Sheffield Health and Social Care NHS Foundation Trust

Board of Directors - Open

Date: **12 August 2020** **Item Ref:** 05

TITLE OF PAPER	**Chief Executive's Report**
TO BE PRESENTED BY	**Jan Ditheridge**
ACTION REQUIRED	**The Board are asked to consider the impact and opportunity of the letter from Sir Simon Stevens and Amanda Pritchard regarding the third phase of the NHS response to CoVid on our strategic priorities and risks.** **The Board are asked to approve the recommendation re Executive lead for Inequalities.** **The Board are asked if there are any other issues that arise from the letter from Sir Simon Stevens and Amanda Pritchard we should consider.** **The Board are asked to consider the National Guardian Freedom to Speak Up Index Report 2020 and if they feel confident where and how we are addressing the issues it raises for us.** **The Board are asked to consider the NHS People Plan 2020/21, and where we may want the People Committee to focus attentions as an organisation, given our risks and challenges and as a contributor to our health and care system.** **The Board are asked to consider the direction of travel of the Accountable Care Partnership; and to understand the key priorities and how they relate to our own transformation programme.** **The Board are asked to acknowledge the Board role changes, consider any opportunities or risks within the changes and join me in thanking individuals for their contributions and wish them well where they have changed or moved into different roles.**

OUTCOME	To update the Board on key policies, issues and events and to stimulate debate regarding potential impact on our strategy and levels of assurance.
TIMETABLE FOR DECISION	August 2020 Board of Directors meeting.

Proud to care in Sheffield

LINKS TO OTHER KEY REPORTS / DECISIONS	CoVid19 Report Strategic Priorities 2020/21 Care Quality Commission Update
STRATEGIC AIM **STRATEGIC OBJECTIVE** **BAF RISK NUMBER & DESCRIPTION**	CQC Getting Back to Good CoVid19

LINKS TO NHS CONSTITUTION /OTHER RELEVANT FRAMEWORKS, RISK, OUTCOMES ETC	
IMPLICATIONS FOR SERVICE DELIVERY & FINANCIAL IMPACT	
CONSIDERATION OF LEGAL ISSUES	

Author of Report	Jan Ditheridge
Designation	Chief Executive
Date of Report	5 August 2020

Chief Executive's Report

1. Purpose

For approval	For assurance	For collective decision	To seek input	To report progress	For information	Other (Please state)
X	X		X	X	X	

The purpose of this report is to inform the Board of current national, regional and local (system) policy and current issues that require consideration in relation to our strategic priorities and Board Assurance Framework risks.

2. National Issues

2.1 CoVid – Third Phase of the NHS Response

(Letter from Simon Stevens and Amanda Pritchard dated 31 July 2020 – appendix A)

Most national and regional communication is related to the management of the CoVid virus and will be covered in the specific CoVid Board report, but I have selected a number of important issues that have wider implications or are important to consider strategically.

On 30th January 2020, NHS England & Improvement declared a Level 4 Incident which triggered the first phase of the NHS pandemic response.

On the 29th April, the second phase response, restarting urgent services, was announced.

On 31st July we received a comprehensive letter from Simon Stevens and Amanda Pritchard setting out the arrangements and expectations for phase 3.

The letter does three things:

- Update on the latest CoVid national alert level;
- Sets out the priorities for the rest of 2020/21;
- Outlines the financial arrangements looking forward and agreed with the government.

The Board can read the letter (appendix A) but there are a number of areas worthy of mention in this report, which directly impact on our strategic priorities and risks.

CoVid-19

CoVid remains in general circulation with local and regional outbreaks across the country. There is a real risk of a return to a level 4 national response. We are expected to continue to run our Emergency Preparedness, Resilience and Response (EPRR) incident arrangements (Gold; Silver; Bronze) overseen by Regional teams.

It is expected that from August we will need to ensure that full services are resumed, ensuring that CoVid precautions continue to be observed wherever we provide services. There are three clear instructions:

- Use the opportunity between now and Winter to accelerate near normal activity levels addressing waiting lists and unmet need;
- Prepare for Winter – while watching for CoVid spikes;
- Take the lessons from the first CoVid peak to prepare for Winter and where appropriate transform services.

Much of the letter directly relates to acute hospital activity although the principles apply to our services.

There are a number of specific areas of focus for those of us delivering services for people with mental health problems, or with a learning disability and/or autism.

These include:

- Every Clinical Commissioning Group must continue to increase investment in line with the Mental Health Investment Standard.

  We are progressing these discussions and the Accountable Care Partnership Mental Health/Learning Disability workstream progress will be reported through the Transformation Report.

- Mental Health Services:
  - Improving Access to Psychological Therapy (IAPT) Services are to fully resume.
  - 24/7 crisis helplines, established during the pandemic should be retained.
  - Proactively review all patients on community mental health team caseloads, increasing therapeutic activity and supportive interventions to prevent relapse or escalation of need.
  - Ensure access to local services advertised.
  - Use the £250m of identified capital to help eliminate mental health dormitory wards.

  The Board are aware of our plans and focus to eradicate dormitory wards and we have applied for some of the identified capital.

  Progress on this can be followed through the CQC Back to Good Reports and the transformation reports.

  The CoVid team are still working to understand potential surges and capacity required to support people through the coming months.

  Progress on this can be found in the CoVid Report.

- Learning Disability and/or Autism:
  - Continue to reduce number of people within specialist inpatient settings.
  - Complete all outstanding Learning Disability Mortality Reviews by December 2020.
  - Everyone with a learning disability should be identified on a GP register, have a completed annual health check and access to screening and vaccinations arranged.

<u>Preparations for Winter</u>
The key areas of focus for our organisation will be:

- Produce a comprehensive, coherent Winter plan demonstrating:
  - Plans take into account CoVid restrictions/guidance.
  - A robust flu vaccination programme is in place.
  - Stocks of PPE are sufficient.
  - Capacity plans take into account Winter potential impacts.

This plan will be produced through our Emergency Preparedness, Resilience & Response (EPRR) arrangements and shared with Board for assurance purposes.

Workforce

The letter signposts us to the recently published people plan "We are the NHS: People Plan for 2020" which will be covered later in this report, due to the importance and relevance for our organisation.

Health Inequalities & Prevention

There are a number of actions that our organisation will play a part in but will be led by commissioning colleagues. However, there are a number of direct asks of our organisation which include:

- Every NHS organisation will have a named Executive Board member for tackling inequalities by September 2020.
- Boards will publish an action plan showing how over the next 5 years our Board and senior staffing will in percentage terms at least match the overall BAME composition of its overall workforce, or community, whichever is higher.
- Review and ensure completeness of patient ethnicity data by no later than 31st December 2020.

I recommend that the Chief Executive becomes the named Executive for tackling inequalities until the Director of People job description is agreed and the post is appointed to substantively.

Financial Arrangements & System Working

The changes in arrangements largely impact on those who would normally operate under a payment by results finance system. This will continue to be suspended through August and September 2020.

There is an emphasis on maintaining and developing the partnership working demonstrated through the pandemic. It calls for a single Integrated Care System (ICS) leader and a non-executive chair, with clearly defined arrangements for provider collaboration, place leadership and integrated care partnerships.

The Sheffield Accountable Care Partnership (ACP) and South Yorkshire & Bassetlaw Integrated Care System (ICS) have been exploring these areas over the last few weeks, as normal business resumes.

Executive Directors will take forward specifications relevant to their portfolios.

The Board are asked to consider the impact and opportunity of the phase three letter on our strategic priorities and key risks.

The Board are asked to approve the recommendation re Executive lead for Inequalities.

The Board are asked if there are any other issues that arise from the letter we should consider.

2.2 Freedom To Speak Up (Index Report 2020)

The national Freedom to Speak Up Guardian, Dr. Henrietta Hughes, produces and publishes an annual FTSU Index. This index uses 4 questions from the staff survey most closely aligned to speaking up and out safely. The index gives an indication of how well equipped and how safe staff feel to speak up about patient safety concerns.

This allows Trusts to compare and consider their safety culture with other Trusts, benchmark and learn. It can also be used to support organisations and specifically Boards to shape and develop their cultures to respond to what the index is telling them.

The report and index can be found at appendix B.

The index is based on the 2019 staff survey results and the Board will note that we have seen a 3.9% decrease in our index score compared with the previous year.

This is not new news, but nonetheless disappointing.

However, it does reinforce how important our work on culture will be, to create an environment in which staff understand patient safety and how to speak up safely.

As you can see from the report there appears to be direct correlation between the staff survey and the CQC ratings of organisations.

Culture does impact on quality and service improvement.

Board members spent the last development day considering our culture and our organisational response to support change. This is work in progress and will form a key element of the Board development programme.

The Board are asked to consider the report and if they feel confident where and how we are addressing the issues it raises for us.

2.3 We are the NHS People Plan 2020/21 – Action for us all

This interim NHS People Plan (the plan) June 2019 set the national strategic framework for the NHS workforce over 5 years.

The plan builds on the NHS response to the pandemic, and aims to set out an NHS Workforce Strategy for the coming eighteen months.

The executive, led by Caroline Parry, Director of HR, with their teams will consider the plan in detail, cross referencing against our own People Strategy and implementation plan. The plan and the implications for our organisation will be explored in more detail at the People Committee, before returning to the Board.

However, it is worth considering the main points of the plan here is to give a steer to the People Committee and inform potential Board discussions.

The main points of the plan are:

- The NHS needs more people, working differently, in a compassionate, inclusive culture.
- To learn from and implement positive workforce changes during the CoVid19 pandemic.
- Encouragement to work as systems to implement local priorities.

We also expect to contribute to our Integrated Care System People Plan.

You can find the full report at:
https://www.england.nhs.uk/ournhspeople/

The Board are asked to consider the plan, and where we may want the People Committee to focus attentions as an organisation, given our risks and challenges and as a contributor to our health and care system.

3. Local/Trust Issues

3.1 Sheffield Accountable Care Partnership

The Sheffield ACP Board recently met for the second time since lockdown in March. There is no doubt that there is a renewed energy and focus to reset, restart and learn from the experience of the last few months.

The system came together to agree the set of priorities to focus our energies through the Winter. The report and priorities were supported by the ACP Board. The paper is included as appendix C for the Board's information.

Our staff were fully engaged in the priority setting workshops and there shouldn't be anything that relates to our organisation that will be a surprise or out of kilter with our internal plans.

There is a planned development session at the September meeting to explore further our vision, focus and priorities for Sheffield in the short, medium and long term.

The priorities that directly relate to us are:

Communication

We will be clear with people about what they can expect from our health and care services, how that might change and the challenges and uncertainties that our services are operating within. We will also encourage people with serious conditions, illnesses, not to stay away. We remain open and here to support.

Mental Health Transformation

We will have a strengthened and clear "emotional wellbeing" offer for children and young people, delivered through, and in close partnership with schools;

And for all people requiring mental health support and advice, we will have a strengthened primary care offer;

And for all those people who need crisis mental health support, they will get support which is age-appropriate and people will not unnecessarily need to go to A&E.

