patients breaching in Q1 compared to 5.6% in Q4.

The Adolescent and Young Adult (under 18) services have an decreased the number of 8 week waiting times breaches from to 22.7% in Q4 to 15.6% in Q4. However this is still over the target of 10%.

### 3.1.2 Decreasing trajectory

The management of Camden CAMHS waiting times is meeting the 8 week target however there was a slight decrease from last quarter, from 94.3% to 92.8% of patients being seen within 8 weeks.

Portman have decreased in trajectory slightly from 96.4% in Q4 to 94.7% meeting the 11 week waiting time target.

### 3.2 DNAs

DNA rates are a yearly average and expected to be no larger than 10%.

#### 3.2.1 Improvements

Westminster FAS service has seen a drop from 14% of DNAs to 5% in Q1 2017/18.

#### 3.2.2 Decreasing trajectory

CYAF have seen a jump in DNAs from 6.8% to 10.2%, a team level analysis will take place within Q1 to see where improvements need to be made

AFS as a whole have also seen a slight increase in DNA rates from 7.2% to 7.7%, still within the trust target of 10%.

City and Hackney PCPCS have seen an increase from 11% to 12.5%

GIDS has seen an increase from 7.4% to 10.7% in Q1 2017/18.

### 3.3 Physical Health KPI Targets and Living Well CQUIN programme

The data below includes patients under a London contract and those *'Patients who have attended their FIRST appointment from the beginning of this financial year.'* Please note that from financial year 2017/18 the Physical Health form should be completed for all patients over the age of 13, rather than the previous year's target that related to everyone over the age of 14.

PHF COMPLETION	
	Trust Performance
Q1 (Target 50%)	53.6%
Q2 (Target 60%)	
Q3 (Target 70%)	
Q4 (Target 80%)	

Data run 6 July 2017

Monthly physical health data is now provided to Service Leads by the Quality Team. From Q2 2017/18 service managers and admin leads will be required to provide a monthly update of Physical Health From

completion rates at Clinical Data Quality Review Group (CDQRG). A newly appointed Physical Health Specialist Practitioner is working with the Trust Physical Health Clinical Leads, Drs Caroline McKenna and Rob Tandy to increase the uptake. It is proposed to review and develop the involvement of Team-level physical health champions to support this work.

### 3.4 Safe and Timely Discharge CQUIN

To be reported in Q2.

Kerri Johnson-Walker  
Data Quality Manager  
14<sup>th</sup> July 2017



## Board of Directors: July 2017

**Item :** 13c

**Title :** Q1 Dashboards

**Purpose:**

Key points to note are:

- The Board level dashboard is, from Q1 2017/18 being managed by the Quality Team with information on the Quality Commentary providing specific service level responses.
- We continue to perform well in almost all areas.
- Increase in patients seen compared to previous year. If trajectory continues this would be over double the numbers seen in 2016/17.
- Gender Identity Clinic waiting time data has been presented separately owing to the length of the waiting list. Further detail is available in the *Waiting Time Analysis By Team Board Report*
- HR - appraisal data shows a fall in Q1. This reflects the new appraisal system implemented in February. Outstanding appraisals are being followed up. Sickness data has reduced to 1% however, this is not robust data. The new electronic staff system now includes sickness information and is slowly being rolled out across the Trust.
- Quality – Safety: Child safeguarding alerts remain elevated, which reflects the introduction of the new system for reporting.
- There were four serious incidents reported externally in Q1. Two were suicides and two IG related incidents.
- Effectiveness: Trust-wide DNA rate has risen to 10.3% above the 10% target. Actions taken by services to address issues are included in the Quarter 1 Quality Report Commentary.
- DET CPD metrics have been updated.
- Single Oversight Framework: Three data quality indicators continue to have a red rating. An action plan is in place to address these.

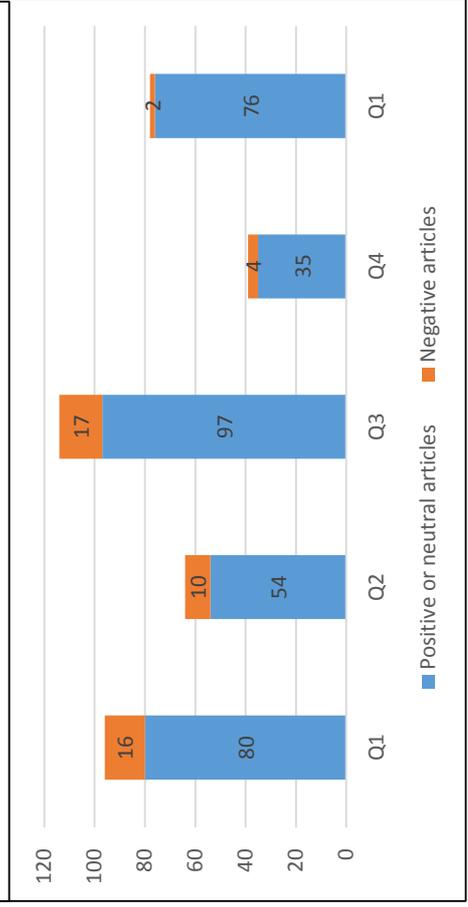
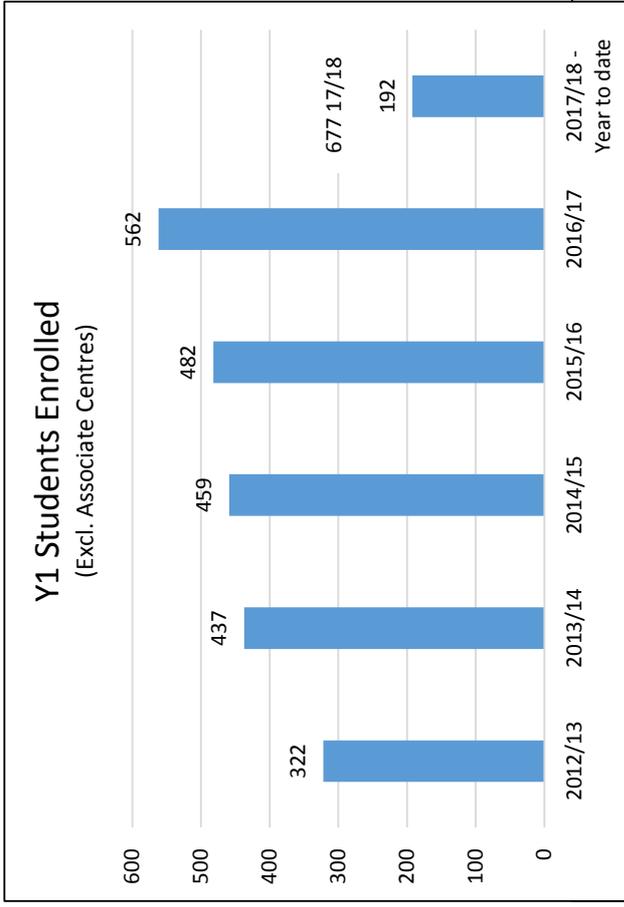
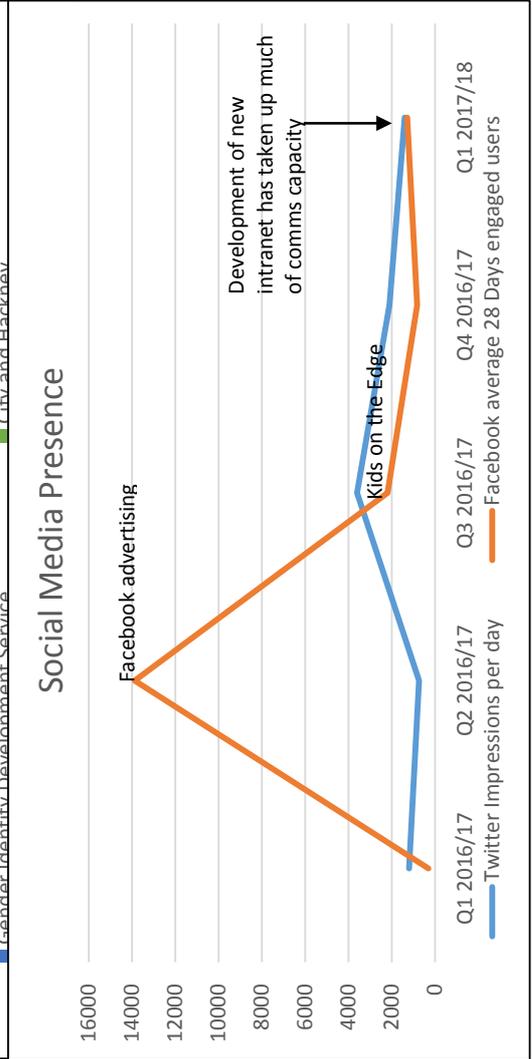
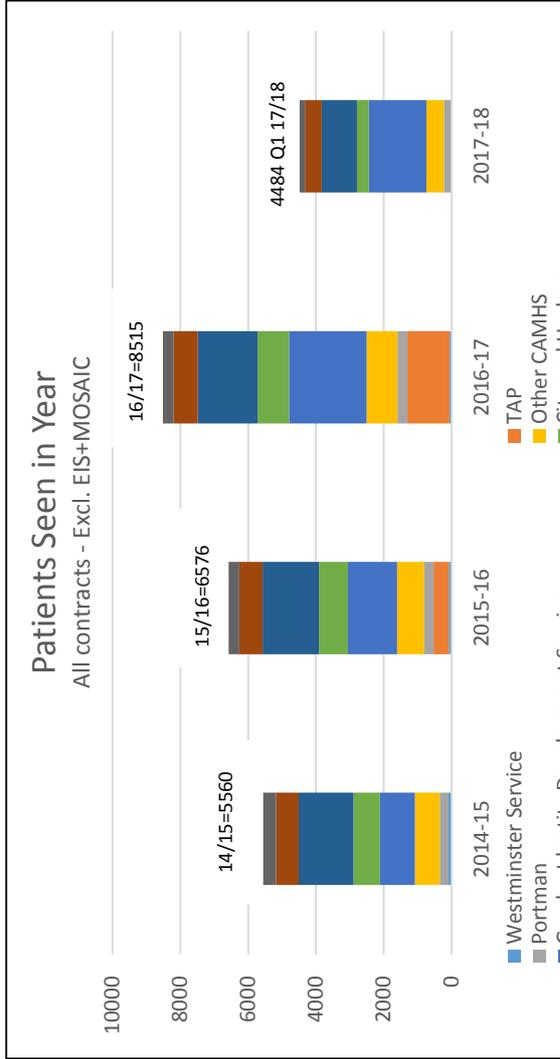
The Dashboards were reviewed at the Management Team on 18 July '17.

**For :** Discussion

**From :** Marion Shipman, Associate Director Quality and Governance  
Kerri Johnson-Walker, Data Quality Manager

Q1 - 2017/18

### Trust Reach



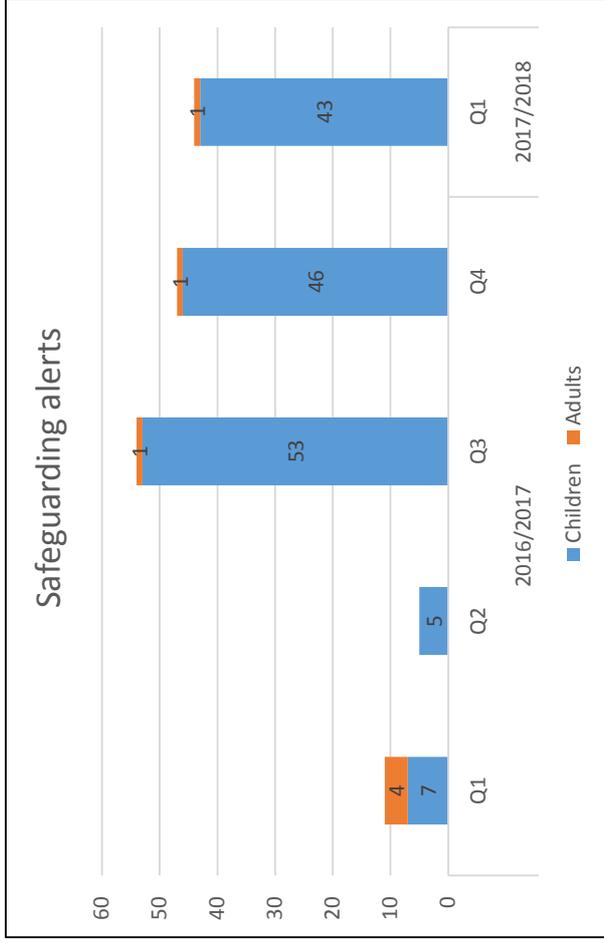
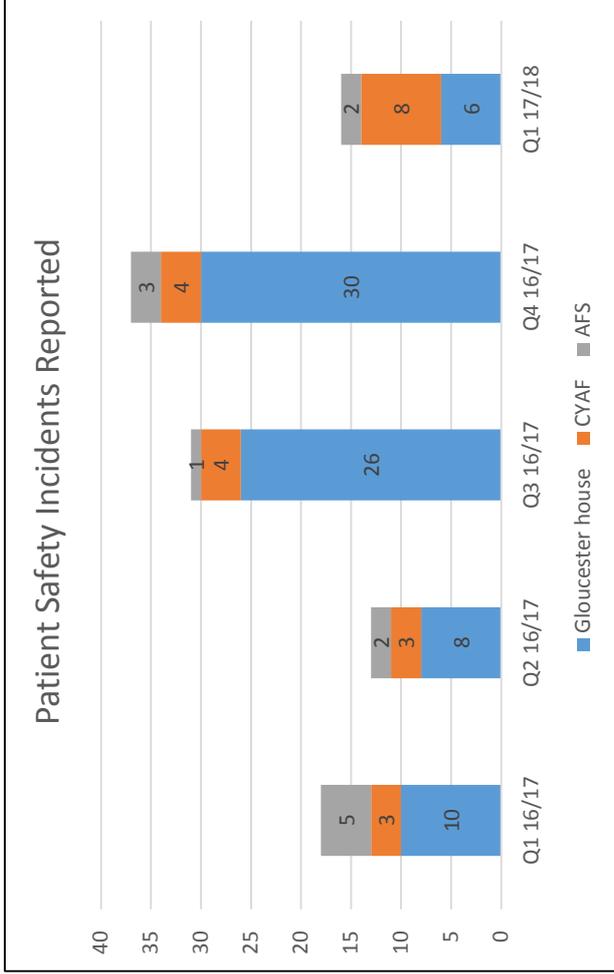
Q1 – 2017/18

