A MEETING OF THE BOARD OF DIRECTORS

To be held in public on

Thursday 22 July 2021 at 09:30am

Via MS Teams link

AGENDA

No.	Item	Action	Paper	Lead	Mins	S.O*
0	**Staff story – reflection, recognition and remembrance week**	**Note**	**Present**	**Sandi Drewett**	**20**	**5**
1.	Apologies for absence	Note	Verbal	Tessa Green		
2.	Declarations of interest	Note	Verbal	Tessa Green		
3.	Minutes of the meetings held on 27 May and 10 June 2021	Approve	Enclosed	Tessa Green	00:05	
4.	Matters arising and action points	Note	Enclosed	Tessa Green	00:05	
5.	Chief Executive's Report	Note	Enclosed	David Probert	00:15	All
6.	Integrated performance report	Assurance	Enclosed	Jon Spencer	00:10	1
7.	Finance report	Assurance	Enclosed	Jonathan Wilson	00:10	7
8.	Learning from deaths	Assurance	Enclosed	Jon Spencer	00:05	1
9.	Trust strategy update	Note	Enclosed	Johanna Moss	00:10	All
10.	Board assurance framework	Assurance	Enclosed	Helen Essex	00:10	6
11.	Report from the audit and risk committee	Assurance	Enclosed	Nick Hardie	00:10	6
12.	Report from the people and culture committee	Note	Enclosed	Tessa Green	00:05	5
13.	Identify any risk items arising from the agenda	Note	Verbal	Tessa Green		
14.	AOB			Tessa Green		
15.	**Date of the next meeting – Thursday 23 September**					

* Strategic Objectives

1 Care 2 Research 3 Knowledge sharing 4 Policy 5 People 6 Infrastructure 7 Finance 8 Enterprise

MOORFIELDS EYE HOSPITAL NHS FOUNDATION TRUST
MINUTES OF THE MEETING OF THE BOARD OF DIRECTORS HELD ON
THURSDAY 27 MAY 2021 (via video link)

Attendees:	Tessa Green (TG)	Chairman
	David Probert (DP)	Chief executive
	Vineet Bhalla (VB)	Non-executive director
	Andrew Dick (AD)	Non-executive director
	Ros Given-Wilson (RGW)	Non-executive director
	Nick Hardie (NH)	Non-executive director
	David Hills (DH)	Non-executive director
	Richard Holmes (RH)	Non-executive director
	Sumita Singha (SS)	Non-executive director
	Adrian Morris (AM)	Non-executive director
	Johanna Moss (JM)	Director of strategy & partnerships
	Peng Khaw (PK)	Director of research & development
	Tracy Luckett (TL)	Director of nursing and AHPs
	Jon Spencer (JS)	Chief operating officer
	Jonathan Wilson (JW)	Chief financial officer
In attendance:	Sandi Drewett (SD)	Director of workforce & OD
	Helen Essex (HE)	Company secretary (minutes)
	Kieran McDaid (KM)	Director of estates, major projects and capital
	Nick Roberts (NR)	Chief information officer
	Ian Tombleson (IT)	Director of quality and safety
	Richard Macmillan (RM)	General counsel
	Pete Thomas (PT)	Chief clinical informatics officer
	Andrew Robertson (AR)	Director of private care
	Dilani Siriwardena (DS)	Divisional director, City Road
	Lauren Barraclough (LB)	Anaesthetic trainee
Governors:	Allan MacCarthy	Public governor, SEL
	John Sloper	Public governor, Beds & Herts
	Ian Wilson	Public governor, NWL
	Richard Collins	Public governor, NEL & Essex
	Kimberley Jackson	Public governor, SWL
	Paul Murphy	Public governor, NCL
	Jane Bush	Public governor, NCL
	Roy Henderson	Patient governor
	Tricia Smikle	Appointed governor, RNIB
	Andrew Clark	Public governor, Beds & Herts
	John Russell	Public governor, NEL & Essex
	Una O'Halloran	Appointed governor, LBI
	Amit Arora	Staff governor, City Road
	Vijay Arora	Public governor, NWL
Public:	Bhavini Makwana	Patient story
	Andrew Pearce	Roche
	Dren Matoshi	Public

21/2570 Apologies for absence
Apologies were received from Louisa Wickham.

21/2571 Declarations of interest
There were no declarations of interests.

21/2572 Minutes of the last meeting
The minutes of the meeting held on the 22 April 2021 were agreed as an accurate record.

21/2573 Matters arising and action points

Appointment of the chief executive
TG advised that following a thorough and rigorous process, Dr Martin Kuper had been appointed to the role of chief executive and would be starting at the trust on 1 September 2021. JW will act up into the chief executive/accountable officer role in the interim. TG thanked everyone involved for their part in the process.

All other actions were completed or attended to via the agenda.

21/2574 Chief executive's report

DP acknowledged the huge effort that has been put in to recovery. There is now focus on the new variant which is present in a number of areas in London.

Communication with patients has been a huge challenge across London. The trust has taken a number of proactive actions including hiring additional staff to support the booking team. There has been improvement across a range of metrics such as calls abandoned. The team will keep this under close review but will also look further back into the pathway to review the quality of interaction with patients. It is important to establish what the experience is for the patient once the call gets answered. TG advised that this is an issue the recovery oversight committee is looking at in detail.

NCL is one of the systems that is operating an Accelerator programme, with trusts expected to achieve over and above the 100% target trajectory.

The trust continues to deliver initiatives such as the cataract drives with one just completed in Croydon. Teams are carefully auditing outcomes and have so far achieved all clinical outcomes at international benchmark standard. Variants do present a risk to the trust achieving 120% due to not being able bring people in en masse. The focus is therefore on trying to find ways to provide care safely and at volume.

83% of staff have so far been vaccinated and the trust is working to understand the reasons why staff remain hesitant with a view to moving as many people as possible into having the vaccine.

The trust is currently undertaking a refresh of the strategy and working on inclusive engagement with staff and patients. Top line messaging is equity and kindness at the forefront of eye care with seven objectives suggested that would frame priorities going forward.

TG and DP have been asked to join the NCL Provider Alliance Board. The Provider Alliance will make a decision on DP's role once he has completed the move to UCLH.

DP referenced the Pathway to Excellence accreditation programme, which aims to help develop our registered nurses to be leaders in ophthalmic practice and will hopefully grow the trust's profile as a centre of excellence and employer of choice for all healthcare professionals.

21/2575 Improving sight loss awareness

The guiding principle of this initiative is that those with the greatest visual need are not always communicated with effectively and the trust needs to understand the challenges and how it is meeting them.

The Moorfields Sight Loss Awareness Group was established as an inclusive group that will use stories from patients to make the strategy more real for staff and develop an appropriate training and induction package.

Of particular importance is helping staff to deliver bad news in a sensitive way and to do so using specific scenarios, in theatres with patients under local anaesthetic, those in outpatients and when leading and guiding. The plan is to use virtual technology to deliver these approaches. The use of digital technology in general is being used to try and enhance the patient experience; the implementation of Dr Doctor will enable patients to manage their appointments more readily and the Moorfields website is being made more patient-centric.

IT read out statement from BM about her negative experiences of services and appointments in clinics. The group has been set up to allow people with lived experiences to help shape the way that services are run and improve the development of staff. Patients and advocates are critical for resolving issues that face people with visual-impairments. BM said that the group has been engaging, collaborative and committed with real action and movement taking place.

Specific questions have been built in to the friends and family test in order to make sure the progress and success of new systems is measurable. Baseline data is based on complaints and suggestions from PALS and feedback from the friends and family test and there are similar themes that come up time and again. Although there is plenty of quantitative data available the cultural transition is the most important element.

SS raised a number of points that should be taken into consideration such as patients with co-morbidities that might need a private discussion, the amount of written information sent out to patients and the accessibility of the website.

It was agreed that an update should come back to the board in six months with a view as to how the trust has been able to embed the work coming out of Covid.

TL to bring an update back to the board in November.

It was agreed that the power of individual patient stories is important and need to be regularly scheduled.

21/2576 NHSX and the department of digital medicine

PT advised that there is a huge amount of innovation taking place around virtual consultations, with 30,000 video consultations taking place at the trust so far, with 20,000 of those in A&E which has reduced the footfall. This provides a platform on which to make plans for the future, with attempts being made to design computerised 'total information systems' to replace conventional paper records.

Clinical informatics is a new medical specialty made up of professionals that use IT to deliver technology pathways. Doctors will in future be able to revalidate as a clinical informaticians with the ultimate aim of developing a workforce of trained informaticists and to strengthen and grow the CCIO field.

There are a lot of people already delivering clinical informatics but they are spread across the organisation in different departments and areas which makes it difficult to establish good oversight as to how doctors are delivering care in this way.

The department of digital medicine has been designed to remove barriers and create stronger connections with other critical areas of the organisation. There are a number of key elements to get right, such as transparency, reducing duplication, embedding the basics, support digital projects to scale and building connections to support transformation.

The department will be responsible for overseeing the safety of digital care systems and improving clinical IT systems by representing clinical needs and opportunities. Another focus will be the training and development of the clinical workforce in digital medicine, innovation in models of care delivery and extraction of insights from data to improve care and deliver some aspects of digital care.

PT described some of the collaboration that will be required with key individuals and progress being made in projects and programme management and with digital medics. The trust is also working with NHSX around transforming eye care and more user-centric design that applies to innovations as well as core systems.

In summary, the objectives are bold but grounded in a digital approach to transforming eye care and producing a replicable model for NHS transformation. It is hoped that some of the effort can be redistributed across the system and potentially into digital ophthalmology hubs that provide expertise without the need for hospital visits.

One of the critical issues for the board will be how to prioritise between the trust and the wider NHS and how to track progress. It was stressed that safety would be prioritised over any other project and the level of impact will need to be regularly

TG/DP will work through how to manage this at the

assessed. The real world implementation of systems is complex and poses significant risk. It is important that the department works 'in the open' and this relies on regular publishing of what is being done.

board, with particular regard to resource

VB supported the ambition of such a department being a catalyst for change and sought assurance as to how it would become embedded across the organisation. PT advised that there are clinicians that are engaged and will become clinical champions within services. Covid has given people the space to be able to think about how to be involved in and drive change and rapid digital transformation. This will be part of the job plan for digital champions, along with development of a fellowship, supported by the organisation

Patient interaction in the process is also important. There is a great deal of granular feedback coming from patients who are experiencing video consultations in real time and therefore lots opportunity to engage in this critical element of the work.

There are challenges with the sustainability of the IT infrastructure and there is a plan to move from the current architecture to what will support developments going forward. However, this is something that needs to be led by the CIO and IT department although there will be close collaboration between the departments.

It is important to allow the team to innovate but then the role of the operational teams is to put the machinery around it, make sure there is appropriate allocation of resources and that there is support to help deliver the identified benefits.

It was agreed that the department of digital medicine is a very important part of the future as it supports service delivery, better care to patients through equity and innovation, research that reaches more people and ability to collect more data, educating the future population of clinicians and leading nationally and internationally in areas of innovation.

The board thanked PT for his presentation and look forward to receiving regular updates on progress.

21/2577 Integrated performance report

JS presented a new set of metrics and in particular noted that there is a clear indication as to how close the trust is to getting back to normal levels. Metrics on the call abandonment rate and added time to recruit for new trials are being established. The R&D team is likely to want to add additional metrics going forward.

