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30 April 2018

[redacted]

By email
[redacted]

Dear [redacted]

Review of your Request under the Freedom of Information Act 2000 (the "FOI Act")

I refer to your email of **13 November 2017** in which you requested an internal review of NHS Improvement's decision dated **25 October 2017** relating to your FOI request dated **27 September 2017**. You made the following request:

Your request

"Under the Freedom of Information Act, please send me the board papers for the private session of September 28th board meeting.

These are:

The chairman's report (BM/17/72(P))
The chief executive's report (BM/17/73(P))
M4 sector performance (BM/17/74(P))
Update on winter resilience preparation 2017/18 (BM/17/75(P))
Update on incident management and emergency preparedness (BM/17/76(P))
Collaboration and joint working with NHS England (BM/17/77(P))
Business cases: i) Shaping a Healthier Future SOC programme; ii) Mersey Care NHS Trust MSU FBC (BM/17/78(P))
Challenged providers update (BM/17/79(P))
NHS Improvement Quarter One i) corporate risk report; ii) corporate performance report (BM/17/80(P))"

Decision

We have now undertaken a review of the original decision and decided to uphold it in part. In the decision letter of 25 October 2017, NHS Improvement explained that it was withholding the information on the basis of the exemptions in sections 31 and 36(2)(b)(i), (ii) and (c) of the FOI Act and that the public interest in withholding the information outweighed the public interest in disclosing it.

We have decided to release some of the information requested and withhold the remainder on the basis of the applicability of the exemptions in sections 21, 31, 33 and 36(2)(b)(i), (ii) and (c) of the FOI Act, as explained below.

The attached Annex sets out the details of the relevant information we hold and whether that information is to be disclosed in whole or in part, or withheld. Where information is being withheld, we have identified which exemptions we consider to be relevant in each case.

Section 21 – information accessible to applicant by other means

Section 21(1) of the FOI Act provides that information is exempt if it is reasonably accessible to the applicant by other means. NHS Improvement has published, in part, the paper "Update on winter resilience". That paper can be found here: https://improvement.nhs.uk/about-us/corporate-publications/publications/foi-board-papers-meeting-28-september-2017-and-decision-board/.

Further, some of the information found in the paper, "M4 sector performance" has now been published and can be found in the Quarter 2 2017/18 report which was published on 16 November 2017: https://improvement.nhs.uk/resources/quarterly-performance-nhs-provider-sector-quarter-2-201718/.

Section 31 – Law enforcement

Under section 31(1)(g) of the FOI Act, information is exempt from disclosure if its disclosure would, or would be likely to, prejudice the exercise by any public authority of its functions for any of the purposes specified in section 31(2). NHS Improvement considers that section 31(2)(c) is engaged in relation to some of the information, as indicated in the Annex. Disclosure of the information in question would be likely to prejudice the exercise by Monitor and Trust Development Authority ("TDA") of their functions for the purpose of ascertaining whether circumstances exist which would justify regulatory action in pursuance of an enactment.

The conditions of Monitor's provider licence enable Monitor to regulate the economy, efficiency and effectiveness of NHS foundation trusts under Chapter 3 of Part 3 of the Health and Social Care Act 2012. Section 5 of The National Health Service Trust Development Authority Directions and Revocations and the Revocation of the Imperial College Healthcare National Health Service Trust Directions 2016 provides that the TDA must exercise its functions with the objective of ensuring that English NHS trusts are able to comply with their duty under section 26 of the NHS Act 2006. Section 26 sets out the general duty of NHS trusts to exercise their functions efficiently, economically and effectively.

In particular, NHS Improvement considers that this information is likely to prejudice their functions relating to the ongoing monitoring of providers' compliance with licence conditions for foundation trusts and the equivalent provision for NHS trusts. Consideration of this information is necessary for NHS Improvement to carry out its regulatory functions and to take into account relevant information needed to make decisions about how to respond to a failure to comply with the rules.

Further, NHS Improvement relies on the full and frank information provided by trusts to carry out its functions effectively. NHS Improvement relies on having a safe space in which providers are freely able to share sensitive and confidential information in the knowledge that the information will not be disclosed more widely. To disclose that information more widely is likely to have a detrimental impact on the quality and content of exchanges between NHS Improvement and the bodies it regulates and its ability to make effective and fully informed regulatory decisions.

Section 33 – audit functions

Section 33(1)(b) and (2) of the FOI Act provides that information may be exempt from disclosure where disclosure would be likely to prejudice the exercise of any public authority's functions in relation to the examination of the economy efficiency and effectiveness with which other public authorities use their resources in discharging their functions.

Where indicated in the Annex, NHS Improvement considers that the withheld information, in so far as it related to NHS foundation trusts is exempt under section 33(1)(b) on the basis that Monitor has functions in relation to the examination of the economy, efficiency and effectiveness with which NHS foundation trusts use their resources. That function is likely to be prejudiced by releasing this information. Monitor has these functions by virtue of its general duty under section 62(1) of the Health and Social Care Act 2012 to protect and promote the interests of health care service users by promoting the provision of services which is economic, efficient and effective and improves the quality of services.

We consider that the information, in so far as it relates to NHS trusts is also exempt under section 33(1)(b) of the FOI Act on the basis that the TDA has functions relating to the examination of the economy, efficiency and effectiveness with which NHS trusts use their resources in discharging their functions (as described above), which is likely to be prejudiced by the release of this information.

As noted above, NHS Improvement depends on the free and frank provision of information from trusts without fear of this being shared more widely, and considers that disclosure would be likely to have a detrimental impact on the quality and the content of information provided in the future if published. This would have a negative impact on the exercise of NHS Improvement's regulatory functions.

Public interest test

Sections 31 and 33 are qualified exemptions and therefore require that a public interest test is carried out to determine whether the exemption should be maintained. Our view is that, on

balance, the public interest in maintaining these exemptions outweighs the public interest in disclosure.

We consider that, in relation to the performance of the sector, there is a public interest in transparency but that it is, in part, satisfied by the information that is already publicly available in NHS Improvement's quarterly reports, which can be found on the NHS Improvement website.

Where information is not already publicly available, we consider that the public interest is in withholding the information. There is a strong public interest in NHS Improvement and providers being able to openly exchange information that is relevant to NHS Improvement's regulatory functions without disclosing the same to a wider audience and to give the sector time to evaluate that information and take action without premature disclosure.

Section 36(2) – Prejudice to the effective conduct of public affairs

NHS Improvement considered that the exemption in section 36 was engaged as NHS Improvement's qualified person, the Chief Executive, Jim Mackey, was of the opinion that disclosure of the Board papers would be likely to inhibit the free and frank provision of advice and/ or the free and frank exchange of views for the purposes of deliberation or otherwise prejudice the effective conduct of public affairs.

Shortly after that decision, Ian Dalton was appointed as the new Chief Executive of NHS Improvement. I have therefore sought his opinion as the qualified person as to whether or not section 36 is engaged.

On the basis of Mr Dalton's opinion, we have decided to withhold some of the information requested, as indicated in the Annex, on the basis that it is exempt from disclosure under section 36(2) of the FOI Act. In his opinion, disclosure of this information would be likely to inhibit the free and frank provision of advice and/or the free and frank exchange of views for the purposes of deliberation and would otherwise prejudice, or be likely to prejudice, the effective conduct of public affairs (section 36(2)(b) and (c)).

NHS Improvement's qualified person is of the opinion that disclosing this information (in whole or in part as indicated in the Annex) would be likely to inhibit NHS Improvement Staff from expressing themselves openly and frankly, or from exploring a wide range of options when providing advice or expressing views as part of the process of enabling the Board to make well-informed decisions. If the authors of those Board papers knew that the advice and views would be disclosed they would be less likely to share those views so openly and in writing. This could have a 'chilling effect' in relation to information provided in future Board papers. As the members of the Board rely on the papers to prepare for and inform their thinking on matters to be considered at the meeting, a lack of comprehensive and detailed information in the Board papers could impair the quality of deliberation and decision-making of NHS Improvement.

Some of the papers contain detailed evaluation of live issues which have yet to be settled and are subject to further discussion. Some of the information provided to the Board includes

advice and views and recommendations about matters which are not yet in the public domain or have yet to be decided.

Some of the papers contain confidential and sensitive information which has been voluntarily made available to NHS Improvement by providers. It is likely that the quality of that information would be compromised if the trusts knew that it would be shared.

NHS Improvement's qualified person is also of the opinion that disclosure of this information would otherwise prejudice the effective conduct of public affairs. The information being withheld consists of papers for a private session of the Board of NHS Improvement which contain confidential and sensitive information, and preliminary views and ideas which are not yet the view of NHS Improvement. Disclosure of this information would jeopardise the safe space for the Board to deliberate and openly discuss live and sensitive issues which would compromise the quality of discussion and subsequent decision-making.

Further, disclosure of some of the information would be likely to have a negative impact on the relationship that NHS Improvement has with both NHS England and the Department of Health and Social Care which could compromise the quality of support to the sector.

Public interest test

Section 36 is a qualified exemption and therefore requires that a public interest test be carried out to determine whether the exemptions should be maintained. My view is that, on balance, the public interest in maintaining these exemptions outweighs the public interest in disclosure.

There is a strong public interest in patients and the public having information about the NHS including financial and performance management information. More openness about process and delivery may lead to greater accountability of NHS Improvement, an improved standard of public debate and a greater level of trust between NHS providers and NHS Improvement.

However, we have also considered the strong public interest in allowing NHS Improvement to obtain and share expert analysis, to share views and opinions and to deliberate policy options and strategies without concern that about premature scrutiny. This allows policy and decision-making to be informed by frank and detailed advice and information. This safe working space allows NHS Improvement to perform its regulatory functions. If NHS Improvement staff are unable to discuss confidential plans with the Board, it is likely that future exchanges will be inhibited which will have a detrimental impact on the quality of decision-making.

Taking all these factors into account in my view the public interest is better served by withholding the information in this case.

Review rights

If you are not content with the outcome of the internal review, you have the right to apply directly to the Information Commissioner for a decision. The Information Commissioner can

be contacted at: Information Commissioner's Office, Wycliffe House, Water Lane, Wilmslow, Cheshire, SK9 5AF.