Chair Arrangements

Jayne Brown chaired this group and resigned from this role when she left our organisation on 31st July.

The Board agreed that Tony Pedder, Chair, Sheffield Teaching Hospitals, will take up this role, on an interim basis to secure continuity and focus.

Kirsten Major, Chief Executive of Sheffield Teaching Hospitals NHS FT, is the executive lead and Terry Hudsen, Chair of Sheffield Clinical Commissioning Group, agreed to be the Deputy Chair during this interim period up to December.

Mike Potts will obviously become a member of this Board, as the Chair and Chief Executive of each statutory organisation in Sheffield have a membership place.

The Board are asked to consider the direction of travel of the ACP; and to understand the key priorities and how they relate to our own transformation programme.

3.2 Sheffield Health & Social Care NHS FT - Board Changes

The Board welcome our new Chair, Mike Potts, saying goodbye and good luck to Jayne Brown at the end of July.

Mr. Potts will join us for up to a year, leading the Board and organisation through a period of significant change and improvement.

Director of Nursing & Professions

The Board are aware that Liz Lightbown remains away from work, and Debra Gilderdale supported this role on an interim basis from 4th May 2020 leaving on Friday, 31st July 2020. This is a statutory role and critical to all three of our strategic priorities, and so it has been agreed with our Remuneration & Nomination Committee, NHS Improvement/England and Regional Director of Nursing that Beverley Murphy will move into the Director of Nursing & Professions role on an interim basis, but with the full range of responsibilities of this portfolio.

Beverley will focus on clinical quality governance, transferred from the Medical Director, Mike Hunter, recruitment and retention of nurses and Allied Health Professionals, professional leadership floor to board and joint responsibility for our Getting Back to Good Programme.

The Chief Operating Officer role has been covered by Michelle Fearon over the last six months. This has now come to its conclusion and Michelle will focus on Winter plans, some aspects of reporting and recruitment.

Clive Clarke has been in the temporary role of Deputy Chief Executive, leading on CoVid, Safeguarding, and Health & Safety. This role has now also come to its agreed time limited conclusion and these areas of responsibility will be subsumed into normal business and relevant Director's portfolios.

The Remuneration & Nomination Committee agreed to support appointment to the substantive post of Director of People to lead the implementation of our People Strategy.

This will be progressed following discussions with relevant staff groups to explore the portfolio and job description content.

The Board are asked to acknowledge the Board role changes, consider any opportunities or risks within the changes and join me in thanking individuals for their contributions, flexibility and wish them well where they have changed or moved into different roles.

JD/jch/August 2020

APPENDIX A

Skipton House
80 London Road
London SE1 6LH
england.spoc@nhs.net

From the Chief Executive Sir Simon Stevens
& Chief Operating Officer Amanda Pritchard

To:
Chief executives of all NHS trusts and foundation trusts
CCG Accountable Officers
GP practices and Primary Care Networks
Providers of community health services
NHS 111 providers

Copy to:
NHS Regional Directors
Regional Incident Directors & Heads of EPRR
Chairs of ICSs and STPs
Chairs of NHS trusts, foundation trusts and CCG governing bodies
Local authority chief executives and directors of adult social care
Chairs of Local Resilience Forums

31 July 2020

Dear Colleague

IMPORTANT – FOR ACTION – THIRD PHASE OF NHS RESPONSE TO COVID-19

We are writing to thank you and your teams for the successful NHS response in the face of this unprecedented pandemic, and to set out the next – third – phase of the NHS response, effective from 1 August 2020.

You will recollect that on 30th January NHS England and NHS Improvement declared a Level 4 National Incident, triggering the first phase of the NHS pandemic response. Since then the NHS has been able to treat every coronavirus patient who has needed specialist care – including 107,000 people needing emergency hospitalisation. Even at the peak of demand, hospitals were still able to look after two non-Covid inpatients for every one Covid inpatient, and a similar picture was seen in primary, community and mental health services.

As acute Covid pressures were beginning to reduce, we wrote to you on 29 April to outline agreed measures for the second phase, restarting urgent services. Now in this Phase Three letter we:

- update you on the latest Covid national alert level;
- set out priorities for the rest of 2020/21; and
- outline financial arrangements heading into Autumn as agreed with Government.

Current position on Covid-19

On 19 June 2020 the Chief Medical Officers and the Government's Joint Biosecurity Centre downgraded the UK's overall Covid alert level from four to three, signifying that the virus remains in general circulation with localised outbreaks likely to occur. On 17 July the Government set out next steps including the role of the new Test and Trace programme in providing us advance notice of any expected surge in Covid demand, and in helping manage local and regional public health mitigation measures to prevent national resurgence.

Fortunately, Covid inpatient numbers have now fallen nationally from a peak of 19,000 a day, to around 900 today. As signalled earlier this month, the current level of Covid demand on the NHS means that the Government has agreed that the NHS EPRR incident level will move from Level 4 (national) to Level 3 (regional) with effect from tomorrow, 1 August. This approach matches the differential regional measures the Government is deploying, including today in parts of the North West and North East. The main implications of this are set out in Annex One to this letter.

However Covid remains in general circulation and we are seeing a number of local and regional outbreaks across the country, with the risk of further national acceleration. Together with the Joint Biosecurity Centre and Public Health England (PHE) we will therefore continue to keep the situation under close review, and will not hesitate to reinstate the Level 4 national response immediately as circumstances justify it. In the meantime NHS organisations will need to retain their EPRR incident coordination centres and will be supported by oversight and coordination by Regional Directors and their teams.

NHS priorities from August

Having pulled out all the stops to treat Covid patients over the last few months, our health services now need to redouble their focus on the needs of all other patients too, while recognising the new challenges of overcoming our current Covid-related capacity constraints. This will continue to require excellent collaboration between clinical teams, providers and CCGs operating as part of local 'systems' (STPs and ICSs), local authorities and the voluntary sector, underpinned by a renewed focus on patient communication and partnership.

Following discussion with patients' groups, national clinical and stakeholder organisations, and feedback from our seven regional 'virtual' frontline leadership meetings last week, we are setting out NHS priorities for this third phase. Our shared focus is on:

A. Accelerating the return to near-normal levels of non-Covid health services, making full use of the capacity available in the 'window of opportunity' between now and winter

B. Preparation for winter demand pressures, alongside continuing vigilance in the light of further probable Covid spikes locally and possibly nationally.

C. Doing the above in a way that takes account of lessons learned during the first Covid peak; locks in beneficial changes; and explicitly tackles fundamental challenges including: support for our staff, and action on inequalities and prevention.

As part of this Phase Three work, and following helpful engagement and discussion, alongside this letter yesterday we published a more detailed 2020/21 People Plan, and will shortly do the same on

inequalities reduction. DHSC are also expected to set out equivalent phase three priorities and support for social care.

Nationally, we will work with the wide range of stakeholders represented on the NHS Assembly to help track and challenge progress against these priorities. As we do so it is vital that we listen and learn from patients and communities. We ask that all local systems act on the Five principles for the next phase of the Covid-19 response developed by patients' groups through National Voices.

A: Accelerating the return of non-Covid health services, making full use of the capacity available in the window of opportunity between now and winter

A1. **Restore full operation of all cancer services. This work will be overseen by a national cancer delivery taskforce, involving major patient charities and other key stakeholders. Systems should commission their Cancer Alliance to rapidly draw up delivery plans for September 2020 to March 2021 to:**

- To reduce unmet need and tackle health inequalities, work with GPs and the public locally to restore the number of people coming forward and appropriately being referred with suspected cancer to at least pre-pandemic levels.

- Manage the immediate growth in people requiring cancer diagnosis and/or treatment returning to the service by:

  - Ensuring that sufficient diagnostic capacity is in place in Covid19-secure environments, including through the use of independent sector facilities, and the development of Community Diagnostic Hubs and Rapid Diagnostic Centres
  - Increasing endoscopy capacity to normal levels, including through the release of endoscopy staff from other duties, separating upper and lower GI (non-aerosol-generating) investigations, and using CT colonography to substitute where appropriate for colonoscopy.
  - Expanding the capacity of surgical hubs to meet demand and ensuring other treatment modalities are also delivered in Covid19-secure environments.
  - Putting in place specific actions to support any groups of patients who might have unequal access to diagnostics and/or treatment.
  - Fully restarting all cancer screening programmes. Alliances delivering lung health checks should restart them.

- Thereby reducing the number of patients waiting for diagnostics and/or treatment longer than 62 days on an urgent pathway, or over 31 days on a treatment pathway, to pre-pandemic levels, with an immediate plan for managing those waiting longer than 104 days.

A2. **Recover the maximum elective activity possible between now and winter**, making full use of the NHS capacity currently available, as well as re-contracted independent hospitals.

In setting clear performance expectations there is a careful balance to be struck between the need to be ambitious and stretching for our patients so as to avoid patient harm, while setting a performance level that is deliverable, recognising that each trust will have its own particular pattern of constraints to overcome.

Having carefully tested the feasible degree of ambition with a number of trusts and systems in recent weeks, trusts and systems are now expected to re-establish (and where necessary redesign) services to deliver through their own local NHS (non-independent sector) capacity the following:

- **In September at least 80% of their last year's activity for both overnight electives and for outpatient/daycase procedures, rising to 90% in October** (while aiming for 70% in August);

- This means that systems need to very swiftly return to **at least 90% of their last year's levels of MRI/CT and endoscopy procedures, with an ambition to reach 100% by October**.

- **100% of their last year's activity for first outpatient attendances and follow-ups (face to face or virtually) from September through the balance of the year (and aiming for 90% in August).**

Block payments will flex meaningfully to reflect delivery (or otherwise) against these important patient treatment goals, with details to follow shortly once finalised with Government.

Elective waiting lists and performance should be **managed at system as well as trust level** to ensure equal patient access and effective use of facilities.

Trusts, working with GP practices, should ensure that, between them, **every patient whose planned care has been disrupted by Covid receives clear communication** about how they will be looked after, and who to contact in the event that their clinical circumstances change.

Clinically urgent patients should continue to be treated first, with next priority given to the **longest waiting patients**, specifically those breaching or at risk of breaching 52 weeks by the end of March 2021.

To further support the recovery and restoration of elective services, a modified national contract will be in place giving **access to most independent hospital capacity** until March 2021. The current arrangements are being adjusted to take account of expected usage, and by October/ November it will then be replaced with a re-procured national framework agreement within which local contracting will resume, with funding allocations for systems adjusted accordingly. To ensure good value for money for taxpayers, systems must produce week-by-week independent sector usage plans from August and will then be held directly to account for delivering against them.

In **scheduling** planned care, providers should follow the new streamlined patient self isolation and testing requirements set out in the guideline published by NICE earlier this week. For many patients this will remove the need to isolate for 14 days prior to a procedure or admission.