The trust has seen a slight increase in activity in April with referrals back to three quarters of normal levels. Services have met the A&E standard and cancer standards with the exception of the 21-day standard. This relates to two patients on a complex pathway and a RCA has been set in motion to understand the cause.

It is anticipated that the trajectory on 52-week waits will be met by July at the latest. The 18-week target will not be met for a number of months. The trust has commissioned some demand and capacity modelling to assess how to balance clearing the backlog with new patients and those on long-term follow up are

managed.

The diagnostic target is not being met due to patient choice and the trust is trying to encourage patients to attend within the timescale.

The written complaints standard is being achieved and appraisal on an upward trajectory so it is hoped that there will be an improvement next month.

It was agreed that it would be useful to see a breakdown of which outpatient appointments are virtual and which remain face to face. The numbers of virtual consultations taking place remain fairly consistent.

JS to include this breakdown for the next report.

21/2578 Finance report – M1

The trust posted a surplus of £0.3m against a plan of £0.8m for M1.

JW advised that the financial reporting architecture for 2021/22 is split into two halves (H1 and H2) and that the trust has been given a £4.85m control total through the ICS. There is also £8.1m funding available through the ICS for Covid-related elements and low value contracts but no clarity as to the allocations for H2 as yet. The trust is on fixed income for the first six months of the year with a significant uplift from March.

Figures exclude impact of ERF (£1.4m) pending ratification from the ICS and the trust would over performing if that was approved.

£17.5m capital has been allocated for this year and this needs to be paced throughout the year.

The cash position is at £65m which reflects the clawback of SLA funding but represents 97 days of liquidity.

There are no major queries coming through external audit with the close out meeting taking place next week and ISA 260 available after that point. One potential query facing all trusts is how annual leave accrual will be treated.

21/2579 Report from the quality and safety committee

A system is now in place for management of network sites and this will be done through Ops.

Work is taking place on consent and moving towards considering it as a process to go through with the patient to make sure they are fully aware of the implications of their consent.

Positive assurance was received in relation to infection control and Covid. There has been a spike in endophthalmitis but these are small numbers and the issue continues to be audited.

Issues for escalation:

The committee considered the serious incident report into the recent patient death and subsequent coroner's report. This was a very rare complication and could not

have been foreseen or prevented although there are a number of areas for potential improvement. It was agreed to look again at the issue of complex surgery and what should only be done with ITU backup on site.

The committee received a presentation from the North division which looked at its response to reduced capacity and the introduction of innovations, along with discussion about the estate and the variability in the relationship between MEH and host sites. It was agreed that it would be important to get clarity on the site strategy and those relationships.

A deep dive was done into imaging systems and IT as clinicians are experiencing frustration with access to systems and this has exposed issues about the sustainability of the network which could potentially lead to safety concerns about patient care.

The committee received a presentation from Pete Addison about clinical audit, plus audit of new pathways and ways of working. Assurance was received about safety and outcomes and the trust continues to maintain a high quality service.

21/2580 Q4 FTSU report

Low number of concerns were raised in Q4 although guardians have continued to provide a service and have been proactive in getting out and visiting services. There is a plan to recruit more guardians as they tend to feel more empowered than champions. Guardians are being sought to work across the network and will have access to a training package.

The National Guardian's Office is undertaking a piece of work on staff survey and effectiveness and this will be fed back to boards.

Two concerns have been raised showing no obvious patterns or themes. It was agreed that it will be interesting to see whether concerns go back to normal levels and the impact of the various initiatives put in place over the pandemic.

21/2581 Membership council report

The main topics of discussion were patient communication and engagement and Oriel engagement, leading to a showcase event in July. The membership council also approved the appointment of the chief executive, as required by the trust constitution.

21/2581 Identify any risk items arising from the agenda

IT sustainability and infrastructure is a key risk but is already on the BAF and corporate risk register.

21/2582 AOB

None.

21/2583 Date of the next meeting – Thursday 10 June 2021

MOORFIELDS EYE HOSPITAL NHS FOUNDATION TRUST
MINUTES OF THE EXTRAORDINARY MEETING OF THE BOARD OF DIRECTORS HELD ON THURSDAY 10 JUNE (via video link)

Attendees:	Tessa Green (TG)	Chairman
	David Probert (DP)	Chief executive
	Vineet Bhalla (VB)	Non-executive director
	Andrew Dick (AD)	Non-executive director
	Ros Given-Wilson (RGW)	Non-executive director
	Nick Hardie (NH)	Non-executive director
	David Hills (DH)	Non-executive director
	Richard Holmes (RH)	Non-executive director
	Sumita Singha (SS)	Non-executive director
	Johanna Moss (JM)	Director of strategy & partnerships
	Peng Khaw (PK)	Director of research & development
	Tracy Luckett (TL)	Director of nursing and AHPs
	Jon Spencer (JS)	Chief operating officer
	Jonathan Wilson (JW)	Chief financial officer
In attendance:	Sandi Drewett (SD)	Director of workforce & OD
	Helen Essex (HE)	Company secretary (minutes)
	Nick Roberts (NR)	Chief information officer
	Ian Tombleson (IT)	Director of quality and safety
	Lubna Dharssi (LD)	Head of financial control
Governors:	Allan MacCarthy	Public governor, SEL
	John Sloper	Public governor, Beds & Herts
	Ian Wilson	Public governor, NWL
	Jane Bush	Public governor, NCL
	Tricia Smikle	Appointed governor, RNIB
	Andrew Clark	Public governor, Beds & Herts
	John Russell	Public governor, NEL & Essex
	Ian Humphreys	Appointed governor, College of Optometrists
	Kimberley Jackson	Public governor, SWL
	Amit Arora	Staff governor, City Road
	Una O'Halloran	Appointed governor, LBI
	Vijay Tailor	Staff governor, City Road

21/2584 Apologies for absence
Apologies were received from Adrian Morris and Kieran McDaid.

21/2585 Declarations of interest
There were no declarations of interests.

21/2586 Chief executive's report
DP advised that Camden Council would be reviewing the planning case for Oriel this evening and that a decision is expected tomorrow morning.

The accelerator programme is under way and the trust has agreed a rate of pay with staff. There is a huge amount of work taking place to support the recovery agenda and on patient communication.

21/2587 Report from the audit and risk committee

The purpose of the audit and risk committee is to gain assurance that appropriate controls are in place and it does this through a programme of audit. In 2020/21 the trust received one green audit, four amber/green audits and one amber/red audit relating to contract management. This led to the head of internal audit opinion being one of 'significant assurance with minor opportunities for improvement'.

NH advised that the committee had taken comfort from internal audit's concluding remarks. There were no overdue actions on the tracker which is a credit to people continuing to work in a challenged environment. The concluding internal audit report on research governance was positive and showed the significant work that has taken place to improve governance and oversight in this area.

External audit review – this was constrained by the pandemic. The key findings are in the subjective area of provisions but nothing has been found that is a cause for alarm and there are no material items meaning that a clean audit opinion cannot be given. There are also no issues raised in the letter of representation or going concern statement which provides additional comfort to the board.

Local counter fraud services – there have been significant changes to monitoring processes which have been applied retrospectively. Work will now take place to bring the trust up to speed with the new indicators.

DP thanked finance team for the work that has been done to keep the trust at such a high standard and has every confidence that the new standards will be met in good time. It is also positive to see progress on the recommendations tracker and no outstanding recommendations.

Audit findings
The audit is now relatively complete and a final review of the accounts being undertaken with no likely significant issues. There is a delay to the vfm report but the trust is seeking the audit certificate to be issued prior to the AGM so that the accounts can be laid before parliament.

One of the key issues is that of prudence and the team has been reviewing management positions in relation to unadjusted misstatements. One of these relates to the additional annual leave day being awarded in 20/21 (to be taken in 21/22). GT has identified the value of the element but the conditionality and the fact that it can be carried over into the next year means it is a misstatement.

Claremont – the purchase price was compared to the NBV of the asset but it has been written out and auditors would assess the asset to be the same value as that paid.

There were no other items in terms of estimate or cut-off to note; this is a solid set of accounts and the trust is in a good position.

It was noted that the issue of prudence is one that relates to technicality of the Group Accounting Manual and whether or not specific items should be included in the position.

21/2588 2020/21 annual report, accounts and quality account

The annual accounts showed income reductions of £8.5m with private income making up £6.5m of that, therefore making a loss on commercial services.

There was no public dividend capital position was the output of having a high cash balance and not having the dividend payable until March.

Statement of financial position – the annual valuation exercise saw land valuations return to pre-pandemic values but there has been a decrease in relation to trust building assets and these impairments have been booked into the accounts.

The trust has £68m in cash. Liabilities are up due to an increase in accruals and deferred balances. Non-current liabilities relate to tax payers equity and the receipt of capital in order to fund the estates programme.

The trust has sufficient liquidity to remain a going concern and it was advised that any organisation undertaking NHS services is deemed a going concern by the Treasury.

The board approved the annual report and annual accounts 2020/21.

Quality accounts 2020/21
The account reflects progress against the quality strategy and sets out the process by which quality governance has been maintained. The document draws together quality achievements and sets out quality priorities. All external assurance functions have been removed but assurance has been obtained through the QSC. Governors and commissioners have also been invited to comment.

The board approved the quality account 2021/21 subject to any final non-material amendments which would be approved by chairman's action.

21/2589 Annual compliance statements

The board approved the annual compliance statements.

21/2590 AOB

None.

21/2591 Date of the next meeting – Thursday 22 July 2021

BOARD ACTION LOG

Meeting Date	Item No.	Item	Action	Responsible	Due Date	Update/Comments	Status
25.03.21	21/2555	Matters arising and action points	Full update on leading and guiding group to be provided at the April meeting	TL	27.05.21	Scheduled for May	Closed
25.03.21	21/2556	Chief Executive's Report	Full report on diagnostic hubs to come to a future meeting	JS	22.07.21		Open
22.04.21	21/2564	Integrated performance report	Revised metrics to be available next month	JS	27.05.21		Closed
27.05.21	21/2575	Improving sight loss awareness	Update to come back to the board in November	TL	25.11.21		Open
27.05.21	21/2576	NHSX and the department of digital medicine	Work through how best to manage this issue at board level, with particular regard to resource allocation	TG/DP	22.07.21		Open
27.05.21	21/2577	Integrated performance report	Include a breakdown of which outpatient appointments are virtual and which remain face to face	JS	22.07.21		Open