Publication

Please note that this letter will shortly be published on our website. This is because information disclosed in accordance with the FOI Act is disclosed to the public at large. We will, of course, remove your personal information (e.g. your name and contact details) from the version of the letter published on our website to protect your personal information from general disclosure.

Yours sincerely,

Sofia Bernsand
Deputy Head of Governance

NHS Improvement is the operational name for the organisation that brings together Monitor, NHS Trust Development Authority, Patient Safety, the National Reporting and Learning System, the Advancing Change team and the Intensive Support Teams.

Annex

Agenda item	Document description	Decision	FOI Act exemptions
11	Chairman's report (BM/17/72(P))	Withheld in part	36(2)(b)(ii) and (c)
12	Chief Executive's report (BM/17/73(P))	Withheld in part	36(2)(b)(ii) and (c)
13	M4 sector performance (BM/17/74(P))	Withheld	21, 31, 33 and 36(2)(b)(ii) and (c)
14	Update on winter resilience preparation 2017/18 (BM/17/75(P))	Withheld in part	21, 36(2)(b)(i) and (ii) and (c)
15	Update on incident management and emergency preparedness (BM/17/76(P))	Disclosed	n/a
16	Collaboration and joint working with NHS England (BM/17/77(P))	Withheld in part	36(2)(b)(i) and (ii) and (c)
17i	Business case: Shaping a Healthier Future SOC programme (BM/17/78(P))	Withheld	33, 36(2)(b)(i) and (ii) and (c)
17ii	Business case: Mersey Care NHS Trust MSU FBC (BM/17/78(P))	Withheld	33, 36(2)(b)(i) and (ii) and (c)
19	Challenged providers update (BM/17/79(P))	Withheld	31(1)(g) and 31(2), 33 and 36(2)(b)(ii)
20i	NHS Improvement Quarter One: Corporate Risk Report (BM/17/80(P))	Withheld	36(2)(b)(i) and (ii) and (c)
20ii	NHS Improvement Quarter One: Corporate Performance Report (BM/17/80(P))	Withheld in part	36(2)(b)(ii) and (c)

NHS Improvement

To: The Board

For meeting on: 28 September 2017

Agenda item: 11

Report by: Richard Douglas, Interim Chairman

Report on: Chairman's report

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1. When I took up the post of Interim Chair in July 2017, I wrote to the Board outlining my objectives for the next few months. This report provides an update on each of these objectives.

Getting to know NHSI better

2. I have spent time 'walking the floor' and meeting with teams across NHS Improvement, to get direct feedback on what it is like to work in our organisation. I have also spent time with each member of our Executive Team, and I seem to have a heavy schedule of 'coffee roulettes', where I meet with staff on a 1:1 basis. I have been impressed by the quality of our staff, by their commitment, and by the broadness of the skills and experience we have in NHS Improvement. It is very important that we and the Executive Team collectively focus on leadership within our organisation, and not just on leading the system / our providers.

Appointing a new Chief Executive

3. I have met with the Permanent Secretary and other senior officials at DH, with recruitment consultants and with NHS Providers to inject as much urgency as possible into the process to appoint a new Chief Executive. The timings of this process are at the mercy of parliamentary procedure, but I am confident that we are doing as much as we can to ensure that we have as strong a field as possible to replace the current Chief Executive.

Preparing for winter

4. The whole organisation – but in particular our Regional Teams and Pauline Philip (National Director for Urgent and Emergency Care) – is focusing on supporting the sector to prepare for winter. I meet regularly with the Chief Executive, Pauline, and with Regional Directors to support them in these preparations.

Financial discipline

5. Earlier, this month, I chaired the first Joint Financial Committee meeting with NHS England. Myself, the Chief Executive, and Chief Financial Officer were present from NHS Improvement. [redacted]

6. You will have seen the Q1 performance report and some of the media activity following its publication. [redacted]

Incident management and emergency preparedness

7. I have been working with Jeremy Marlow on NHS Improvement's arrangements for incident management and emergency preparedness. A lot of work has been undertaken internally since the events of this summer and NHS Improvement is substantially better prepared in the event of a major incident – either to the support the sector, or to deal with an incident that affects our own staff. There is still more work to do to refine these processes and procedures; the recent attack in Parsons Green served as a reminder of the importance of this work.

8. NHS Improvement's Business Continuity Framework and external Major Incident and Response Policy were also discussed at the Audit and Risk Assurance Committee earlier this month, which I chair.

Joint working with other ALBs

9. I have met a number of times with Anne Eden, our Executive Regional Managing Director (South), and Jennifer Howells her counterpart within NHS England, regarding the current test of joint NHS Improvement / NHS England Regional Director posts in the South. [redacted]

NHS Improvement

To: The Board

For meeting on: 28 September 2017

Agenda item: 12

Report by: Jim Mackey, Chief Executive

Report on: Chief Executive's report

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1. This will be my last CEO report in this role and firstly I would like to thank NHS Improvement colleagues, provider leaders and other partners for all of your support over the last two years. The advertisement for my replacement has gone out; however a substantive Chair is to be appointed before a substantive Chief Executive can be made.

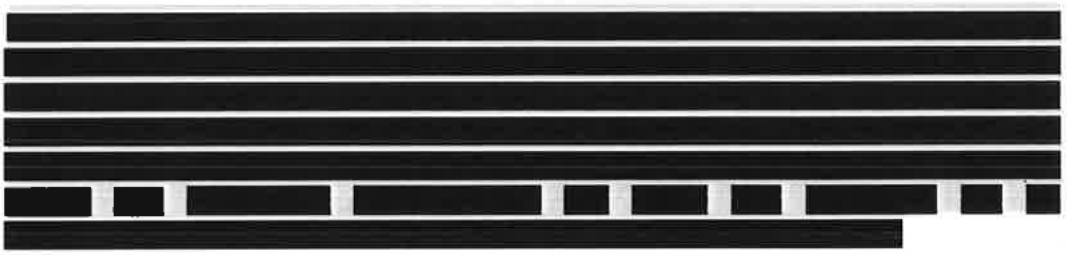
2. Q1 financial results have recently been published showing that finances are broadly on track and our urgent focus is now to prepare for a potentially difficult winter. While A&E performance remains at around 90%, emergency admissions are high as well as attendances; delayed transfers of care are also higher than compared to this time last year. [redacted]

[redacted]

4. The launch of NHS Improvement's values and behaviours also happened this month. It brings together how we work internally as an organisation including our purpose, our objectives, our values and ten overarching principles. We'll now start to embed these values and behaviours in all aspects of our work at NHS Improvement.

5. We have also started to kick off our internal AGMs this month and aim to use this as a time to reflect on what we have all achieved so far, actions taken to respond to the all staff survey, to discuss the new values and behaviours, and for staff to ask questions of myself and other executives. We will be heading around to most offices and encouraging staff to engage with their local event.

6. I have attended various speaking events over the last two months where I have spoken to clinical leaders, provider CEOs, Financial Directors, the Society of Acute Medicine and medical leaders. During these engagements and through various visits to providers, I have covered topics such as reflecting on 2016/17 and what we all have agreed to deliver in 2017/18, the tough winter we have ahead of us, planning for next year and thanking everyone for their hard work. A key theme throughout these discussions has been the need to reduce variation and it is apparent everywhere that colleagues have really embraced improvement in their own way across the NHS.

7. 

8. In addition, we continue to develop out joint working with CQC around the use of resources and the well led framework. This is complex work but both organisations are committed to developing this in a joined up way for providers in line with the stated timetable.

9. Finally, I wanted to welcome Richard Douglas as our interim Chairman and thank him for all of his work and support already in his short time as Chairman.

Jim

NHS Improvement

To: The Board

For meeting on: 28 September 2017

Agenda item: 14

Report by: Pauline Philip, National Urgent and Emergency Care Director
Raghuv Bhasin, Deputy Director, Provider Projects

Report on: Update on winter resilience preparation 2017/18

Purpose

1. This paper sets out the joint NHS England and NHS Improvement plan for winter. It covers:
   - Our objectives for winter;
   - The current context for delivery; and
   - Our approach to deliver these objectives.

Our objectives for winter

2. The Next Steps on the Five Year Forward View[1] sets out that:

   "Trusts and CCGs will be required to meet the Government's 2017/18 mandate to the NHS that: 1) in or before September 2017 over 90% of emergency patients are treated, admitted or transferred within 4 hours – up from 85% currently [in March]; 2) the majority of trusts meet the 95% standard in March 2018; and 3) the NHS overall returns to the 95% standard within the course of 2018."

3. [redacted]

4. Beyond the pure performance measure there further 'informal' objectives particularly around patient safety. These include that we:
   - ensure that we proactively identify and put in place support for our most pressurised systems to reduce patient safety risk; and,
   - manage the escalation process more appropriately than in previous years.

Background

5. The Next Steps on the Five Year Forward View set out the ambitions for delivery for the Urgent and Emergency Care System for the coming two years. For Trusts this included a

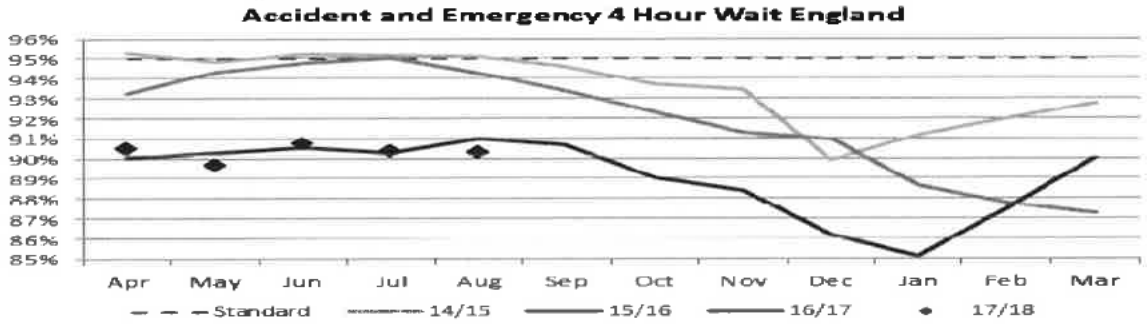
[1] https://www.england.nhs.uk/wp-content/uploads/2017/03/NEXT-STEPS-ON-THE-NHS-FIVE-YEAR-FORWARD-VIEW.pdf

significant focus on improving patient flow and reducing discharge delays (acute, community and mental health) and redesigning the clinical standards for the service (ambulance). Much of this will support delivery this winter but is also focused on ensuring that we move to a more sustainable future model of delivery for Urgent and Emergency Care. A priority over winter is to ensure that this medium-term transformation work continues to be delivered, which has not been the case in previous years, with dedicated, ring-fenced resource in place to ensure this is the case.