Trusts should ensure their e-Referral Service is fully open to referrals from primary care. To reduce infection risk and support social distancing across the hospital estate, clinicians should consider avoiding asking patients to attend physical **outpatient appointments** where a clinically-appropriate and accessible alternative exists. Healthwatch have produced useful advice on how to support patients in this way. This means collaboration between primary and secondary care to use advice and guidance where possible and treat patients without an onward referral, as well as giving patients more control over their outpatient follow-up care by adopting a patient-initiated follow-up approach across major outpatient specialties. Where an outpatient

appointment is clinically necessary, the national benchmark is that at least 25% could be conducted by telephone or video including 60% of all follow-up appointments.

A3. **Restore service delivery in primary care and community services.**

- General practice, community and optometry services should **restore activity to usual levels where clinically appropriate**, and **reach out proactively** to clinically vulnerable patients and those whose care may have been delayed. Dental practices should have now mobilised for face to face interventions. We recognise that capacity is constrained, but will support practices to deliver as comprehensive a service as possible.

- In restoring services, GP practices need to make rapid progress in addressing the backlog of childhood **immunisations** and cervical **screening** through specific catch-up initiatives and additional capacity and deliver through their Primary Care Network (PCN) the service requirements coming into effect on 1 October as part of the Network Contract DES.

- GPs, primary care networks and community health services should build on the enhanced support they are providing to **care homes**, and begin a programme of structured medication reviews.

- CCGs should work with GP practices to expand the range of services to which patients can self-refer, freeing-up clinical time. All GP practices must offer face to face **appointments** at their surgeries as well as continuing to use remote triage and video, online and telephone consultation wherever appropriate – whilst also considering those who are unable to access or engage with digital services.

- Community health services **crisis responsiveness** should be enhanced in line with the goals set out in the Long Term Plan, and should continue to support patients who have recovered from the acute phase of Covid but need **ongoing rehabilitation** and other community health services. Community health teams should fully resume appropriate and safe **home visiting care** for all those vulnerable/shielding patients who need them.

- The Government is continuing to provide funding to support timely and appropriate discharge from hospital inpatient care in line with forthcoming updated Hospital Discharge Service Requirements. From 1 September 2020, hospitals and community health and social care partners should fully embed the **discharge to assess** processes. New or extended health and care support will be funded for a period of up to six weeks, following discharge from hospital and during this period a comprehensive care and health assessment for any ongoing care needs, including determining funding eligibility, must now take place. The fund can also be used to provide short term urgent care support for those who would otherwise have been admitted to hospital.

- The Government has further decided that CCGs must resume NHS **Continuing Healthcare assessments** from 1 September 2020 and work with local authorities using the trusted assessor model. Any patients discharged from hospital between 19 March 2020 and 31 August 2020, whose discharge support package has been paid for by the NHS, will need to be assessed and moved to core NHS, social care or self-funding arrangements.

A4. **Expand and improve mental health services and services for people with learning disability and/or autism**

- Every CCG must continue to **increase investment** in mental health services in line with the Mental Health Investment Standard and we will be repeating the independent audits of this. Systems should work together to ensure that funding decisions are decided in partnership with Mental Health Providers and CCGs and that funding is allocated to core Long Term Plan (LTP) priorities.

- In addition, we will be asking systems to validate their existing LTP **mental health service expansion** trajectories for 2020/21. Further advice on this will be issued shortly. In the meantime:
  - IAPT services should fully resume
  - the 24/7 crisis helplines for all ages that were established locally during the pandemic should be retained, developing this into a national service continue the transition to digital working
  - maintain the growth in the number of children and young people accessing care
  - proactively review all patients on community mental health teams' caseloads and increase therapeutic activity and supportive interventions to prevent relapse or escalation of mental health needs for people with SMI in the community;
  - ensure that local access to services is clearly advertised
  - use £250 million of earmarked new capital to help eliminate mental health dormitory wards.

- In respect of support for people with a **learning disability, autism or both**:
  - Continue to reduce the number of children, young people and adults within a specialist inpatient setting by providing better alternatives and by ensuring that Care (Education) and Treatment Reviews always take place both prior to and following inpatient admission.
  - Complete all outstanding Learning Disability Mortality Reviews (LeDeR) by December 2020.
  - GP practices should ensure that everybody with a Learning Disability is identified on their register; that their annual health checks are completed; and access to screening and flu vaccinations is proactively arranged. (This is supported by existing payment arrangements and the new support intended through the Impact and Investment Fund to improve uptake.)

B: Preparation for winter alongside possible Covid resurgence.

B1. Continue to follow good **Covid-related practice** to enable patients to access services safely and protect staff, whilst also preparing for localised Covid outbreaks or a wider national wave. This includes:

- Continuing to follow PHE's guidance on defining and managing communicable disease **outbreaks**.

- Continue to follow PHE/DHSC-determined policies on which patients, staff and members of the public should be tested and at what frequency, including the further PHE-endorsed

actions set out on testing on 24 June. All NHS employers should prepare for the likelihood that if background infection risk increases in the Autumn, and DHSC Test and Trace secures 500,000+ tests per day, the Chief Medical Officer and DHSC may decide in September or October to implement a policy of regular routine **Covid testing** of all asymptomatic staff across the NHS.

- Ongoing application of PHE's infection prevention and control guidance and the actions set out in the letter from 9 June on minimising **nosocomial infections** across all NHS settings, including appropriate Covid-free areas and strict application of hand hygiene, appropriate physical distancing, and use of masks/face coverings.

- Ensuring NHS staff and patients have access to and use **PPE** in line with PHE's recommended policies, drawing on DHSC's sourcing and its winter/EU transition PPE and medicines stockpiling.

B2. **Prepare for winter** including by:

- Sustaining current NHS staffing, beds and **capacity**, while taking advantage of the additional £3 billion NHS revenue funding for ongoing independent sector capacity, Nightingale hospitals, and support to quickly and safely discharge patients from NHS hospitals through to March 2021.

- Deliver a very significantly expanded seasonal **flu vaccination** programme for DHSC-determined priority groups, including providing easy access for all NHS staff promoting universal uptake. Mobilising delivery capability for the administration of a Covid19 vaccine if and when a vaccine becomes available.

- Expanding the **111 First** offer to provide low complexity urgent care without the need for an A&E attendance, ensuring those who need care can receive it in the right setting more quickly. This includes increasing the range of dispositions from 111 to local services, such as direct referrals to Same Day Emergency Care and specialty 'hot' clinics, as well as ensuring all Type 3 services are designated as Urgent Treatment Centres (UTCs). DHSC will shortly be releasing agreed **A&E capital** to help offset physical constraints associated with social distancing requirements in Emergency Departments.

- Systems should maximise the use of 'Hear and Treat' and 'See and Treat' pathways for 999 demand, to support a sustained reduction in the number of patients conveyed to Type 1 or 2 emergency departments.

- Continue to make full use of the NHS Volunteer Responders scheme in conjunction with the Royal Voluntary Society and the partnership with British Red Cross, Age UK and St. Johns Ambulance which is set to be renewed.

- Continuing to **work with local authorities**, given the critical dependency of our patients – particularly over winter - on resilient social care services. Ensure that those medically fit for discharge are not delayed from being able to go home as soon as it is safe for them to do so in line with DHSC/PHE policies (see A3 above).

C: Doing the above in a way that takes account of lessons learned during the first Covid peak; locks in beneficial changes; and explicitly tackles fundamental challenges including support for our staff, action on inequalities and prevention.

C1. **Workforce**

Covid19 has once again highlighted that the NHS, at its core, is our staff. Yesterday we published We are the NHS: People Plan for 2020/21 - actions for us all which reflects the strong messages from NHS leaders and colleagues from across the NHS about what matters most. It sets out practical actions for employers and systems, over the remainder of 2020/21 ahead of Government decisions in the Autumn Spending Review on future education and training expansions. It includes specific commitments on:

- Actions all NHS employers should take to keep staff safe, healthy and well – both physically and psychologically.
- Specific requirements to offer staff flexible working.
- Urgent action to address systemic inequality that is experienced by some of our staff, including BAME staff.
- New ways of working and delivering care, making full and flexible use of the full range of our people's skills and experience.
- Growing our workforce, building on unprecedented interest in NHS careers. It also encourages action to support former staff to return to the NHS, as well as taking steps to retain staff for longer – all as a contribution to growing the nursing workforce by 50,000, the GP workforce by 6,000 and the extended primary care workforce by 26,000.
- Workforce planning and transformation that needs to be undertaken by systems to enable people to be recruited and deployed across organisations, sectors and geographies locally.

All systems should develop a local People Plan in response to these actions, covering expansion of staff numbers, mental and physical support for staff, improving retention and flexible working opportunities, plus setting out new initiatives for development and upskilling of staff. Wherever possible, please work with local authorities and local partners in developing plans for recruitment that contribute to the regeneration of communities, especially in light of the economic impact of Covid. These local People Plans should be reviewed by regional and system People Boards, and should be refreshed regularly.

C2. **Health inequalities and prevention.**

Covid has further exposed some of the health and wider inequalities that persist in our society. The virus itself has had a disproportionate impact on certain sections of the population, including those living in most deprived neighbourhoods, people from Black, Asian and minority ethnic communities, older people, men, those who are obese and who have other long-term health conditions and those in certain occupations. It is essential that recovery is planned in a way that inclusively supports those in greatest need.

We are asking you to work collaboratively with your local communities and partners to take urgent action to increase the scale and pace of progress of reducing health inequalities, and

regularly assess this progress. Recommended urgent actions have been developed by an expert national advisory group and these will be published shortly. They include:

- Protect the most vulnerable from Covid, with enhanced analysis and community engagement, to mitigate the risks associated with relevant protected characteristics and social and economic conditions; and better engage those communities who need most support.

- Restore NHS services inclusively, so that they are used by those in greatest need. This will be guided by new, core performance monitoring of service use and outcomes among those from the most deprived neighbourhoods and from Black and Asian communities, by 31 October. Develop digitally enabled care pathways in ways which increase inclusion, including reviewing who is using new primary, outpatient and mental health digitally enabled care pathways by 31 March.

- Accelerate preventative programmes which proactively engage those at greatest risk of poor health outcomes. This should include more accessible flu vaccinations, the better targeting of long-term condition prevention and management programmes, obesity reduction programmes including self-referral to the NHS Diabetes Prevention Programme, health checks for people with learning disabilities, and increasing the continuity of maternity carers including for BAME women and those in high risk groups.

- Strengthen leadership and accountability, with a named executive Board member responsible for tackling inequalities in place in September in every NHS organisation. Each NHS board to publish an action plan showing how over the next five years its board and senior staffing will in percentage terms at least match the overall BAME composition of its overall workforce, or its local community, whichever is the higher.

- Ensure datasets are complete and timely, to underpin an understanding of and response to inequalities. All NHS organisations should proactively review and ensure the completeness of patient ethnicity data by no later 31 December, with general practice prioritising those groups at significant risk of Covid19 from 1 September.

Financial arrangements and system working

To support restoration, and enable continued collaborative working, current financial arrangements for CCGs and trusts will largely be extended to cover August and September 2020. The intention is to move towards a revised financial framework for the latter part of 2020/21, once this has been finalised with Government. More detail is set out in Annex Two.