NB Items greyed out have been completed and will be removed from the next log

Bold shows updates

Moorfields Eye Hospital NHS Foundation Trust

NHS

Glossary of terms – July 2021	
Oriel	A project that involves Moorfields Eye Hospital NHS Foundation Trust and its research partner, the UCL Institute of Ophthalmology, along with Moorfields Eye Charity working together to improve patient experience by exploring a move from our current buildings on City Road to a preferred site in the Kings Cross area by 2023.
A&E	Accident & Emergency
AAR	After action review
AfL	Agreement for lease
AHP	Allied health professional
AI	Artificial intelligence
ALB	Arms length body
AMRC	Association of medical research charities
ASI	Acute slot issue
BAF	Board assurance framework
BAME	Black, Asian and minority ethnic
BRC	Biomedical research centre
CCG	Clinical commissioning group
CCIO	Chief clinical informatics officer
CIO	Chief information officer
CIP	Cost improvement programme
CQC	Care quality commission
CSC	Capital scrutiny committee
CSSD	Central sterile services department
DHCC	Dubai Healthcare City
DSP	Data security protection [toolkit]
ECLO	Eye clinic liaison officer
EDI	Equality diversity and inclusivity
EDHR	Equality diversity and human rights
EIS	Elective incentive scheme
EMR	Electronic medical record
ENP	Emergency nurse practitioner
ERF	Elective recovery funding
FBC	Full business case
FFT	Friends and family test
FTSUG	Freedom to speak up guardian
GDPR	General data protection regulations
GIRFT	Getting it right first time
GMC	General medical council
GoSW	Guardian of safe working
HCA	Healthcare assistant
I&E	Income and expenditure
ICS	Integrated care system
IOL	Intra ocular lens

IPR	Integrated performance report
IT	Information technology
ITU	Intensive therapy unit
JDV	Joint development vehicle
KPI	Key performance indicators
LCFS	Local counter fraud service
LD	Learning disability
MEH	Moorfields Eye Hospital
NAO	National audit office
NCL	North Central London
NHSI/E	NHS Improvement/England
NIHR	National institute for health research
NMC	Nursing & midwifery council
OBC	Outline business case
OD	Organisation development
PALS	Patient advice and liaison service
PAS	Patient administration system
PbR	Payment by results
PDC	Public dividend capital
PID	Patient identifiable data
PP	Private patients
PPA	Pre-planning agreement
PPE	Personal protective equipment
PQQ	Pre-qualification questionnaire
QIA	Quality impact assessment
QIPP	Quality, innovation, productivity and prevention
QRA	Quantitative risk assessment
QSC	Quality & safety committee
QSIS	Quality service improvement and sustainability
RAG	Red amber green [ratings]
RCA	Root cause analysis
R&D	Research & development
RTT	Referral to treatment
SCC	Strategy & commercial committee
SGH	St Georges University Hospital
SI	Serious Incident
SLA	Service level agreement
ST	Senior trainee
STP	Sustainability and transformation partnership
UAE	United Arab Emirates
UCL	University College London
UCLH	University College London Hospital
VFM	Value for money
VR	Vitreo-retinal
WDES	Workforce disability equality standards
WRES	Workforce race equality standards
YTD	Year to date

Moorfields Eye Hospital NHS Foundation Trust

NHS

Agenda item 05
Chief executive's report
Board of directors 22 July 2021

Chief Executive's report

I would like to provide continued assurance to the board about the **Trust response to the COVID-19** pandemic.

Operational Response to COVID-19 and recovery of clinical services

Through the month of June we have been seeking to increase the number of patients who we are able to offer diagnosis and treatment to week on week. The majority of services are now achieving at least 90% of the activity levels which they managed in 2019/20 and with the support of the NHSE Accelerator Programme we are aiming to get this up to at least 100% by the end of July. The Trust is now close to treating all patients who have waited over 52 weeks for their treatment and is also making good progress in reducing both the number of new patients who have waited over 18 weeks and those who are waiting a follow up appointment to review the progress of their care. Significant focus remains in risk assessing the large volume of patients who have waited between 1 and 35 weeks for their first appointment. At present the number of patients in this category remains static, and it will be the final area of focus when the backlog of follow up patients has returned to the pre-Covid 19 level in November.

The Trust has recently been notified of a revised requirement from our commissioners to achieve 95% of our 2019/20 activity levels from 1st July 2021. To achieve the best use of our resources we have also been asked to explore the utilisation of advice and guidance and patient initiated follow up initiatives for our patients. These two initiatives will be key priorities within our Digital Transformation work stream this year, as will a desire to increase the number of virtual appointments which we are providing to patients. The proportion of virtual appointments in this Trust reached 50% in the height of the pandemic but has now stabilised at an 8% rate.

Despite the recent announcement from the Government on the relaxation of social distancing, we intend to keep a number of measures in place to prevent the spread of Covid-19 and protect our patients and staff. These measures will include the continued wearing of face masks by all staff, patients and visitors alongside the current social distancing and infection prevention and control policies in operation.

Moorfields is beginning to receive an increasing number of requests for mutual aid from surrounding NHS providers. These requests are being considered on a case by case basis and we are only agreeing to provide support where we have sufficient capacity to do this without it causing a significant detriment to us being able to provide care for our own patients.

As part of our service changes in response to Covid we have looked at new ways of working, one of these being the development of a new diagnostic hub at Hoxton. A draft six-month review has been shared with the executive team and this will come back to the public board later this year.

Staff Covid Vaccinations

The trust has vaccinated 86% of its substantive staff and vaccinations are still available on site and at several community sites for those staff who have yet to be vaccinated. Support is in place for staff who remain hesitant either by contacting one of the trust's vaccinator champions or accessing specialist advice from the Moorfields pharmacy team. Additional information is also available on our intranet site.

System and partnership working

NHS England and NHS Improvement has this week published a new **integrated care system (ICS) design framework**, to support progression and development. The framework sets out some of the ways NHS leaders and organisations will operate with their partners in ICSs from April 2022.

It is subject to legislation, which is expected to begin passage through Parliament before the end of summer. It has been designed to help ICSs and the organisations within them to put in place practical measures to prepare for the new functions that we expect to be enabled by legislation.

This document builds on what is working well in ICSs across the country, and indeed here in North Central London. The framework also provides further clarity about the direction of travel and areas where consistency will be important, while allowing local flexibility to design systems in a way that will be most effective in each local area.

The ICS design framework has been produced through close collaboration with ICS leaders, a wide range of NHS organisations, representatives of patient groups, clinical and professional leaders, local government and the voluntary sector.

Alongside the framework, a summary document has also been published. Both are available on the NHS England and Improvement website: https://www.england.nhs.uk/publication/integrated-care-systems-design-framework/

People and awards

Congratulations go to Adam Mapani, nurse consultant, who has been awarded Member of the Order of the British Empire (MBE) honours in the most recent Queen's birthday honours list. The MBE recognises Adam's enormous contribution to the field of ophthalmology, in particular the rollout and delivery of intra-vitreal injections by non-medical staff. His has influenced policy and trained and mentored over 1,200 nurses and allied healthcare professionals; around two thirds of practitioners who currently administer intraocular injections in the UK.

I would also like to congratulate Sumita Singha, non-executive director, who was awarded an Order of the British Empire (OBE) for her services to architecture and is the founding director of Charushila, an international design charity for sustainable community projects and Professor Carrie MacEwen, Moorfields Eye Charity trustee, who has been appointed Dame Commander in the Order of the British Empire (DBE) for services to ophthalmology and healthcare leadership during the Covid-19 response.

I am delighted to announce the following **academic promotions** for Moorfields and UCL colleagues with congratulations from the board:

- Keith Barton – Professor of Ophthalmology
- Pearse Keane – Professor of Artificial Medical Intelligence
- Omar Mahroo – Professor of Retinal Neuroscience
- Carlos Pavesio – Professor of Ocular Inflammation and Infection
- Konstantinos Balaskas – Associate Professor, Institute of Ophthalmology
- Rashmi Matthew – Associate Professor (Teaching), Institute of Ophthalmology

Professor Narciss Okhravi has also been accredited by UCL Arena as a Principal Fellow of the Higher Education Academy (PFHEA), awarded to the most experienced professionals with a sustained and effective record of impact at a strategic level in teaching and academic practice.

Professor Sobha Sivaprasad has been appointed as the new director of our clinical research facility. Her responsibilities will include leading the CRF renewal bid, attracting more research trials to the trust and providing support to principal investigators and clinical trial staff. This role was previously held by Frank Larkin who will remain active in research and clinic at the trust.

Reflection, reconnection and recognition week

From 5th – 10th July we held a week of events to recognise and thank staff as part of our Covid response. During the week executives visited 12 network sites and hosted reflect and reconnect sessions which focussed on listening to staff and their experiences from the past 16 months, launching and sharing the 'This is Moorfields' film which was

specially commissioned for the week. In addition to these visits we hosted two memorial services, one for Barry Crane at City Road and one for Dr Paul Kabasele at Croydon which were organised in conjunction with their families and commemorated with the unveiling of plaques. Staff had the opportunity to share tea and time with each other, write their own messages of thanks and recognition on specially commissioned reflection walls and view a curated 'faces of Moorfields' photo gallery of staff, volunteers and fundraisers. The week closed with a multi-faith and no-faith service led by our chaplain Tola Badejo, and the distribution of Moorfields pin badges as a small token of appreciation, gratitude and thanks.

The feedback and learning from the week will be written up and shared with the people committee. Actions will be incorporated into the staff engagement work stream of the workforce strategy delivery plan and the series of planned executive visits continued and reported on quarterly to the board.

Oriel

I am pleased to announce that another significant milestone has been achieved for Oriel – our partnership with the UCL Institute of Ophthalmology (IoO) and Moorfields Eye Charity that would see us move from our current premises to a new, integrated centre in Camden.

On 30 June Camden Council's Planning Committee made a resolution to grant planning permission for the new centre. This is the culmination of several years' work, including extensive patient, staff, student and public consultation on the relocation and design of the new building and brings us one step closer to moving existing services at City Road into a new purpose-built centre on the two-acre site in Camden's Knowledge Quarter, which is already home to the UCL Bloomsbury campus and the Crick Institute. This new centre would deliver the integration and exemplar conditions we need to continue our ground-breaking work efficiently and in partnership, enabling the speedier delivery of new treatments and therapies for patients.

The next step is for the planning application to be considered by the Greater London Authority (GLA) and we will await their decision.

Financial position – June

The trust is reporting a surplus of £1.87m against a planned £1.87m surplus, a breakeven performance to plan. Cumulative performance now stands at a surplus of £4.41m against a planned surplus of £4.36m, £0.05m ahead of plan. Patient activity increased during June to 86% against the equivalent month in 2019/20, compared to 87% in the previous month. Cash balances stood at £69.6m at the end of June, an increase of £7.3m on the previous month, as debtor levels reduced by £6.3m in June. Capital expenditure in June was £0.4m, and cumulatively stands at £1.6m, some £1.4m adverse to plan. It is anticipated that the shortfall in capital expenditure will be recovered over the course of the year.

Digital resilience

As the trust has increased patient care up to and beyond pre-COVID-19 levels, we have stretched the capacity and capability of our IT systems to the limit. This has created some instances of clinical applications poor performance. In order to rectify these challenges we have instigated a programme of IT remediation that upgrades and improves a number of digital services and increases capacity in systems and staffing expertise. This will ensure stability and performance of our systems in the short-term, and help prepare us to have a fully digital new hospital with Oriel. The areas of focus cover resourcing, IT infrastructure, imaging, and our clinical data warehouse repositories, and our solutions both expand existing capabilities and build new services in the Cloud. We will assure that the programme of work delivers on time and to budget through clear Board level reporting to the capital scrutiny committee and executive oversight through the executive team.

Farewell

I would like to take this final opportunity to thank the board and all the staff of Moorfields for their tremendous support over the past five and half years. It has been an absolute honour and pleasure to be your Chief executive and I wish my successor Martin Kuper the very best of luck as he joins Moorfields and an incredibly exciting time full of opportunity for this great institution.