## Quality – Well Led



Q1 – 2017/18

### Quality – Safety



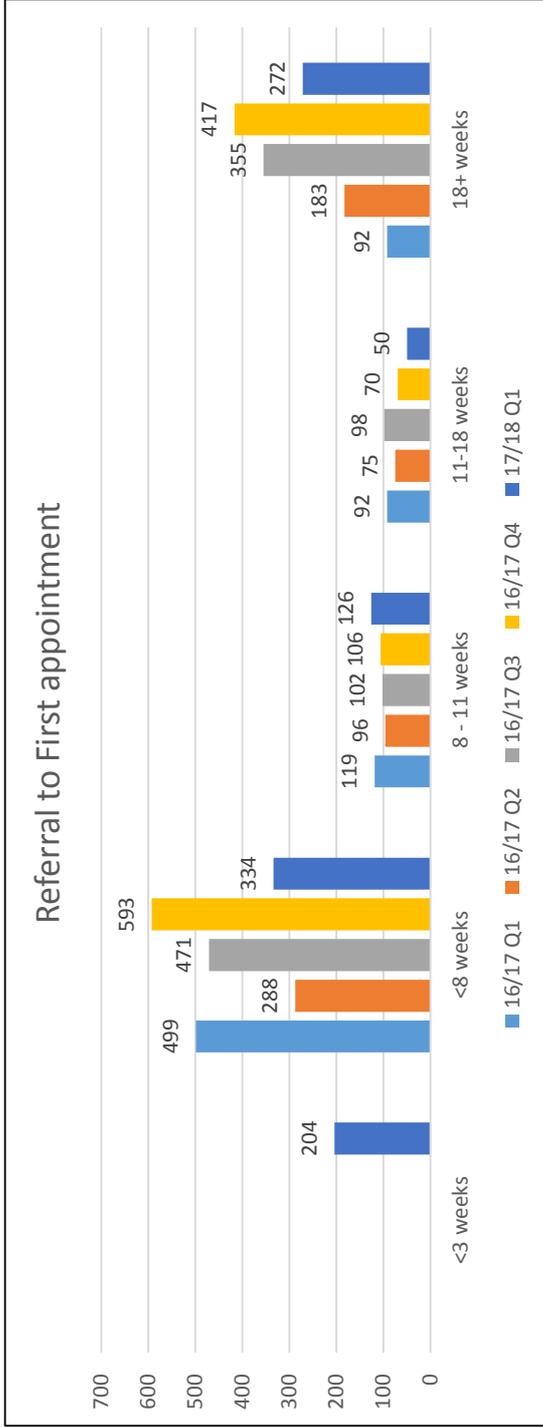
<b>% staff experiencing harassment / bullying last 12m</b>	
Trust 2016 Score	<b>24%</b>
Trust 2015 Score	19%
National MH Average 2016	<b>33%</b>
Best MH Score 2016	<b>24%</b>

<b>% staff witnessing potentially harmful errors / near misses or incidents in last month</b>	
Trust 2016 Score	<b>16%</b>
Trust 2015 Score	13%
National MH Average 2016	<b>27%</b>
Best MH Score 2016	<b>16%</b>

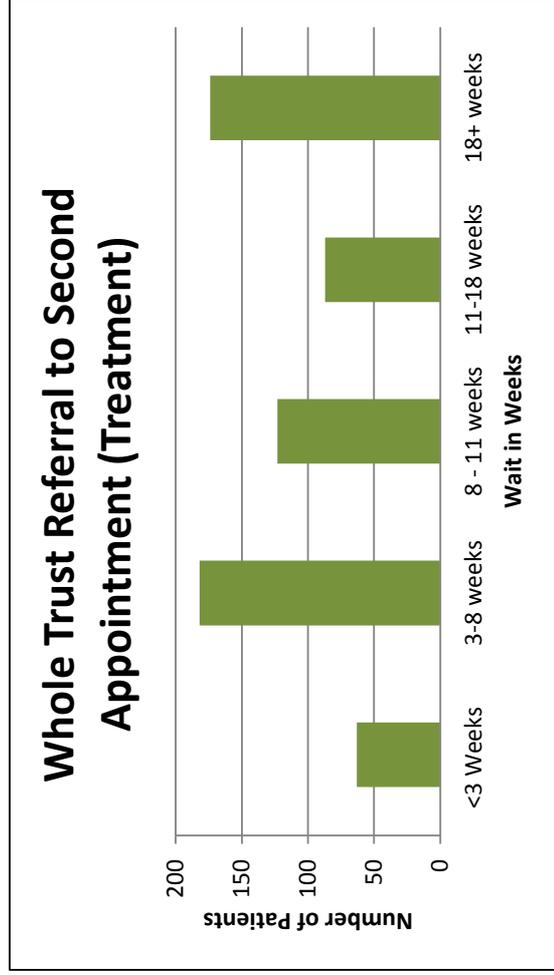
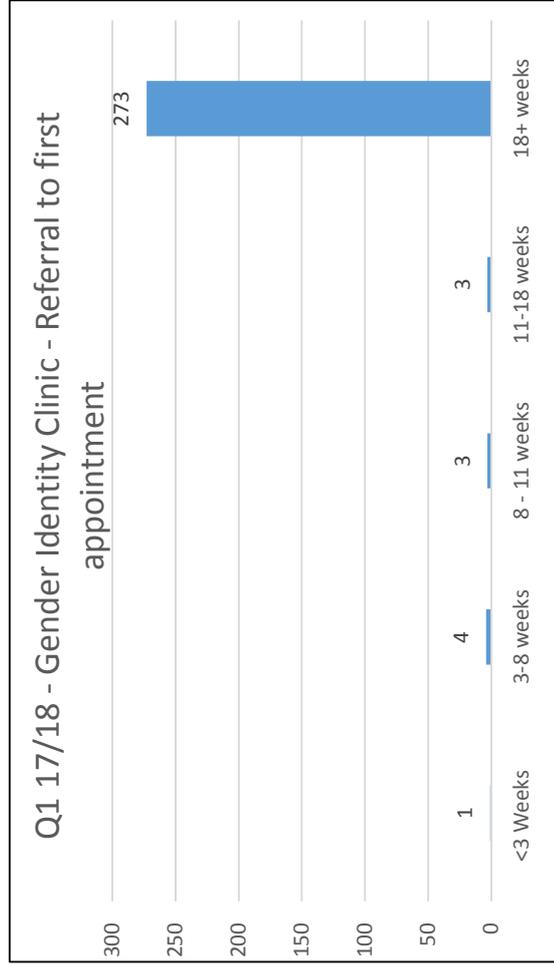
Q1 – 2017/18

<b>Serious Incident Investigations: reported to STEIS and the Information Commissioner Office (Q1 – 16/17)</b>	
GIC Suicide	
GID Suicide	
Corporate – Reopened IG Incident	
Confidential information leak (stolen Laptop with patient data (IG))	

### Quality – Responsive (waiting times)



Q1 2016/17 – 802 First Attendances
Q2 2016/17 – 642 First Attendances
Q3 2016/17 – 1026 First Attendances
Q4 2016/17 – 1186 First Attendances
Q1 2017/18 – 782 First Attendances

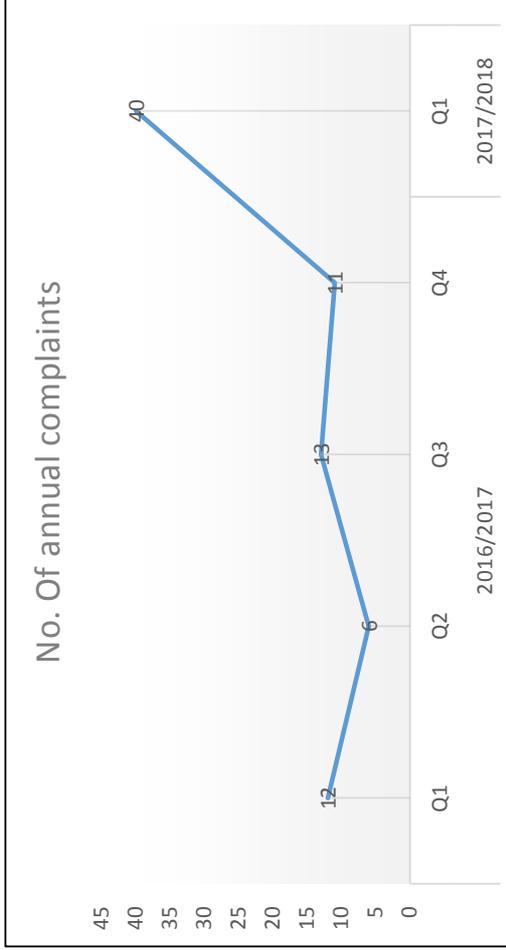


Q1 – 2017/18

### Quality - Responsive

	2016-17				2017/18
	Q1	Q2	Q3	Q4	Q1
Views and worries were taken seriously (Q4)	93%	93%	94%	94%	100%
Involved in important decisions about my care (Q13)	86%	87%	86%	86%	97%

### Quality – Effective:



Excludes DET complaints

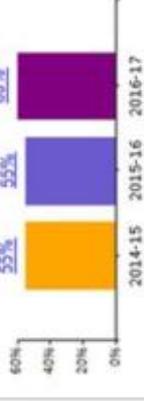
KPI	2016-17				2017/18	Target Value
	Q4	Q1	Q2	Q3	Q4	
DNA Rate	7.00%	9.10%	10.00%	8.60%	10.00%	10.00%
Patient Experience	78%	81%	81%	80%	80%	75%
Patient Satisfaction	93%	94%	93%	93%	93%	92%
	89%	91%	91%	91%	91%	80%

Q1 – 2017/18

**Quality –  
Effective:**

## Outcomes

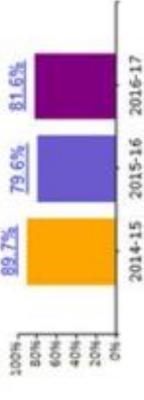
**Over 18s Outcome Improvement On Core OM Who Have Been Discharged And Have Attended >= 4 Appts**



- Q127 Positive Outcomes Out Of 49 Outcomes
- Q118 Positive Outcomes Out Of 33 Outcomes
- Q118 Positive Outcomes Out Of 30 Outcomes

Excluding Portman, TAP, City and Hackney and CYAF (apart from adolescent team).

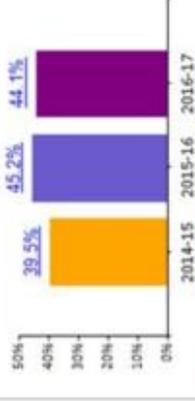
**Under 18s Outcome Improvement With >=2 Goals Who Have Been Discharged And Have Attended >= 4 Appts**



- Q178 Positive Outcomes Out Of 87 Outcomes
- Q174 Positive Outcomes Out Of 93 Outcomes
- Q193 Positive Outcomes Out Of 114 Outcomes

Excluding AYA, FDAC, YPDAS, First Step, Westminster, Mosaic, GIDS and Portman.

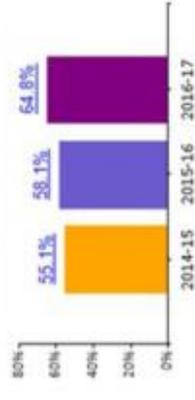
**Over 18s Core OM Data Collected**



- Q149 Collected Out Of 124 Discharged Patients
- Q133 Collected Out Of 73 Discharged Patients
- Q130 Collected Out Of 88 Discharged Patients

Excluding Portman, TAP, City and Hackney and CYAF (apart from adolescent team).

**Under 18s Core OM GBM Scores Collected**



- Q187 Collected Out Of 158 Discharged Patients
- Q193 Collected Out Of 160 Discharged Patients
- Q114 Collected Out Of 176 Discharged Patients

Excluding AYA, FDAC, YPDAS, First Step, Westminster, Mosaic, GIDS and Portman.

Q1 – 2017/18

## Directorate of Education and Training (DET)

Student Experience and Outcomes			
<b>Satisfaction:</b>			
<b>"Overall, I am satisfied with the quality of the course"</b>			
	<b>Benchmark</b>	<b>Tavistock</b>	
<b>2013/14</b>	88.3%	92.8%	
<b>2014/15</b>	87.0%	93.0%	
<b>2015/16</b>	83.0%	94.0%	
<b>2016/17</b>	86.0%	90.0%	
*excludes associate centres			
<b>Personal Development /Prepared:</b>			
<b>"I feel better prepared for my future career"</b>			
	<b>Benchmark</b>	<b>Tavistock</b>	
<b>2013/14</b>	72.4%	82.3%	
<b>2014/15</b>	77.9%	86.2%	
<b>2015/16</b>	81.0%	91.0%	
<b>2016/17</b>	82.0%	89.0%	
*excludes associate centres			
<b>Effectiveness</b>			
<b>"I have been able to apply my learning on the course to my job"</b>			
	<b>Benchmark</b>	<b>Tavistock</b>	
<b>2013/14</b>	80.3%	87.1%	
<b>2014/15</b>	77.0%	81.3%	
<b>2015/16</b>	78.0%	87.0%	
<b>2016/17</b>	87.0%	96.0%	
*excludes associate centres			

Awaiting results from recent survey - report in Q2 (September 2017)

Benchmark UK data: [www.hefce.ac.uk/lt/nss/results](http://www.hefce.ac.uk/lt/nss/results) (Summary UK) [2016]



Q1 – 2017/18

## Directorate of Education and Training (DET)

### CPD/CEDU

Based on full costs including internal training costs and library (not reflected in the ledger for J55103 as accounted for elsewhere within DET)

As at 30/06/2017

Year	13-14 FY	14-15 FY	15/16 FY	16/17FY Actual	17/18 FY predicted
Course numbers					
CPD/E-learning	45	58	70	94	91
Bespoke work	14	18	10	38	36
Conferences	18	18	16	4	4
Perinatal	n/a	n/a	n/a	2	
Students	2079	2738	2063	2279	1719
Income	501,917	556,261	493,090	692,710	596,758
Income growth on previous year	35%	16%	11%	40%	21%
Contribution	160,769	158,104	123,616	197,122	141301
Staffing	3	3	2	3.5	3.5

Only ran HCUK conferences for 16-17. Previous years included conferences delivered at Tavistock which have not been run this year.

including perinatal and HCUK but not including bespoke courses for 16-17

Excludes LCCPD. Includes deferred income in from 15-16 and out to 17-18



Q1 – 2017/18

## Single Oversight Framework

Segmentation under the Single Oversight Framework: **1** (the best of the four possible ratings, no identified support needs)

There are five themes under the Single Oversight Framework that NHS Improvement considers when assigning organisations to Trusts. Of these Finance and Use of Resources is covered in the monthly board papers. Our current status for the other four themes is:

Quality of Care: **Green**

Strategic change: **Green**

Leadership and Improvement Capability: **Green**

Operational Performance: **Amber**

	Target (%)	Month 1 (%)	Current / Future Target
Valid NHS number	99%	99.7%	Current
Valid Postcode	99%	99.8%	Current
Valid Date of Birth	99%	100%	Current
Valid Organisation code of Commissioner	99%	99.5%	Current
Valid Organisation code GP Practice	99%	99.1%	Current
Valid Gender	99%	100%	Current
Ethnicity	85%	74%	Current
Employment Status (for adults)	85%	54%	Current
Accommodation status (for adults)	85%	53%	Current
ICD10 coding	85%	NA	N/A



## Board of Directors: July 2017

**Item :** 13d

**Title :** Waiting Time Analysis by Team

**Purpose:**

The purpose of this report is to provide analysis and narrative commentary for waiting times by Team. The waiting time definition is from receipt of referral to first appointment. Data is presented on a quarterly basis in order to show whether the waiting time trajectory is improving or worsening. Actions taken to address identified issues are included.