6. In July 2017 NHS England and NHS Improvement sent a letter to the system (CCGs and Trusts) setting out expectations and priorities to build resilience across the system ahead of winter (more detail later in the paper) alongside the joint review of winter 2016/17. The review emphasised the need for:
    - earlier planning for winter than in previous years;
    - a more joined-up approach from NHSE and NHSI; and,
    - the need for sufficient, seven-day a week capacity (including through a significant reduction in delayed transfers of care) to maintain bed occupancy below 92% throughout winter.

Current context for delivery

7. A&E performance is currently averaging just over 90%, slightly lower than at this point last year.



8. Whilst performance is currently meeting the ambition of achieving 90% in or before September 2017 the key operational indicators point to a very challenging winter.
    - **Demand** – emergency admissions are 2.4% higher over the past year than at the same period the year before. This is largely in line with long-term trend;
    - **Supply** – bed occupancy has averaged 92.3% over the past six weeks. The winter review clearly set an objective for bed occupancy to be no more than 92%[2] at any point in winter. Winter bed occupancy has averaged around 2% higher than that seen in summer.
    - **Flow** – delayed transfers of care (DTOCs) are slightly down in July with 5,861 DTOC beds compared to 5,954 beds per day compared to July 2016. The number of patients waiting 4-12 hours from decision to admit to admission is 9% higher than last year.

[2] Recent work by the Economics Team in NHSI analysing daily data from last winter estimates that, after controlling for other operational and capacity factors, an occupancy rise from below 88% to the 88%-92% range is accompanied by a one-off drop in performance of 3% for the average trust. When occupancy moves above 92% there are increasingly large reductions in performance reaching 8% when occupancy is at 100%.

9. Therefore with supply more constrained than last year and flow not improving, coupled with reductions in funding growth in 2017/18 and the risk of flu and/or a prolonged cold snap (which were not observed last year) there are significant concerns ahead of winter.

Our approach to winter

10. Planning for this winter has started earlier and is being taken forward in more granular detail than in previous years. Importantly the joint nature of the programme across NHS England and NHS Improvement enables a single message from the top down through to local system leaders and the sharing of resource to support delivery.

11. Whilst the context running into winter is challenging the planning detailed below will ensure that the highest risk systems are identified at an early stage and difficult decisions taken early to mitigate patient safety risks.

Local planning

12. The preparations for winter are being led by the joint National Director for Urgent and Emergency Care, Pauline Philip, who leads the Urgent and Emergency Care Programme across NHS England and NHS Improvement.

13. She wrote out to the system (A&E Delivery Boards (AEDBs)) on 14 July setting out expectations and priorities for winter. Local systems were asked to submit their plans by 19 September. The specific areas of focus for local systems set out in the letter were:
    - Demand and capacity planning;
    - Front door processes and primary care streaming;
    - Flow through the UEC pathway;
    - Effective discharge processes;
    - Planning for peaks in demand over weekends and bank holidays; and,
    - Ensuring the adoption of best practice as set out in the NHS Improvement guide: *Focus on Improving Patient Flow.*[3]

14. [redacted]

[redacted]

[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]

[3] https://improvement.nhs.uk/resources/good-practice-guide-focus-on-improving-patient-flow/

16. [redacted]

17. All Trusts will also have to have in place signed-off plans (by the Medical Director, Nursing Director and local AEDB Chair) setting out how they will manage clinical prioritisation at peak times. This may involve potentially difficult measures, such as 'boarding' patients on wards once their A&E treatment is completed to manage patient safety risks, which are being discussed with the CQC and the Royal Colleges.

National actions

18. The letter of 14 July also highlighted the importance of **reducing Delayed Transfers of Care** to free up much needed beds ahead of winter. Local Authorities and CCGs each have individual trajectories that add up to a national reduction of 2,400 beds by November 2017, split equally across the NHS and Social Care. Initial signs are despite the additional investment in social care that this is unlikely to be delivered.

19. A **National Operations Function** is being developed under a National Operations lead reporting into Pauline Philip. This will go live in October. This national function will be linked into dedicated regional operational functions and then to local systems. The national function will be focused on ensuring patient flow is maintained 7-days a week and during periods of stress during winter. It will:
    - co-ordinate, monitor and report performance and pressures;
    - provide predictive analysis to allow early intervention;
    - act as an escalation; and
    - provide direct management/oversight of particularly challenged systems in agreement with with regional teams.

20. A number of actions have been taken to increase the normalisation of poor performance amongst many systems focused on **leadership and behaviours**. These are:
    - A national A&E Event on 18 September for the Trust CEs and Chairs, and CCG AOs and [redacted] At the event Secretary of State, Jim Mackey and Simon Stevens emphasised the priority given to A&E delivery and set the expectations of Executive Teams and Boards over winter; David Behan set out the CQC views on the importance of reducing congestion in Emergency Departments for patient safety; and, regional directors worked through winter plans in detail with attendees;
    - An event for Category 2 Trust CEOs and CCG AOs on 2 October with Secretary of State, Jim Mackey and Simon Stevens;
    - [redacted]
    - CQC will be conducting a series of unannounced inspections and winter specific Emergency Department visits over the coming months;
    - [redacted]

21. A national **patient safety** campaign will be launched in October focused on safety through the winter. It will be based around the rollout of an Emergency Department Patient Safety checklist developed in University Hospital Bristol and now used by seven Trusts in the area with evidence showing a resulting reduction in Serious Incidents.
22. £100m of funding for **primary care streaming** has been disbursed to over 100 Trusts to support the nationwide implementation of streaming by the end of October. This will ensure patients see the most appropriate clinician when attending A&E and reduce the pressure on Emergency Departments.

23. A **single daily sitrep** is being put in place (from October) across NHSE and NHSI. This will be accompanied by a new daily sitrep for Community Providers showing for the first time regular data on capacity and occupancy in the community sector. In primary care a new workload tool will enable a better understanding of primary care capacity system by system. Further work is underway on what specific primary care data collections will be needed over winter.

24. Ambulance Providers are implementing the **Ambulance Response Programme** so that by the end of October all Ambulance Trusts (with the exception of the Isle of Wight) will be working to a new set of clinically based standards that will free up resource to focus on the most urgent patients whilst ensuring that the 'tail' of patients are covered by some standards of service. The new standards will be fully implemented by April and until then contractual sanctions are being suspended.

Governance

25. As described Pauline Philip has been appointed as the single national leader accountable to both NHS England and NHS Improvement. In addition, a nominated Regional Director, accountable to Pauline Philip, from either NHS Improvement or NHS England holds both CCGs and trusts in each STP area to account for the delivery of the local urgent care plan. Each Regional Director therefore acts with the delegated authority of both NHS Improvement and NHS England in respect of urgent and emergency care.

26. The National Director is supported by a joint programme team and works with and through the regions with local A&E Delivery Boards to prepare for and manage winter. An Urgent and Emergency Care Programme Board sets the strategic framework for delivery and its membership includes representatives from NHS England, NHS Improvement, Department of Health, Care Quality Commission, Local Government Authority, Association of Directors of Adult Social Services, and Health Education England.

Funding

27. Learning from the experience of last winter and Board discussions at the time we are focused on the **additional capacity** that will be needed through winter, and the associated costs, particularly given the number of escalation beds opened last year, the very ambitious DTOC reductions we are relying on this year and the high rate of occupancy we are currently seeing.

28. Information on the bed capacity planned [redacted] has been collected and an assessment is being made with Financial Directors on how much of that capacity is in current financial plans. This assessment will also seek to understand the potential additional costs of winter (e.g. from cancelling elective work) faced by Trusts and how much of these are factored into plans. This work will then support discussions

about how these additional costs may be covered and the impact on the provider deficit position.

Conclusion

29. [redacted]
Wide-ranging action is and will be taken over the coming weeks to mitigate these risks including a renewed focus on ensuring there is sufficient capacity in the system, board leadership and accountability and escalation arrangements to manage patient safety risks. The Board is asked to comment on and note this update.

NHS Improvement

To: The Board

For meeting on: 28 September 2017

Agenda item: 15

Report by: Jeremy Marlow, Executive Director of Operational Productivity

Report on: Update on Incident Management and Emergency Preparedness

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Summary

1. In the event of disruption to NHS Improvement's own staff or critical functions, the organisation must have strong management and recovery plans in place to return to full operations as rapidly as possible. At the same time, NHS Improvement has an important role to play in supporting trusts during their response to and recovery from any disruption they experience, linking in with the formal NHS emergency preparedness, resilience and response arrangements led by NHS England. This paper provides an update on the progress to date in establishing clear frameworks for both internal business continuity and external NHS emergency response scenarios, as well as the lessons learned from recent exercises to test both. There is further work underway to embed duty arrangements across the organisation to enable responsiveness out of hours; to train and exercise the staff likely to be involved in responding to such events; and to put in place the appropriate resource for this work within NHS Improvement.

Background

2. Executive responsibility for business continuity transferred to me in March 2017 and new arrangements have been agreed and progressed since then.

3. NHS Improvement had not yet got a business continuity framework in place, nor a defined team to take forward this work. Major incident considerations had not been taken into account, nor had out of hours duty arrangements been reviewed.

4. A standing business continuity team was established in March 2017 to take forward the development of business continuity planning. The group includes representatives from all directorates and regions and meets monthly, chaired by myself.

5. In England there have been six significant major incidents since March:
   - Westminster Attack on 22 March

- Ransomware cyber-attack on 13 May
- Suicide bombing at Manchester Arena on 22 May
- London Bridge and Borough Market attack on 3 June
- Grenfell Tower block fire on 14 June
- Finsbury Park mosque attack on 19 June

Although not disrupting NHS Improvement's own operations, all had an impact on the NHS. This led to the expansion of the business continuity work into major incident response and duty planning in June 2017.