David Probert
Chief executive
July 2021

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Integrated Care Systems: design framework

Version 1, June 2021

Contents

Introduction and summary

Everyone across the health and care system in England, in the NHS, local authorities and voluntary organisations, has made extraordinary efforts to manage the COVID-19 pandemic and deliver the vaccination programme while continuing to provide essential services.

We still face major operational challenges: tackling backlogs; meeting deferred demand, new care needs, changing public expectations; tackling longstanding health inequalities; enabling respite and recovery for those who have been at the frontline of our response; and re-adjusting to a post-pandemic financial regime. The intensity of the incident may have abated, but we are still managing exceptional pressure and uncertainty, with differential impacts across the country.

As we respond, Integrated Care Systems (ICSs) will play a critical role in aligning action between partners to achieve their shared purpose: to improve outcomes and tackle inequalities, to enhance productivity and make best use of resources and to strengthen local communities.

Throughout the pandemic our people told us time and time again that collaboration allowed faster decisions and better outcomes. Co-operation created resilience. Teamwork across organisations, sectors and professions enabled us to manage the pressures facing the NHS and our partners.

As we re-focus on the ambitions set out in the NHS Long Term Plan, it is imperative we maintain our commitment to collaborative action, along with the agility and pace in decision-making that has characterised our response to the pandemic.

We want to do everything we can to support this nationally and give you the best chance of making effective and enduring change for the people you serve.

This means seizing the opportunities presented by legislative reform to remove barriers to integrated care and create the conditions for local partnerships to thrive. And it means asking NHS leaders, working with partners in local government and beyond, to continue developing Integrated Care Systems during 2021/22, and preparing for new statutory arrangements from next year.

We know this is a significant ask. This document sets out the next steps. It builds on previous publications[1] to capture the headline ambitions for how we will expect NHS leaders and organisations to operate with their partners in ICSs from April 2022. It aims to support you as you continue to deliver against the core purpose of ICSs and put in place the practical steps to prepare for their new arrangements that we expect to be enabled by legislation in this Parliamentary session.

The ambition for ICSs is significant and the challenge for all leaders within systems is an exciting one. Successful systems will align action and maintain momentum during transition, with systems continuing to make progress in improving outcomes and supporting recovery while embedding new arrangements for strategic planning and collective accountability across partners. The collective leadership of ICSs and the organisations they include will bring teams with them on that journey and will command the confidence of NHS and other public sector leaders across their system as they deliver for their communities. The level of ambition and expectation is shared across all ICSs – and there will be consistent expectations set through the oversight framework, financial framework national standards and LTP commitment – with ICSs adjusting their arrangements to be most effective in their local context.

It is important that this next year of developing ICSs and implementing statutory changes, if approved by Parliament and once finalised, builds on progress to date and the great work that has already taken place across the country. Effective transition will see high performing systems taking their existing ways of working and creatively adapting these to the new statutory arrangements. It is an acceleration, in the current direction.

This document begins to describe future ambitions for:

- the **functions of the ICS Partnership** to align the ambitions, purpose and strategies of partners across each system[2]
- the **functions of the ICS NHS body**, including planning to meet population health needs, allocating resources, ensuring that services

[1] Integrating care: next steps to building strong and effective integrated care systems and Integration and innovation: working together to improve health and social care for all NHS Operational Planning and Contracting Guidance

[2] Guidance on the Partnership will be developed by DHSC with local government, NHS and other stakeholders. Expectations described here are based on the proposals set out in the Government's White Paper and initial discussions with local government partners.

are in place to deliver against ambitions, facilitating the transformation of services, co-ordinating and improving people and culture development, and overseeing delivery of improved outcomes for their population

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

Further information or guidance, developed through engagement with systems and stakeholders, will be made available to support detailed planning. Where relevant, this will follow the presentation of proposed legislation to Parliament.

We have heard a clear message from systems that they are looking for specificity about the consistent elements of how we will ask them to operate, alongside a high degree of flexibility to design their ways of working to best reflect local circumstances. This document aims to achieve both: to be clear and specific on the consistent requirements for systems and to define the parameters for the tailoring to local circumstances which is key to success. It goes beyond likely minimum statutory requirements and sets out the ambition from NHS England and NHS

Improvement[3] on what will be necessary for systems to be successful as they lead our recovery from the pandemic and the wider delivery of the Long Term Plan.

The Framework does not attempt to describe the full breadth of future ICS arrangements or role of all constituent partners but focuses on how we expect the NHS to contribute. For non-NHS organisations, we hope this document will provide helpful framing on how the NHS will be approaching the proposed establishment of ICS NHS bodies, and inform broader discussions on the creation of system-wide and place-based partnership arrangements.

From the outset, our ambition for ICSs has been co-developed with system leaders, people who use services and many other stakeholders. We will continue this approach as we develop guidance and implementation support, based on feedback and ongoing learning from what works best.

The Framework is based on the objectives articulated in Integrating Care: next steps, which were reflected in the Government's White Paper.[4] But content referring to new statutory arrangements and duties, and/or which is dependent on the implementation of such arrangements and duties, is subject to legislation and its parliamentary process. Systems may make reasonable preparatory steps in advance of legislation but should not act as though the legislation is in place or inevitable.

[3] In this document we use 'NHS England and NHS Improvement' when referring to the functions and activities of both NHS England and NHS Improvement prior to April 2022, and NHS England only from April 2022 (subject to legislation).

[4] This document uses the terminology of the White Paper (ICS Partnership and ICS NHS Body). The final legal terms to be adopted for the new statutory components of each ICS will be determined by the legislation.

Context

In November 2020 NHS England and NHS Improvement published *Integrating care: Next steps to building strong and effective integrated care systems across England*. It described the core purpose of an ICS being to:

- **improve outcomes** in population health and healthcare
- **tackle inequalities** in outcomes, experience and access
- **enhance productivity** and value for money
- help the NHS support broader **social and economic development**.

It emphasised that the next phase of ICS development should be rooted in underlying principles of subsidiarity and collaboration. It described common features that every system is expected to have and develop, as the foundations for integrating care, with local flexibility in how best to design these to achieve consistent national standards and reduce inequalities, as:

- decisions taken closer to, and in consultation with, the communities they affect are likely to lead to better outcomes
- collaboration between partners, both within a place and at scale, is essential to address health inequalities, sustain joined-up, efficient and effective services and enhance productivity
- local flexibility, enabled by common digital capabilities and coordinated flows of data, will allow systems to identify the best way to improve the health and wellbeing of their populations.

Reflecting insight drawn from local systems, the document outlined the key components to enable ICSs to deliver their core purpose, including:

- **strong place-based partnerships** between the NHS, local councils and voluntary organisations, local residents, people who access service their carers and families, leading the detailed design and delivery of integrated services within specific localities (in many places, long-established local authority boundaries), incorporating a number of neighbourhoods
- **provider collaboratives**, bringing NHS providers together across one or more ICSs, working with clinical networks and alliances and other partners, to secure the benefits of working at scale.

In February 2021 NHS England and NHS Improvement made recommendations to Government to establish ICSs on a statutory basis, with strengthened provisions to ensure that local government could play a full part in ICS decision-making. These proposals were adopted in the Government's White Paper *Integration and Innovation: working together to improve health and social care for all*, and we expect legislation to be presented to Parliament shortly. This document is based on our expectations as to the content of that legislation, describing how new arrangements would look if the proposals were implemented, while recognising that the legislation is subject to Parliament's amendment and approval.

Subject to the passage of legislation, the statutory[5] ICS arrangements will comprise:

- an ICS Partnership, the broad alliance of organisations and representatives concerned with improving the care, health and wellbeing of the population, jointly convened by local authorities and the NHS
- an ICS NHS body, bringing the NHS together locally to improve population health and care.

This ICS Design Framework sets out in more detail how we expect NHS organisations to respond in the next phase of system development, including the anticipated establishment of statutory ICS NHS bodies from April 2022. It describes the 'core' arrangements we will expect to see in each system and those we expect local partners to determine in their local context; depending on their variation in scale, geography, population health need and maturity of system arrangements.

Its purpose is to provide some 'guide rails' for NHS organisations as they develop their plans - reflecting the best ways of serving communities and patients in their specific local context - to give them the best chance of delivering on the four core purposes, in the urgent context of COVID recovery.

[5] ICSs will comprise a much wider set of partnership arrangements supported by this statutory framework.

The ICS Partnership

Each ICS will have a Partnership at system level established by the NHS and local government as equal partners. The Partnership will operate as a forum[6] to bring partners – local government, NHS and others – together across the ICS area to align purpose and ambitions with plans to integrate care and improve health and wellbeing outcomes for their population.

The Partnership will facilitate joint action to improve health and care services and to influence the wider determinants of health and broader social and economic development. This joined-up, inclusive working is central to ensuring that ICS partners are targeting their collective action and resources at the areas which will have the greatest impact on outcomes and inequalities as we recover from the pandemic.

We expect the ICS Partnership will have a specific responsibility to develop an 'integrated care strategy' for its whole population using best available evidence and data, covering health and social care (both children's and adult's social care), and addressing the wider determinants of health and wellbeing. This should be built bottom-up from local assessments of needs and assets identified at place level, based on Joint Strategic Needs Assessments. We expect these plans to be focused on improving health and care outcomes, reducing inequalities and addressing the consequences of the pandemic for communities. We expect each Partnership to champion inclusion and transparency and to challenge all partners to demonstrate progress in reducing inequalities and improving outcomes. It should support place- and neighbourhood-level engagement, ensuring the system is connected to the needs of every community it includes.

The Government has indicated that it does not intend to bring forward detailed or prescriptive legislation on how these Partnerships should operate. Rather the intention is to set a high-level legislative framework within which systems can develop the partnership arrangements that work best for them, based on the core principles of equal partnership across health and Local Government, subsidiarity, collaboration and flexibility.

[6] The ICS Partnership will be a committee, rather than a corporate body.

To support this process, formal guidance on ICS Partnerships will be developed jointly by the Department of Health and Social Care (DHSC), NHS England and NHS Improvement, and the Local Government Association (LGA), and consulted on ahead of implementation, including on the role and accountabilities of the chair of the Integrated Care Partnership. This document gives an overview of the type of information that we expect to be included in that guidance.

Establishment and membership

The Partnership will be established locally and jointly by the relevant local authorities and the ICS NHS body, evolving from existing arrangements and with mutual agreement on its terms of reference, membership, ways of operating and administration. Appropriate arrangements will vary considerably, depending on the size and scale of each system.

Members must include local authorities that are responsible for social care services in the ICS area, as well as the local NHS (represented at least by the ICS NHS body). Beyond this, members may be from health and wellbeing boards, other statutory organisations, voluntary, community and social enterprise (VCSE) sector partners, social care providers and organisations with a relevant wider interest, such as employers, housing and education providers and the criminal justice system. They should draw on experience and expertise from across the wide range of partners working to improve health and care in their communities, including ensuring that the views and needs of patients, carers and the social care sector are built into their ways of working. The membership may change as the priorities of the partnership evolve.

To facilitate broad membership and stakeholder participation, Partnerships may use a range of sub-groups, networks and other methods to convene parties to agree and deliver the priorities set out in the shared strategy.