This report has been reviewed by the following Committees:

- Executive Management Team

**This report focuses on the following areas:**

- Quality
- Patient / User Experience
- Patient / User Safety
- Risk
- Productivity

**For :** Discussion

**From :** Louise Lyon, Director of Clinical Quality and Patient Experience

Kerri Johnson-Walker, Data Quality Manager

## Waiting Times Analysis by Service

### 1. Introduction

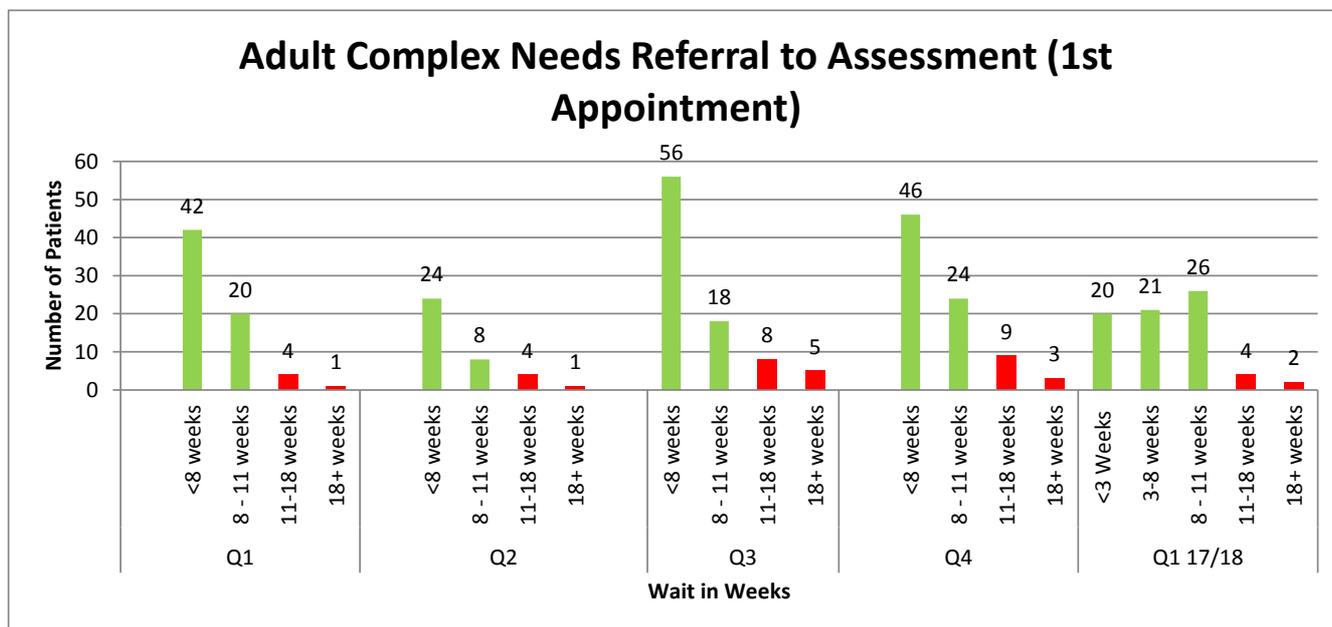
- 1.1 As requested by the October Board of Directors the following paper provides an analysis and narrative for waiting times by Team on a quarterly basis in order to show whether the waiting time trajectory is improving or worsening. Actions being taken to address identified issues are included. Data is provided for the period 1<sup>st</sup> April 2017 to the 30<sup>th</sup> June 2017.
- 1.2 The following services and the relevant referral to first appointment waiting time targets have been included:
  - 1.2.1 Adults = 11 weeks
  - 1.2.2 City and Hackney = 18 weeks
  - 1.2.3 Portman Clinic = 11 weeks
  - 1.2.4 Camden CAMHS = 8 weeks
  - 1.2.5 Other CAMHS = 8 weeks
  - 1.2.6 Adolescent = 8 weeks, 11 weeks for over 18s
  - 1.2.7 GIDS = 18 weeks
  - 1.2.8 GIC = 18 weeks
  - 1.2.9 Westminster = 6 weeks
- 1.3 This report shows the time to first attended appointment from referral received and subsequently, as asked by the commissioners, referral to second attended appointment (defined by the Commissioning group as a 'treatment' appointment). Please note although the targets above apply to referral to first appointment there are no targets for Referral to Treatment (2<sup>nd</sup> appointment).
- 1.4 Service Leads and Team Administrators have provided commentary on where these are not well met and what action plans are in place to improve waiting times and meet the target.
- 1.5 Please note First Step and Gloucester House School have been excluded from the analysis.

## 2. Summary

- 2.1 Appendix 1 shows the number of patients that have been seen in the quarter and how long they waited at a team level. The numbers in green indicate the number of people within their targeted waiting time and those in red have not met the target waiting time.
- 2.2 Appendix 2 shows the number of patients that have been seen for a second time (treatment appointment) in the quarter and how long they waited at a team level. There are no specific targets this is a monitoring exercise.
- 2.3 Adult teams: Overall Adult Complex Needs Service has improved their waiting times. Their breaches are well under the 10% Trust target, which had been exceeded in Q4 2016/17. City and Hackney have reduced their breaches a significant amount whilst also keeping their RTT (Referral to Treatment) waiting times low. Portman have seen less people in Q1 2017/18 however only 1 person has breached the target waiting times of 11 weeks.
- 2.4 Other CAMHS, GIDS (Gender Identity Service, under 18), GIC (Gender Identity Clinics, over 18s) and Westminster FAS Family Assessment Team all report higher breach percentages than the trust target of 10%.
- 2.5 Camden CAMHS has performed consistently well throughout 2016/17 which has continued in to Q1 of 2017/18, with such a high volume of patients.
- 2.6 A visual presentation of RTT (Referral to Treatment) waiting times has also been included in this year report, as this is something the commissioners now request from us. Please note that GIC has been excluded from this analysis because of the nature of their service only providing assessment for ongoing treatment. With this taken in to consideration only GIDS have a large proportion of patients waiting over 18 weeks for their second appointment (defined as treatment)

### 3. Detailed analysis and commentary

#### 3.1 Adult Complex Needs (All Teams included in analysis)

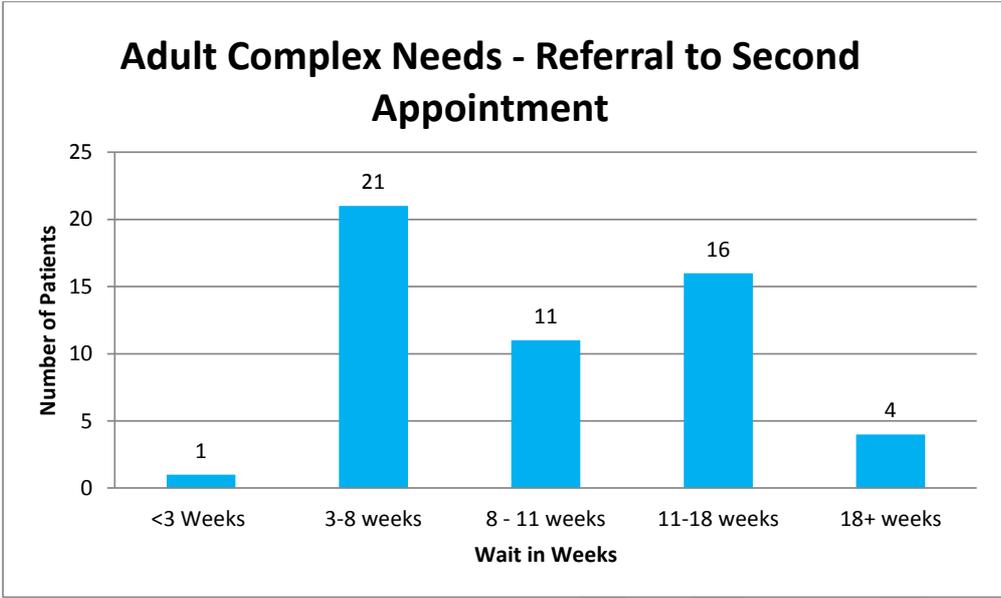


Number of new patients seen in Quarter 1 is 109, which has increased again since Q4 2016/17. 5.5% of patients breached the 11 week waiting times target, which is comparable to 14.6% seen in Quarter 4.

Total open referrals waiting at the end of quarter: 73

The performance against waiting time targets has improved and there has been an increase in patients seen for Q1. This has been made possible by a number of staff changes, including the arrival of new medical trainees and appointment of new junior staff replacing staff at the end of their training. In addition a number of honorary staff have been appointed which increase capacity in the Trauma/Fitzjohns/Couples Units. The waiting time for long term treatments however is increasing. The situation in the Fitzjohns and Trauma Units is acute for these treatments. Also there may be a dip in the summer period whilst waiting for the new trainees to start their courses in the autumn.

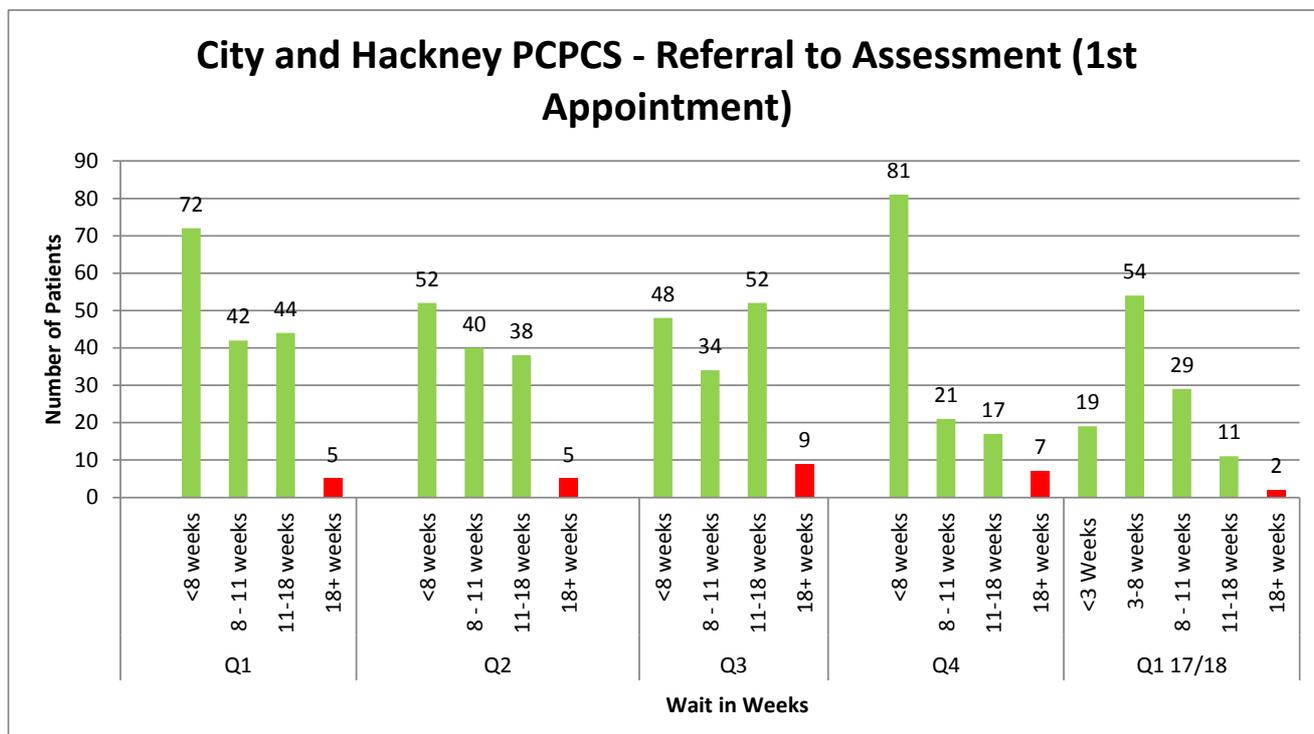
*Michael Mercer, Head of Adult Complex Needs*



92.5% were seen with in the national RTT (Referral to treatment) target of 18 weeks.

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### 3.2 City and Hackney Service (PCPCS)



The waiting time target for City and Hackney is 18 weeks with 98.3% meeting this target in Q1. In the Quarter 1 City and Hackney saw 115 patients from the waiting list, only 1.7% of the patients breached the 18 week target.

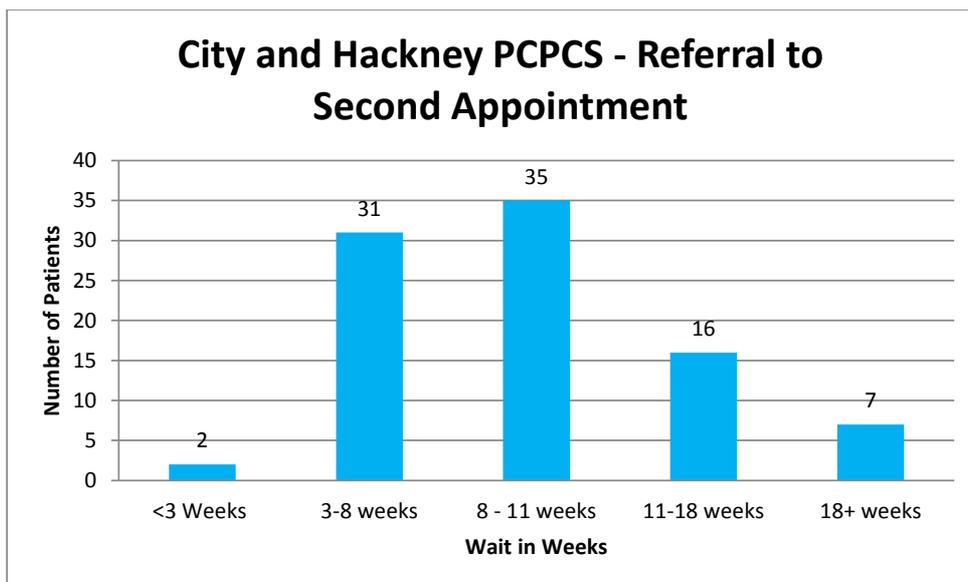
**Total open referrals waiting at the end of quarter: 48**

We are pleased with the improvements which are due to a cluster of factors;

- PCPCS has re-defined our referral criteria to GP only referral of MUS and Frequent attenders. This has effectively restricted the cohort of patients. NB We previously had up to 35 different agencies referring all sorts of complex, multi-morbid & high risk patients.
- Intake systems and staff are more attuned to rejecting and signposting inappropriate referrals – i.e. we are less porous at intake. This has disadvantages for the population as no other services locally offer similar treatments in primary care.

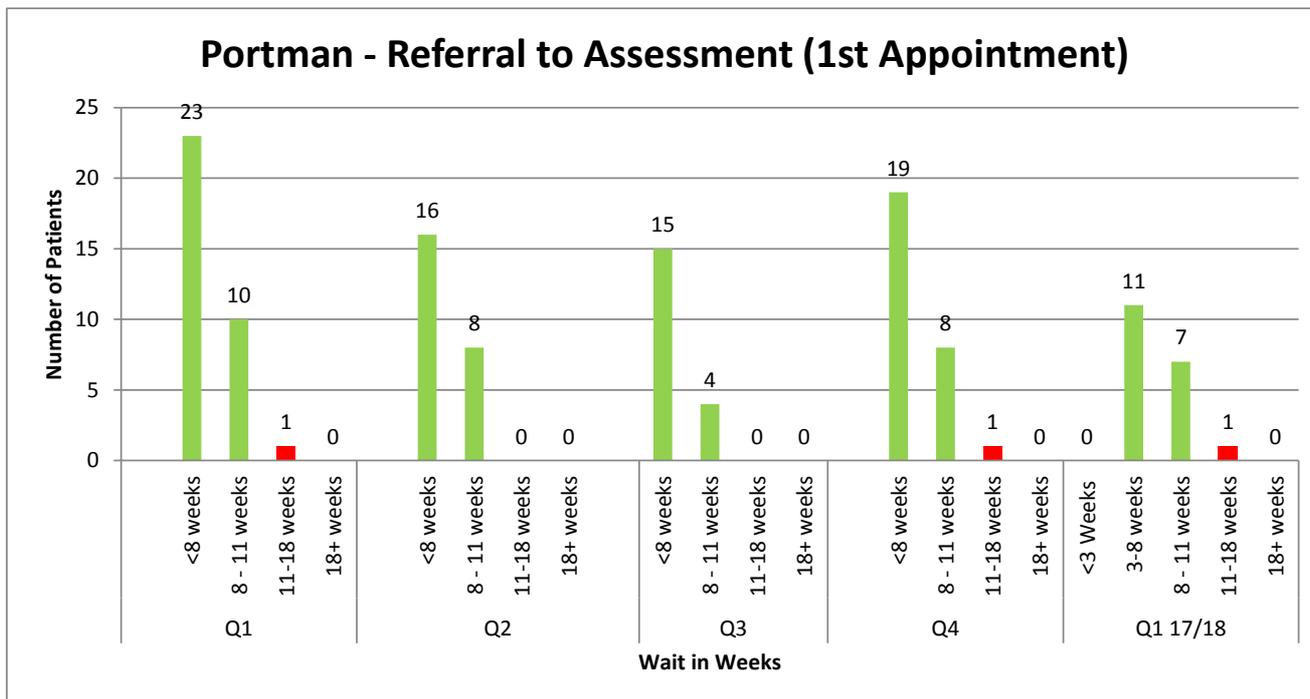
- Over the quarter our referral numbers have been gradually dropping to more realistic levels BUT this is also more typical of this time of year (historically) so we are not yet ready to think of this as a new trend quite yet.
- Looking forward we have two new trainees coming in October, one new staff member (will be fully staffed) and hopefully one or more honorary therapists (boosts capacity moderately.)