Working across systems, including NHS, local authority and voluntary sector partners, has been essential for dealing with the pandemic and the same is true in recovery. As we move towards comprehensive ICS coverage by April 2021, all ICSs and STPs should embed and accelerate this joint working through a development plan, agreed with their NHSE/I regional director, that includes:

- Collaborative leadership arrangements, agreed by all partners, that support joint working and quick, effective decision-making. This should include a single STP/ICS leader and a non-executive chair, appointed in line with NHSE/I guidance, and clearly defined arrangements for provider collaboration, place leadership and integrated care partnerships.

- Organisations within the system coming together to serve communities through a Partnership Board, underpinned by agreed governance and decision-making arrangements including high standards of transparency – in which providers and commissioners can agree actions in the best interests of their populations, based on co-production, engagement and evidence.

- Plans to streamline commissioning through a single ICS/STP approach. This will typically lead to a single CCG across the system. Formal written applications to merge CCGs on 1 April 2021 needed to give effect to this expectation should be submitted by 30 September 2020.

- A plan for developing and implementing a full shared care record, allowing the safe flow of patient data between care settings, and the aggregation of data for population health.

Finally, we are asking you – working as local systems - to return a draft **summary plan by 1 September** using the templates issued and covering the key actions set out in this letter, with **final plans due by 21 September**. These plans need to be the product of partnership working across STPs/ICSs, with clear and transparent triangulation between commissioner and provider activity and performance plans.

Over the last few months, the NHS has shown an extraordinary resilience, capacity for innovation and ability to move quickly for our patients. Like health services across Europe, we now face the double challenge of continuing to have to operate in a world with Covid while also urgently responding to the many urgent non-Covid needs of our patients. If we can continue to harness the same ambition, resilience, and innovation in the second half of the year as we did in the first, many millions of our fellow citizens will be healthier and happier as a result. So thank you again for all that you and your teams have been – and are – doing, in what is probably the defining year in the seven-decade history of the NHS.

With best wishes,

Simon Stevens
NHS Chief Executive

Amanda Pritchard
NHS Chief Operating Officer

ANNEX ONE: IMPLICATIONS OF EPRR TRANSITION TO A LEVEL 3 INCIDENT

As previously signalled, effective 1 August 2020 the national incident level for the Covid19 response will change from level 4 (an incident that requires NHS England National Command and Control to support the NHS response) to level 3 (an incident that requires the response of a number of health organisations across geographical areas within an NHS England region), until further notice.

It is entirely possible that future increases in Covid demands on the NHS mean that the level 4 incident will need to be reinstated. In which case, there will be no delay in doing so. However this change does, for the time being, provide the opportunity to focus local and regional NHS teams on accelerating the restart of non-Covid services, while still preparing for a possible second national peak.

The implications of the transition from a level 4 to level 3 incident are as follows:

- *Oversight*: Transition from a national command, control and coordination structure to a regional command, control and coordination structure but with national oversight as this remains an incident of international concern.

- *Reporting*: We will be stopping weekend sit rep collections from Saturday 8 August 2020 (Saturday and Sunday data will be collected on Mondays with further detail to follow). Whilst we are reducing the incident level with immediate effect reports will still be required this weekend (1 and 2 August 2020) and we will subsequently need to be able to continue to align to DHSC requirements. Additional reporting will be required for those areas of the country experiencing community outbreaks in line with areas of heightened interest, concern or intervention.

- *Incident coordination functions*: The national and regional Incident Coordination Centres will remain in place (hours of operation may be reduced). The frequency of national meetings will decrease (for example IMT will move to Monday, Wednesday, Friday). Local organisations should similarly adjust their hours and meeting frequency accordingly. It is however essential that NHS organisations fully retain their incident coordination functions given the ongoing pandemic, and the need to stand up for local incidents and outbreaks.

- *Communications:* All communications related to Covid19 should continue to go via established Covid19 incident management channels, with NHS organisations not expected to respond to incident instructions received outside of these channels. Equally, since this incident continues to have an international and national profile, it is important that our messaging to the public is clear and consistent. You should therefore continue to coordinate communications with your regional NHS England and NHS Improvement communications team. This will ensure that information given to the media, staff and wider public is accurate, fully up-to-date and aligns with national and regional activity.

ANNEX TWO: REVISED FINANCIAL ARRANGEMENTS

The current arrangements comprise nationally-set block contracts between NHS providers and commissioners, and prospective and retrospective top-up funding issued by NHSE/I to organisations to support delivery of breakeven positions against reasonable expenditure. The M5 and M6 block contract and prospective top-up payments will be the same as M4. Costs of testing and PPE will continue to be borne centrally for trusts and general practices funded by DHSC who continue to lead these functions for the health and social care sectors.

The intention is to move towards a revised financial framework for the latter part of 2020/21, once this has been finalised with Government.

The revised framework will retain simplified arrangements for payment and contracting but with a greater focus on system partnership and the restoration of elective services. The intention is that systems will be issued with funding envelopes comprising funding for NHS providers equivalent in nature to the current block and prospective top-up payments and a system-wide Covid funding envelope. There will no longer be a retrospective payment mechanism. Providers and CCGs must achieve financial balance within these envelopes in line with a return to usual financial disciplines. Whilst systems will be expected to breakeven, organisations within them will be permitted by mutual agreement across their system to deliver surplus and deficit positions. The funding envelopes will comprise:

- CCG allocations – within which block contract values for services commissioned from NHS providers within and outside of the system will continue to be nationally calculated;

- Directly commissioned services from NHS providers – block contract values for specialised and other directly commissioned services will continue to be nationally calculated;

- Top-up – additional funding to support delivery of a breakeven position; and

- Non-recurrent Covid allocation – additional funding to cover Covid-related costs for the remainder of the year.

Funding envelopes will be calculated on the basis of full external income recovery. For relationships between commissioners and NHS providers we will continue to operate nationally calculated block contract arrangements. For low-volume flows of CCG-commissioned activity, block payments of an appropriate value would be made via the Trust's host CCG; this will remove the need for separate invoicing of non-contract activity.

However block payments will be adjusted depending on delivery against the activity restart goals set in Section A1 and A2 above.

Written contracts with NHS providers for the remainder of 2020/21 will not be required.

For commissioners, non-recurrent adjustments to commissioner allocations will continue to be actioned – adjustments to published allocations will include any changes in contracting responsibility and distribution of the top-up to CCGs within the system based on target allocation.

Reimbursement for high cost drugs under the Cancer Drugs Fund (CDF) and relating to treatments under the Hepatitis C programme will revert to a pass-through cost and volume basis, with adjustments made to NHS provider block contract values to reflect this. For the majority of other high cost drugs and devices, in-year provider spend will be tracked against a notional level of spend

included in the block funding arrangements with adjustments made in-year to ensure that providers are reimbursed for actual expenditure on high cost drugs and devices. This will leave a smaller list of high cost drugs which will continue to be funded as part of the block arrangements.

In respect of Medical pay awards, on 21 July 2020 the Government confirmed the decision to uplift pay in 2020/21 by 2.8% for consultants, specialty doctors and associate specialists, although there is no uplift to the value of Clinical Excellence Awards, Commitment Awards, Distinction Awards and Discretionary Points for 2020/21. We expect this to be implemented in September pay and backdated to April 2020. In this event, NHS providers should claim the additional costs in September as part of the retrospective top-up process. Future costs will be taken into account in the financial framework for the remainder of 2020/21, with further details to be confirmed in due course.

Appendix B

National Guardian
Freedom to Speak Up

Freedom to Speak Up Index Report 2020

Contents

Foreword by Sir Simon Stevens

With the onset of the Coronavirus pandemic, NHS staff have been on the frontline of the greatest challenge our health service has ever faced.

In the NHS, speaking up is a fundamental matter of patient and staff safety, which is why we are so determined that NHS employers should support anyone who wants to make their voice heard.

Freedom to Speak Up Guardians are therefore a powerful force for good in helping this happen. NHS England is proud to have tripled our funding to support them across the NHS.

And having first suggested the creation of a Freedom to Speak Index, I'm personally pleased to endorse this annual report, and grateful to all those who have helped shine a spotlight on this crucial aspect of the NHS's work.

This is the second year the Index has been published and we've seen an improvement in people's sense of power to speak up, with this year's results showing the national FTSU Index has now risen to 78.7 per cent. This is both important progress and a reminder that more is needed.

The impact of Covid-19 will be felt for a long time, but all the evidence shows that when colleagues feel empowered to speak up, the NHS will make great progress in our founding mission of health high quality care - for all.

Foreword by Dr Henrietta Hughes

Speaking up has never been more important, and the reality of whether leaders and organisations listen, act and learn is a critical part of this process. The introduction of Freedom to Speak Up Guardians in 2015 following the Francis Freedom to Speak Up Review has seen an improvement in the speaking up culture nationally.

Measuring the effect of culture change can be difficult, and the acid test is the view of staff. In NHS Trusts we can seek to measure the impact of improvements that have been put into place through the responses to the NHS Annual Staff Survey, on whether staff feel knowledgeable, encouraged and supported to raise concerns and if they agree they would be treated fairly if involved in an error, near miss or incident.

The Freedom to Speak Up (FTSU) Index, first published in 2019, is a key metric for organisations to monitor their speaking up culture. The index has risen nationally from 75.5 per cent in 2015 to 78.7 per cent in 2019. When compared with other sectors, a score of 70 per cent is perceived as a healthy culture, so I believe that we have a lot to celebrate. But for us in health, the stakes are higher. Within this national average there continues to be variation, both within and between organisations. For example, in one trust only four in 10 responders believe that the organisation treats staff who are involved in an error, near miss or incident fairly. This can act as a barrier to speaking up, which could have devastating consequences for patient and worker safety and wellbeing. Fostering a positive speaking up culture sits firmly with the leadership, and we can see that organisations with higher FTSU Index scores tend to be rated as Outstanding or Good by CQC.

All organisations need to look at the results of their staff surveys, the FTSU Index score and the changes over time. The voices of workers who are otherwise unheard also need to be amplified, including those who do not have the opportunity or confidence to complete the survey. I would encourage organisations to use the index to identify pockets of their organisation where workers feel less supported to speak up and to focus on ways to improve this. We work with organisations with higher scores to share their experience and ideas for improvement, through our publications, regional and national network meetings and through October Speak Up Month. Similarly, for organisations with lower scores, there is an opportunity to use this information to listen to staff, reflect on the barriers, learn from others and implement changes to instil confidence in workers that speaking up will be heard and acted upon without risk of victimisation. I am delighted to announce that we will be working with the ambulance sector to share learning and to support improvement and innovation.

Introduction

Freedom to Speak Up is vital in healthcare – it can be a matter of life or death. When workers feel psychologically safe, they will speak up to avoid harm, bring great ideas and be able to express their concerns. The National Guardian's Office (NGO) believes a good speaking up culture makes for a safer workplace, for workers, patients and service users.