Leadership and accountability

The ICS NHS body and local authorities will need to jointly select a Partnership chair and define their role, term of office and accountabilities.

Some systems will prefer the Partnership and ICS NHS body to have separate chairs. This may, for instance, provide greater scope for democratic representation. Others may select the appointed NHS ICS body chair as the chair for both the NHS

Board and the Partnership to help ensure co-ordination. This will be a matter for local determination.

We expect public health experts to play a significant role in these partnerships, specifically including local authority directors of public health and their teams who can support, inform and guide approaches to population health management and improvement.

Partnerships will need clear and transparent mechanisms for ensuring strategies are developed with people with lived experience of health and care services and communities, for example including patients, service users, unpaid carers and traditionally under-represented groups. These mechanisms should draw on best engagement practice; for example, by using citizens' panels and co-production approaches, including insights from place and neighbourhood engagement. Partnerships should build on the expertise, relationships and engagement forums that already exist across local areas, building priorities from the bottom up, to ensure the priorities in the strategy resonate with people across the ICS.

As a key forum for convening and influencing and engaging the public, the Partnership will need to be transparent with formal sessions held in public. Its work must be communicated to stakeholders in clear and inclusive language.

Partnership principles

The ICS Partnership will play a key role in nurturing the culture and behaviours of a system. We invite systems to consider these 10 principles:

1. Come together under a distributed leadership model and commit to working together equally.
2. Use a collective model of decision-making that seeks to find consensus between system partners and make decisions based on unanimity as the norm, including working though difficult issues where appropriate.
3. Operate a collective model of accountability, where partners hold each other mutually accountable for their shared and individual organisational contributions to shared objectives.
4. Agree arrangements for transparency and local accountability, including meeting in public with minutes and papers available online.

5. Focus on improving outcomes for people, including improved health and wellbeing, supporting people to live more independent lives, and reduced health inequalities.
6. Champion co-production and inclusiveness throughout the ICS.
7. Support the triple aim (better health for everyone, better care for all and efficient use of NHS resources), the legal duties on statutory bodies to co-operate and the principle of subsidiarity (that decision-making should happen at the most local appropriate level).
8. Ensure place-based partnership arrangements are respected and supported, and have appropriate resource, capacity and autonomy to address community priorities, in line with the principle of subsidiarity.
9. Draw on the experience and expertise of professional, clinical, political and community leaders and promote strong clinical and professional system leadership.
10. Create a learning system, sharing evidence and insight across and beyond the ICS, crossing organisational and professional boundaries.

The ICS NHS body

ICS NHS bodies will be established as new organisations that bind partner organisations together in a new way with common purpose. They will lead integration within the NHS, bringing together all those involved in planning and providing NHS services to take a collaborative approach to agreeing and delivering ambitions for the health of their population. They will ensure that dynamic joint working arrangements, as demonstrated through the response to COVID-19, become the norm. They will establish shared strategic priorities within the NHS and provide seamless connections to wider partnership arrangements at a system level to tackle population health challenges and enhance services at the interface of health and social care.

Functions of the ICS NHS body

The ICS NHS body will be a statutory organisation responsible for specific functions that enable it to deliver against the four core purposes:

- **Developing a plan** to meet the health needs of the population within their area, having regard to the Partnership's strategy. This will include ensuring NHS services and performance are restored following the pandemic, in line with national operational planning requirements, and Long Term Plan commitments are met.
- **Allocating resources** to deliver the plan across the system, including determining what resources should be available to meet the needs of the population in each place and setting principles for how they should be allocated across services and providers (both revenue and capital). This will require striking the right balance between enabling local decision-making to meet specific needs and securing the benefits of standardisation and scale across larger footprints, especially for more specialist or acute services.
- **Establishing joint working arrangements** with partners that embed collaboration as the basis for delivery of joint priorities within the plan. The ICS NHS body may choose to commission jointly with local authorities, including the use of powers to make partnership arrangements under section 75 of the 2006 Act and supported through the integrated care strategy, across the whole system; this may happen at place where that is the relevant local authority footprint.

- **Establishing governance arrangements** to support collective accountability between partner organisations for whole-system delivery and performance, underpinned by the statutory and contractual accountabilities of individual organisations, to ensure the plan is implemented effectively within a system financial envelope set by NHS England and NHS Improvement.
- **Arranging for the provision of health services** in line with the allocated resources across the ICS through a range of activities including:

– Putting contracts and agreements in place to secure delivery of its plan by providers. These may be contracts and agreements with individual providers or lead providers within a place-based partnership or provider collaborative. They will reflect the resource allocations, priorities and specifications developed across the whole system and at place level. We expect contracts and agreements to be strategic, long-term and based on outcomes, with providers responsible for designing services and interventions to meet agreed system objectives.

– Convening and supporting providers (working both at scale and at place) to lead[7] major service transformation programmes to achieve agreed outcomes, including through joining-up health, care and wider support. In addition to ensuring that plans and contracts are designed to enable this, the ICS NHS body will facilitate partners in the health and care system to work together, combining their expertise and resources to deliver improvements, fostering and deploying research and innovations.

– Working with local authority and VCSE partners to put in place personalised care for people, including assessment and provision of continuing healthcare and funded nursing care, and agreeing personal health budgets and direct payments for care. This may be delegated to individual place partnerships and delivered through integrated teams working in neighbourhoods or across local places, further supporting the integration of planning and provision with adult social care and VCSE organisations.

- **Leading system implementation of the People Plan** by aligning partners across each ICS to develop and support the ‘one workforce’, including through closer collaboration across the health and care

[7] It is expected that the ICS NHS body will be able to delegate functions to statutory providers to enable this.

sector, and with local government, the voluntary and community sector and volunteers (See ‘People and culture’ section below).

- **Leading system-wide action on data and digital**: ICS NHS bodies will work with partners across the NHS and with local authorities to put in place smart digital and data foundations to connect health and care services and ultimately transform care to put the citizen at the centre of their care (see ‘Data and digital’ section below);
- Using joined-up data and digital capabilities to **understand local priorities, track delivery of plans, monitor and address variation and drive continuous improvemen**t in performance and outcomes.
- Working alongside councils to **invest in local community organisations and infrastructure** and, through joint working between health, social care and other partners including police, education, housing, safeguarding partnerships, employment and welfare services, **ensuring that the NHS plays a full part in social and economic development and environmental sustainability**.
- **Driving joint work on estates, procurement, supply chain and commercial strategies** to maximise value for money across the system and support these wider goals of development and sustainability
- **Planning for, responding to and leading recovery from incidents** (EPRR), to ensure NHS and partner organisations are joined up at times of greatest need, including taking on incident coordination responsibilities as delegated by NHS England and NHS Improvement.
- **Functions NHS England and NHS Improvement will be delegating** including commissioning of primary care and appropriate specialised services.

We expect that all clinical commissioning group (CCG) functions and duties will transfer to an ICS NHS body when they are established, along with all CCG assets and liabilities including their commissioning responsibilities and contracts.

Relevant statutory duties of CCGs regarding safeguarding, children in care and special educational needs and disabilities (SEND) will apply to ICS NHS bodies. We will clarify in guidance how these statutory duties will transition to ICS NHS bodies. ICSs should support joint working around responsibilities such as safeguarding through new and existing partnership arrangements; and health and

care strategies and governance should account for the needs of children and young people.

The board of the ICS NHS body will be responsible for ensuring that the body meets its statutory duties. We expect these duties will include supporting achievement of the triple aim, improving quality of services, reducing inequalities, ensuring public involvement, obtaining clinical and public health advice, promoting innovation and research, and other duties that may be defined in law.

We are reviewing our own operating model - including how our functions and activities will be carried out in future and how associated resources will be deployed -in the context of the expected creation of statutory ICS NHS bodies. We are committed to ensuring that the principle of subsidiarity is applied in considering our own functions, that resources are devolved accordingly, and that the creation of ICS NHS bodies does not lead to duplication or create additional bureaucracy within the NHS. We will co-design our new arrangements with the sector and our partners.

People and culture

Better care and outcomes will be achieved by people – local residents, service users, carers, professionals and leaders – working together in different ways. Successful ICSs will develop a culture that attracts people to work in and for their community and supports them to achieve their full potential.

The NHS People Plan sets out the ambition of having 'more people, working differently, in a compassionate and inclusive culture'. Although individual employers remain the building blocks for delivering the People Plan, ICSs have an important role in leading and overseeing progress on this agenda – including strengthening collaboration among health and care partners – and have already developed their own local People Plans setting out how they will achieve this ambition in their area. These plans should be aligned with the ICS Partnership's Strategy as it is developed and be refreshed annually, taking account of national priorities.

From April 2022, ICS NHS bodies are expected to have specific responsibilities for delivering against the themes and actions set out in the NHS People Plan and the people priorities in operational planning guidance. ICS NHS bodies will play a critical role in shaping the approach to growing, developing, retaining and supporting the entire local health and care workforce. While the People Plan sets out specific objectives and responsibilities for NHS organisations, we expect ICS NHS bodies to adopt a 'one workforce' approach and develop shared principles and ambitions for people and culture with local authorities, the VCSE sector and other partners.

Those planning and delivering health and care services are employed by a range of different organisations (including the ICS NHS body in future). Each will have strategies for attracting, retaining and developing the people they need to deliver the services and functions they are responsible for. To deliver against the ICS's four core purposes and to make the local area a great place to work and live, the ICS NHS body – working with the ICS Partnership – will help bring these partners together to develop and support the 'one workforce' which contributes to providing care across the system. This includes supporting the expansion of primary care and integrated teams in the community and closer collaboration on workforce development across the health and care sector, and with local government, the third sector and volunteers.

The ICS NHS body will be expected to establish the appropriate people and workforce capability to discharge their responsibilities, including strong local leadership. In particular, the ICS NHS body will need to:

- have clear leadership and accountability for the organisation's role in delivering agreed local and national people priorities, with a named SRO with the appropriate expertise (registered people professional (CIPD accredited) or with equivalent experience)
- demonstrate how it is driving equality, diversity and inclusion. It should foster a culture of civility and respect, and develop a workforce and leadership that are representative of the population they serve.

To support local and national people priorities for the one workforce in the system, the ICS NHS body should work with organisations across the ICS to:

- Establish clear and effective governance arrangements for agreeing and delivering local strategic and operational people priorities. This will include ensuring there are clear lines of accountability and streamlined ways of working between individual organisations within the system, with other ICSs and with regional workforce teams
- Support the delivery of standardised, high-quality transactional HR services (eg payroll) across the ICS, supported by digital technology. These services should be delivered at the most effective level within the ICS footprint, based on the principle of subsidiarity, but proactively taking opportunities for collaboration and securing the benefits of delivering at scale. Local arrangements for delivering these services should be agreed by relevant employers across the system, facilitated by the NHS ICS Body, to support standardisation and remove duplication to allow for the reallocation resources to deliver on the strategic people agenda across the ICS
- Ensure action is taken to protect the health and wellbeing of people working within the ICS footprint, delivering the priorities set out in the 2021/22 planning guidance and in the People Promise, to improve the experience of working in the health and care system for all
- Establish leadership structures and processes (including leadership development, talent management and succession planning approaches) to drive the culture, behaviours and outcomes needed for

people working in the system and the local population, in line with the Leadership Compact[8]

- Undertake integrated and dynamic workforce, activity and finance planning based on population need, transformation of care models and changes in skills and ways of working – reflected in the system people plan and in the ICS Partnership's Strategy
- Plan the development – and where required, growth – of the one workforce to meet future need. This should include agreeing collaborative recruitment and retention approaches where relevant, planning local educational capacity and opportunities, and attracting local people into health and care employment and careers (including creating long-term volunteering opportunities)
- Develop new ways of working and delivering care that optimise staff skills, technology and wider innovation to meet population health needs and to create flexible and rewarding career pathways for those working in the system. This should be enabled by inclusive employment models, workforce sharing arrangements and passporting or accreditation systems
- Contribute to wider local social and economic growth and a vibrant local labour market, through collaboration with partner organisations, including the care home sector and education and skills providers.