*Tim Kent, Service Manager at City and Hackney PCPCS*



92.4% of patients were seen with in the national RTT (Referral to treatment) target of 18 weeks.

### 3.3 Portman Clinic



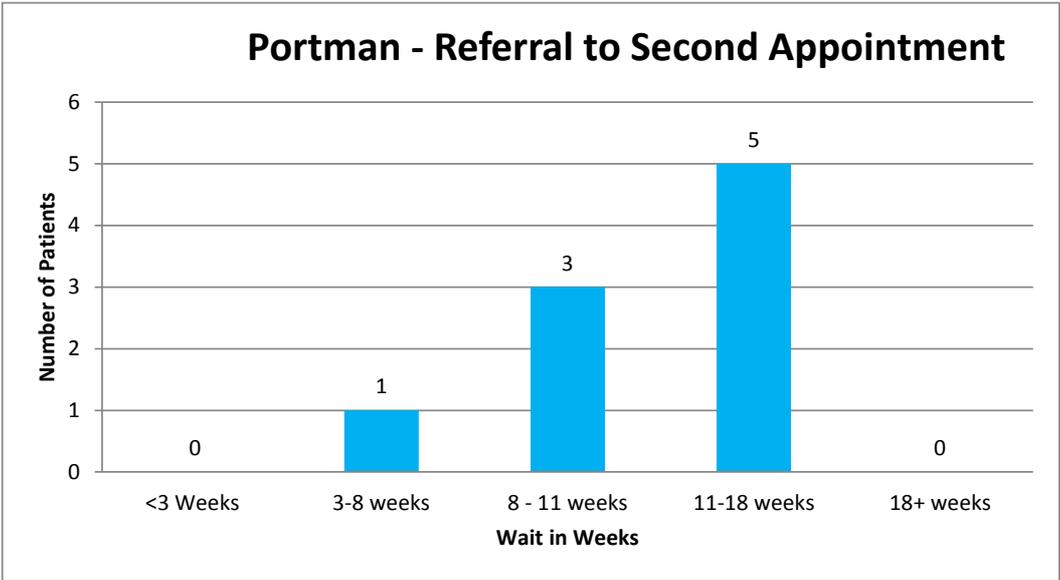
The waiting time target for Portman is 11 weeks with 94.7% meeting this target in Q1, which is a pleasing figure. Portman have only breached on 1 patient in this quarter.

**Total open referrals waiting at the end of quarter: 9**

‘These are well within the waiting time limit (or actually much lower), so I don’t think there is anything to be concerned about, and presently no action needed. There is no evidence that our times are increasing, being steady around 5–6 weeks. What was recorded as a breach was an appointment that was offered well within the 11 weeks deadline but the patient DNAd and failed to respond to a subsequent offer of another appointment. The clinician closed the case, but had not passed the file to administrators for closure on CareNotes. So this was no a breach.

We have a lot of contact with referrers on the telephone to facilitate the referral process, and are flexible in our approach with patients in offering them days and times that are most convenient for them.’

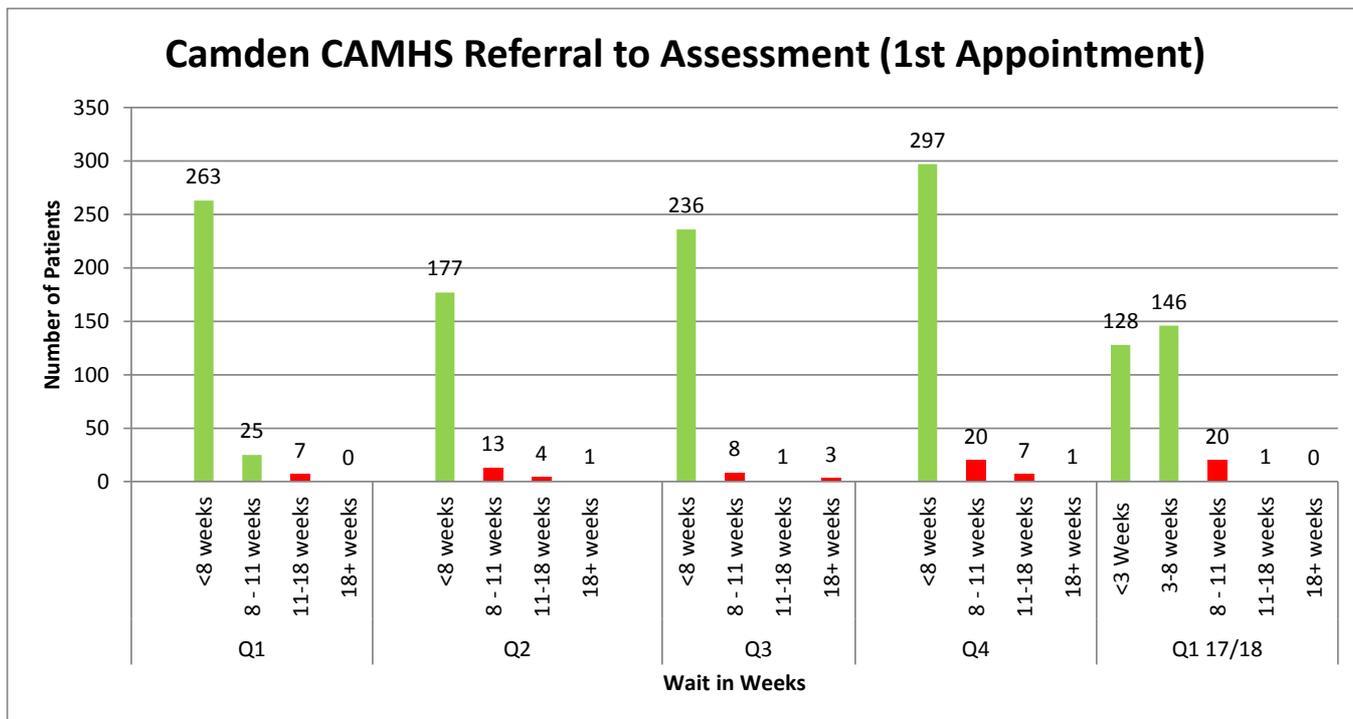
Jessica Yakeley, Director of the Portman Clinic'



100% of patients were seen with in the national RTT (Referral to treatment) target of 18 weeks.

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### 3.4 CYAF (Camden CAMHS – All Teams Selected)

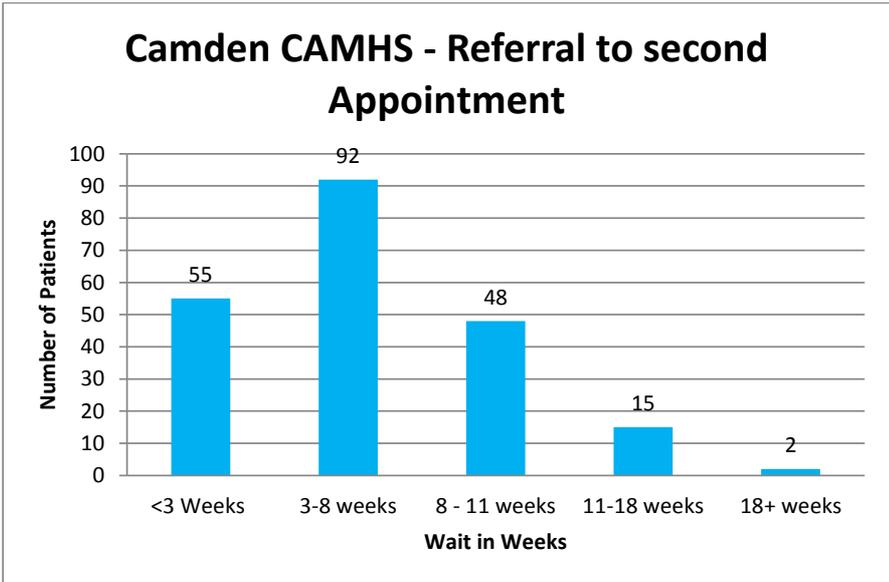


The waiting time target for Camden is 8 weeks with 92.8% meeting this target in Q1, a slight improvement on previous quarters waiting times.

Total open referrals waiting at the end of quarter: 93

‘We are pleased that our waiting times continue to be low and in line with the CAMHS transformation expectations. Our clinicians are based in community settings such as schools and GP practices which improves both accessibility and response time.’

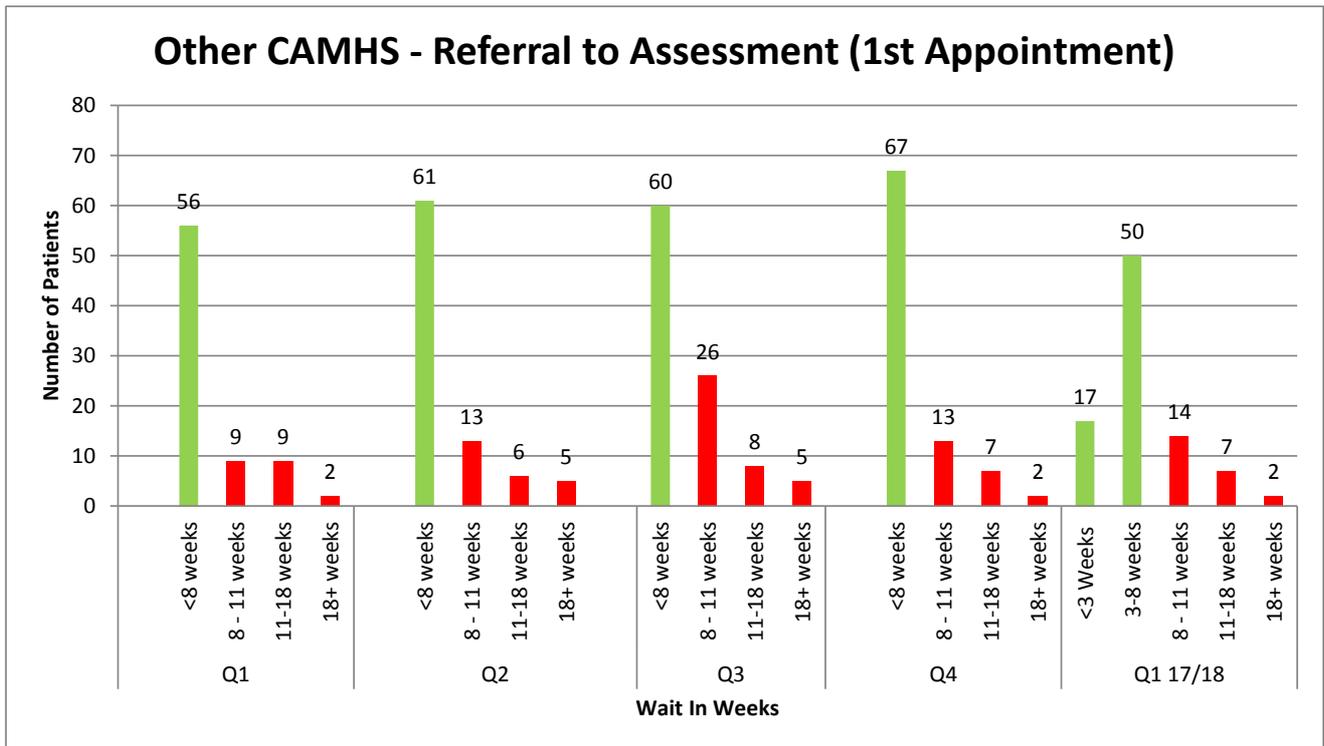
*Sally Hodges, Director of CYAF*



99.1% of patients were seen with in the national RTT (Referral to treatment) target of 18 weeks.

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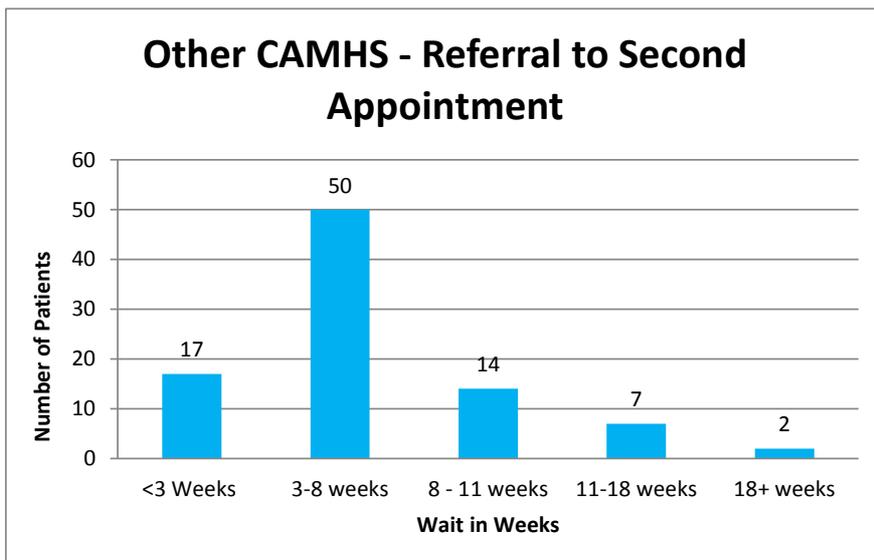
3.5 CYAF (Other CAMHS – First Step excluded from analysis)



The waiting time target for Other CAMHS is 8 weeks with 75.0% meeting this target in Q1.