6. Despite the lack of staff, effective tactical responses were put in place to manage all of the above incidents but it has given extra impetus to improve our systems, which is in hand.

7. The rest of this paper sets out what is being done to improve capabilities in the three distinct areas of:
   - Internal Business Continuity
   - External Major Incident Support
   - Duty and out of hours responsiveness.

Internal business continuity planning

8. NHS Improvement has legal and pastoral duties to its staff, and has important functions which would need to be recovered in the event of disruption.

9. A clear Concept of Operations has been established and agreed by the Executive Committee. This sets out the management chain of command in the event of a business continuity threat, including the roles comprising an incident management team.

10. Each NHS Improvement directorate and region has been asked to complete a Business Impact Assessment to describe sequence in which critical functions would need to be recovered, enabling prioritisation across the organisation.

11. On 16 August 2017 a desk-based exercise was undertaken to test the draft framework and NHS Improvement's recovery plans. The lessons arising were:

    - A clear concept of operations is in place, with defined roles across a business continuity threat response team
    - Mass communications tools, back up facilities, and IT recovery options are all in place and can be called upon
    - Loggists need to be in place to record decisions taken during any business continuity response
    - Business impact assessments from the directorates and regions need to be improved in order to give a clearer sequence of recovery priorities
    - IT infrastructure needs to be described in a clear way for future business continuity incident managers to be able to ask the right questions
    - Deputies need to be in place and well briefed to cover for the absence of the principal lead from each directorate or region.

12. A full framework is now well developed, and will incorporate the lessons from the first desk-based exercise. The full document is expected to be ready for the executive committee's consideration in September 2017. Its finalisation will be subject to iterating each directorate and region's business impact analysis.

13. Further business continuity desk-based exercises will be conducted on a regular basis. The next exercise is scheduled for 20 September 2017.

Supporting the NHS to recover from major incidents

14. NHS Improvement currently has no formal or legal requirement to respond to major incidents affecting NHS trusts. NHS England is a Category 1 responder under the Civil Contingencies Act 2004, with an established Emergency Preparedness, Resilience and Response (EPRR) framework at national, regional and sub-regional levels, including an on-call infrastructure to manage major and critical incidents.

15. It is important that this lead role is not muddied in any way. Nevertheless, the sector has a reasonable expectation that NHS Improvement would have a role in supporting trusts during a major incident. For that reason, a temporary major incident plan was put in place on 19 May 2017.

16. A more permanent plan was then developed and was approved by NHS Improvement's executive committee in July 2017. This document, the Major Incident and Response Policy, sets out the operational arrangements to be undertaken by NHS Improvement in preparation for, and at the time of, a level 2, 3 and 4 major incident.

17. The policy has been developed in consultation with NHS England's national EPRR team, to ensure that it aligns with the NHS England Major Incident and Response plan. Care has been taken to reduce the risk of duplicating or cutting across NHS England's EPRR response.

18. The document will be iterated on a regular basis in order to remain up to date. Towards the end of 2017, NHS England will review its national EPRR arrangements and will seek to incorporate NHS Improvement's role, as described in the policy. This will formalise NHS Improvement's place in the national response to major incidents, working in line with NHS England's EPRR arrangements.

19. On 23 August 2017, a desk-based major incident exercise was undertaken to test NHS Improvement's major incident and response policy. The lessons arising were:

    - NHS Improvement now has a clear role supporting national EPRR arrangements, taking instructions from NHS England
    - Established communications, regional senior manager and executive duty arrangements work well, with clear plans for supporting trusts recover from disruption

- NHS Improvement's action cards for each role in the incident response team enabled a structured response to the situation
- Earlier involvement in NHS England's incident command centre is important and this is being reflected in revised action cards within NHS Improvement's plan
- Phases of response should be developed, with NHS England leading on support to the sector in commanding and controlling the response to a major incident and NHS Improvement taking the lead in supporting trusts to recover and return to normal business operations in the aftermath of an incident – this work is now underway
- Further exercises should be carried out within NHS Improvement's regional teams to improve readiness.

20. Further desk-based exercises will be held across each NHS Improvement region, as well as at national level, and with the executive team, to maximise our ability to respond effectively.

Improving our duty arrangements to respond out of hours

21. NHS Improvement needs to ensure it is able to respond to significant events at any time. To do so, strong and clear duty arrangements are required across critical functions.

22. These include the ability to respond to internal business continuity risks, external major incidents affecting the sector, or other urgent issues such as the NHS estates response to the cladding issues raised by the Grenfell fire.

23. In July 2017, a short consultation was held with NHS Improvement's regional senior managers on call to clarify the links between these roles and the NHS national EPRR arrangements led by NHS England.

24. Final proposals for the roles, responsibilities, handover, management and maintenance of NHS Improvement's duty arrangements will be presented to the executive committee in September 2017 for discussion and agreement.

25. Depending on the proposals agreed by the executive committee, the HR and financial implications of the proposed duty arrangements would then need to be considered and worked through, and the agreement of sufficient staff for duty posts gained, before the updated system is implemented.

26. The aim is to agree and implement a full, revised duty system for NHS Improvement by October 2017.

Training, exercising and resourcing

27. As NHS Improvement's policies for incident management and emergency preparedness are agreed and implemented, it will be important to ensure that appropriate training is provided to all staff with a role in this work.

28. On 10 October 2017, NHS England's Head of EPRR will provide NHS Improvement's executive team with training on strategic leadership in a crisis and emergency response, with particular reference to NHS Improvement's role and the above business continuity and major incident policies.

29. Further exercises of both business continuity preparedness and major incident response will be conducted on a regular basis. NHS Improvement's regional teams are being encouraged to conduct major incident response exercises outside the schedule of national exercises to ensure maximum preparedness.

30. Staff cascade arrangements have been developed and implemented, including a test exercise, to ensure that an all-staff welfare check can be conducted when required. NHS Improvement has also signed up for access to a mass communications software platform (provided by Everbridge),which enables messages to be broadcast via email and text message to all staff, groups of staff, or key leaders across the provider sector. This was tested with all staff on 19 May 2017.

31. To date, NHS Improvement's work on incident management and emergency preparedness has been taken forward by a small group of colleagues from across directorates alongside their usual job roles. Given the scale of this work, NHS Improvement needs dedicated, permanent resource to develop and maintain these systems.

32. The close links between NHS Improvement and NHS England in respect to emergency preparedness and response mean that the close working already undertaken to date should be enhanced. While NHS Improvement will need dedicated, permanent resource for this work, it is proposed that strategic guidance and direction should be shared with NHS England. Executive-level agreement has been reached between the organisations to formalise these arrangements, with further meetings scheduled to discuss the practicalities of doing so.

33. NHS Improvement is due to advertise a permanent emergency preparedness lead position in the autumn.

NHS Improvement

To: The Board

For meeting on: 28 September 2017

Agenda item: 16

Report by: Bob Alexander, Executive Director of Resources
Ben Dyson, Executive Director of Strategy

Report on: Proposals for:
(a) Principles for collaboration and joint working with NHS England
(b) Testing joint NHS Improvement/NHS England Regional Director posts in the South
(c) Joint Regional Nurse posts

Introduction

1. This paper:
   - sets out proposed principles for NHS Improvement's overall approach to collaboration and joint working with NHS England, in the context of wider strategic aims for development of Sustainability and Transformation Partnerships (STPs) and accountable care systems (ACSs) – see **Annex A**
   - seeks the Board's agreement to testing an approach that involves a joint Regional Director post, working for both NHS Improvement and NHS England, in the South East and an equivalent post in the South West – see **Annex B**
   - seeks the Board's agreement to the underlying accountability and review/evaluation arrangements – see **Annex C**
   - [redacted]

2. In summary, the proposals in **Annex A** are based on the principle that NHS Improvement and NHS England need to collaborate more closely to support trusts and CCGs in managing their collective financial resources and using those resources more efficiently and effectively to improve quality of care and health outcomes. This mirrors and supports the development of STPs and ACSs. At the same time, it is important to distinguish between those aspects of

NHS Improvement's work that can be carried out largely through its own interaction with trusts and those that require a joint or coordinated approach with NHS England and commissioners to prevent duplication or contradictory behaviours. The proposed key principles that flow from this are:

(a) Focus on areas where cross-system working is most important for local health and care economies and to coordinate the support and oversight provided by NHS Improvement and NHS England: always be guided by what will most improve quality, health outcomes and efficiency for the NHS and the patients it serves.

(b) Be clear about functions that are more distinctively NHS Improvement's or NHS England's business [redacted]

(c) Build on the styles and approaches of NHS Improvement and NHS England – be stronger together, whilst preserving those distinctive values and behaviours that are most important to success. Use cross-organisational development activities to develop shared values and behaviours.

(d) Always ensure clear accountability for the exercise of NHS Improvement's functions. For any joint posts, make sure that there is clear accountability to both organisations for how the post-holder fulfils the respective functions of those organisations. For all forms of collaborative working, make sure that the relevant NHS Improvement decision-making bodies continue to make decisions that fall within their remit.

(e) Involve staff – and STPs, provider trusts, CCGs and other stakeholders – in making judgements about which areas will most benefit from joint working and how to improve joint working.

(f) Maintain an agile approach, following a Plan, Do, Study, Act cycle to learn what is working well or less well, and adjust plans accordingly.

3. **Annex B** explains the rationale for the proposal to test a new arrangement in the South, whereby the current NHS Improvement Executive Regional Managing Director (ERMD) for the South holds a dual appointment as NHS England Regional Director and NHS Improvement ERMD for the South East, whilst the current NHS England Regional Director for the South West becomes also the NHS Improvement ERMD for the South West.

4. The anticipated benefits, explored in more detail in the Annex, include deploying people resources in the two regional teams in more efficient and effective ways; helping to reengineer the relationship between commissioners and providers, in line with emerging models of accountable care; reducing time spent on 'man-marking' and increasing time spent on direct support for local health economies; ensuring consistent expectations of CCGs and trusts in relation to quality of care, financial performance and operational performance; improving job satisfaction for staff; and streamlining engagement with STP/ACS leaders, local government and other partners.