To support ICS NHS bodies to discharge these responsibilities and deliver national and local people and workforce priorities, we will work with Health Education England to publish supplementary guidance and implementation support resources for ICSs on developing their strategic People capabilities, including a People operating model.

[8] The NHS Leadership Compact will set out the compassionate and inclusive behaviour we want all our leaders to show towards people. It will require every leader, at every level, to recognise, reflect and bring to life every day six core principles focused on: equality and diversity; continuous improvement; kindness, compassion and respect; trust; supporting people and celebrating success; and collaboration and partnership. The Compact will be published in due course.

Governance and management arrangements

Strong and effective governance and management arrangements are essential to enable ICSs to deliver their functions effectively. The pandemic has shown the success of partnership approaches that allow joined-up, agile and timely decision-making underpinned by common objectives. ICSs will build from this to establish robust governance and management arrangements that are flexibly designed to fit local circumstances and that bind partners together in collective endeavour.

This guidance provides an overview of our expectations for ICS governance and management arrangements. We will provide further resources throughout the year that share learning on the different approaches ICSs are developing.

The ICS NHS board

The statutory governance requirements for the NHS ICS body will be set out in legislation and NHS England and NHS Improvement will provide further guidance on the constitution of the board and process for this being agreed prior to establishment. This section provides an overview of our current expectations which will be developed, through engagement. As a new type of organisation, the governance arrangements for ICS NHS bodies will be different to those of existing commissioner and provider organisations in the NHS. They will need to reflect the different ways of working that will be required for ICS NHS bodies to effectively deliver their functions - as independent statutory NHS bodies, that bring together parties from across the NHS. The minimum requirements we set out are designed to provide a common framework for effective leadership and governance in this context.

The ICS NHS body will have a unitary board. The board will be responsible for ensuring the body plays its role in achieving the four purposes of the wider ICS and should be constituted in a way that ensures this focus on improving outcomes in population health and healthcare; tackling inequalities in outcomes, experience and access; enhancing productivity and value for money; and contributing to broader social and economic development.

All members of the ICS NHS board (referred to below as “the board”) will have shared corporate accountability for delivery of the functions and duties of the ICS

and the performance of the organisation. This includes ensuring that the interests of the public and people who use health and care services remain central to what the organisation does. The board will be the senior decision-making structure for the ICS NHS body.

The statutory minimum membership of the board of each ICS NHS body will be confirmed in legislation. To carry out its functions effectively we will expect every ICS NHS body to establish board roles above this minimum level, so in most cases they will include the following roles:

- Independent non-executives: chair plus a minimum of two other independent non-executive directors (as a minimum required to chair the audit and remuneration committees). These individuals will normally not hold positions or offices in other health and care organisations within the ICS footprint.
- Executive roles (employed by the body): chief executive (who will be the accountable officer for the funding allocated to the ICS NHS body), director of finance, director of nursing and medical director.
- Partner members: a minimum of three additional board members, including at least:
  - one member drawn from NHS trusts and foundation trusts who provide services within the ICS's area
  - one member drawn from the primary medical services (general practice) providers within the area of the ICS NHS body
  - one member drawn from the local authority, or authorities, with statutory social care responsibility whose area falls wholly or partly within the area of the ICS NHS body.

We expect all three partner members will be full members of the unitary board, bringing knowledge and a perspective from their sectors, but not acting as delegates of those sectors.

We expect the partner members from NHS trusts/foundation trusts and local authorities will often be the chief executive of their organisation or in a relevant executive-level local authority role.

The process of appointing the partner members, and the rules for qualification to be a member, will be set out in the constitution of the body.

The final composition of the board and the process of appointment of partner members will need to be consistent with any requirements set out in primary legislation and is therefore subject to Parliamentary process.

ICS NHS bodies will be able to supplement these minimum board positions as they develop their own ICS NHS body constitution, which will be subject to agreement with NHS England and NHS Improvement.

We expect all members of the board will be required to comply with the Nolan Principles of Public Life and meet the Fit & Proper Persons test, and boards must have clear governance and board level accountability for discharging the associated regulations.

Boards of ICS NHS bodies will need to be of an appropriate size to allow effective decision making to take place. Through a combination of their membership, and the ways in which members engage partners, the board and its committees should ensure they take into account the perspectives and expertise of all relevant partners. These should include all parts of the local health and care system across physical and mental health, primary care, community and acute services, patient and carer representatives, social care and public health, with directors of public health having an official role in the ICS NHS bodies and the Partnership.

It will be important that boards have strong leadership on issues that impact upon organisations and staff across the ICS, including the people agenda and digital transformation.

The ICS NHS body will be expected to promote open and transparent decision-making processes that facilitate finding consensus, drawing on agreed decision-making processes to manage areas of disagreement to ensure that the statutory duties of the ICS NHS body continue to be met. The board and its committees will have to make decisions transparently, holding meetings in public and publishing the papers.

NHS England and NHS Improvement will publish further guidance on the composition and operation of the board, including a draft model constitution. We will also provide guidance on the management of conflicting roles and interests,

ensuring partners can work together effectively and that the public can have confidence decisions are being made in their best interests as taxpayers and service users (see below for new provider selection regime).

Committees and decision-making

All ICS NHS bodies will need to put arrangements in place to ensure they can effectively discharge their full range of duties and functions. This is likely to include arrangements for committees and groups to advise and feed into the board, and to exercise functions delegated by the board. Boards may be supported by an executive group including, for example, other professional and functional leads, to manage the day-to-day running of the organisation.

These arrangements should address the cross-cutting functional responsibilities of the body including finance and resources, people, quality, digital and data performance and oversight. They should enable full involvement of clinical and professional leaders, leaders of place-based partnerships and providers, including relevant provider collaboratives. We expect the ICS NHS body will have arrangements that bring all relevant partners together to participate in decision-making.

We expect that each board will be required to establish an audit committee and a remuneration committee. The board may establish other decision-making committees, in accordance with its scheme of delegation. The board may also establish advisory committees to advise it on discharging certain duties, such as public and patient engagement.

The legislation is expected to give ICS NHS bodies flexibility in how they establish and deploy such committees. In particular, they will have the power to:

- appoint individuals who are not board members or staff of the ICS NHS body to be members of any committee it has established
- establish joint committees with NHS Trusts/FTs to which they may delegate responsibilities (decision making) in accordance with those bodies' schemes of delegation.

As ICSs will have significant flexibility in how and where decisions and functions are undertaken, every ICS NHS body should maintain a 'functions and decision map' showing its arrangements with ICS partners to support good governance and

dialogue with internal and external stakeholders. This should include arrangements for any commissioning functions delegated or transferred by NHS England and NHS Improvement.

The boards of ICS NHS bodies, and their committees, should conduct their business in a way that builds consensus, and should seek to achieve consensus on decisions. They should foster constructive challenge, debate and the expression of different views, reflecting the scope of their remit and their constituencies. They should have agreed processes for resolving differences in the first instance, if consensus cannot be reached; for example, through referencing the principles and behaviours set out in the ICS NHS body's constitution and by assessing the decision for consistency with overarching objectives (including the triple aim) and plans already agreed. The chair may make decisions on behalf of the board where there is disagreement. Where necessary boards may draw on third party support such as peer review or mediation by NHS England and NHS Improvement.

The ICS NHS body's constitution may provide for a vote to be taken where consensus cannot be reached and to set out how the vote will be conducted (for example, the chair having the casting vote). However, voting should be considered a last resort rather than a routine mechanism for board decision-making.

Place-based partnerships

Partnerships between organisations to collectively plan, deliver and monitor services within a locally defined 'place' have a long history. These place-based partnerships have typically been established by local agreement according to their context and this bottom-up approach has been an important enabler to meaningful collaboration. However, as part of the development of ICSs, we now expect that place-based partnerships are consistently recognised as key to the coordination and improvement of service planning and delivery, and as a forum to allow partners to collectively address wider determinants of health.

We have asked each system to define its place-based partnership arrangements, covering all parts of its geography, agreed collaboratively between the NHS, local government and other system partners working together in a particular locality or community.

There is no single way of defining place or determining a fixed set of responsibilities that a place-based partnership should hold. All systems should establish and

support place-based partnerships with configuration and catchment areas reflecting meaningful communities and geographies that local people recognise. In the smallest ICSs, the whole system may operate as a single place-based partnership. The arrangements for joint working at place should enable joined-up decision-making and delivery across the range of services meeting immediate care and support needs in those local places but should be designed flexibly to reflect what works in that area.

The ICS NHS body will want to agree with local partners the membership and form of governance that place-based partnerships adopt, building on or complementing existing local configurations and arrangements such as Health and Wellbeing Boards. At a minimum, these partnerships should involve primary care provider leadership, local authorities, including directors of public health, providers of acute, community and mental health services and representatives of people who access care and support.

The ICS NHS body will remain accountable for NHS resources deployed at place-level. Governance and leadership arrangements for place-based partnerships should support safe and effective delivery of the body's functions and responsibilities alongside wider functions of the partnership. Each ICS NHS body should clearly set out the role of place-based leaders within the governance arrangements for the body.

An NHS ICS body could establish any of the following place-based governance arrangements with local authorities and other partners, to jointly drive and oversee local integration:

- consultative forum, **informing** decisions by the ICS NHS body, local authorities and other partners
- committee of the ICS NHS body with delegated authority to take decisions about the use of ICS NHS body resources[9]
- joint committee of the ICS NHS body and one or more statutory provider(s), where the relevant statutory bodies delegate decision making on specific functions/services/populations to the joint committee in accordance with their schemes of delegation

[9] Contracts would be awarded and held, and payments made, by the ICS NHS body as the legal entity.

- individual directors of the ICS NHS body having delegated authority, which they may choose to exercise through a committee. This individual director could be a joint appointment with the local authority or with an NHS statutory provider and could also have delegated authority from those bodies
- lead provider managing resources and delivery at place-level under a contract with the ICS NHS body, having lead responsibility for delivering the agreed outcomes for the place.

Effective leadership at place level is critical to effective system working, but the specific approach is to be determined locally. The roles of place-based leaders will include convening the place-based partnership, representing the partnership in the wider structures and governance of the ICS and (potentially) taking on executive responsibility for functions delegated by the ICS NHS body CEO or relevant local authority.