Total open referrals waiting at the end of quarter: 92, (Over double of the previous quarter)

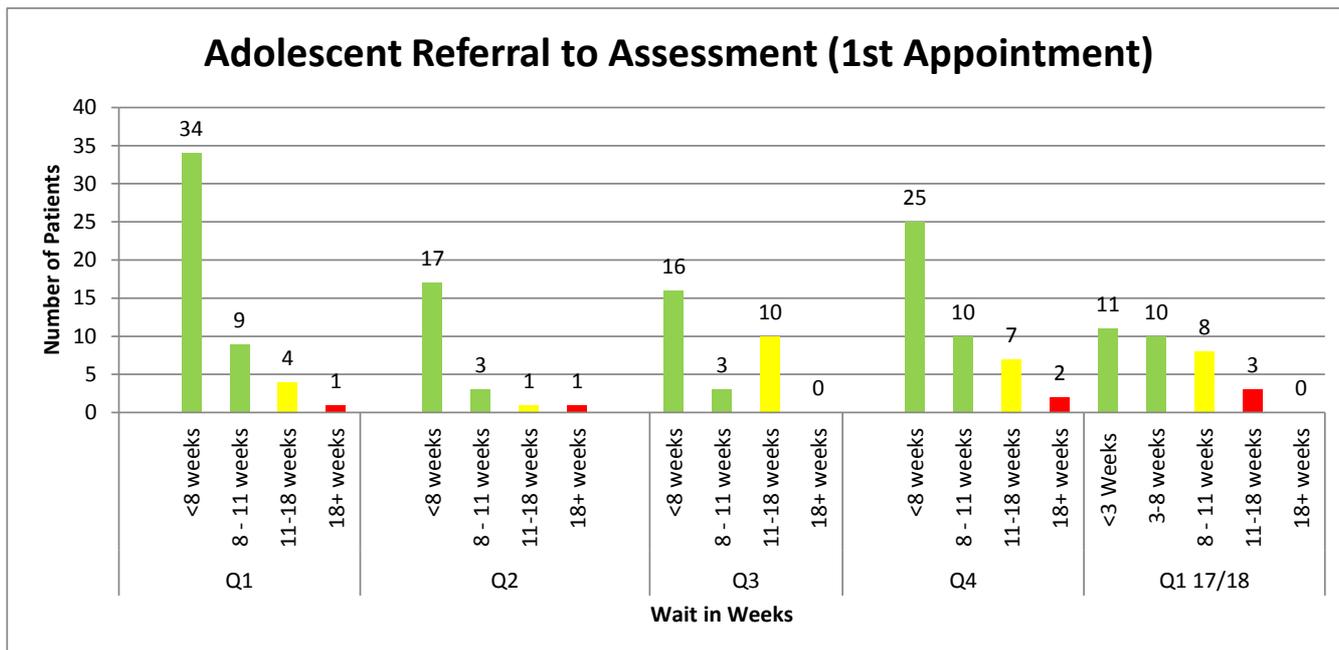
**Awaiting Rachel James**



97.8% of patients were seen with in the national RTT (Referral to treatment) target of 18 weeks

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### 3.6 Adolescent Service

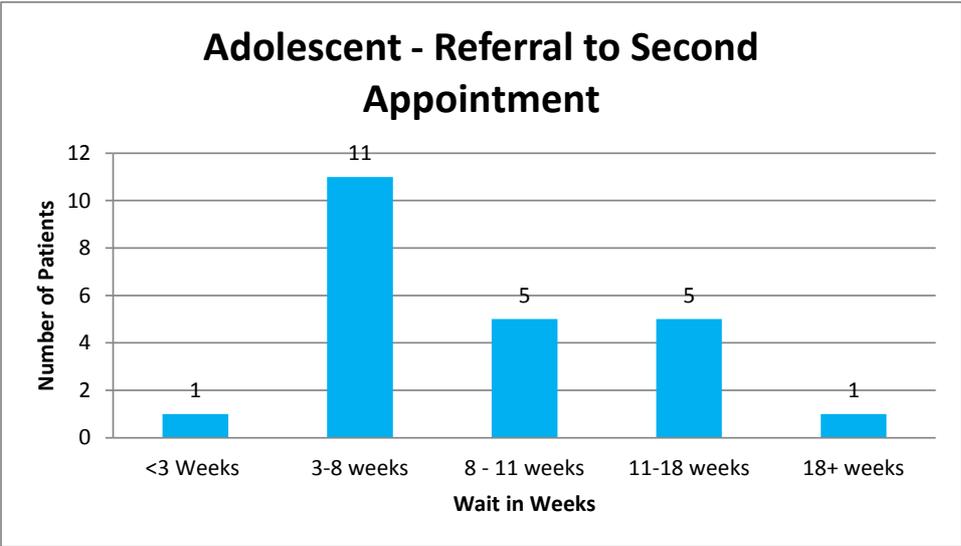


The waiting time target for Adolescent is 8 weeks for those under 18 and 11 weeks for those over 18. With this taken in to consideration 84.4% of patients were seen with in these targets. This is a vast improvement on Q4 data where only 77.3% of patients were seen with in target times.

Total open referrals waiting at the end of quarter: 13

‘The specialised resources required for often complex patients seen in this service are scarce and there have been some staffing reductions. However, as a Service we endeavour to keep waiting times as short as possible for patients and so pleased that there has been an improvement in the waiting times this Quarter.’

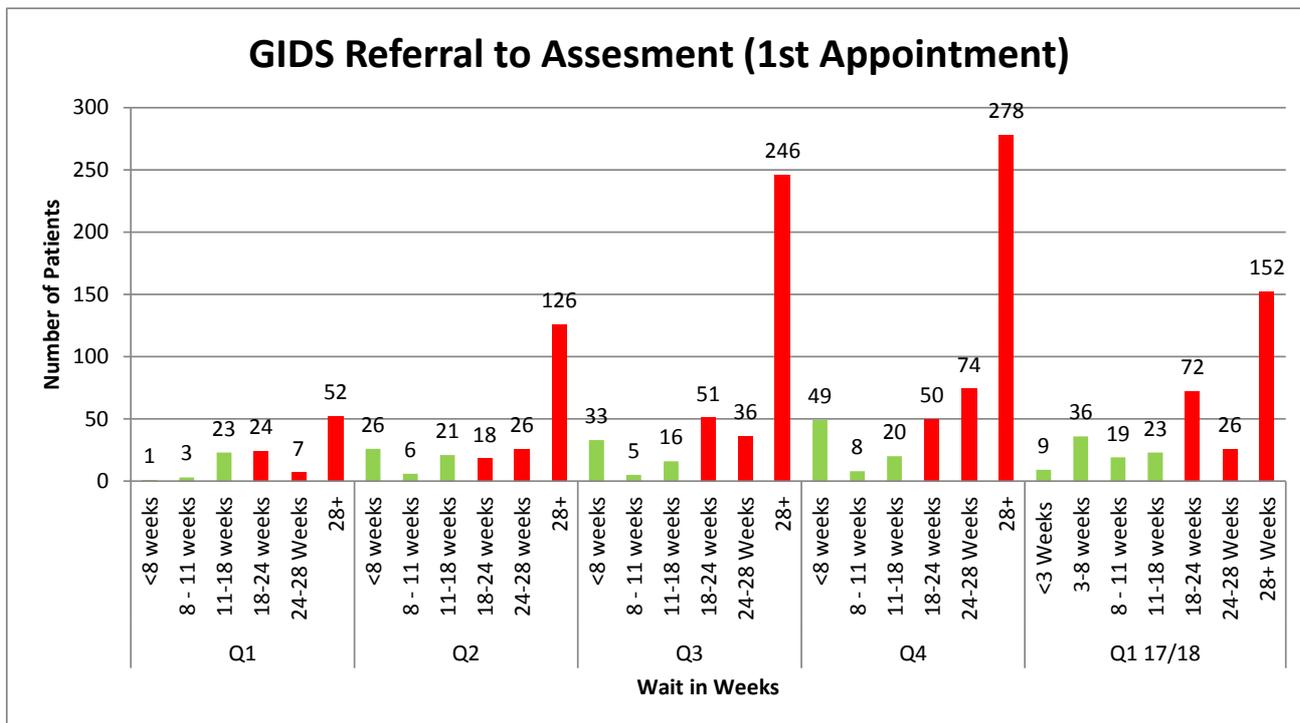
*Justine McCarthy Woods, Service Lead, Adolescent and Young Adult Service*



95.7% of patients were seen with in the national RTT (Referral to treatment) target of 18 weeks.

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### 3.7 Gender Identity Development Service



The number of patients seen in Q1 has fallen by 148 when compared to Q4 of the last financial year. There were 1002 patients waiting at the end of Q3, compared to the improved figure in Q4, 803. Those waiting at the end of quarter has also risen from 803 to 921.

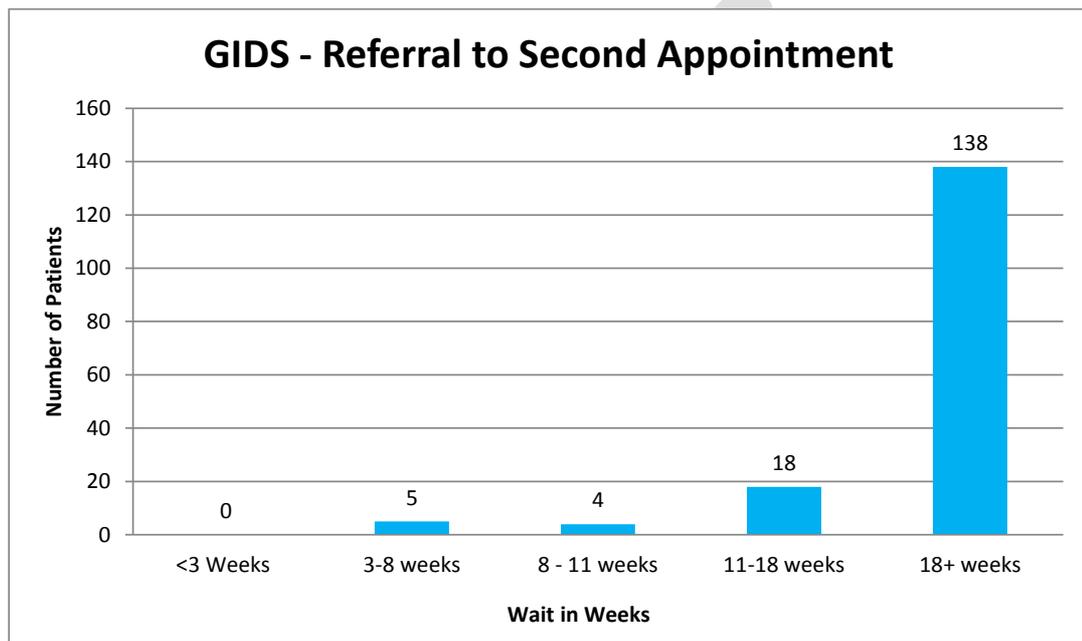
25.8% of patients were seen with in the 18 week target time for GIDS.

**Total open referrals waiting at the end of quarter: 923**

The waiting times have reduced over the last 2 quarters, however they are currently remaining at around 26 weeks. This is due to the increase in referrals again, above those that were modelled with NHS England. There had been an assumption of 125 referrals a month, but this is now averaging 200 per month. We are working closely with our commissioners to manage this and their expectations and they have been told we are looking at another year before we can reach the 18 week target. They are aware this is due to the increase in referrals again and the restraints on staff training and space. We are addressing this with another round of recruitment. There are a number of projects underway which have been developed to improve access to the service

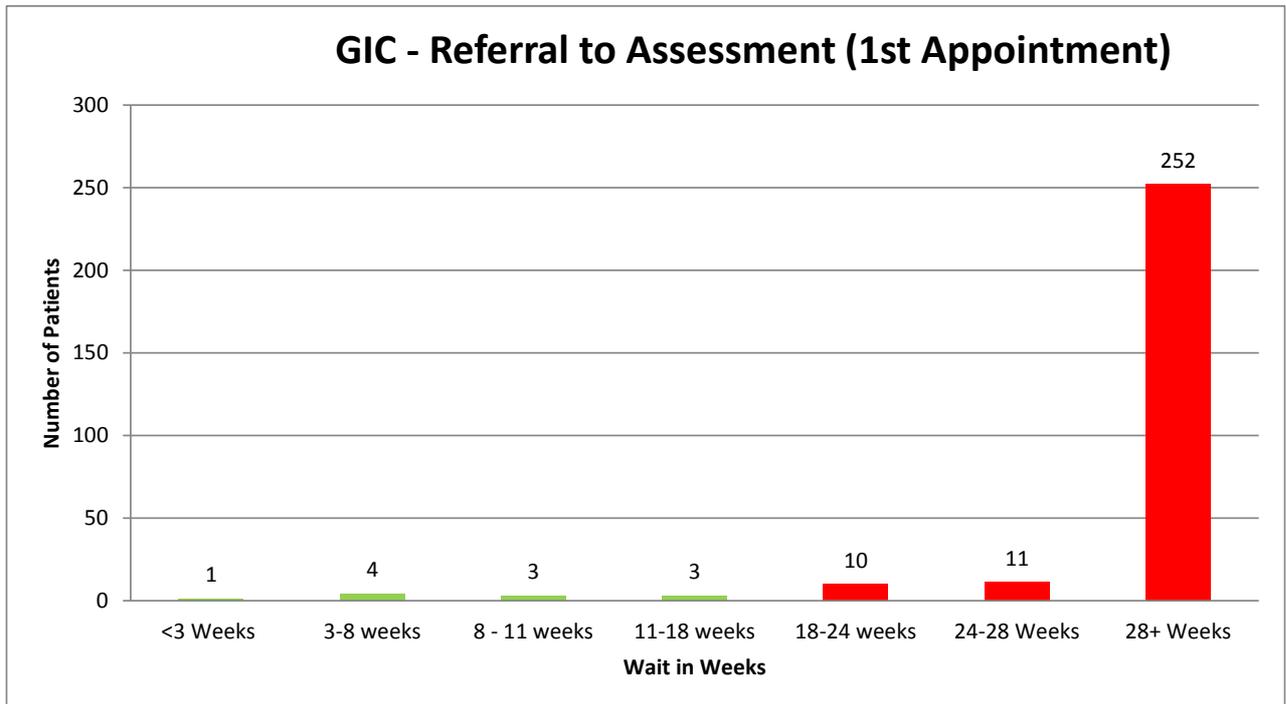
and will potentially have a positive impact on the waiting list. Projects include more outreach clinics, assessment clinics, group first appointments for carefully selected young people and telemedicine. In addition we are working closely with Charing Cross adult GIC to improve transfer from the GIDS to the adult GIC. Timely transfer of young people to adult services would reduce staff caseloads, which in turn creates space for new referrals to be picked up.

*Polly Carmichael, Director of GIDS*



**16.4% of patients were seen with in the national RTT (Referral to treatment) target of 18 weeks.**

### 3.8 Gender Identity Clinic (GIC)



The waiting time target GIC is 18 weeks with 3.9% meeting this target in Q1. This is a new service with a huge number of referrals.

**Total Waiting at the end of Quarter: 1123**

‘Due to the large numbers of patients and the rising number of referrals, the GIC waiting times for first appointment are currently around 12 months. This is the same waiting time that the GIC had when they were with their previous provider. We are in constant contact with NHS England about these difficulties in hopes that together we will be able to find a solution.

It is worth noting that the GIC currently have 6181 open cases which are being supported by 18 clinicians and 27 administrators.

This compared to the remained of CYAF including GIDS which has 6066 open cases in total.