5. [redacted]

6. The other key issue that will need to be tested is how far having a joint Regional Director working formally for both organisations, as compared with a 'lead' Regional Director with a less formal role for overseeing designated STP areas (the model currently used for urgent and emergency care), helps create better decision-making across CCGs and trusts over the winter period.

7. The two Regional Directors have been working with colleagues across the two organisations to begin developing these proposed working arrangements, with a view – subject to the Board's views – to beginning the formal testing phase from 1 October. In advance of that proposed formal go-live, the two Regional Directors have started in September to adopt some new ways of working on a shadow basis, mirroring the informal approaches already used in some other regions, but without any change to formal underlying accountabilities.

8. **Annex C** sets out the key proposed arrangements for this phase of testing, with a particular focus on accountability, legal considerations, and values and behaviours. These arrangements are designed to ensure (among other outcomes) that difficult decisions, e.g. on leadership issues, are made efficiently and effectively, with absolute clarity about legal powers and delegated authority.

9. Annex C also sets out the proposed arrangements for review and evaluation. These are designed to enable the two organisations to identify quickly how well the arrangements are working, with a view to course correction where necessary to maximise the chances of success, and to help inform subsequent decisions by the two Boards as to whether to put the arrangements onto a substantive footing and whether to adopt similar arrangements in other regions.

10. **Annex D** explains the background to the two joint regional nurse posts already in place (in the South and London) and the options as to whether and, if so, when to roll these arrangements out to other regions. [redacted]

ANNEX A

PROPOSED OVERALL APPROACH TO COLLABORATION AND JOINT WORKING WITH NHS ENGLAND

A1. NHS Improvement and NHS England have distinctive but complementary roles in relation to leadership, oversight and support for the NHS in England. Broadly speaking, in legal terms:

- NHS England is responsible for allocating funding to clinical commissioning groups (CCGs), supporting and overseeing CCGs, directly commissioning some services (e.g. primary care, specialised services, prison health), and certain other functions such as coordinating responses to major incidents
- NHS Improvement (in carrying out Monitor's functions and those Secretary of State functions delegated to the NHS Trust Development Authority) is responsible for supporting and overseeing NHS trusts and foundation trusts, which provide around two-thirds of the services commissioned by CCGs and NHS England, as well as specific functions such as pricing (mostly carried out jointly with NHS England) and licensing of non-NHS providers.

A2. In practice, there is a large and increasing need for close coordination in how these functions are carried out. It has become ever more apparent since implementation of the Health and Social Care Act 2012 that it is not possible to make the most efficient and effective use of NHS resources – and thereby secure the best possible improvements in quality of care and population health – if commissioners and providers make decisions in isolation from each other:

- [redacted]
- Another key example is patient flow, particularly for urgent and emergency care, where quality of care and efficient use of resources rely on close coordination of decisions between commissioners and providers, for instance in relation to planning community-based services that seek to provide care in more appropriate settings, moderate growth in emergency hospital admissions and avoid delayed transfers of care from acute settings.
- More generally, improvements in quality of care and health outcomes are more likely to be achieved by breaking down boundaries between primary and secondary care, physical and mental health, and health and social care.
- Most of the system-level improvements identified in the Five Year Forward View, e.g. in relation to cancer outcomes or mental health, require a carefully coordinated approach across local health economies, not just a set of annual contractual transactions between commissioners and providers.

A3. For all these reasons, the approach followed by NHS England, NHS Improvement and other arm's length bodies (ALBs) since the publication of the Five Year Forward View has been to promote and enable a stronger focus across local health economies on joined-up service and resource planning through the vehicle of Sustainability and Transformation Partnerships (STPs). The more recent development of accountable care systems (ACSs) seeks to put this collaboration on an even stronger footing, by having commissioners, providers and local authorities take more explicit collective responsibility for population health and use of NHS resources for their local area.

A4. The development of STPs and ACSs – and the increasing moves to more strategic forms of commissioning, which place greater onus on providers for activities traditionally carried out by commissioners (e.g. resource allocation, pathway design) – strengthens, in turn, the case for a more joined-up approach between NHS England and NHS Improvement at national and regional level.

A5. The ongoing challenge for both NHS Improvement and NHS England is how to adopt this more joined-up approach, whilst at the same time preserving the value that comes from having organisations with a distinctive focus on particular aspects of quality, health and cost improvement. This means working on an agile basis to make ongoing decisions about:

- those aspects of NHS Improvement's work that can to a large degree be carried out effectively through interaction with individual trusts, e.g. specific areas of quality improvement, cost improvement, productivity and leadership
- those areas of work that most benefit from a joint or coordinated approach with NHS England and STPs/ACSs, particularly where an uncoordinated approach could result in conflicting expectations of CCGs and trusts.

A6. The predominant examples of this latter category to date have been:

- financial planning and financial risk management, where NHS Improvement and NHS England have established formal arrangements to support STPs – and, through them, CCGs and trusts – in making decisions that are optimal for their overall health economy
- urgent and emergency care, where NHS Improvement and NHS England have appointed a joint national director to oversee work on transforming urgent and emergency care and improving A&E performance and winter planning, with the eight Regional Directors each (on behalf of both organisations) overseeing system performance for a set of STPs
- joint programmes on mental health and cancer services
- support for, and oversight, of STPs and ACSs, where there has been an increasing trend towards having a Regional Director (from either NHS Improvement or NHS England) take the lead role in managing the relationship with that STP or ACS.

A7. NHS Improvement and NHS England have established a Joint Functions Group to keep under review the operation of these arrangements.

A8. In what is currently a small minority of cases, these forms of joint working also involve joint appointments, where the same individual carries out functions on behalf of both organisations. The main examples of this to date are the National Director for Urgent and Emergency Care; two Regional Director of Nursing posts in London and the South; the NHS Chief Clinical Information Officer and NHS Chief Information Officer; and the National Clinical Director for Mental Health. In addition, a lead Regional Director, acting for both organisations (though not with formal delegated authority from the partner organisation), has been allocated to each STP area to oversee urgent and emergency care.

A9. Ideally, NHS Improvement and NHS England would agree the desired 'steady state' for the respective roles of the two organisations, the areas that require joint working or joint appointments, and the relationship with STPs/ACSs, trusts and CCGs. In practice, it is difficult to define that 'steady state' with precision, because different parts of the country are taking different approaches to developing STPs/ACSs; and because testing different models of collaboration and integration will allow NHS Improvement and NHS England to define more clearly the implications for national and regional ways of working.

A10. Taking into account these factors, the suggested principles for NHS Improvement's overall approach to joint working and collaboration with NHS England are as follows:

(c) Focus on areas where cross-system working is most important for local health and care economies and to coordinate the support and oversight provided by NHS Improvement and NHS England: always be guided by what will most improve quality, health outcomes and efficiency for the NHS and the patients it serves.

(d) Be clear about functions that are more distinctively NHS Improvement's or NHS England's business and do not require collaboration for collaboration's sake: trust each other to carry out these distinctive functions without the need for 'man-marking'.

(e) Build on the styles and approaches of NHS Improvement and NHS England – be stronger together, whilst preserving those distinctive values and behaviours that are most important to success. Use cross-organisational development activities to develop shared values and behaviours.

(f) Always ensure clear accountability for the exercise of NHS Improvement's functions. For any joint posts, make sure that there is clear accountability to both organisations for how the post-holder fulfils the respective functions of those organisations. For all forms of collaborative working, make sure that the relevant NHS Improvement decision-making bodies continue to make decisions that fall within their remit.

(g) Involve staff – and STPs, provider trusts, CCGs and other stakeholders – in making judgements about which areas will most benefit from joint working and how to improve joint working.

(h) Maintain an agile approach, following a Plan, Do, Study, Act cycle to learn what is working well or less well, and adjust plans accordingly.

ANNEX B

PROPOSED ARRANGEMENTS FOR SOUTH REGIONAL TEAMS

B1. In each of the current four regions, Regional Directors and their teams in both organisations have been developing an increasingly collaborative approach in recent years, with the aim of providing more coherent oversight and support for local health economies, [redacted]

B2. [redacted]

B3. Following extensive discussions with the individuals involved and with other staff working in regional teams, the senior executive leadership of both organisations consider that there would be considerable advantages in using this opportunity to test an approach whereby:

- NHS Improvement follows the same approach in sub-dividing its South regional team in two (for the purposes of most regional team functions)
- the current Executive Regional Managing Director (ERMD) for the South holds a dual appointment as NHS England Regional Director and NHS Improvement ERMD for the South East
- the current NHS England Regional Director for the South West becomes also the NHS Improvement ERMD for the South West.

B4. Annex C sets out in more detail the ground rules, accountability arrangements, legal considerations and review/evaluation arrangements for this proposed approach. One of the most important points to emphasise is that the only immediate change in terms of joint roles is at the level of the Regional Directors. This would not represent a formal merger of the two teams (NHS England and NHS Improvement) that sit underneath each Regional Director, and any proposals for joint roles elsewhere in the structures would need to be agreed with both organisations. It would in practice, however, allow the people in those teams to work in a different and more cohesive way.

B5. The executive team envisage the following key benefits from this arrangement:

- There are c.800 posts in the NHS England regional team for the South and 80 posts in the NHS Improvement regional team. Having a joint Regional Director should help deploy this combined resource in more efficient and effective ways for the benefit of local health economies and patients.
- Particularly in more challenged health economies [redacted], there is a pressing need to reengineer the relationship between commissioners and providers, with significant opportunities for streamlining the commissioning function and moving to a more strategic form of commissioning. This will give greater opportunities for provider organisations to make collaborative decisions about resource allocation and service planning, in line with the principles of accountable care. Having a joint Regional Director, who can coordinate the work of NHS England and NHS Improvement regional teams, could help accelerate these strategic developments.
- [redacted]. Having a joint Regional Director should help secure more consistent approaches to CCG and trust oversight, thereby supporting improvements in quality of care and operational/financial performance.
- This should help improve job satisfaction for staff working in regional teams, as they spend more time looking outwards to health economies [redacted]
- The greater coordination possible under the supervision of a joint Regional Director should allow for more streamlined forms of engagement with key stakeholders in local health economies, [redacted]

B6. The table at the end of this Annex sets out key anticipated benefits in more detail, mapping them to key objectives for both organisations and indicators that will be used in the proposed review and evaluation arrangements.