Supra-ICS arrangements

There are some functions where ICS NHS bodies will need to work together; for example, commissioning more specialised services, emergency ambulance services and other services where relatively small numbers of providers serve large populations, and when working with providers that span multiple ICSs or operate through clinical networks. In many areas, multiple providers and ICS NHS bodies will need to work together to develop a shared plan for cancer services, with existing Cancer Alliances[10] continuing to use their expertise to lead whole-system planning and delivery of cancer care on behalf of their constituent ICSs, as well as providing clinical leadership and advice on commissioning. Similarly, provider collaboratives, including those providing specialised mental health, learning disability and autism services, will span multiple ICS footprints where this is right for the clinical pathway for patients.

The governance arrangements to support this will need to be co-designed between the relevant providers, NHS ICS bodies clinical networks or alliances and, where relevant, NHS England and NHS Improvement regional teams. In smaller ICSs it will be particularly important to establish joint working arrangements at the appropriate scale for the task, joining up planning for services across a wider

[10] Service Development Funding for cancer will continue to be provided to Cancer Alliances to enable them to continue to deliver their existing functions on behalf of their constituent ICS(s).

footprint where that makes sense to establish provider collaboratives at the appropriate scale to support service transformation across wider clinical networks.

ICSs and ambulance providers, which typically provide services to a population across multiple ICSs, should agree their working relationships carefully to ensure that, where appropriate, there is a joined-up dialogue between ICSs and their relevant ambulance provider, avoiding unnecessary variation in practice or duplication of communication. Alongside this, ambulance providers should consider how they can play their role effectively as part of individual systems, provider collaboratives and place partnerships, for example supporting the implementation of an effective integrated urgent care offer.

Quality governance

Quality is at the heart of all that we do. Each NHS organisation has individual responsibilities to ensure the delivery of high quality care. ICS NHS bodies will also have statutory duties to act with a view to securing continuous improvement in quality. We expect them to have arrangements for ensuring the fundamental standards of quality are delivered including to manage quality and safety risks and to address inequalities and variation; and to promote continual improvement in the quality of services, in a way that makes a real difference to the people using them.

ICSs are expected to build on existing quality oversight arrangements, with collaborative working across system partners, to maintain and improve the quality of care. ICS NHS bodies will need to resource quality governance arrangements appropriately, including leading System Quality Groups (previously Quality Surveillance Groups) and ensuring that clinical and care professional leads have capacity to participate in quality oversight and improvement. Operational support will also be provided through NHS England and NHS Improvement regional and national teams in line with National Quality Board's guidance, namely the refreshed *Shared Commitment to Quality* and the *Position Statement*. These key documents set out the core principles and consistent operational requirements for quality oversight that ICS NHS bodies are expected to embed during the transition period (2021/22) and beyond.

The role of providers

Organisations providing health and care services are the frontline of each ICS. They will continue to lead the delivery and transformation of care and support, working alongside those who access their services and the wider communities they serve. As ICSs have developed, providers have increasingly embraced wider system leadership roles, working with partners to join up care pathways, embed population health management, reduce unwarranted variation and tackle heath inequalities.

The arrangements put in place by each ICS Partnership and ICS NHS body must harness the expertise, energy and ambition of the organisations directly responsible for delivering integrated care.

As constituent members of the ICS Partnership, the ICS NHS body and place-based partnerships, providers of NHS services will play a central role in establishing the priorities for change and improvement across their healthcare systems and delivering the solutions to achieving better outcomes.

We expect the contracts health service providers hold (NHS Standard, or national primary care[11] supplemented locally) to evolve to support longer term, outcomes-based agreements, with less transactional monitoring and greater dialogue on how shared objectives are achieved.

Primary care in Integrated Care Systems

All primary care professionals have a fundamental role to play in ensuring that ICSs achieve their objectives. The success of efforts to integrate care will depend on primary care and other local leaders working together to deliver change across health and care systems.

Primary care should be represented and involved in decision-making at all levels of the ICS, including strategic decision-making forums at place and system level. It should be recognised that there is no single voice for primary care in the health and care system, and so ICSs should explore different and flexible ways for seeking primary care professional involvement in decision-making. In particular, primary care should have an important role in the development of shared plans at place and

[11] Primary care contracts will continue to be negotiated nationally

system, ensuring they represent the needs of their local populations at the neighbourhood level of the ICS, including with regards to health inequalities and inequality in access to services.

ICSs should explore approaches that enable plans to be built up from population needs at neighbourhood and place level, ensuring primary care professionals are involved throughout this process.

The role of primary care networks

Primary care networks (PCNs), serving the patients of the constituent general practices, play a fundamental role improving health outcomes and joining up services. They have a close link to local communities, enabling them to identify priorities and address health inequalities. PCNs will develop integrated multi-disciplinary teams that include staff from community services and other NHS providers, local authorities and the voluntary, community and social enterprise (VCSE) sector to support effective care delivery. Joint working between PCNs and secondary care will be crucial to ensure effective patient care in and out of hospital.

PCNs in a place will want to consider how they could work together to drive improvement through peer support, lead on one another's behalf on place-based service transformation programmes and represent primary care in the place-based partnership. This work is in addition to their core function and will need to be resourced by the place-based partnership.

ICSs and place-based partnerships should also consider the support PCN clinical directors, as well as the wider primary care profession, may need to develop primary care and play their role in transforming community-based services. Place-based partnerships may also wish to consider how to leverage targeted operational support to their PCNs, for example with regard to data and analytics for population health management approaches, HR support or project management.

Voluntary, community and social enterprise partners

The VCSE sector is a vital cornerstone of a progressive health and care system. ICSs should ensure their governance and decision-making arrangements support close working with the sector as a strategic partner in shaping, improving and delivering services and developing and delivering plans to tackle the wider determinants of health. VCSE partnership should be embedded as an essential part

of how the system operates at all levels. This will include involving the sector in governance structures and system workforce, population health management and service redesign work, leadership and organisational development plans.

We expect that by April 2022 Integrated Care Partnerships and the ICS NHS body will develop a formal agreement for engaging and embedding the VCSE sector in system level governance and decision-making arrangements, ideally by working through a VCSE alliance to reflect the diversity of the sector. These arrangements should build on the involvement of VCSE partners in relevant forums at place and neighbourhood level. A national development programme is in place to facilitate this in all areas.

Independent sector providers

All providers, including independent providers to the NHS and local authorities, will need to be engaged with other relevant partners in the ICS, through existing or newly formed arrangements, to ensure care meets the needs of the population and is well co-ordinated.

NHS trusts and foundation trusts

NHS trusts and foundation trusts will play a critical role in the transformation of services and outcomes within places and across and beyond systems.

As now, they will work alongside primary care, social care, public health and other colleagues in each of the places or localities they serve, to tailor their services to local needs and ensure they are integrated in local care pathways. They will also be more involved in collectively agreeing with partners how services and outcomes can be improved for that community, how resources should be used to achieve this and how they can best contribute to population health improvement as both service providers and as local ‘anchor institutions’. The most efficient and appropriate ways of doing this will vary for different types of providers and in different local contexts. ICS NHS bodies will need to work with providers that span multiple ICSs and cross ICS boundaries, including ambulance and community trusts, to agree arrangements that ensure they are fully engaged.

In future, we expect the ICS NHS body could ask NHS trusts and foundation trusts to take on what have been ‘commissioning’ functions for a certain population,

building on the model that NHS-led provider collaboratives for specialised mental health, learning disability and autism services have been developing.

The success of individual trusts and foundation trusts will increasingly be judged against their contribution to the objectives of the ICS, in addition to their existing duties to deliver safe and effective care. This will include delivering their agreed contribution to system financial balance, improving quality and outcomes and reducing unwarranted variation and inequalities across the system as a whole, in the context of the new 'triple aim' duty to promote better health for everyone, better care for all and efficient use of NHS resources.

The new provider selection regime

NHS England and NHS Improvement has recommended that Parliament legislates to remove the current rules governing NHS procurement of healthcare services; and these are replaced by a new regime specifically created for the NHS.

This regime would give decision-makers greater discretion in how they decide to arrange services, with competition and tendering a tool to use where appropriate, rather than the default expectation. We want to make it straightforward for local organisations to continue with existing service provision where the arrangements are working well and there is no value in seeking an alternative provider. Where the system wants or needs to consider making changes to service provision, we want there to be a flexible, sensible, transparent and proportionate process for decision-making that allows shared responsibility to flow through it, rather than forcing the NHS into pointless tendering and competition.

The central requirement of the proposed new regime is that decisions about who provides NHS services must be made in a transparent way, in the best interests of patients, taxpayers and the population. The regime would need to be applied by NHS bodies (NHS England and NHS Improvement, ICS NHS bodies, NHS trusts and foundation trusts) and local authorities when making decisions about who provides healthcare services (the new regime will not apply to other local authority services).

The regime sets out the steps that decision-making bodies should take when seeking to justify continuing existing arrangements with an existing provider; how to select the most suitable provider when a service is new or changing substantially, but a competitive procurement is not appropriate; and how to run a competitive

procurement where this is considered appropriate. The regime sets out some key criteria decision-makers need to consider when arranging services, as well as requirements around transparency and scrutiny of decisions. Further details can be found at www.england.nhs.uk/publication/nhs-provider-selection-regime-consultation-on-proposals/

Provider collaboratives

Provider collaboratives are partnership arrangements involving two or more trusts (foundation trusts or NHS trusts) working across multiple places to realise the benefits of mutual aid and working at scale. The response to COVID-19 has demonstrated both the need for and potential of this type of provider collaboration. During 2021/22 the dynamic management of capacity and resources, greater transparency and collective accountability seen during the pandemic must be continued and developed. Specifically, providers are expected to work together to agree and deliver plans to achieve inclusive service recovery, restoration and transformation across systems, and to ensure services are arranged in a way that is sustainable and in the best interests of the population.

From April 2022 trusts providing acute and/or mental health services are expected to be part of one or more provider collaboratives. Community trusts, ambulance trusts and non-NHS providers (eg community interest companies) should participate in provider collaboratives where this is beneficial for patients and makes sense for the providers and systems involved.[12]

The purpose of provider collaboratives is to better enable their members to work together to continuously improve quality, efficiency and outcomes, including proactively addressing unwarranted variation and inequalities in access and experience across different providers. They are expected to be important vehicles for trusts to collaboratively lead the transformation of services and the recovery from the pandemic, ensuring shared ownership of objectives and plans across all parties.

[12] Community trusts, ambulance trusts and other providers may need to maintain relationships with multiple provider collaboratives, and/or focus on relationships within place-based partnerships, in ways they should determine with partners.

Provider collaboratives will agree specific objectives with one or more ICS, to contribute to the delivery of that system's strategic priorities. The members of the collaborative will agree together how this contribution will be achieved.

Provider collaboratives will help facilitate the work of alliances and clinical networks, enabling specialty-level plans and decisions to be made and implemented in a more coordinated and systematic way in the context of whole system objectives. For example, Cancer Alliances already work with the providers in their local systems to lead a whole system approach to operational delivery and transformation, and in future Alliances will work with their relevant Provider Collaboratives.

It will be up to providers, working with partners, to decide on the specific model and best governance arrangements for their collaboratives.

ICS NHS bodies will contract with NHS trusts and foundation trusts for the delivery of services, using the NHS Standard Contract. For services delivered through collaborative arrangements, ICS NHS bodies could:

- contract with and pay providers within a collaborative individually. The providers would then agree as a provider collaborative how to use their respective resources to achieve their agreed shared objectives
- contract with and pay a lead provider acting on behalf of a provider collaborative (whole budget for in-scope services). The lead provider would agree sub-contracting and payment arrangements across the collaborative. The existing mental health provider collaboratives have been successfully based on lead provider arrangements.