Some of the ways we are working to improve the current situation is:

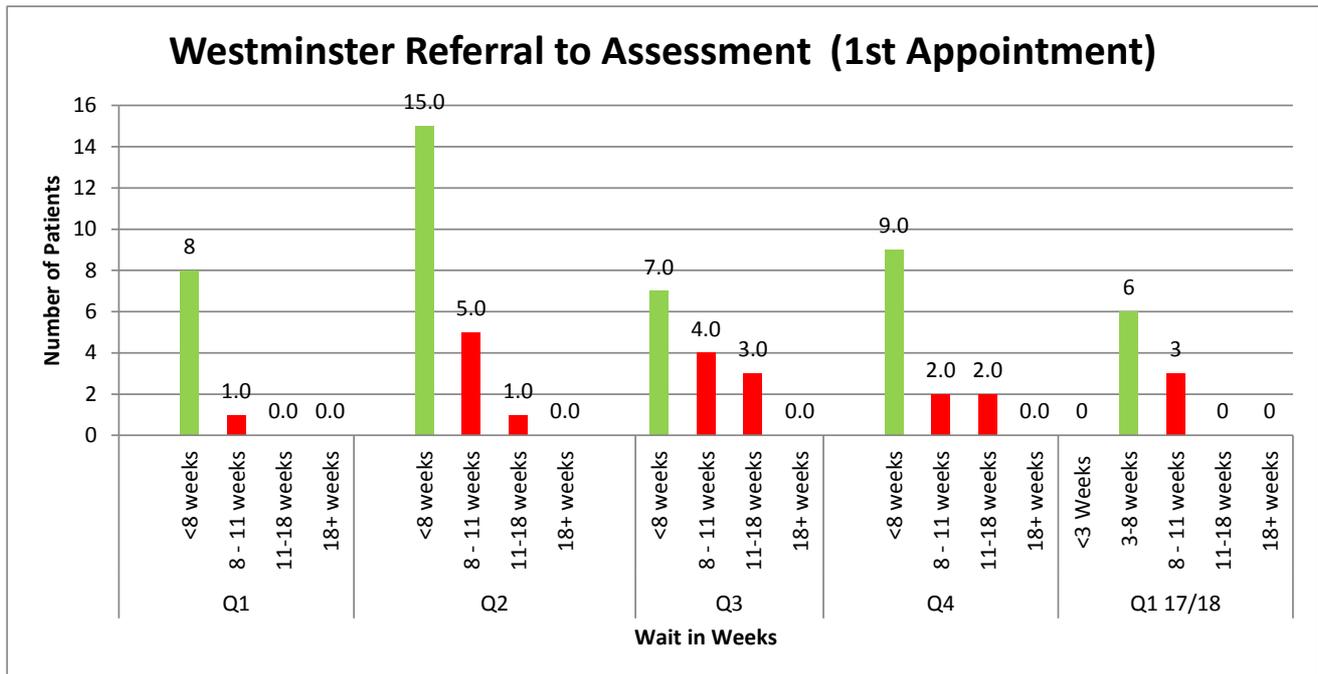
- 1) Introducing a system of 'pooling' appointments instead of patients waiting to see particular Doctors which can cause unnecessary delays.
- 2) Better communication with those on the waiting list to help contain anxiety
- 3) Working with the newly trained clinicians to ensure their diaries are accessible for patients as soon as their training is complete.'

*Frances Endres, Acting Service Manager for GIC*

**Due to the nature of the service it would not be helpful to measure Referral to treatment as this service does not provide treatment to man of their patients. 100% of patients were seen at a second appointment after the national RTT target of 18 weeks.**

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### 3.9 Westminster Service



The waiting time target for FAS is 8 weeks with 66.6% meeting this target in Q1, identical to that in Q4.

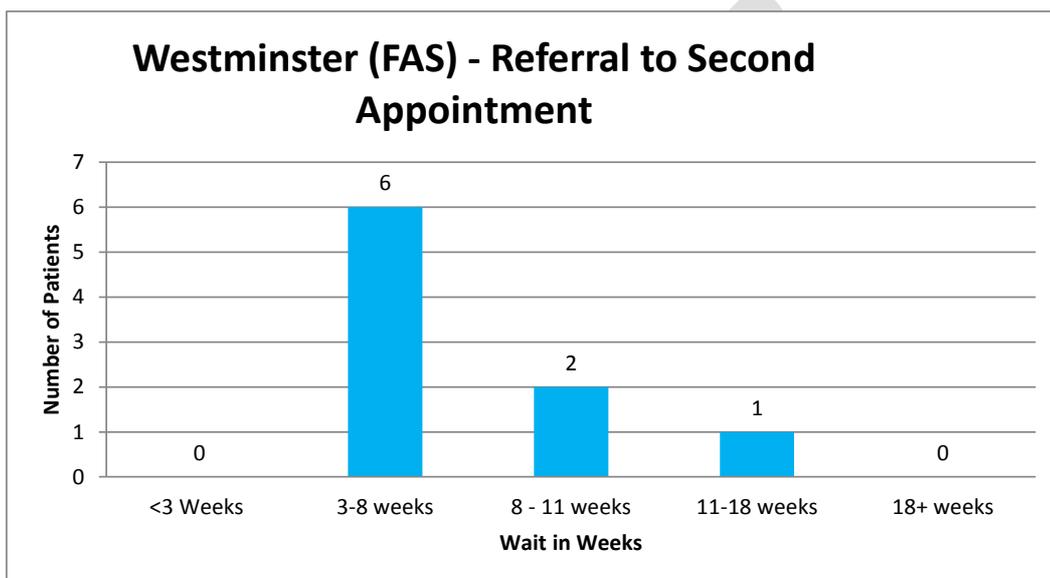
#### Number waiting at the end of the quarter: 9

‘Waiting times at Westminster are a complex picture and the variables are not all within our control. Cases can wait if the statutory social worker in the local authority (Westminster or Hammersmith & Fulham) doesn’t supply all the required information at the point of referral. We have this clearly listed in our referral processes but this is not always adhered to by the local authority. We have an unusually high number of referrals in the last three quarters which exceeds our capacity and also exceeds targets for the year. This has means cases have had to wait for clinicians to become available to carry out the work. Since we are a multi-disciplinary team, some of the referrals state the need for adult or child psychiatric input. This usually has to be explored further by the service prior to allocating this very limited resource in the team. For example the child psychiatrist works half a day per week and if they are named as specifically required in too many assessments at any one time, this will alter the

time the case has to wait before being assessed. This is done in consultation with the referrer.

We are in on-going discussions with the commissioners and referring teams to devise solutions to these issues, including better referral gatekeeping by the service leads in the children’s services. However, the waiting times are largely a result of increased use of the service by the local authority, beyond the targets for which we were commissioned.’

*Steve Bambrough, Associate Clinical Director of Westminster FAS*



100% of Patients were seen with in the national RTT (Referral to Treatment) target of 18 weeks.

**Kerri Johnson-Walker**, Data Quality Manager  
11<sup>th</sup> July 2017

### Appendix 1. Referral to First Appointment

		Q1					
		<3 Weeks	3-8 weeks	8 - 11 wee	11-18 wee	18+ weeks	
Adolescents (Under 18s)	ADOLESCENT Camden Team	Number Pts Referral to First Appointment	0	4	4	2	0
		%	0.0%	40.0%	40.0%	20.0%	0.0%
	ADOLESCENT Central and East Team	Number Pts Referral to First Appointment	0	2	2	0	0
		%	0.0%	50.0%	50.0%	0.0%	0.0%
	ADOLESCENT Family Therapy	Number Pts Referral to First Appointment	0	2	0	0	0
		%	0.0%	100.0%	0.0%	0.0%	0.0%
	ADOLESCENT North and West Team	Number Pts Referral to First Appointment	2	0	2	1	0
		%	40.0%	0.0%	40.0%	20.0%	0.0%
	ADOLESCENT Parents Consultation Service	Number Pts Referral to First Appointment	2	0	0	0	0
		%	100.0%	0.0%	0.0%	0.0%	0.0%
ADOLESCENT Trauma Unit	Number Pts Referral to First Appointment	0	0	0	0	0	
	%	0.0%	0.0%	0.0%	0.0%	0.0%	
ADOLESCENT YPCS	Number Pts Referral to First Appointment	7	2	0	0	0	
	%	77.8%	22.2%	0.0%	0.0%	0.0%	
<b>Total</b>		11	10	8	3	0	
		34.4%	31.3%	25.0%	9.4%	0.0%	
GIC	Adult Gender Identity Clinic	Number Pts Referral to First Appointment	1	4	3	3	273
		%	0.4%	1.4%	1.1%	1.1%	96.1%

Adults	ADULTS Belsize	Number Pts Referral to First Appointment	2	8	7	0	0
		%	11.8%	47.1%	41.2%	0.0%	0.0%
	ADULTS Couple Waiting Team	Number Pts Referral to First Appointment	0	0	0	0	0
		%	0.0%	0.0%	0.0%	0.0%	0.0%
	ADULTS Couples Unit	Number Pts Referral to First Appointment	1	1	4	2	0
		%	12.5%	12.5%	50.0%	25.0%	0.0%
	ADULTS Fitzjohn	Number Pts Referral to First Appointment	3	2	3	0	0
		%	37.5%	25.0%	37.5%	0.0%	0.0%
	ADULTS Fitzjohn Waiting	Number Pts Referral to First Appointment	0	0	0	0	1
		%	0.0%	0.0%	0.0%	0.0%	100.0%
	ADULTS Group Waiting Team	Number Pts Referral to First Appointment	0	0	1	0	0
		%	0.0%	0.0%	100.0%	0.0%	0.0%
	ADULTS Hemel Team	Number Pts Referral to First Appointment	0	0	0	0	0
		%	0.0%	0.0%	0.0%	0.0%	0.0%
	ADULTS Individual Intensive Waiting Team	Number Pts Referral to First Appointment	0	0	1	0	0
		%	0.0%	0.0%	100.0%	0.0%	0.0%
	ADULTS Individual Once Week Waiting Team	Number Pts Referral to First Appointment	1	4	4	0	0
		%	11.1%	44.4%	44.4%	0.0%	0.0%
	ADULTS Lyndhurst	Number Pts Referral to First Appointment	6	6	5	2	1
		%	30.0%	30.0%	25.0%	10.0%	5.0%
ADULTS Maresfield	Number Pts Referral to First Appointment	1	0	0	0	0	
	%	100.0%	0.0%	0.0%	0.0%	0.0%	
ADULTS Trauma Unit	Number Pts Referral to First Appointment	4	0	1	0	0	
	%	80.0%	0.0%	20.0%	0.0%	0.0%	
ADULTS Watford	Number Pts Referral to First Appointment	2	0	0	0	0	
	%	100.0%	0.0%	0.0%	0.0%	0.0%	
<b>Total</b>			20	21	26	4	2
			27.4%	28.8%	35.6%	5.5%	2.7%

Camden CAMHS	Camden Adolescent Intensive Support Service	Number Pts Referral to First Appointment	21	1	0	0	0
		%	95.5%	4.5%	0.0%	0.0%	0.0%
	Camden CAMHS Intake	Number Pts Referral to First Appointment	10	0	0	0	0
		%	100.0%	0.0%	0.0%	0.0%	0.0%
	CAMHS LAC	Number Pts Referral to First Appointment	6	4	0	0	0
		%	60.0%	40.0%	0.0%	0.0%	0.0%
	Complex Assessment	Number Pts Referral to First Appointment	0	0	1	0	0
		%	0.0%	0.0%	100.0%	0.0%	0.0%
	Complex Needs Outreach	Number Pts Referral to First Appointment	0	0	0	0	0
		%	0.0%	0.0%	0.0%	0.0%	0.0%
	NORTH Primary Care	Number Pts Referral to First Appointment	1	2	0	0	0
		%	33.3%	66.7%	0.0%	0.0%	0.0%
	NORTH Primary School Service	Number Pts Referral to First Appointment	5	1	0	0	0
		%	83.3%	16.7%	0.0%	0.0%	0.0%
	NORTH Secondary School	Number Pts Referral to First Appointment	7	3	0	0	0
		%	70.0%	30.0%	0.0%	0.0%	0.0%
	NORTH Service	Number Pts Referral to First Appointment	26	42	4	0	0
		%	36.1%	58.3%	5.6%	0.0%	0.0%
	Refugee Service	Number Pts Referral to First Appointment	1	10	1	0	0
		%	8.3%	83.3%	8.3%	0.0%	0.0%
SOUTH Primary Care	Number Pts Referral to First Appointment	2	2	1	0	0	
	%	40.0%	40.0%	20.0%	0.0%	0.0%	
SOUTH Primary School Service	Number Pts Referral to First Appointment	2	3	1	0	0	
	%	33.3%	50.0%	16.7%	0.0%	0.0%	
SOUTH Secondary School	Number Pts Referral to First Appointment	1	6	0	0	0	
	%	14.3%	85.7%	0.0%	0.0%	0.0%	
SOUTH Service	Number Pts Referral to First Appointment	17	29	8	0	0	
	%	31.5%	53.7%	14.8%	0.0%	0.0%	

TOPS	Number Pts Referral to First Appointment	0	1	0	0	0
	%	0.0%	100.0%	0.0%	0.0%	0.0%
WFPerinatal - Camden	Number Pts Referral to First Appointment	1	2	0	0	0
	%	33.3%	66.7%	0.0%	0.0%	0.0%
WF Perinatal - Euston	Number Pts Referral to First Appointment	5	6	0	0	0
	%	45.5%	54.5%	0.0%	0.0%	0.0%
WF Perinatal - Kentish Town East	Number Pts Referral to First Appointment	1	1	0	0	0
	%	50.0%	50.0%	0.0%	0.0%	0.0%
WF Perinatal - Kentish Town West	Number Pts Referral to First Appointment	1	8	0	0	0
	%	11.1%	88.9%	0.0%	0.0%	0.0%
WF Perinatal - Kilburn	Number Pts Referral to First Appointment	3	6	0	0	0
	%	33.3%	66.7%	0.0%	0.0%	0.0%
WF Perinatal - Kings Cross and Holborn	Number Pts Referral to First Appointment	1	1	0	0	0
	%	50.0%	50.0%	0.0%	0.0%	0.0%
WF Perinatal - YPS	Number Pts Referral to First Appointment	1	2	1	0	0
	%	25.0%	50.0%	25.0%	0.0%	0.0%
Whole Family	Number Pts Referral to First Appointment	16	16	3	1	0
	%	44.4%	44.4%	8.3%	2.8%	0.0%
YPS	Number Pts Referral to First Appointment	0	0	0	0	0
	%	0.0%	0.0%	0.0%	0.0%	0.0%
<b>Total</b>		128	146	20	1	0
		43.39%	49.49%	6.78%	0.34%	0.00%

City and Hackney	CHPC Community Project Team	Number Pts Referral to First Appointment	0	0	0	0	0
		%	0.0%	0.0%	0.0%	0.0%	0.0%
	CHPC Waiting Team	Number Pts Referral to First Appointment	0	0	0	0	0
		%	0.0%	0.0%	0.0%	0.0%	0.0%
	CHPC A	Number Pts Referral to First Appointment	19	54	29	11	2
		%	16.5%	47.0%	25.2%	9.6%	1.7%
	CHPC B	Number Pts Referral to First Appointment	0	0	0	0	0
		%	0.0%	0.0%	0.0%	0.0%	0.0%
	CHPC C	Number Pts Referral to First Appointment	0	0	0	0	0
		%	0.0%	0.0%	0.0%	0.0%	0.0%
	TCPS Care Planning Team	Number Pts Referral to First Appointment	0	0	0	0	0
		%	0.0%	0.0%	0.0%	0.0%	0.0%
	<b>Total</b>		19	54	29	11	2
			16.5%	47.0%	25.2%	9.6%	1.7%

Other CAMHS	Child Sex Abuse Hub	Number Pts Referral to First Appointment	0	1	0	0	0
		%	0.0%	100.0%	0.0%	0.0%	0.0%
	Family Service	Number Pts Referral to First Appointment	5	24	2	1	0
		%	15.6%	75.0%	6.3%	3.1%	0.0%
	FDAC-Kent	Number Pts Referral to First Appointment	3	1	0	1	1
		%	50.0%	16.7%	0.0%	16.7%	16.7%
	Fostering and Adoption	Number Pts Referral to First Appointment	3	8	1	1	1
		%	21.4%	57.1%	7.1%	7.1%	7.1%
	Lifespan	Number Pts Referral to First Appointment	5	15	10	3	0
		%	15.2%	45.5%	30.3%	9.1%	0.0%
	New Rush Hall School	Number Pts Referral to First Appointment	1	0	1	0	0
		%	50.0%	0.0%	50.0%	0.0%	0.0%
	VIPP	Number Pts Referral to First Appointment	0	1	0	1	0
		%	0.0%	50.0%	0.0%	50.0%	0.0%
<b>Total</b>		17	50	14	7	2	
		18.9%	55.6%	15.6%	7.8%	2.2%	