B7. There are a number of issues and risks that would need to be reviewed and managed in testing the proposed new arrangements, including:

- [redacted]

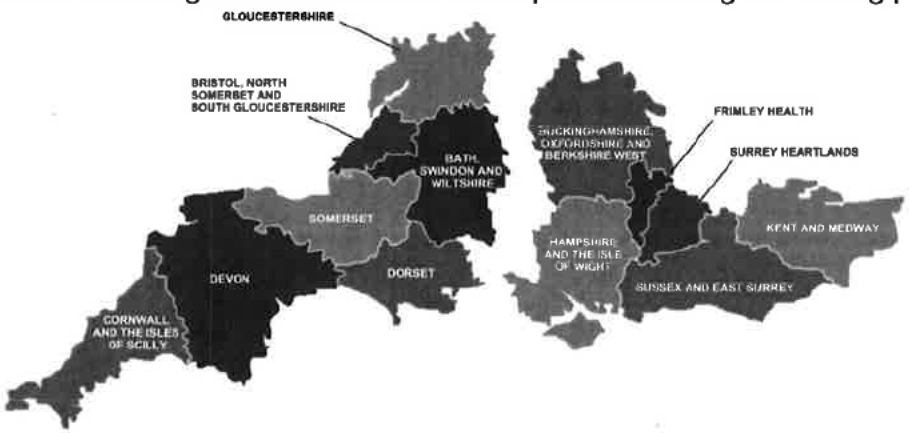
[redacted]

B8. In view of the potential benefits, the executive team strongly recommends that NHS Improvement move formally to testing the proposed new arrangements from 1 October, subject to the arrangements described in Annex C. The executive team would keep the Board informed of progress during this testing phase. The Board would need to make a decision, following this phase of review and evaluation, on whether to make this a longer term arrangement for the South and whether to adopt similar arrangements in other regions.

B9. The two Regional Directors have been working with their teams and other parts of NHS England and NHS Improvement to develop a set of arrangements that are ready, subject to the Board's agreement, to begin formally from 1 October. In advance of that proposed formal go-live, the two Regional Directors have started in September to adopt some new ways of working on a shadow basis, i.e. with one Regional Director managing the day-to-day interactions with health economies in the South East and the other with health economies in the South West, mirroring the approaches that already exist in some other regions, but it is only from 1 October that formal underlying accountabilities would change.

Proposed geographical split

B10. The map below shows the proposed STP areas for which the South East and South West regional directors will be responsible during the testing phase.



Mapping benefits to objectives and review/evaluation indicators

B11. The table below sets out in more detail key anticipated benefits, mapping them to key organisational objectives and to proposed review/evaluation indicators.

Supporting system-wide improvements in quality and health outcomes
Objectives • Meet Five Year Forward View objectives for urgent and emergency care, mental health, cancer services and elective care • Support the development of STPs and accountable care systems • Improve the number of providers with a CQC 'good' or 'outstanding' rating.
Anticipated benefits of new arrangements The joint Regional Directors will seek to deploy the resources in NHS England and NHS Improvement regional teams in ways that: • have a greater focus on system-level improvements • assess challenges and risks through a whole-system lens • use the full range of NHS England and NHS Improvement levers, relationships and support mechanisms to effect system-level change • develop single points of contact for priority programmes such as mental health.
Example indicators • Feedback from STPs/ACSs, trusts and CCGs • Resources provided directly to support STPs/ACSs • Performance against A&E 95% standard • Performance against cancer services 62-day standard • Performance against mental health access standards • Numbers of providers with a 'good' or 'outstanding' CQC rating
Better support for challenged health economies
Objectives • Provide appropriate, timely response to the most challenged health economies • Reduce the number of CCGs under legal directions • Reduce the number of trusts in special measures for quality and/or finance
Anticipated benefits of new arrangements • The joint Regional Directors and their teams will seek to focus resources more effectively on supporting challenged health economies, with shared diagnosis of

the drivers of system-wide challenges and more targeted, joined-up support for commissioners and providers in those health economies.
Example indicators • Feedback from STPs/ACSs, trusts and CCGs, assessing effectiveness of support • Number of CCGs under legal directions • Number of trusts in special measures • Performance against the STP metrics agreed with Secretary of State
Coherent and joined-up engagement with CCGs, trusts, STPs/ACSs and other NHS England/NHS Improvement teams
Objectives • Single consistent messages to local health systems • Streamline arrangements for meetings and engagement with STPs and other system partners • [redacted] • [redacted]
Anticipated benefits of new arrangements • The joint Regional Directors will be able to speak with one voice, helping to streamline engagement with key stakeholders in local health economies, including STP/ACS leaders, local MPs and local government. • They and their teams will promote consistent approaches to CCG and trust oversight, with aligned expectations for each. They will establish a single 'go-to' person with whom STPs/ACSs and other system partners in a given local health economy can interact. • Implementation of single financial and performance data sets
Example indicators • Feedback from STPs/ACSs, trusts and CCGs • Feedback from NHS England and NHS Improvement regional staff • Numbers of internal meetings
Improvement in system finances
Objectives • Improve performance against system financial control totals

Anticipated benefits of new arrangements

- The joint Regional Directors will have a holistic overview of the drivers of commissioners' and providers' financial performance and the interaction between them. This should enable them and their teams to support forms of shared financial planning and financial risk management that optimise performance against system control totals.
- [redacted]

Example indicators

- Performance of local health economies against system financial control totals
- Trust performance against organisational control totals
- CCG performance against organisational control totals

Improvement in staff satisfaction

Objectives

- Reduce duplication in work of NHS England and NHS Improvement regional teams, minimising low-value work
- Rationalise number of – and attendance at – internal and external meetings

[redacted]

Anticipated benefits of new arrangements

- The joint Regional Directors will seek to help teams focus on activities that better support local health economies, facilitate service improvement and enhance quality of care for patients. By improving alignment between NHS Improvement and NHS England, they will seek to ensure greater focus on value-add activities, reducing duplication and bureaucracy.
- The joint Regional Directors will streamline end-to-end processes for support and oversight and seek to eliminate duplication. They will encourage greater collaboration between NHS England and NHS Improvement teams, helping to direct resources to where they will have greatest impact.

Example indicators

- Feedback from NHS England and NHS Improvement regional staff on staff satisfaction
- Numbers of internal meetings

ANNEX C

PROPOSED PRINCIPLES, ACCOUNTABILITIES, LEGAL CONSIDERATIONS, VALUES/BEHAVIOURS AND REVIEW/EVALUATION ARRANGEMENTS

C1. This Annex sets out in more detail the proposed new arrangements to be tested for the South regional teams.

Key principles

C2. The two Regional Directors working jointly for NHS England and NHS Improvement in the South East and South West will be joint appointments who work equally for both organisations. Their responsibilities and accountabilities, both as an NHS England and as an NHS Improvement Regional Director, will be fully equivalent to those of other Regional Directors in NHS England and NHS Improvement.

C3. Below Regional Director level, the default position is that there is no change in employment arrangements. In other words, NHS England regional staff continue to work for NHS England and NHS Improvement regional staff continue to work for NHS Improvement.

C4. At the same time, one of the main intended benefits is to help NHS England and NHS Improvement regional teams work in a more cohesive, coordinated way for the benefit of local health systems and the patients they serve. [redacted]

C5. [redacted]

C6. The two Regional Directors will need to consider whether any other posts in the two sub-regional teams (beyond existing joint appointments) should be formally shared between the two organisations during the testing phase. Any such proposals will need to be agreed by both organisations after discussion with the individuals concerned. Where it is agreed to have further joint appointments, it will need to be clear who is the host employer.

C7. There are a number of functions in each organisation that currently span the whole of the South region, e.g. senior finance, nursing, medical, operational and other posts that do not currently fit into a South East or South West portfolio of work. The two Regional Directors will need to consider – and agree with both organisations after discussion with the individuals concerned – which functions should continue to operate on a pan-South basis and which should be split between the South East and South West during the testing phase.

C8. [redacted]

Accountabilities

C9. Each Regional Director will be accountable to NHS England for discharging functions that fall specifically to NHS England's regional teams (e.g. in respect of oversight of CCGs, primary care, emergency planning) and to NHS Improvement for functions that fall specifically to NHS Improvement's regional teams (e.g. in respect of oversight of – and support for – trusts).

C10. To underpin these arrangements during the testing phase, the joint Regional Director for the South West (who already has a contract of employment with NHS England) will also have a secondment agreement with NHS England. The joint Regional Director for the South East (who already has a contract of employment with NHS Improvement) will have a contract with no remuneration with NHS England. This will enable them to carry out organisational functions on a delegated basis and be properly accountable to both organisations. [redacted]

C11. One of the key hypotheses to be tested is that Regional Directors should be able to fulfil this dual set of responsibilities more effectively by being able to deploy more flexibly the resources that sit in the two regional teams that they will manage. [redacted]

C12. Each Regional Director in the South will report jointly to the CEO of NHS Improvement (as do other ERMDs) and to the NHS England National Director for Operations & Information (as do other NHS England Regional Directors).

C13. The Delivery and Improvement Directors (NHS Improvement) and Directors of Commissioning Operations (NHS England) will report on a day-to-day basis to the Regional Director covering their sub-regional area. However, formal line management arrangements will not change at this stage.

Legal considerations

C14. There is nothing in law to prevent NHS England and NHS Improvement from appointing the same individual to be the head of their respective regional teams for a particular geographic area.

[redacted]

[redacted]

Values and behaviours

C16. NHS Improvement and NHS England are developing a Memorandum of Understanding to govern the proposed new approach to regional working in the South East and South West. This includes setting out a set of shared values and behaviours to guide the approach taken by joint Regional Directors and their teams – and by colleagues in other parts of NHS Improvement and NHS England who will need to support the new arrangements.

C17. NHS England has identified organisational development support to help regional teams develop these values and behaviours and apply them to their day-to-day work, with a particular focus on building relationships.

Review and evaluation

C18. The arrangements will be tested before the Boards of NHS Improvement and NHS England are asked to consider whether they should continue on a substantive basis and before considering whether and, if so how/when, similar arrangements should be adopted in other regions. There would need to be consultation with staff and trade unions before deciding to put the arrangements on a permanent footing.