The NGO is working to make speaking up business as usual across the health sector.[1] This work includes developing, promoting and supporting an expanding network of Freedom to Speak Up Guardians, who work within their organisations to support workers to speak up and to effect culture change to make speaking up business as usual. The NGO also challenges and supports the health system in England on all matters related to speaking up.

Every year, NHS staff in trusts are invited to take part in the NHS Staff Survey to share their views about working in their organisation. The data gathered is used to monitor trends over time, as well as to compare organisational performance to improve the experiences of workers and patients.

Working with NHS England, the National Guardian's Office has brought together four questions from the NHS Staff Survey into a 'Freedom to Speak Up (FTSU) Index'. These questions relate to whether staff feel knowledgeable, secure and encouraged to speak up and whether they would be treated fairly after an incident.

The FTSU Index seeks to allow trusts to see how an aspect of their FTSU culture compares with other organisations so learning can be shared, and improvements made. This is the second year in a row we have published the FTSU Index.[2]

This year's results show the national average for the FTSU index has continued to rise. This continued improvement is a fantastic achievement and testament to the hard work of Freedom to Speak Up Guardians and those who support them. However, we are starting from a place where many staff do not feel psychologically safe. The responses to the questions on which the index is based show there is still much to do to make speaking up business as usual. For example, less than two thirds of respondents nationally (59.7%) agreed their organisation treats staff who are involved in an error, near miss or incident fairly. Seventy-two per cent (71.7%) of respondents said they would feel secure raising concerns about unsafe clinical practice – which suggests that over a quarter of the workforce potentially does not feel secure raising concerns.

The index once again suggests a positive speaking up culture is associated with higher-performing organisations as rated by the Care Quality Commission (CQC). In other words, trusts with higher index scores are more likely to be rated 'Good' or 'Outstanding' by the CQC. However, this correlation is less apparent with ambulance trusts which tend to perform comparatively less well in the FTSU Index despite most of them receiving 'Good' ratings by the CQC (see Annex 1, below).

[1] National Guardian's Office, https://www.nationalguardian.org.uk/
[2] Freedom to Speak Up Index Report 2019, National Guardian's Office, https://www.nationalguardian.org.uk/wp-content/uploads/2020/02/ftsu-index-report-updated.pdf

We want the index to promote the sharing of good practice and learning, by encouraging trusts to work to improve their speaking up arrangements and culture.

The Freedom to Speak Up Index for each trust and the CQC ratings for Overall and Well Led are included in Annex 1. The information is taken from the CQC website and the annual NHS Staff Survey at the time of publication.[3]

[3] This information is correct as of July 3rd, 2020.

Survey questions and FTSU Index

The annual NHS staff survey contains several questions that are helpful indicators of speaking up culture. The FTSU index was calculated as the mean average of responses to the following four questions from the NHS Staff Survey:

- % of staff "agreeing" or "strongly agreeing" that their organisation treats staff who are involved in an error, near miss or incident fairly (question 17a)
- % of staff "agreeing" or "strongly agreeing" that their organisation encourages them to report errors, near misses or incidents (question 17b)
- % of staff "agreeing" or "strongly agreeing" that if they were concerned about unsafe clinical practice, they would know how to report it (question 18a)
- % of staff "agreeing" or "strongly agreeing" that they would feel secure raising concerns about unsafe clinical practice (question 18b)

This year's index is based on the results from the 2019 NHS Staff Survey.[4]

Please note all figures in this report are rounded to one decimal place.

[4] NHS England and NHS Improvement Staff Survey, https://www.nhsstaffsurveys.com/Page/1085/Latest-Results/NHS-Staff-Survey-Results/

Summary of results

A. *FTSU Index – National averages*

The national average for the Freedom to Speak Up (FTSU) Index score has continued to improve over the past year, up one percentage point to 79 per cent.

2015	2016	2017	2018	2019
75.5%	76.7%	76.8%	78.1%	78.7%

The FTSU index is based on four questions from the annual NHS Staff Survey (questions 17a, 17b, 18a and 18b).

Question 17a

Question 17a asks staff whether they agree their organisation treats staff who are involved in an error, near miss or incident fairly.

Question	2018	2019
% of staff agreeing that their organisation treats staff who are involved in an error, near miss or incident fairly (17a)	58.3%	59.7%

Of the four questions on which the index is based, the response to this question has seen the biggest improvement over the past year.[5]

However, it remains the case that fewer than two thirds of respondents agreed their organisation treats staff who are involved in an error, near miss or incident fairly.

This question saw the widest disparity in trust performance compared to the other questions making up the index. The highest scoring trust for this question, the Royal Marsden NHS Foundation Trust, scored 72.9 per cent, while the lowest scoring trust scored 40.3 per cent.

[5] This question has also seen the biggest improvement since 2015, with the percentage of respondents agreeing with the statement rising from 52.2 per cent in 2015 to 59.7 per cent in 2019.

Question 17b

Question 17b asks whether staff agree their organisation encourages them to report errors, near misses or incidents. Eighty-eight per cent (88%) of respondents agreed their organisation encourages them to report errors, near misses or incidents.

Question	2018	2019
% of staff agreeing that their organisation encourages them to report errors, near misses or incidents (17b)	88.1%	88.4%

Hounslow and Richmond Community Healthcare NHS Trust was the highest scoring trust for this question, achieving a score of 95.3 per cent. The lowest scoring trust scored 79.1 per cent.

Question 18a

Question 18a asks whether staff agree that if they were concerned about unsafe clinical practice, they would know how to report it. Ninety-five per cent (95%) of respondents agreed that if they were concerned about unsafe clinical practice, they would know how to report it.

Question	2018	2019
% of staff agreeing that if they were concerned about unsafe clinical practice, they would know how to report it (18a)	94.8%	94.6%

Isle of Wight NHS Trust (community sector) was the highest scoring trust for this question (99.3 per cent). The lowest scoring trust scored 89.5 per cent.

Question 18b

Question 18b asks whether staff agree that they would feel secure raising concerns about unsafe clinical practice. Seventy-two per cent (72%) of respondents agreed they would feel secure raising concerns about unsafe clinical practice.

Question	2018	2019
% of staff agreeing that they would feel secure raising concerns about unsafe clinical practice (18b)	70.7%	71.7%

Cambridgeshire Community Services NHS Trust was the highest scoring trust for this question (82.1 per cent). The lowest scoring trust achieved 58.6 per cent.

B. *FTSU Index – By region*

We reviewed performance in the index by region. The region with the highest index score was the South West (79.8 per cent), followed by the South East. The region with the lowest index score was the East of England (78.5 per cent).

All regions saw an improvement in their index score over the last year. The region which saw the biggest improvement was the South West, followed by the South East.

Region	**2018**	**2019**
South West	78.6%	79.8%
South East	78.6%	79.6%
North West	78.5%	79.1%
Midlands	78%	78.8%
London	78.4%	78.7%
North East and Yorkshire	78.3%	78.5%
East of England	78.3%	78.5%

C. *FTSU Index – By trust type*

Index scores varied by trust type. Community trusts had the highest score (83.9 per cent), with ambulance trusts achieving a score of 73.8 per cent.

Most trust types saw an improvement in their index score over the last year. The trust type with the biggest improvement was community trusts.

Trust type	**2018**	**2019**
Community Trusts	82.6%	83.9%
Acute Specialist Trusts	81.7%	81.2%
Combined Mental Health / learning Disability and Community Trusts	79.9%	80.2%
Mental Health / Learning Disability Trusts	78.7%	79.4%
Combined Acute and Community Trusts	78.5%	79%
Acute Trusts	77.4%	77.9%
Ambulance Trusts	73.8%	73.8%

D. *Trusts with the highest FTSU Index scores*

The following are the ten trusts with the highest score in the Freedom to Speak Up Index:

Name of trust[6]	2018	2019
Cambridgeshire Community Services NHS Trust	87%	86.6%
Solent NHS Trust	86.1%	86.1%
Northamptonshire Healthcare NHS Foundation Trust	84.9%	85.2%
Hounslow and Richmond Community Healthcare NHS Trust	85.1%	85%
Leeds Community Healthcare NHS Trust	84.1%	85%
Liverpool Heart and Chest Hospital NHS Foundation Trust	85.6%	84.7%
Wirral Community NHS Foundation Trust[7]	82.5%	84.5%
Derbyshire Community Health Services NHS Foundation Trust	82.7%	84.4%
The Royal Marsden NHS Foundation Trust	83.8%	84.3%
South Warwickshire NHS Foundation Trust	81.6%	84.3%

[6] Trusts highlighted in blue are new entries into the top ten trusts with the highest score in the Freedom to Speak Up Index.
[7] Also known as Wirral Community Health and Care NHS Foundation Trust.

E. *Trusts with the greatest overall increase and decrease in FTSU Index score*

The following are the ten trusts which have seen the greatest overall increase in their FTSU Index score:

Name of trust	2018	2019	Change
County Durham and Darlington NHS Foundation Trust*	75.1%	80.5%	5.4%
Taunton and Somerset NHS Foundation Trust	77.8%	82.5%	4.7%
Worcestershire Acute Hospitals NHS Trust	73.9%	78.5%	4.6%
Liverpool Women's NHS Foundation Trust	75.7%	79.8%	4.1%
Medway NHS Foundation Trust	72.2%	76.1%	3.9%
East Midlands Ambulance Service NHS Trust	68.2%	71.9%	3.7%
Whittington Health NHS Trust	75.9%	78.9%	3%
Great Ormond Street Hospital for Children NHS Foundation Trust	77.9%	80.9%	3%
Great Western Hospitals NHS Foundation Trust	79.1%	82.1%	3%
Oxford University Hospitals NHS Foundation Trust	76.7%	79.5%	2.8%

*Cate Woolley-Brown, Freedom to Speak Up Guardian at County Durham and Darlington NHS Foundation Trust, said, *"We're delighted with the response from our staff, indicating their confidence to speak up. The role of the Freedom to Speak Up Guardian is supported at the very top of the organisation. The Chair, Chief Executive, the wider executive team and non-executive directors are fully behind and engaged with the valuable role the Guardian plays in giving staff a channel through which they can speak up on any issue – and be listened to. This senior level support is critical in reassuring staff that they will be taken seriously. My role is widely promoted with the emphasis on concerns being dealt with speedily, a culture of openness, honesty and learning - to prevent recurrence."*

The following are the ten trusts which have seen the greatest overall decrease in their FTSU Index score:

Name of trust	2018	2019	Change
Tavistock and Portman NHS Foundation Trust	81.6%	77.5%	-4.1%
Sheffield Health and Social Care NHS Foundation Trust	76.2%	72.3%	-3.9%
University Hospitals of Morecambe Bay NHS Foundation Trust	79.1%	75.8%	-3.3%
North East Ambulance Service NHS Foundation Trust	76.2%	72.9%	-3.3%
Moorfields Eye Hospital NHS Foundation Trust	82.8%	79.7%	-3.1%
North Cumbria University Hospitals NHS Trust	71.6%	68.5%	-3.1%
The Princess Alexandra Hospital NHS Trust	78.4%	75.4%	-3%
Luton and Dunstable University Hospital NHS Foundation Trust	79.5%	76.9%	-2.6%
Basildon and Thurrock University Hospitals NHS Foundation Trust	76.8%	75%	-1.8%
Tees, Esk and Wear Valleys NHS Foundation Trust	80.7%	79.1%	-1.6%

What we will do next

- We will use the index as an indicator of potential areas of good practice and concern when it comes to the speaking up culture in trusts.