Portman	Portman Glasser	Number Pts Referral to First Appointment	0	5	4	1	0
		%	0.0%	50.0%	40.0%	10.0%	0.0%
	Portman Limentani	Number Pts Referral to First Appointment	0	6	3	0	0
		%	0.0%	66.7%	33.3%	0.0%	0.0%
<b>Total</b>			0	11	7	1	0
			0.0%	57.9%	36.8%	5.3%	0.0%
Westminster	FAS Family Assessment	Number Pts Referral to First Appointment	0	5	3	0	0
		%					
	FAS Intervention	Number Pts Referral to First Appointment	0	0	0	0	0
		%					
	FAS Pre Birth Assessment	Number Pts Referral to First Appointment	0	1	0	0	0
		%					
<b>Total</b>			0	6	3	0	0
			0.0%	66.7%	33.3%	0.0%	0.0%

			<3 Weeks	3-8 weeks	8 - 11 wee	11-18 wee	18-24 wee	24-28 Wee	28+ Weeks
GIDS	GIDS Leeds	Number Pts Referral to First Appointment	4	4	7	13	58	10	11
		%	3.7%	3.7%	6.5%	12.1%	54.2%	9.3%	10.3%
	GIDS London	Number Pts Referral to First Appointment	5	28	10	10	13	15	140
		%	2.3%	12.7%	4.5%	4.5%	5.9%	6.8%	63.3%
	GIDS South West	Number Pts Referral to First Appointment	0	4	2	0	1	1	1
		%	0.0%	44.4%	22.2%	0.0%	11.1%	11.1%	11.1%
<b>Total</b>			9	36	19	23	72	26	152
			2.7%	10.7%	5.6%	6.8%	21.4%	7.7%	45.1%
GIC	Adult Gender Identity Clinic	Number Pts Referral to First Appointment	1	4	3	3	10	11	252
		%	0.4%	1.4%	1.1%	1.1%	3.5%	3.9%	88.7%



## Board of Directors : July 2017

**Item :** 15

**Title:** Responsible Officer's Report: Revalidation of Medical Staff.

**Purpose:**

The purpose of this report is to assure the Board about the fitness to practice of medical staff in the Trust.

The Board of Directors is asked to confirm whether this paper is accepted as adequate assurance, and where not, whether the Board of Directors is satisfied with the action plans that have been put in place.

**This report focuses on the following areas:**

- Quality
- Patient / User Safety
- Risk

**For :** Noting

**From :** Dr Rob Senior, Medical Director & Responsible Officer

## Summary

- 1) We have confirmed with the General Medical Council (GMC) that all doctors for whom we are the designated body have been given a date for revalidation. This report outlines the systems and processes we have established to facilitate and support the revalidation of doctors in the Trust.
- 2) Doctors require revalidation or renewal of their licence to practice once every five years. This year, there have been no doctors due for revalidation. One doctor is due in September 2017, who is currently compliant.
- 3) Of the 51 consultants for whom Dr Senior is their Responsible Officer (RO), none were deferred, resulting in full compliance.
- 4) The RO for our medical trainees is the Postgraduate Dean in HENCEL our Local Education and Training Board. Currently this is Professor Tim Swanwick.
- 5) None of the doctors for whom the Tavistock and Portman NHS FT is the designated body is currently subject to any GMC fitness to practice procedures or any imposed conditions or undertakings.

**Dr Rob Senior**  
**Medical Director,**  
**Responsible Officer**

## **Medical Appraisal and Revalidation** **at the Tavistock and Portman NHS Foundation Trust**

### **Report for the Board**

1. The Revalidation Lead, Dr Caroline McKenna, and Dr Rob Senior, RO, email regular updates on revalidation to all doctors in the Trust. All medical staff in the Trust have been informed that revalidation requires them to have a full appraisal which has to be recorded on the electronic system of SARD (Strengthened Appraisal and Revalidation Database). They have also been informed that the Trust cannot allow medical staff who are not revalidated to continue to work with patients and that failure to have up to date appraisals, properly recorded, can impede incremental progression. Dr Senior meets on a termly basis with the Trust GMC employment advisor who informs him of any doctors who have been referred to the GMC.

### **2. Doctors on honorary contracts and other 'external' doctors**

- 2.1 We are obliged to appraise and revalidate any existing medically qualified honorary employed by the Trust who wishes to be revalidated and cannot be revalidated elsewhere. This includes doctors employed on an honorary contract.

The Trust has taken on the Adult Gender Identity Service in Hammersmith, AGIC, this year adding a further 8 consultant doctors to the Trust revalidation system.

- 2.2 The Trust still offers limited places for external consultant doctors who do not work for another designated body, to join the Trust's revalidation programme, at a cost of £1,000 annually. The uptake for this continues to grow and currently stands at 12 external doctors on the system. Although this is a useful income stream, we need to be mindful that the Trust consultants who provide the externals appraisals have limited time to undertake the extensive work that is involved in providing a full appraisal and revalidation service, and this is monitored closely by the revalidation manager.

All external doctors will have access to some of the mandatory Training provided by the Trust such as CPR, as well as limited CPD opportunities, e.g. the Scientific Meetings.

### **3. Internal audit**

3.1 To ensure the revalidation process is fit for purpose a series of internal audits has been undertaken, the last of which was in October 2016. This audit reviewed a random selection of twelve appraisals looking at:

- completeness and contents of annual appraisal
- recording of reflective aspects of clinical work
- management processes for revalidation
- timeframe compliance
- support provided to consultants

It was found that although most of the appraisals conducted were considered to be of a good standard it was felt that more could be done in terms of recording clinical reflections on many aspects of clinical work and the findings were fed back to consultants at their monthly revalidation meeting. A further audit will be undertaken in the autumn of 2017 to ensure that audit findings have been understood and incorporated into future appraisals.

**Rob Senior,  
Medical Director and Responsible Officer  
July 2017**

## Board of Directors : July 2017

**Item:** 16

**Title:** Finance And Performance Report for the period  
ended June 2017

**Summary:** The Board are asked to note the contents of the report

**For :** Noting / Discussion

**From :** Terry Noys, Director of Finance  
17 July 2017



## MONTHLY FINANCE AND PERFORMANCE REPORT

Period 3

30 June 2017

### Section

- 1 Summary I&E
- 2 Highlights
- 3 I&E Forecast By Area
- 4 Balance Sheet
- 5 Funds flow

FINANCE AND PERFORMANCE REPORT SUMMARY I&E

Period 3

30 June 2017

	2016/17 Actual Month £'000	2017/18 Actual Month £'000	2017/18 Budget Month £'000	Variance 2017/18 v 2016/17 £'000	Variance Actual v Budget £'000
Income	3,962	<b>4,055</b>	4,036	93	19
Staff costs	(2,597)	<b>(2,974)</b>	(2,977)	(377)	3
Non-staff costs	(1,078)	<b>(826)</b>	(846)	252	20
Operational costs	(3,674)	<b>(3,800)</b>	(3,823)	(125)	24
EBITDA	<b>288</b>	<b>255</b>	<b>213</b>	<b>(33)</b>	<b>42</b>
- Margin	7%	6%	5%		
Interest receivable	1	1	1	(1)	(0)
Interest payable	0	0	0	0	0
Depreciation / amortisation	(61)	<b>(65)</b>	(65)	(4)	0
Public Dividend Capital	(48)	<b>(45)</b>	(48)	4	4
Restructuring costs	0	0	0	0	0
Other					
Net surplus	180	<b>146</b>	100	(33)	46
- Margin	5%	4%	2%		

	2016/17 Actual YTD £'000	2017/18 Actual YTD £'000	2017/18 Budget YTD £'000	Variance 2017/18 v 2016/17 £'000	Variance Actual v Budget £'000	Variance Actual v Budget %
Income	11,785	12,019	12,258	234	<b>(239)</b>	(2)%
Staff costs	(7,766)	(8,934)	(9,267)	(1,168)	<b>333</b>	(4)%
Non-staff costs	(2,935)	(2,499)	(2,446)	436	<b>(54)</b>	2%
Operational costs	(10,701)	(11,433)	(11,713)	(732)	<b>279</b>	
EBITDA	<b>1,084</b>	<b>586</b>	<b>546</b>	<b>(498)</b>	<b>40</b>	0
- Margin	9%	5%	4%	0%		
Interest receivable	2	2	2	(0)	0	0%
Interest payable	0	0	0	0	0	
Depreciation / amortisation	(183)	(194)	(195)	(11)	1	(1)%
Public Dividend Capital	(145)	(134)	(145)	11	<b>11</b>	(8)%
Restructuring costs	(61)	0	0	61	0	
Other		0	0	0	0	
Net surplus	697	<b>259</b>	208	(437)	<b>52</b>	(0)
- Margin	6%	2%	2%			

COMMENTARY

As at 30th June actual net surplus of £260k is £52k ahead of the Budget and ahead of the NHSI Month 3 target of £221k. Therefore the Trust is able to receive the first tranche of STF funding of £125k.

Income is £239k below budget, due to shortfalls in Education income across a range of its activities. Staff costs are £333k below Budget, whilst non-pay costs are £42k worse than budget (primarily in Education and Training)

Whilst YTD income is only slightly higher than last year, staff costs are significantly higher due to the expansion of GIDS / GIC. This growth in costs is matched by higher CYAF income, the issue (YoY) being a shortfall in Education and Training income exacerbated by E&T costs also being higher (YoY)

## FINANCE AND PERFORMANCE REPORT

Period 3

30 June 2017

## HIGHLIGHTS

### RATINGS

	Year To Date	Full Year Forecast
Net surplus	GREEN	GREEN
Cash flow	GREEN	GREEN
Agency spend	GREEN	GREEN
SOF rating for finance and resources	GREEN	GREEN
Supplier payments	AMBER	GREEN

### STAFF NUMBERS (WTE)

YTD Budget	YTD Actual	YTD Var
664	627	6%

### PROVISIONS / ACCRUALS

	31-Mar-17	30-Jun-17
Holiday pay accrual	305	305
Bad debt provision	305	305
Restructuring	179	179
Adult GIC Employee Claim	15	15
Other staff related	65	65
Camden Shed'	50	50

### CREDITORS / BETTER PAYMENT PRACTICE CODE

	YTD Target	YTD Actual
Number of invoices	95%	90%
Value of invoices	95%	93%

**FINANCE AND PERFORMANCE REPORT**
**Period 3**
**30 June 2017**
**Full Year Forecast**

	2017/18 Forecast <b>Full Year</b> £'000	2017/18 Budget <b>Full Year</b> £'000	Variance Actual v Budget £'000
Education and Training	17,761	18,473	(712)
CYAF	24,985	24,679	306
AFS	5,343	5,306	37
Corporate	964	1,285	(321)
SFT	500	500	0
<b>TOTAL INCOME</b>	<b>49,553</b>	<b>50,243</b>	<b>(690)</b>
Education and Training	(8,177)	(8,675)	498
CYAF	(17,897)	(17,975)	78
AFS	(4,188)	(4,147)	(41)
Corporate	(6,587)	(6,668)	81
<b>STAFF COSTS</b>	<b>(36,849)</b>	<b>(37,466)</b>	<b>617</b>
Education and Training	(3,468)	(3,632)	164
CYAF	(3,121)	(3,048)	(73)
AFS	(368)	(388)	21
Corporate	(4,798)	(4,758)	(40)
<b>NON-STAFF COSTS</b>	<b>(11,754)</b>	<b>(11,827)</b>	<b>72</b>
Education and Training	6,116	6,165	(50)
CYAF	3,967	3,656	311
AFS	787	770	17
Corporate	(10,420)	(10,141)	(279)
STF	500	500	0
<b>EBITDA</b>	<b>950</b>	<b>950</b>	<b>(0)</b>
Education and Training	34.4%	33.4%	
CYAF	15.9%	14.8%	
AFS	14.7%	14.5%	
Corporate			
<b>EBITDA MARGIN</b>	<b>1.9%</b>	<b>1.9%</b>	

**COMMENTARY**

The net underperformance within Education, is partly due to income reduction in clinical psychotherapy trainees, with a corresponding reduction in staff costs

Reductions in Portfolio income are partially offset by increases in CPD income - net negative contribution impact of £12k Within CYAF, new revenue streams for Syrian Refugees and increased NPA income in GIDS, offsets losses within FDAC

The positive variance to contribution within AFS is due to Camden TAP, City & Hackney and Adult Complex needs which is partially offset by expected underperformance within the Portman Clinic

**FINANCE AND PERFORMANCE REPORT**  
**Period 3**  
**30 June 2017**

**BALANCE SHEET**

	Prior Year End £'000	April £'000	May £'000	June £'000	July £'000	Aug £'000	Sept £'000	Oct £'000	Nov £'000	Dec £'000	Jan £'000	Feb £'000	Mar £'000
Intangible assets	191	188	199	194									
Land and buildings	18,381	18,432	18,673	18,720									
IT equipment	1,329	1,345	1,311	1,354									
Other	0	0	0	0									
<b>Property, Plant &amp; Equipment</b>	<b>19,709</b>	<b>19,777</b>	<b>19,984</b>	<b>20,074</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
<b>Total non-current assets</b>	<b>19,900</b>	<b>19,964</b>	<b>20,183</b>	<b>20,268</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
Trade and other receivables	5,518	3,740	2,979	3,760									
Accrued Income and prepayments	2,098	3,614	4,701	3,763									
Cash / equivalents	2,152	5,279	3,224	2,480									
<b>Total current assets</b>	<b>9,768</b>	<b>12,634</b>	<b>10,905</b>	<b>10,003</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
Trade and other payables	(2,272)	(2,456)	(2,374)	(1,997)									
Accruals	(3,289)	(3,221)	(2,921)	(2,687)									
Deferred income	(3,010)	(5,684)	(4,583)	(4,273)									
Provisions	(254)	(254)	(254)	(210)									
<b>Total current liabilities</b>	<b>(8,824)</b>	<b>(11,616)</b>	<b>(10,132)</b>	<b>(9,167)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
<b>Total assets less current liabilities</b>	<b>20,844</b>	<b>20,982</b>	<b>20,955</b>	<b>21,103</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
Non-current provisions	(82)	(84)	(81)	(82)									
<b>Total assets employed</b>	<b>20,761</b>	<b>20,898</b>	<b>20,875</b>	<b>21,021</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
Public dividend capital	3,474	3,474	3,474	3,474									
Revaluation reserve	12,263	12,263	12,263	12,263									
I&E reserve	5,024	5,162	5,138	5,283									
<b>Total taxpayers equity</b>	<b>20,761</b>	<b>20,899</b>	<b>20,875</b>	<b>21,020</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>

**FINANCE AND PERFORMANCE REPORT**  
**Period 3**  
**30 June 2017**

**FUNDS FLOW**

	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	YTD
	Act	Act	Act	Act	Act	Act	Act	Act	Act	Act	Act	Act	Act
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Net Surplus	138	(25)	146										259
Depreciation / amortisation	75	54	65										194
PDC dividend paid	45	45	45										134
(Increase) / Decrease in receivables	261	(326)	158										93
Increase / (Decrease) in liabilities	2,792	(1,484)	(965)										343
Increase / (Decrease) in provisions	2	(3)	2										0
<b>Net operating cash flow</b>	<b>3,312</b>	<b>(1,739)</b>	<b>(550)</b>	<b>0</b>	<b>1,024</b>								
Interest received	0	1	1										2
Interest paid	0	0	0										0
PDC dividend paid	(45)	(45)	(45)										(134)
<b>Cash flow available for investment</b>	<b>3,268</b>	<b>(44)</b>	<b>(44)</b>	<b>0</b>	<b>(132)</b>								
Purchase of intangible assets	3	(11)	5										(3)
Purchase of property, plant & equipment	(142)	(262)	(154)										(559)
<b>Net cash flow before financing</b>	<b>3,128</b>	<b>(2,056)</b>	<b>(744)</b>	<b>0</b>	<b>329</b>								
Drawdown of debt facilities	0	0	0										0
Repayment of debt facilities	0	0	0										0
<b>Net increase / (decrease) in cash</b>	<b>3,128</b>	<b>(2,056)</b>	<b>(744)</b>	<b>0</b>	<b>329</b>								
Opening Cash	2,152	5,279	3,224										2,152
<b>Closing cash</b>	<b>5,279</b>	<b>3,224</b>	<b>2,480</b>	<b>0</b>	<b>2,480</b>								
	5,279	3,224	2,480	0	0	0	0	0	0	0	0	0	0
	0	(0)	(0)	0	0	0	0	0	0	0	0	0	0

## Board of Directors : July 2017

**Item :** 17

**Title :** Directorate of Education and Training Board Report

**Purpose:**

To update on issues in the Education & Training Directorate.  
To report on issues considered and decisions taken by the Training & Education Programme Management Board at its meeting of 3<sup>rd</sup> July 2017.