C19. Both organisations will commit to doing everything they can to make a success of the new arrangements.

C20. There will be an ongoing, agile process of review and evaluation that both:

- allows the two organisations to identify what is going well and what is going less well and course-correct as necessary to maximise the chances of success
- helps inform any decision by the two Boards as to whether to put the arrangements onto a substantive footing.

C21. The review/evaluation process will be predominantly qualitative and will involve systematically seeking views from staff and from local systems – trusts, CCGs and STPs/ACSs – as to how successfully the intended benefits are being realised and how successfully any issues, concerns or risks identified by staff and systems are being addressed.

C22. The process will also include looking at performance against a number of existing trust, CCG and system performance measures, both in terms of movement against a September 2017 baseline and in terms of relative trends compared with the national average. It will be necessary to consider performance trends in close conjunction with the qualitative feedback we are gathering to make judgements as to how far changes in performance can be attributed wholly or partly to new ways of working.

C23. The NHS Improvement Executive Director of Strategy and the NHS England National Director for Commissioning Strategy will be responsible for overseeing the review/evaluation process.

C24. The review will be delivered through external partners and a small internal project team. To ensure the right capacity and capability, it is proposed to bring in external support, with a particular focus on specialist skills in designing and delivering agile qualitative reviews. Subject to Board approval of the proposed testing phase, a partnership of external delivery partners should be ready to commence delivery by the beginning of October.

C25. At the start of the testing phase (October 2017), a baseline will be established by seeking views from local systems and staff, alongside relevant national stakeholders (e.g. NHS Providers, NHS Clinical Commissioners, NHS Confederation). This will be followed by quarterly review cycles starting in December 2017 and running to June 2018.

C26. A joint review group will consider the findings from each review cycle and decide when to make recommendations to the two organisations' Executive Teams and, in turn, their Boards about whether to put the arrangements onto a substantive basis, whether to discontinue the arrangements, or whether to continue testing for a further period. Following each cycle, there will be feedback tailored for specific audiences (Boards, staff and external stakeholders) on the progress of the new arrangements.

ANNEX D

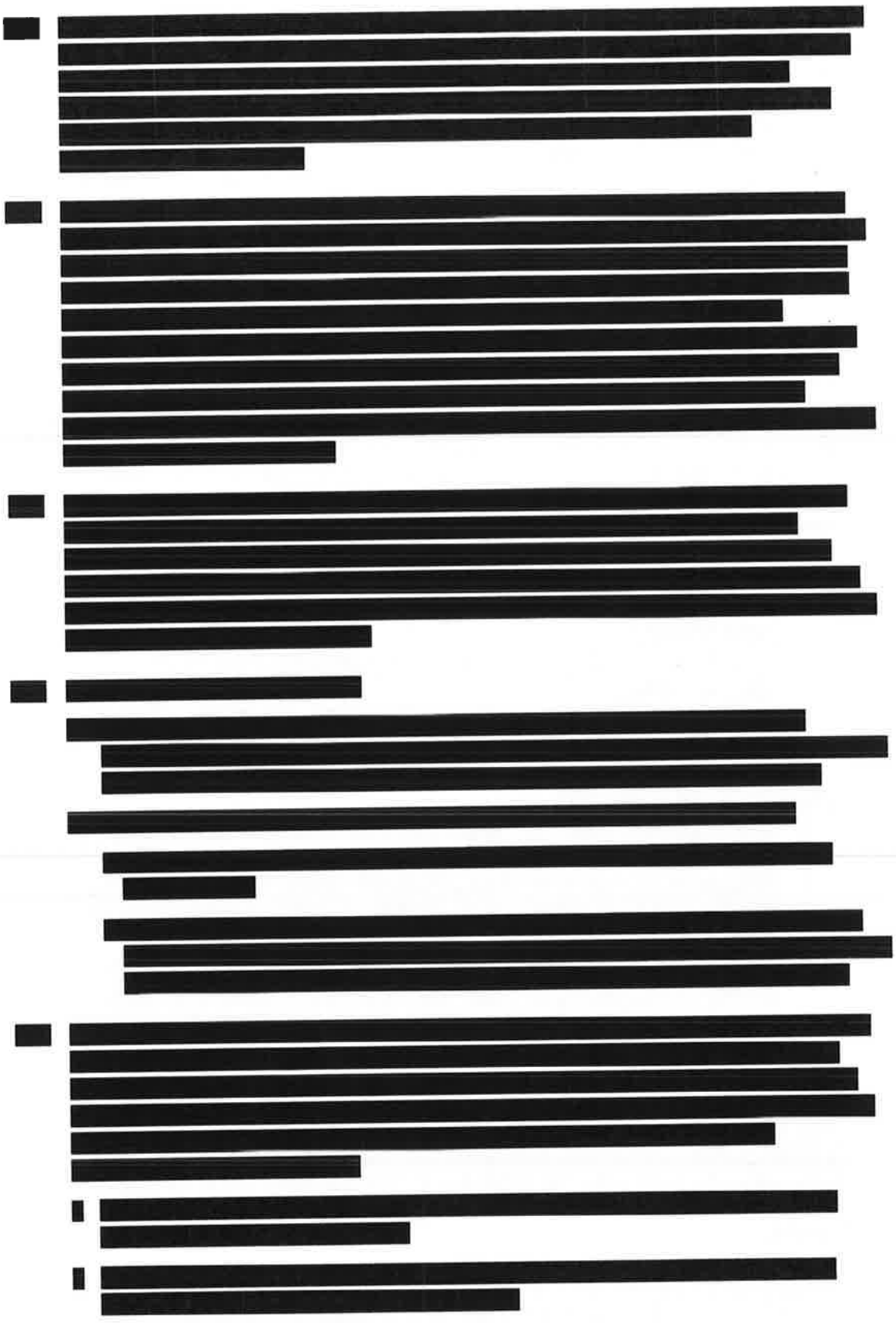
OPTIONS FOR JOINT REGIONAL NURSE POSTS

D1. Soon after its formation, NHS Improvement agreed with NHS England that the two organisations' Regional Nurse posts should be merged into joint posts in the South and London regions, with a formal evaluation after nine months. It was agreed that there would continue to be separate Regional Nurse posts in the Midlands and East and in the North. The opportunity to change the arrangements in London and the South arose because of vacancies in those regions.

D2. NHS Improvement and NHS England recruited to the two joint posts on a permanent basis in summer 2016, and the arrangements have been operating for the last eleven months in the South and nine months in London. A joint NHS England and NHS Improvement project team undertook an evaluation of the joint posts in June 2017. The evaluation found that although there were some challenges, particularly in the breadth of the role and having two managers and two professional managers, the change had generally been a positive one. The advantages and disadvantages identified in the report are set out below.

[redacted]

D4. [redacted]



NHS Improvement

To:	The Board
For meeting on:	28 September 2017
Agenda item:	20ii
Report by:	Bob Alexander, Deputy Chief Executive and Executive Director of Resources
Report on:	NHS Improvement Corporate Performance Update (Q1)

Purpose

1. This report summarises the Quarter One (Q1) delivery of NHS Improvement's 2017-19 Business Plan and information about the delivery of the Department of Health (DH) Remit Letter and additional impact measures. The Board is asked to note the contents and provide comment about NHS Improvement's progress and impact against its key objectives.

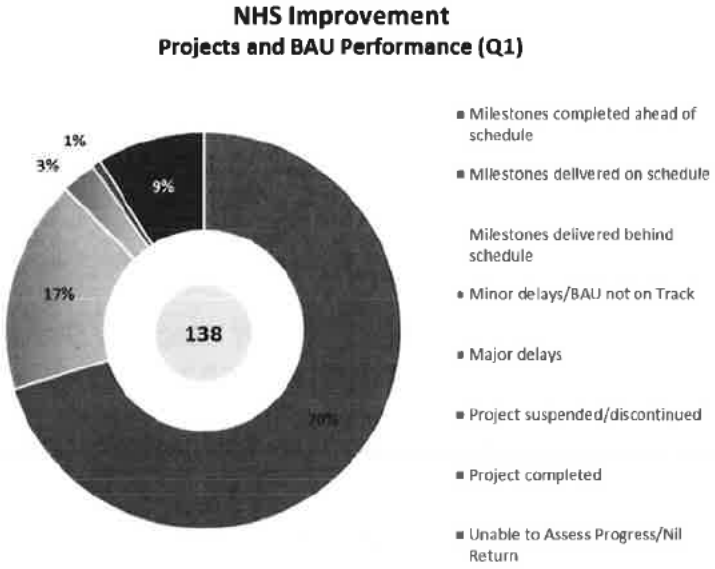
2. NHS Improvement's 2017-19 Business Plan is based on eight work programmes, each divided into individual work streams, as described in Appendix One (available in the Library section of the Board portal) . Paragraphs nine to 36 provide a summary of progress against key elements in each work programme. Appendix Two (available in the Library section of the Board portal) provides additional detail on the progress of the individual work streams.

Overall assessment of progress

Delivery of the 2017-19 Business Plan

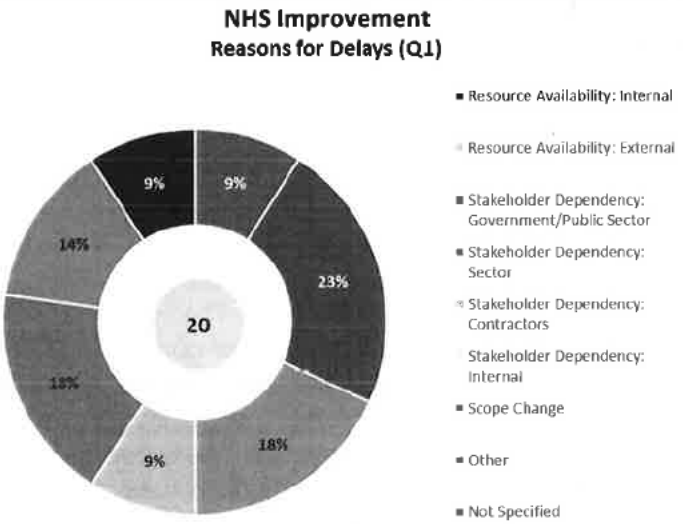
3. Overall, NHS Improvement directorates have made a positive start to implementing commitments outlined in our 2017-19 Business Plan and maintaining business as usual (BAU) activities. To date, 70 per cent of projects and BAU activities (equating to 97 out of 138 agreed projects/BAU activities) are considered on track (see Figure One). A further 17 per cent of projects/BAU activities are up to one month behind schedule, three per cent between one and three months behind schedule and one project has been discontinued, with the key elements subsumed into other work. This quarter, we have not been able to ascertain current progress for nine per cent of the projects/BAU activities listed in our business plan. Please note that the number inside each light blue circle refers to the number of project and business as usual activities assessed.