- We will share the index with our stakeholders, including the Care Quality Commission (CQC), and NHS England and NHS Improvement, so it may also inform their work to support trusts.

- We will also be working with the survey team at NHS England to develop the index to provide a more holistic understanding of speaking up culture.

Ambulance trusts

As mentioned above, the index suggests a positive speaking up culture is associated with higher-performing organisations as rated by the CQC. This correlation is less apparent with ambulance trusts which tend to perform comparatively less well in the index despite most of them receiving ‘good’ ratings by the CQC.

We will be undertaking a piece of work later this year to work with ambulance trusts and our partners to understand why ambulance trusts tend to perform comparatively less well in the index. We will also be working with ambulance trusts and our partners to develop a better understanding of the relationship between the FTSU index and CQC ratings.

Acknowledgements

We want to thank everyone who has helped with the preparation of the Freedom to Speak Up Index and this report. This includes all the trusts featured, the survey team at NHS England and members of the team at the National Guardian's Office.

Annex 1

FTSU Index including CQC Overall and Well Led Ratings

Outstanding
Good
Requires improvement
Inadequate

FTSU Index	Name of trust	CQC Overall	Well Led
86.6%	Cambridgeshire Community Services NHS Trust	Outstanding	Outstanding
86.1%	Solent NHS Trust	Good	Good
85.2%	Northamptonshire Healthcare NHS Foundation Trust	Outstanding	Outstanding
85%	Hounslow and Richmond Community Healthcare NHS Trust	Good	Good
85%	Leeds Community Healthcare NHS Trust	Good	Good
84.7%	Liverpool Heart and Chest Hospital NHS Foundation Trust	Outstanding	Outstanding
84.5%	Wirral Community NHS Foundation Trust	Requires improvement	Requires improvement
84.4%	Derbyshire Community Health Services NHS Foundation Trust	Outstanding	Outstanding
84.3%	The Royal Marsden NHS Foundation Trust	Outstanding	Outstanding
84.3%	South Warwickshire NHS Foundation Trust	Outstanding	Outstanding
84.2%	Kent Community Health NHS Foundation Trust	Outstanding	Good
84.1%	The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust	Good	Outstanding
84.1%	Gloucestershire Care Services NHS Trust[8]	Good	Good
83.9%	Hertfordshire Community NHS Trust	Good	Good
83.9%	Sussex Community NHS Foundation Trust	Good	Good
83.8%	The Royal Orthopaedic Hospital NHS Foundation Trust	Good	Good
83.6%	Lincolnshire Community Health Services NHS Trust	Outstanding	Outstanding
83.4%	Norfolk Community Health and Care NHS Trust	Outstanding	Outstanding
83.3%	Northumbria Healthcare NHS Foundation Trust	Outstanding	Good
83.2%	Berkshire Healthcare NHS Foundation Trust	Outstanding	Outstanding
83.1%	Northern Devon Healthcare NHS Trust	Requires improvement	Requires improvement
83%	Royal Brompton and Harefield NHS Foundation Trust	Good	Good
82.9%	Worcestershire Health and Care NHS Trust	Good	Good
82.8%	Gateshead Health NHS Foundation Trust	Good	Good
82.6%	Guy's and St Thomas' NHS Foundation Trust	Good	Outstanding
82.5%	Hertfordshire Partnership University NHS Foundation Trust	Outstanding	Outstanding
82.5%	Cambridge University Hospitals NHS Foundation Trust	Good	Outstanding
82.5%	Taunton and Somerset NHS Foundation Trust[9]	Good	Good
82.4%	Dudley and Walsall Mental Health Partnership NHS Trust	Good	Good
82.4%	Shropshire Community Health NHS Trust	Good	Good

[8] Merged with 2gether NHS Foundation Trust to form Gloucestershire Health & Care NHS Foundation Trust in October 2019.
[9] Merged with Somerset Partnership NHS Foundation Trust to form Somerset NHS Foundation Trust in April 2020.

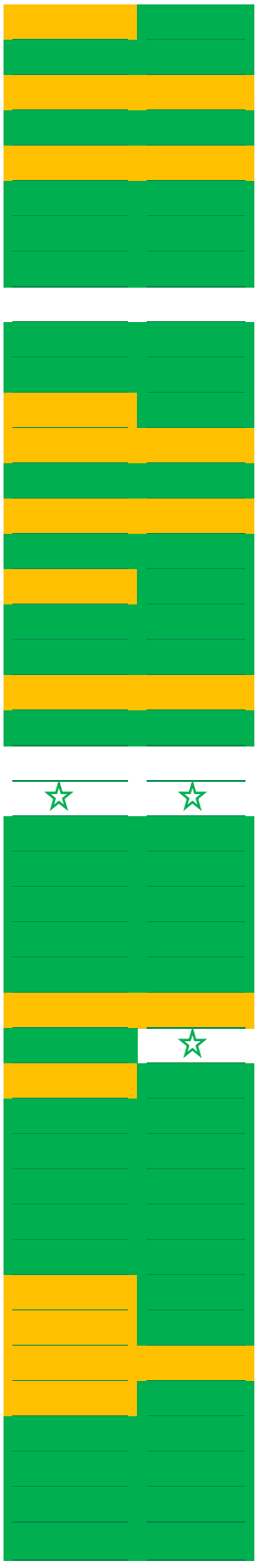
82.2%	The Christie NHS Foundation Trust	☆☆
82.1%	Dorset Healthcare University NHS Foundation Trust	☆☆
82.1%	Cambridgeshire and Peterborough NHS Foundation Trust	
82.1%	Great Western Hospitals NHS Foundation Trust	
82%	Midlands Partnership NHS Foundation Trust	
82%	Surrey and Borders Partnership NHS Foundation Trust	
82%	The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust	
81.9%	Lincolnshire Partnership NHS Foundation Trust	☆
81.9%	East Lancashire Hospitals NHS Trust	
81.9%	Surrey and Sussex Healthcare NHS Trust	☆☆
81.7%	Airedale NHS Foundation Trust	
81.6%	West Suffolk NHS Foundation Trust	
81.5%	Southern Health NHS Foundation Trust	
81.4%	Mersey Care NHS Foundation Trust	☆
81.4%	The Clatterbridge Cancer Centre NHS Foundation Trust	
81.3%	Yeovil District Hospital NHS Foundation Trust	
81.3%	Oxford Health NHS Foundation Trust	
81.2%	Bolton NHS Foundation Trust	☆
81.2%	University Hospital Southampton NHS Foundation Trust	
81.2%	St Helens and Knowsley Teaching Hospitals NHS Trust	☆☆
81.1%	Royal Berkshire NHS Foundation Trust	
81.1%	North Tees and Hartlepool NHS Foundation Trust	
81%	Harrogate and District NHS Foundation Trust	
81%	Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust[10]	☆☆
80.9%	Somerset Partnership NHS Foundation Trust[11]	
80.9%	Great Ormond Street Hospital for Children NHS Foundation Trust	
80.9%	Kingston Hospital NHS Foundation Trust	☆☆
80.7%	Frimley Health NHS Foundation Trust	
80.7%	Royal Papworth Hospital NHS Foundation Trust	☆☆
80.7%	Cornwall Partnership NHS Foundation Trust	
80.7%	The Walton Centre NHS Foundation Trust	☆
80.7%	Royal Surrey NHS Foundation Trust[12]	
80.7%	University Hospitals Plymouth NHS Trust	
80.6%	2Gether NHS Foundation Trust[13]	
80.6%	The Newcastle upon Tyne Hospitals NHS Foundation Trust	☆☆
80.5%	Central London Community Healthcare NHS Trust	
80.5%	Salisbury NHS Foundation Trust	
80.5%	Portsmouth Hospitals NHS Trust	
80.5%	University Hospitals Coventry and Warwickshire NHS Trust	
80.5%	Sheffield Children's NHS Foundation Trust	

[10] The trust changed its name from Northumberland, Tyne and Wear NHS Foundation Trust to Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust in October 2019.
[11] Merged with Taunton and Somerset NHS Foundation Trust to form Somerset NHS Foundation Trust in April 2020.
[12] The trust changed its name from Royal Surrey County Hospital NHS Foundation Trust to Royal Surrey NHS Foundation Trust in September 2019.
[13] Merged with Gloucestershire Care Services NHS Trust to form Gloucestershire Health & Care NHS Foundation Trust in October 2019.

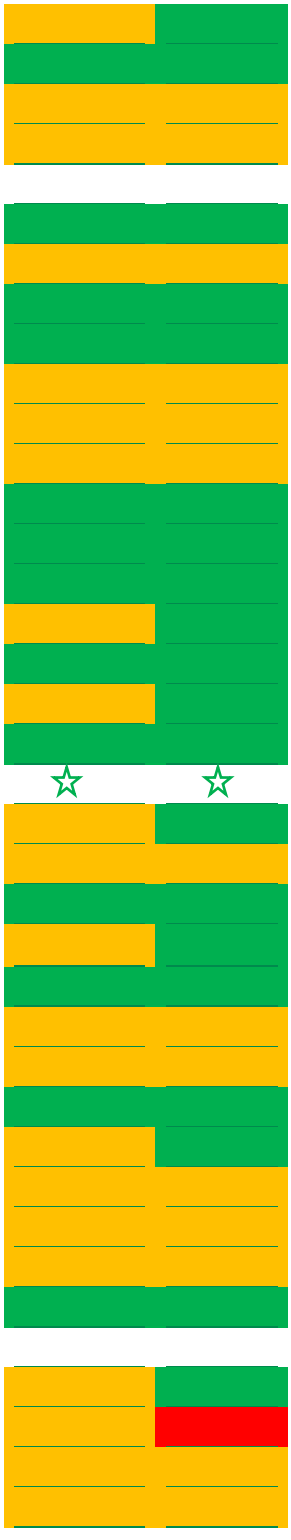
80.5%	County Durham and Darlington NHS Foundation Trust	
80.5%	North East London NHS Foundation Trust	
80.5%	North Staffordshire Combined Healthcare NHS Trust	
80.4%	Oxleas NHS Foundation Trust	
80.3%	University Hospitals Bristol NHS Foundation Trust[14]	
80.3%	Cheshire and Wirral Partnership NHS Foundation Trust	
80.3%	Poole Hospital NHS Foundation Trust	
80.2%	East London NHS Foundation Trust	
80.2%	Rotherham Doncaster and South Humber NHS Foundation Trust	
80.2%	Tameside and Glossop Integrated Care NHS Foundation Trust	
80.2%	Royal National Orthopaedic Hospital NHS Trust	
80.2%	Devon Partnership NHS Trust	
80.2%	Southend University Hospital NHS Foundation Trust[15]	
80%	East Sussex Healthcare NHS Trust	
80%	Bradford Teaching Hospitals NHS Foundation Trust	
80%	Buckinghamshire Healthcare NHS Trust	
80%	Cumbria Partnership NHS Foundation Trust[16]	
79.9%	Pennine Care NHS Foundation Trust	
79.9%	Sherwood Forest Hospitals NHS Foundation Trust	
79.9%	North West Boroughs Healthcare NHS Foundation Trust	
79.8%	Queen Victoria Hospital NHS Foundation Trust	
79.8%	Liverpool Women's NHS Foundation Trust	
79.8%	Nottingham University Hospitals NHS Trust	
79.7%	Moorfields Eye Hospital NHS Foundation Trust	
79.7%	South Tyneside and Sunderland NHS Foundation Trust	
79.6%	Birmingham Community Healthcare NHS Foundation Trust	
79.6%	Chelsea and Westminster Hospital NHS Foundation Trust	
79.6%	Royal Devon and Exeter NHS Foundation Trust	
79.6%	Leeds Teaching Hospitals NHS Trust	
79.5%	Oxford University Hospitals NHS Foundation Trust	
79.5%	Sussex Partnership NHS Foundation Trust	
79.5%	East Cheshire NHS Trust	
79.5%	Central and North West London NHS Foundation Trust	
79.4%	Leeds and York Partnership NHS Foundation Trust	
79.4%	Chesterfield Royal Hospital NHS Foundation Trust	
79.4%	Warrington and Halton Teaching Hospitals NHS Foundation Trust	
79.4%	Kent and Medway NHS and Social Care Partnership Trust	
79.3%	Leicestershire Partnership NHS Trust	
79.3%	Bradford District Care NHS Foundation Trust	
79.2%	Sheffield Teaching Hospitals NHS Foundation Trust	
79.2%	Blackpool Teaching Hospitals NHS Foundation Trust	
79.2%	Birmingham Women's and Children's NHS Foundation Trust	
79.2%	Essex Partnership University NHS Foundation Trust	