**This report focuses on the following areas:**

- Risk
- Finance
- Communications
- User Experience
- Equality

**For :** Noting

**From :** Brian Rock, Director of Education and Training/Dean of Postgraduate Studies

## Directorate of Education and Training Board Report

### 1. Introduction

1.1 This report provides an update on the issues considered and decisions taken by the Training & Education Programme Management Board at its meeting of 3<sup>rd</sup> July 2017.

### 2. SITS Update

2.1 Brian Rock, Director of Education and Training, updated the programme board on the progress of the project.

2.2 Stage 4 of the project which relates to assessment, has now gone live and stage 5 is due for release in the autumn.

2.3 A project completion plan will be brought to the programme board in November and a benefits realisation plan will come in September.

2.4 There are elements of work, such as modules to track student supervisions, which will continue beyond the end of the project.

2.5 Karen Tanner, Deputy Director of Education and Training, expressed a feeling that things were calmer within the teams and current issues were not related to the implementation of the system but were more centred on issues such as marking not being completed on time.

### 3. Student Recruitment and Marketing Update

3.1 Laure Thomas, Director of Marketing and Communications, presented a paper on this item.

3.2 As of 12<sup>th</sup> July 2017 we have the following applications

3.2.1 There are 775 submitted applications. This compares to 553 at this point last year (37.4% increase).

3.2.2 30s offers made of which 238 have been accepted compared to 191 last year (16.8% increase).

3.2.3 371 students interviewed

3.2.4 82 rejected

3.3 More information can be found in Appendix A

3.4 There are issues in ensuring that as many interview slots as possible are available as July is a peak month for applications. Brian Rock, Karen Tanner and Elisa Reyes Simpson will be supporting the course teams in conducting interviews. We would like to reduce the amount of interviews taking place in September as much as possible.

3.5 The group discussed the benefits of interviewing all of our students on long courses. It was agreed that they were often helpful in redirecting students to other courses. Consideration is being given as to how we can make this a more efficient process such as group interviews or assessment days.

3.6 Elisa Reyes Simpson, Associate Dean for Academic Governance and Quality Assurance, enquired about the pipeline and who exactly this included. Laure Thomas advised that it included all students that had started an application. She confirmed that we do chase up incomplete applications, applicants that have made changes in the past 6 weeks are viewed as the most likely to continue their applications.

3.7 It was agreed that a fortnightly report on headline figures would be circulated to programme board members through the summer.

3.8 PJ asked where LT thought we would land at the end of the cycle. She suggested that we could reach 677 but that this would not be across all courses and relies on some over recruiting making up for those that are not.

3.9 Fiona Hartnett, Dean's Office Manager, advised that in terms of space growth was possible but there needed to be consideration of where the students were and focussing them on blended and evening programmes.

#### **4. Finance Report**

4.1 Bhavna Tailor, Finance Manager, presented a paper on this item.

4.2 At present there will be a £154,000 gap if we were to recruit 565 students.

4.3 This will be reviewed weekly and updates sent through the summer with the recruitment reports.

- 4.4 The group discussed how many students we would need to have to remove this gap. BT explained that contribution per student varies by course and therefore the impact of the total number of students alone would not allow for an accurate projection however BT thought 625 student should be sufficient to remove the gap.
- 4.5 BT confirmed that this gap was in addition to the £200,000 required saving and any other variance.

## **5. PPI Initiative**

- 5.1 Paul Dugmore, Portfolio Manager for Social Work, Leadership and Management, attended and presented a paper for this item.
- 5.2 He explained that the Learning & Teaching committee had a work stream for improving user or patient participation in our teaching. This work has been progressing over the last year and they have recently held an event with a group of young people.
- 5.3 A psychology student is undertaking a literature review on the benefits of including service users in education activity. PD highlighted the time taken to take this forward and that his own session in this area would come to an end in November. PPI activity is well resourced in the clinical teams but less so within DET. He would propose that if we wish to take this work forward we need to consider how it can be better aligned to other Trust PPI activity and ensure it is resourced properly.
- 5.4 Paul Jenkins suggested that there needed to be discussions with Louise Lyon, Director of Quality and Patient Experience, as to how her team could support this work. We also need to do more to identify “what good looks like” in this area. PJ will facilitate these discussions.

## **6. Race Equality Strategy**

- 6.1 PJ presented the race equality strategy paper.
- 6.2 KT explained that an equalities questionnaire was being put together for students. Staff would then be asked to respond to the issues raised.

- 6.3 Dinesh Bhugra, Non – Executive Director, suggested that issues related to BAME students did get lost somewhat in the strategy and this may need to be in 3 separate, but connected documents with policies for staff, patients and students.
- 6.4 It was agreed that the overarching report would be complete for September with a separate DET report to be completed at a later date.

## **7. Student Visa's**

- 7.1 Simon Carrington, Head of Academic Governance and Quality Assurance, attended for this item.
- 7.2 BR explained that SC and Bev Nicholson, Head of Course Administration, Data and Reporting, had been taking forward the work in this area.
- 7.3 DB highlighted that in a few years' time we would leave the EU and this would make this a more significant issue. If we wish to pursue international students we need to be prepared. SC highlighted the constantly changing government policy in this area and the issues this brought.
- 7.4 The TEPMB noted the report. It agreed to raise this issue with Essex University and to request additional support and to pursue the work with our solicitors with greater guidance on what we wanted from this advice.

## **8. Short Course Pipeline**

- 8.1 Victoria Buyer, Consultant, attended and presented a paper on this item.
- 8.2 She explained that in the upcoming year additional income will, for the most part, come from bespoke requests. The Visitor's Programme is also increasing its contribution.
- 8.3 The CPD team are looking to automate their processes with the introduction of SITs release 5 due in the autumn. It is foreseen that 1 to 1.5 days per week of the Portfolio Development and Events Manager, Vicky Howells, time would be taken up with this project.
- 8.4 There is close to £700,000 of committed income at the beginning of quarter 1 (£187,000 has been invoiced so far). The large contribution reflected is down to staff

time not being significant for these courses however Rob Senior, Medical Director, highlighted the impact this had on staff themselves.

8.5 The group discussed the contribution level noting that the £700,000 quoted above was based on all places booked for the year, some of these courses may not run and costs may increase.

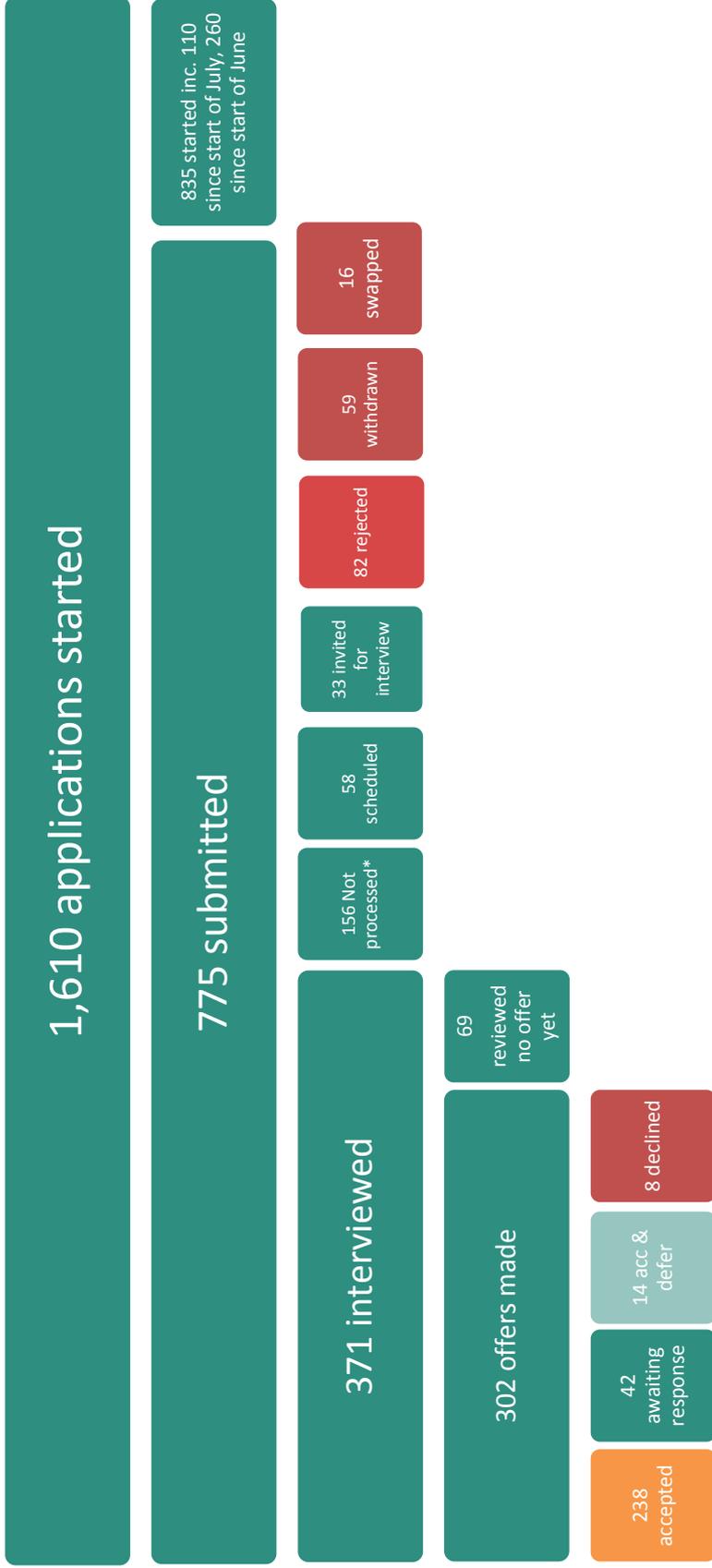
8.6 ERS suggested that long courses that aren't recruiting could be converted to CPD provision, this work would need to progress quickly.

**Brian Rock**

**Director of Education and Training/Dean of Postgraduate Studies**

**10<sup>th</sup> July 2017**

## Appendix A July Recruitment Figures



**Adding non-SITS courses: offers accepted**







## BOARD OF DIRECTORS (PART 1)

Meeting in public

Tuesday 25<sup>th</sup> July 2017, 2.00 – 5.00pm

Lecture Theatre, Tavistock Centre, 120 Belsize Lane, London NW3 5BA

### AGENDA

PRELIMINARIES				
1.	<b>Chair's Opening Remarks</b> Prof Paul Burstow, Trust Chair		Verbal	-
2.	<b>Apologies for absence and declarations of interest</b> Prof Paul Burstow, Trust Chair	To note	Verbal	-
3.	<b>Minutes of the previous meeting</b> Prof Paul Burstow, Trust Chair	To approve	Enc.	p.1
3a.	<b>Outstanding Actions</b> Prof Paul Burstow, Trust Chair	To note	Enc.	p.7
4.	<b>Matters arising</b> Prof Paul Burstow, Trust Chair	To note	Verbal	-
REPORTS				
5.	<b>Service User Story</b> FNP Patient – video story	To note	Verbal	-
6.	<b>Service Line Report: Family Nurse partnership (FNP)</b> Ms Ailsa Swarbrick, Family Nurse Partnership Director	To discuss	Enc.	p.8
7.	<b>Trust Chair's and NED's Reports</b> Prof Paul Burstow, Trust Chair	To note	Verbal	-
8.	<b>Chief Executive's Report</b> Mr Paul Jenkins, Chief Executive	To discuss	Enc.	p.17
9.	<b>STP Revised Narrative</b> Mr Paul Jenkins, Chief Executive	To discuss	Enc.	p.42
10.	<b>a. Board Assurance Framework</b> <b>b. Risk Register</b> Mr Terry Noys, Deputy CEO and Finance Director	To approve	Enc.	p.125 p.154
11.	<b>Fire Safety Review</b> Mr Paul Jenkins, Chief Executive	To note	late	-
12.	<b>a. Workforce Race Equality</b> Mr Craig de Sousa, Human Resources Director <b>b. Draft Race Equality Standard</b> Ms Louise Lyon, Director of Quality and Patient Experience	To approve  To discuss	Enc.  	p.170  p.177

<b>13.</b>	<b>Performance and Quality Reports</b> Ms Louise Lyon, Director of Quality and Patient Experience & Ms Marion Shipman, Associate Director, Quality & Governance	To discuss	Enc.	p.204
	<ul style="list-style-type: none"> <li>Quality Quarterly Report</li> <li>Dashboard Quarterly Report</li> <li>Waiting Times Quarterly Report</li> </ul>			p.207 p.216 p.231
<b>14.</b>	<b>IMT Quarterly Report</b> Mr David Wyncham-Lewis, Director of IM&T	To discuss	late	-
<b>15.</b>	<b>Responsible Officer's Annual Revalidation Report</b> Dr Rob Senior, Medical Director	To approve	Enc.	p.258
<b>16.</b>	<b>Finance &amp; Performance Report</b> Mr Terry Noyes, Deputy CEO and Finance Director	To note	Enc.	p.262
<b>17.</b>	<b>Training and Education Report</b> Mr Brian Rock, Director of E&T/Dean	To note	Enc.	p.269
<b>CLOSE</b>				
<b>18.</b>	<b>Notice of Future Meetings:</b> <ul style="list-style-type: none"> <li>12<sup>th</sup> September, Directors' Conference, 2.00 – 5.00pm, Lecture Theatre</li> <li>25<sup>th</sup> &amp; 26<sup>th</sup> September, Board Away Day</li> <li>26<sup>th</sup> September, Board of Directors' Meeting, 2.00-5.00pm, Lecture Theatre</li> <li>10<sup>th</sup> October, Joint Boards Meeting, 2.00 – 5.00pm, Lecture Theatre</li> <li>31<sup>st</sup> October, Board of Directors' Meeting, 2.00 – 5.00pm, Lecture Theatre</li> </ul>			