Figure One: NHS Improvement Projects and BAU Performance (Q1)



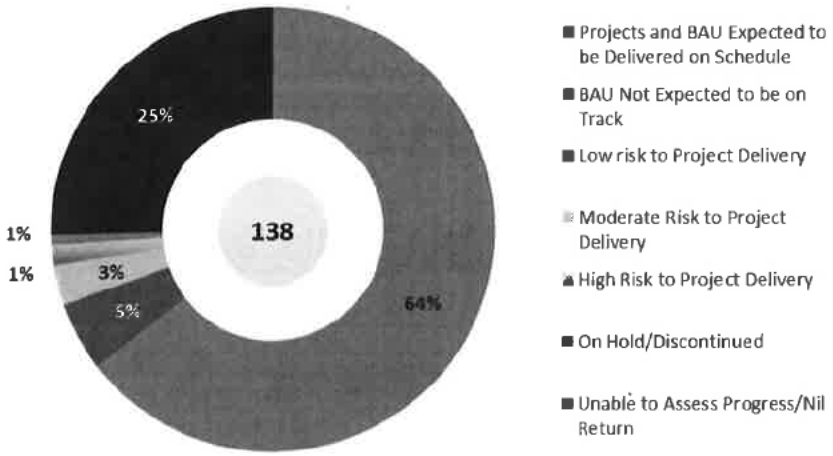
4. Internal resourcing constraints continue to be the most significant cause of business plan delays, although teams report greater success recruiting to key positions and flexibly using resources within directorates to focus on higher-priority projects. NHS Improvement's new responsibility for Use of Resources and Financial Governance assessments is a particular challenge and updated resourcing proposals are under development. Scope changes and reliance on contractors account for some delays, particularly within IT projects, but these are now mitigated. Sector dependencies account for a few delays, particularly in the Quality Improvement and Provider Productivity work programmes.

Figure Two: Project/BAU Activity Reasons for Delays (Q1)



[redacted]

Figure Three: Forecast Project and Business as Usual Performance (as at Q1)



Impact of NHS Improvement's Business Plan on Remit Letter commitments

[redacted]

8. The following section provides a high-level summary against key areas within the work programmes, where available. Further information on progress on individual work streams is in Appendix Two is available to download from the Library section of the Board portal.

2017-18 WORK PROGRAMME SUMMARIES

Quality Improvement

[redacted]

Financial Control and Turnaround

12. The financial results for Q1 indicate that the provider sector is broadly on track, although we anticipate that 2017/18 will be challenging. The focus is to accelerate the financial recovery trajectory on a recurrent basis. The majority of providers have set stretching plans to achieve value for money, with 206 (88 per cent) accepting a control total, and 166 (71 per cent) at or above plan as at Q1.

13. We conducted the Capped Expenditure Process (CEP) with NHS England to finalise 2017/18 planning, leading to some improved financial plans from commissioners and small improvements in the provider sector. The plan resubmission process was designed to capture the impacts on operating plans of CEP, as well as the Financial Special Measures and Financial Improvement Programmes. [redacted]

14. The assurance approach for 2018/19 operating plans is agreed with NHS England and will be issued in a letter to the NHS during September, pending internal NHS England and NHS Improvement governance. Accompanying tools are under development.

15. Capital investment and property business transactions have been approved in line with the capital regime for NHS Trusts and FTs, enabling them to proceed

with their capital plans. Additional ad-hoc requests, including Fire Safety capital plans, have been met, enabling the safe delivery of services.

16. Work is underway across several directorates on the Use of Resources Assessment and Well-Led Financial Governance Assessment delivery models. [redacted]

Operational Performance

17. [redacted]

18. The DH Remit Letter requires co-implementation of the agreed A&E recovery plan with NHS England. We have completed the patient flow good practice checklist ready for publication, the EFIT tool ready for testing and made progress with a workforce plan. We are also carrying out further work on reducing delayed transfers of care (DToC), including building a support offer for NHS and social care DToC, and scoping work to understand the factors that most influence the resilience of in-year trust-level A&E performance.

19. In conjunction with NHS England, we developed an RTT delivery plan and governance accountability framework to support recovered performance against the 62-day wait target. We have also supported 40 trusts on RTT, principally on performance and data quality, with the aim of meeting Remit requirements to reduce the total RTT list size and improve performance against the 92 per cent standard.

Provider Productivity

20. The DH Remit Letter specifies savings of between £1.0 and £1.8 billion across several work streams. At present, some, including doctor, nursing and AHP productivity, and pathology, are rated amber-red due to adverse variances against planned CIPs at the end of Q1. The Model Hospital now provides trusts with high quality benchmarking data across over 2,000 metrics.

21. The year-on-year reduction in medical locum spend is on track and, for the first time in recent years, providers report an underspend against plans on agency usage, [redacted] Work to reduce agency spend across all staff groups, support the strategy

to increase the availability of staff banks, produce an overall work plan, and refresh agency rules guidance is complete.

Leadership, Workforce and Improvement Capability

22. Implementation of the Junior Doctor Contract continues smoothly, with 88 per cent of rotas redesigned and 69 per cent of job offers made under the contract.

23. Our leadership development programmes continue to produce support for aspirational leaders and the Transformational Change through System Leadership programme has designed a sister programme aimed at individuals. The ACT Academy has delivered 12 days QSIR training to over 300 NHS staff, with an additional four days provided to 100 staff.

24. Directorates are working together to develop a comprehensive workforce programme across NHS Improvement, supporting the Remit request to improve the recruitment, retention and motivation of staff. The clinically-led, nursing retention Direct Support Programme, targeting providers with high leaver rates, began. [redacted]

25. We have been developing, testing and embedding the well-led framework in conjunction with the CQC. Over Q1, we published the well-led framework for developmental reviews, agreed an approach to supporting the CQC with well-led assessments and began joint testing.

Strategic Change

26. We are working with NHS England and other ALBs to develop and implement a shared framework for support to, and oversight of, local health economies. Four work streams on STPs, ACSs and ACOs are currently in place.

Oversight, Regulation and Support

27. The updated SOF policy document is ready for Q2 consultation. This will enable the framework to align with changes in national policy and performance standards. It will also help ensure our approach to monitoring providers and identifying their support needs is consistent, clear and transparent.

Building NHS Improvement and Supporting our Business

28. During Q1, extensive consultation was undertaken with NHS Improvement staff across the country to create organisational values and behaviours and to launch the culture and leadership toolkit. This important step helps build a collaborative

culture following a period of change and clear feedback from the 2016 staff survey. Team development has been supported across the organisation through facilitated team away days to ensure they have a clear focus for local action to enable NHS Improvement to be a great place to work. A new approach to performance development was also piloted during Q1, steering our culture towards a greater focus on coaching and improvement, with a network created to deliver in-house coaching. In addition, further work has been undertaken on induction and line management development and career progression.

29. Improvements to the recruitment process are on track. After working with our business partner to identify potential improvements, we have introduced internal improvement support to test the impact of proposed changes, and will continue this into Q2. Further detail is contained in the HR paper going to the IOC.

30. The majority of Single Network links were installed by the end of May, with two offices anticipating issues taking slightly longer. The start of the migration was delayed to resolve technical issues and undertake further assurance work. The data migration was completed at the end of June, with office migrations scheduled for July and August now complete.

31. Work continues on supporting a peripatetic workforce. Direct Access was implemented on schedule, with hundreds of laptops issued to staff. Recruiting a technical project manager, as well as introducing specialist IT services to ensure smooth migration, mitigated minor delays in the rollout.

32. The Business Systems Transformation programme has completed the discovery phase and started the procurement process. It has obtained approval to establish OM2 (Operating Model Level 2) to ensure ways of working are understood and variations in practice impacting system configuration are identified and standardised through consultation and collaboration. OM2 has begun business analysis process mapping and developed a set of underlying principles for how NHS Improvement will operate.

Regional Work Programmes

North

33. The North region has agreed the structure linking the regional business plan to the eight programmes, objectives and tasks identified in NHS Improvement's business plan, and will identify regional objectives, agree prioritisation and demonstrate how the region contributes to national programme objectives and priorities ready for Q2 performance monitoring.

Midlands and East

34. Midlands and East reports good progress across all NHS Improvement 2020 objectives, with a particular focus on the continued rollout of seven day services, the quality improvement initiatives at the trusts in special measures for quality, A&E, RTT and cancer operational improvements and support for the work

streams in provider productivity, such as the Model Hospital, pathology and pharmacy optimisation. There are still a small number of business areas that need to finalise plans for the remainder of the year.

London

35. London region have signed off their business plan, ensuring alignment with the NHS Improvement 2017-19 Business Plan and 2020 objectives. [redacted] Operational performance remains a strong focus, in particular working with trusts to clear the cancer backlog and attain national standards. The finance team has been working closely with NHSE on how best to support trusts with the CEP. There has also been joint working on Emergency Preparedness, Resilience and Response strategies in light of terror and cyber attacks. A Regional Productivity Director is now appointed to establish operational productivity and GIRFT.

South

36. The South has a regional business plan linked to the eight work programmes in NHS Improvement's business plan, and continues to progress work across all areas. In addition, development continues with the proposed integration arrangements between NHS Improvement and NHS England in the South. This will impact on the way the joint Regional Directors deliver business objectives across the South East and South West for the remainder of 2017/18.

Recommendation

The Board is invited to:

- note progress against the NHS Improvement Business Plan 2017-19, and
- comment on the impact on NHS Improvement objectives.