[14] Merged with Weston Area Health NHS Trust to form University Hospitals Bristol and Weston NHS Foundation Trust in April 2020.
[15] Merged to form Mid and South Essex NHS Foundation Trust.
[16] Merged with North Cumbria University Hospitals NHS Trust to form North Cumbria Integrated Care NHS Foundation Trust.

79.1%	Tees, Esk and Wear Valleys NHS Foundation Trust
79%	Homerton University Hospital NHS Foundation Trust
79%	North West Anglia NHS Foundation Trust
79%	Ashford and St Peter's Hospitals NHS Foundation Trust
79%	Sandwell and West Birmingham Hospitals NHS Trust
78.9%	Whittington Health NHS Trust
78.9%	Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust
78.8%	Mid Cheshire Hospitals NHS Foundation Trust
78.8%	Isle of Wight NHS Trust (mental health sector)
78.8%	Derbyshire Healthcare NHS Foundation Trust
78.8%	University College London Hospitals NHS Foundation Trust
78.7%	Lancashire Teaching Hospitals NHS Foundation Trust
78.7%	Wye Valley NHS Trust
78.7%	Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust
78.6%	Bridgewater Community Healthcare NHS Foundation Trust
78.6%	Greater Manchester Mental Health NHS Foundation Trust
78.5%	Hull University Teaching Hospitals NHS Trust
78.5%	Calderdale and Huddersfield NHS Foundation Trust
78.5%	West London NHS Trust
78.5%	Worcestershire Acute Hospitals NHS Trust
78.4%	Dorset County Hospital NHS Foundation Trust
78.3%	Isle of Wight NHS Trust (community sector)
78.3%	Salford Royal NHS Foundation Trust
78.3%	Barnsley Hospital NHS Foundation Trust
78.3%	Gloucestershire Hospitals NHS Foundation Trust
78.3%	Humber Teaching NHS Foundation Trust
78.2%	South West Yorkshire Partnership NHS Foundation Trust
78.1%	Coventry and Warwickshire Partnership NHS Trust
78.1%	Countess of Chester Hospital NHS Foundation Trust
78.1%	North Bristol NHS Trust
78.1%	West Hertfordshire Hospitals NHS Trust
78.1%	Manchester University NHS Foundation Trust
78.1%	Milton Keynes University Hospital NHS Foundation Trust
78%	Black Country Partnership NHS Foundation Trust
78%	Camden and Islington NHS Foundation Trust
78%	The Royal Wolverhampton NHS Trust
77.9%	Imperial College Healthcare NHS Trust
77.8%	Kettering General Hospital NHS Foundation Trust
77.7%	Mid Yorkshire Hospitals NHS Trust
77.7%	Royal Cornwall Hospitals NHS Trust
77.7%	University Hospitals of Derby and Burton NHS Foundation Trust
77.6%	Torbay and South Devon NHS Foundation Trust
77.6%	Epsom and St Helier University Hospitals NHS Trust
77.6%	Brighton and Sussex University Hospitals NHS Trust



77.6%	Mid Essex Hospital Services NHS Trust[17]	
77.6%	Aintree University Hospital NHS Foundation Trust[18]	
77.6%	London North West University Healthcare NHS Trust	
77.5%	Stockport NHS Foundation Trust	
77.5%	Isle of Wight NHS Trust (ambulance sector)	
77.5%	Bedford Hospital NHS Trust[19]	
77.5%	Norfolk and Norwich University Hospitals NHS Foundation Trust	
77.5%	Tavistock and Portman NHS Foundation Trust	
77.3%	Barnet, Enfield and Haringey Mental Health NHS Trust	
77.3%	The Rotherham NHS Foundation Trust	
77.3%	Lewisham and Greenwich NHS Trust	
77.3%	East Kent Hospitals University NHS Foundation Trust	
77.2%	Dartford and Gravesham NHS Trust	
77.2%	Royal United Hospitals Bath NHS Foundation Trust	
77.2%	Alder Hey Children's NHS Foundation Trust	
77.1%	Maidstone and Tunbridge Wells NHS Trust	
77.1%	The Royal Liverpool and Broadgreen University Hospitals NHS Trust[20]	
77.1%	North Middlesex University Hospital NHS Trust	
77%	Hampshire Hospitals NHS Foundation Trust	
77%	Western Sussex Hospitals NHS Foundation Trust	
77%	Barts Health NHS Trust	
77%	York Teaching Hospital NHS Foundation Trust	
77%	University Hospitals of Leicester NHS Trust	
76.9%	Royal Free London NHS Foundation Trust	
76.9%	Luton and Dunstable University Hospital NHS Foundation Trust[21]	
76.9%	Avon and Wiltshire Mental Health Partnership NHS Trust	
76.9%	Northampton General Hospital NHS Trust	
76.8%	South Central Ambulance Service NHS Foundation Trust	
76.7%	Barking, Havering and Redbridge University Hospitals NHS Trust	
76.5%	Croydon Health Services NHS Trust	
76.5%	George Eliot Hospital NHS Trust	
76.4%	Wirral University Teaching Hospital NHS Foundation Trust	
76.3%	Pennine Acute Hospitals NHS Trust	
76.2%	Isle of Wight NHS Trust (acute sector)	
76.1%	East Suffolk and North Essex NHS Foundation Trust	
76.1%	Medway NHS Foundation Trust	
76%	The Dudley Group NHS Foundation Trust	
75.9%	Lancashire and South Cumbria NHS Foundation Trust[22]	



[17] Merged with Basildon and Thurrock University Hospitals NHS Foundation Trust and Southend University Hospital NHS Foundation Trust to form Mid and South Essex NHS Foundation Trust in April 2020.
[18] Merged with Royal Liverpool and Broadgreen University Hospitals NHS Trust to form Liverpool University Hospitals NHS Foundation Trust in October 2019.
[19] Merged with Luton and Dunstable University Hospital NHS Foundation Trust to form Bedfordshire Hospitals NHS Foundation Trust in April 2020.
[20] Merged with Aintree University Hospital NHS Foundation Trust to form Liverpool University Hospitals NHS Foundation Trust in October 2019.
[21] Merged with Bedford Hospital NHS Trust to form Bedfordshire Hospitals NHS Foundation Trust in April 2020.
[22] The trust changed its name from Lancashire Care NHS Foundation Trust to Lancashire and South Cumbria NHS Foundation Trust in October 2019.

75.9%	Nottinghamshire Healthcare NHS Foundation Trust	
75.9%	James Paget University Hospitals NHS Foundation Trust	
75.9%	South West London and St George's Mental Health NHS Trust	
75.8%	University Hospitals of Morecambe Bay NHS Foundation Trust	
75.8%	South London and Maudsley NHS Foundation Trust	
75.6%	Weston Area Health NHS Trust[23]	
75.6%	The Hillingdon Hospitals NHS Foundation Trust	
75.6%	St George's University Hospitals NHS Foundation Trust	
75.5%	University Hospitals of North Midlands NHS Trust	
75.5%	Walsall Healthcare NHS Trust	
75.4%	The Princess Alexandra Hospital NHS Trust	
75.3%	King's College Hospital NHS Foundation Trust	
75.2%	East and North Hertfordshire NHS Trust	
75%	Basildon and Thurrock University Hospitals NHS Foundation Trust[24]	
74.7%	University Hospitals Birmingham NHS Foundation Trust	
74.6%	Southport and Ormskirk Hospital NHS Trust	
74.5%	South East Coast Ambulance Service NHS Foundation Trust	
74.4%	Birmingham and Solihull Mental Health NHS Foundation Trust	
74.1%	West Midlands Ambulance Service University NHS Foundation Trust	
73.9%	London Ambulance Service NHS Trust	
73.8%	North West Ambulance Service NHS Trust	
73.7%	Norfolk and Suffolk NHS Foundation Trust	
73.6%	The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust	
73.5%	United Lincolnshire Hospitals NHS Trust	
73.5%	Yorkshire Ambulance Service NHS Trust	
73.3%	Northern Lincolnshire and Goole NHS Foundation Trust	
73.2%	South Western Ambulance NHS Foundation Trust	
73.1%	South Tees Hospitals NHS Foundation Trust	
72.9%	North East Ambulance Service NHS Foundation Trust	
72.3%	Sheffield Health and Social Care NHS Foundation Trust	
72.3%	The Shrewsbury and Telford Hospital NHS Trust	
71.9%	East Midlands Ambulance Service NHS Trust	
69.5%	East of England Ambulance Service NHS Trust	
68.5%	North Cumbria University Hospitals NHS Trust[25]	

CQC ratings are correct as of July 3rd, 2020.

If you any queries regarding this report, please contact enquiries@nationalguardianoffice.org.uk.

[23] Merged with Weston Area Health NHS Trust to form University Hospitals Bristol and Weston NHS Foundation Trust in April 2020.
[24] Merged with Mid Essex Hospital Services NHS Trust and Southend University Hospital NHS Foundation Trust to form Mid and South Essex NHS Foundation Trust in April 2020.
[25] Merged with Cumbria Partnership NHS Foundation Trust to form North Cumbria Integrated Care NHS Foundation Trust in October 2019.

Framing our work as an ACP; and winter priorities

Sheffield Accountable Care Partnership (ACP)

Board meeting 31st July 2020

Author(s)	**Mark Tuckett**
Sponsor	**Kirsten Major**

1. Purpose

To frame the areas we are focussing on as an ACP and to provide more detail about a set of specific, relatively near-term, knotty challenges which we have identified as needing particular focus ahead of a difficult winter and upcoming 6-9 months.

2. Is your report for Approval / Consideration / Noting

Approval, noting, and commitment

3. Recommendations / Action Required by Accountable Care Partnership

- To note and support the framing of our work as an ACP in the four areas identified in Section 1
- To note, approve and support the set of specific priorities that our system has identified as knotty challenges to focus on for winter 2020/21
- To commit personally to supporting the work:
    - As executives, this will be through EDG; as points of liaison with named leads; and through your leadership of organisations providing staff to work on and develop recommendations; and – pending discussions and decisions – to support the implementation of changes;
    - As non-executives, and notwithstanding internal schemes of delegation etc., supporting this work as the chairs of organisations' boards; and committing to fast track any required discussions and decisions relating to recommendations and changes that are identified.

Are there any Resource Implications (including Financial, Staffing etc.)?

N/A

Framing our work as an ACP; and winter priorities

July 2020

1. Framing our work as an ACP

Emerging from discussions at the ACP Board, at ACP EDG, within the Core Team, and across our health and care system, we have identified four linked areas that we need to work on across our ACP. We will

1. Develop our **vision for the provision of health and care services** in Sheffield in 5-10 years' time
2. Continue to **shift *how* we work as a system** (system leadership, CEX team development, Leading Sheffield, devolved problem solving approach, regular operational check ins etc.)
3. Focus on some **specific, knotty challenges that are facing our system** now.
4. **Clarify and strengthen the role for our ACP within the context of a developing ICS and our relationship there, and a changing commissioning landscape** .

The work on *developing our vision* is progressing – we are on track to appoint an external organisation to support this work during August, and for this work to develop in earnest in September and October 2020.

The focus on '*how we work as a system*' is ongoing – we are already shifting to greater emphasis on devolved problem solving, less emphasis on set piece meetings etc. During the week of the Board discussion, we will have had a workshop session with Helen Bevan (Chief Transformation Officer at NHS England) and Göran Henricks (Chief Executive of the Learning and Innovation Institute in Jönköping, Sweden), on 29th July. This is an initial session with a small number of people from across our ACP – looking at principles for system transformation – which will, hopefully, lead to subsequent and broader discussions.

A set of *specific, knotty – and relatively near term – challenges* is the main focus of the rest of this paper – those system challenges that we need to have in place for our system to work through what will be a very challenging 6-9 months.

Reaching clarity and *strengthening our work as an ACP in a changing context* will be discussed at the Board today.

2. Planning, priorities for winter

We have talked as an ACP about taking a 'devolved problem solving' approach: the right people, from across our Sheffield communities and ACP workforce, coming together and being empowered to solve particular and specific challenges or problems.

Inevitably, with a system under intense operational pressure, undergoing a huge amount of change, and a pretty long 'to-do' list even before Covid-19, we have identified **a large number of areas of work**.

Earlier this month, a session was held with ~40 people from across Sheffield – to identify and focus on priorities and next steps that will play a key role in our winter response across Sheffield in areas relating to urgent care, planned care, mental health and admissions, discharge and transitions between care settings, people homes etc.

The areas that emerged from this discussion are set out in the following table, with a narrative which sets out how these areas sit together; and some more specificity in each area – what we identified as needing to be in place, by when.

Focus area	Our narrative	Specificity about each area – what do expect to be in place by when
Communications	**Communication** We will be clear with people about what they can expect from our health and care services, how that might change and the challenges and uncertainties that our services are operating within. We will also encourage people with serious conditions, illnesses, not to stay away. We remain open and are here to support	Clear, aligned, frank public and staff communications messages, delivered regularly over the rest of 2020/21 about how people can and can expect to access health and care services. These need to start asap, certainly no later than September. Local Authority connections with and through community groups will be important to help messages get *through* to people - it's not just about getting messages *out*. CEXs will be supporting and lead the delivery of many of these messages - we are looking to communications leads for their expertise, given the complexity and difficulty of some of the messages we need to communicate. The work will need to connect closely with what we are doing across our ICS.
Mental Health Transformation	**Mental health** We will have a strengthened and clear 'emotional wellbeing' offer for children and young people, delivered through, and in close partnership with schools…	Children's mental and emotional health and wellbeing offer needs to be in place, in schools in September: we will have done all we can do in September, and will continue to introduce additional service/offers through Term 1 (including on neurodevelopmental pathways)
	…and for all people requiring mental health support and advice, we will have a strengthened primary care offer…	Clarity reached (by September) about how we are going to roll out the MH primary care approach in all PCNs and communities; and then implemented by end November
	…and for all those people who need crisis mental health support, they will get support which is age-appropriate and people will not unnecessarily need to go to A&E	By September, we will have agreed our arrangements, support, capacity and approach for MH crisis support for children, adults, and including 16-17 y.o.s. And this agreed approach is implemented asap after then, no later than November

Urgent and out of hours access	**Urgent and out of hours access** We will make it clearer and simpler for people to access urgent, and out of hours '*health*' care and communicate this effectively across all relevant partners…	By October 2020, we have an integrated pathway for urgent care, across primary care, walk-in centre, A&E. This needs a single point of access (see '*Talk Before You Walk*', below); triage and record. Our approach needs appropriate and adequate resourcing, and needs to be well-communicated and understood. We will clarify offers, expectations, and implications for different services, and with overarching coordination of capacity.
	… and help people more easily access other, out of hours, care: including social care, voluntary sector support…	Clear understanding for staff and public about what out of hours provision exists (and how it is accessed) for social care and voluntary sector support; with any changes (especially increases) to provision agreed and implemented by October
	…and we will introduce a way of signposting, navigating, for staff and public and have a 'talk before you walk' service	A 'signposting'/navigation approach - which should include delivery of a '*talk before you walk*' function - in place for November 2020. This needs to reach across health, care and voluntary services, and should make use of and build upon what is already in place - particularly the linkages with 111 and single points of access
'Discharge': transitions from one care setting to another	**Discharge and transitions from one care setting to another** We have developed and will embed our clear principles for people moving between care settings; and we will implement national guidance on this	Our principles for transitions between care settings [which we have already agreed], are embedded in ways of working with staff by September 2020. Building on these, and on the same timescales - end September - we will have implemented the national guidance on discharge arrangements
	We will be clear and ready to launch a 'surge' plan for additional community-based beds and other support	By end September, we are clear about the implications of these principles for capacity planning and we have a surge/capacity plan in place both for beds and non-bedded support (in different settings) agreed. This surge plan will be implemented by December 2020

Community hubs and supporting people at home	**Community and supporting people at home** The connections between our community-based services will be clear and people will understand how different services work together. These connections are strengthening	By October, we will have community based care and support that responds to escalating and de-escalating needs of populations via a coordinated hub approach. The multi-professional, multi-organisational team will have access to the information/intelligence they need in order to respond proactively in a way that prevents people requiring a hospital attendance and enables discharges to happen without delay. Hubs will be aligned to Primary Care Network footprints. This will require the established health, care and voluntary sector hubs to work together to achieve the result. It is acknowledged that a) there will be differential starting points across the hubs and therefore not all will be fully functional within the timeframe and b) that the work needs to be tailored to the particular circumstances of different communities and the lead in different communities will probably differ.
	We recognise the critical role that informal carers have played and will play over the coming months and we will ensure that we do all we can to support them	By October, we have agreed what we will do to support informal carers over 2020/21
Planned and elective care	**Planned and elective care** For people needing planned - non emergency - care, we are taking a joined-up approach across primary and secondary care: GPs and hospital based specialists working together	By mid-August, across all ten CASES specialities (plus any others identified), specialty GP peer reviewers and hospital specialists (both adults and relevant children's specialties) will be taking active and shared ownership for the planned care caseload. By October, we will have implemented commitments already made pre-Covid for skin, ENT, neurology. By November, we will be clear about the implications of this approach for our longer term planned care model: in terms of levels of activity and resource at different levels of care; and how we will resolve constraints (e.g., physical estate capacity in the community).
	We will be led by clinical expertise to help us with difficult decisions about what we need to prioritise	By start October, we will have developed clear principles/criteria/an approach for prioritising elective and planned care, based on clinical risk and need

	and are making sure that all our health services have timely and appropriate - access to diagnostics and monitoring services that they need - blood tests, CT scans etc. - though we recognise that this will be a constraint for our system as well	By September - we will have a clear set of system principles about supporting the population to access diagnostic tests - minimising visits, minimising attendance in risky setting, with clarity of what's in scope and any limitations/restrictions. Subsequent and more specific challenges and opportunities will arise from that work for how we can improve access to diagnostics and results (including out of hours and across organisational boundaries)
Staff wellbeing	**Staff wellbeing** Importantly, as employers, we will be continuing to look after our staff health and wellbeing - they have been the most important part of our response and will continue to be so. We will share best practices between ourselves about how we can support staff (including particular staff groups). And for those parts of Sheffield's health and care workforce who aren't under in direct employment (in primary care, social care, voluntary sector), we will be working with other organisations and employers to offer help and support	Each organisation will retain its employer responsibilities regarding the health and wellbeing of its staff. We will have clarity about how we will approach staff health and wellbeing for those areas where ACP reps don't have direct employment responsibilities (in the voluntary sector, social care, prime care). We will also be regularly and routinely sharing our approaches, best practices between our organisations

Leadership, and liaison with our Executive Delivery Group

For each of the areas identified above, we have identified people who will take on, 'own' and lead the development work for each challenge. In keeping with the approach of 'devolved problem solving' we are not proposing to specify how this done but anticipating these people pulling together perspectives from across our ACP. Note that the different elements of this are linked (and particularly closely linked in some cases – e.g., the three areas described under 'urgent and out of hours access'). Treating them as separate, distinct pieces of work is a risk we will work hard to avoid.

To demonstrate our Executive commitment to this work, we are identifying for each of these challenges a member of the ACP Executive Group to be a point of liaison – to connect to EDG and across our system, to support those people leading on this work, and to demonstrate senior executive commitment to the work.

Asks of the ACP Board

- To note and support the framing of our work as an ACP in the four areas identified in Section 1
- To note, approve and support the set of specific priorities that our system has identified as knotty challenges to focus on for winter 2020/21
- To commit personally to supporting the work:
    - As executives, this will be through EDG; as points of liaison with named leads; and through your leadership of organisations providing staff to work on and develop recommendations; and – pending discussions and decisions – to support the implementation of changes;
    - As non-executives, and notwithstanding internal schemes of delegation etc., supporting this work as the chairs of organisations' boards; and committing to fast track any required discussions and decisions relating to recommendations and changes that are identified.