The ICS NHS body and provider collaboratives should define their working relationship, including participation in committees via partner members and any supporting local arrangements, to facilitate the contribution of the provider collaborative to agreed ICS objectives.

Further guidance on provider collaboratives will be published in due course.

Clinical and professional leadership

All ICSs should develop a model of distributed clinical and care professional leadership, and a culture which actively encourages and supports such leadership to thrive. This includes ensuring professional and clinical leaders have protected time and resource to carry out system roles, and are fully involved as key decision-makers, with a central role in setting and implementing ICS strategy.

These arrangements should support and enhance those of the organisations within the ICS footprint, which are responsible for the professional and clinical leadership of their people and services.

They should reflect the learning and experience gained from CCG clinical leadership, building out from this to reflect the rich diversity of clinical and care professions across the wider ICS partnership, including health, social care and the VCSE sectors, embedding an inclusive model of leadership at every level of the system.

Specific models for clinical and care professional leadership will be for ICSs to determine locally and we recognise that ICSs are at different stages of development in this regard. We will provide further resources describing the features of an effective model, informed by more than 2,000 clinical and care professionals and illustrating case studies from systems with more advanced approaches. These features include:

- effective structures and communication mechanisms to connect clinical and care professional leaders at each level of the system
- a culture which systematically embraces shared learning, supporting its clinical and care professional leaders to collaborate and innovate with a wide range of partners, including patients and local communities
- protected time, support and infrastructure for clinical and care professional leaders to carry out their system leadership roles
- clearly defined and visible support for clinical and care profession leaders, including support to develop the leadership skills required to work effectively across organisational and professional boundaries
- transparent approaches to identifying and recruiting leaders, which promote equity of opportunity and a professionally and demographically diverse talent pipeline which reflects that community it serves.

We will expect ICSs to use the resources to support self-assessment of their clinical and professional leadership model and implement mechanisms to measure their progress and performance. We encourage systems to consider how they could use a peer review approach to support their development in this area, buddying with other systems to undertake their assessment and develop subsequent plans.

For the NHS ICS body, the clinical roles on the Board, described in the 'Governance and management arrangements' section, are a minimum expectation, ensuring executive-level professional leadership of the organisation. Individuals in these roles are expected to ensure leaders from across clinical and care professions are involved and invested in the purpose and work of the ICS.

The ICS NHS board will be expected to sign off a model and improvement plan for clinical and care professional leadership that demonstrates how this will be achieved, and to ensure that the five guiding principles described above are reflected in its governance and leadership arrangements.

Working with people and communities

The parties in an ICS, including those of the ICS Partnership, the NHS ICS body and place-based partnerships will be expected to agree how to listen consistently to, and collectively act on, the experience and aspirations of local people and communities. This includes supporting people to sustain and improve their health and wellbeing, as well as involving people and communities in developing plans and priorities, and continually improving services.

As part of the ICS-wide arrangements, we expect each ICS NHS body to build a range of engagement approaches into their activities at every level and to prioritise engaging with groups affected by inequalities. The solutions to reducing inequalities will often be found by engaging with communities through relational and strengths-based approaches drawing on the experience of local authority, VCSE and other partners with experience and expertise in this regard.

We expect that this will be supported by a legal duty for ICS NHS bodies to make arrangements to involve patients, unpaid carers and the public in planning and commissioning arrangements, and by the continuation of the existing NHS trust and foundation trust duties in relation to patient and public involvement, including the role of foundation trusts governors.

Working with a range of partners such as Healthwatch, the VCSE sector and experts by experience, the ICS NHS body should assess and where necessary strengthen public, patient and carers' voice at place and system levels. Places are an important component, as they typically cover the area and services with which most residents identify. We are working with ICSs, Healthwatch England and others to identify and disseminate some of the most effective place-based approaches, for example through place-level citizens' panel work.

Arrangements in a system or place should not just provide a mechanism for commentary on services but should be a source of genuine co-production and a key tool for supporting accountability and transparency of the system. Where decision-making affects communities, groups or specific services, these arrangements (including any formal consultation) should fully engage those affected, including populations, patients and carers across health and social care.

We have previously set out seven principles for how ICSs should work with people and communities. These are:

1. Use public engagement and insight to inform decision-making
2. Redesign models of care and tackle system priorities in partnership with staff, people who use care and support and unpaid carers
3. Work with Healthwatch and the voluntary, community and social enterprise sector as key transformation partners
4. Understand your community's experience and aspirations for health and care
5. Reach out to excluded groups, especially those affected by inequalities
6. Provide clear and accessible public information about vision, plans and progress to build understanding and trust
7. Use community development approaches that empower people and communities, making connections to social action.

Each ICS NHS body should use these principles as a basis for developing a system-wide strategy for engaging with people and communities, building on the existing relationships, good practice and networks across system partners.

As part of this strategy, the body should work with its partners across the ICS to develop arrangements for:

- ensuring the ICS Partnership and place-based partnerships have representation from local people and communities in priority setting and decision-making forums
- gathering intelligence about the experience and aspirations of people who use care and support, together with clear approaches to using these insights to inform decision making and quality governance.

More detailed information will be made available to systems in guidance on membership and governance of ICS NHS bodies and in the implementation support for how ICSs work with people and communities.

Accountability and oversight

The ICS NHS body will be a statutory organisation. The members of its unitary board will have collective and corporate accountability for the performance of this organisation and will be responsible for ensuring its functions are discharged. NHS England and NHS Improvement through its regional teams, will agree the constitutions and plans of ICS NHS bodies and hold them to account for delivery through the chair and chief executive.

ICSs more broadly bring together NHS, local government and other partners, who each retain formal accountability for the statutory functions they are responsible for. Building on the relationships and ways of working they have developed to date, these partners will need to maintain a working principle of mutual accountability, where, irrespective of their formal accountability relationships, all partners consider themselves collectively accountable to the population and communities they serve, and to each other for their contribution the ICS's objectives.

Providers of NHS services will continue to be accountable:

- for quality, safety, use of resources and compliance with standards through the provider licence (or equivalent conditions in the case of NHS trusts) and CQC registration requirements
- for delivery of any services or functions commissioned from or delegated to them, including by an NHS ICS body, under the terms of an agreed contract and/or scheme of delegation.

Executives of provider organisations will remain accountable to their boards for the performance of functions for which their organisation is responsible. Where an executive of an NHS provider organisation sits on the board of an NHS ICS body, they will in their capacity as a member of that board also be accountable – collectively with other board members – for the performance of the ICS body and ensuring its functions are discharged. And when acting as an ICS body board member, they must act in the interests of the ICS body and the wider system, not those of their employing provider. NHS England and NHS Improvement will provide guidance to support ICS NHS bodies to manage conflicting roles and interests of board members.

Approach to NHS oversight within ICSs

The oversight arrangements for 2022/23 will build on the final 2021/22 System Oversight Framework (SOF) reflecting the statutory status of ICS NHS bodies from April 2022. We expect these arrangements to confirm ICSs' formal role in oversight including:

- bringing system partners together to identify risks, issues and support needs and facilitate collective action to tackle performance challenges
- leading oversight and support of individual organisations and partnership arrangements within their system.

While ICS NHS bodies will, by default, lead local oversight and assurance, NHS England and NHS Improvement's future statutory regulatory responsibilities will be similar to its existing ones. This means that any formal regulatory action with providers will, when required, be taken by NHS England and NHS Improvement.

We will work with each ICS NHS body to ensure effective and proportionate oversight of organisations within the ICS area, with arrangements that reflect local delivery and governance arrangements and avoid duplication. In particular, where additional assurance or intervention is required, NHS England and NHS Improvement will work with the ICS partners to ensure such action is informed by the perspective of system stakeholders, and that any recovery plans agreed align with system objectives and plans.

NHS England and NHS Improvement and ICS NHS bodies may, over time, decide to take the role of provider collaboratives and place-based partnerships into account when determining how to address issues identified through system oversight. This may, for instance, include looking to these arrangements (and the partners involved) for support where poor performance is identified; or considering the effectiveness of collaborative working arrangements when considering whether systems/providers have an effective plan for improvement/recovery.

Systems will also benefit from existing local authority health overview and scrutiny committees reviewing and scrutinising their work. Scrutiny provides a mechanism for local democratic accountability through local government elected members. It enables valuable connections to be made between the experience and aspirations of residents and ICS governance, via the relationships that local councillors have with their constituents.

Accountability and transparency in ICSs will also be supported via:

- clearly agreed and articulated arrangements for how the system works with people and communities
- public meetings, published minutes, and regular and accessible updates on the ICSs' vision, plans and progress against priorities.

We are working with colleagues from the Care Quality Commission (CQC) and DHSC to agree the process and roles for reviewing and assessing systems. The aim is that this would complement the role of NHS England and NHS Improvement, avoiding duplication and overlap, and support the delivery of integrated care across system partners.

The proposed principles for NHS system oversight are:

- working with and through ICSs, wherever possible, to provide support and tackle problems
- a greater emphasis on local priorities and on system performance and quality of care outcomes alongside the contributions of individual organisations to system goals
- matching accountability for results with improvement support, as appropriate
- greater autonomy for ICSs and organisations with evidence of collective working and a track record of successful delivery of NHS priorities, including tackling inequality, health outcomes and access
- compassionate leadership behaviours that underpin all oversight interactions.

Financial allocations and funding flows

Systems are currently funded under the COVID financial regime through a system funding envelope for each ICS, which includes system top-up and COVID fixed allocation arrangements. In due course, system funding allocations will move back towards the population-based distribution and funding quantum allocated as part of the Long Term Plan funding settlement, taking account of subsequent funding allocations and the outcome of the Spending Review.

ICS allocations

NHS England and NHS Improvement will make financial allocations to each ICS NHS body for the performance of its functions. Decisions about spending will be devolved to ICS NHS bodies.

This will include the budgets for:

acute, community and mental health[13] services (currently CCG commissioned)

primary medical care (general practice) services (currently delegated to CCGs)

running cost allowances for the ICS NHS body.

This may also include the allocations for a range of functions currently held by NHS England and NHS Improvement, including:

- other primary care budgets
- relevant specialised commissioning services suitable for commissioning at ICS level (for example, excluding highly specialised services)
- the allocations for certain other directly commissioned services
- a significant proportion of nationally held transformation funding and service development funding
- the Financial Recovery Fund
- funding for digital and data services.

[13] Every ICS will be required to continue to meet the mental health investment standard and as such a minimum level of mental health funding remains ringfenced (ICSs are free to invest above this level).

Funding will continue to be linked to population need. Allocations will be based on longstanding principles of supporting equal opportunity of access for equal needs and contributing to the reduction of health inequalities. NHS England and NHS Improvement's approach will continue to be informed by the independent Advisory Committee on Resource Allocation (ACRA).[14] Allocations will be set in a way that avoids large swings in funding that would risk destabilising local health economies.

NHS England and NHS Improvement will allocate funding to ICSs, continuing to take into account both the need of their population ('the target allocation') and how quickly ICSs move towards their target allocations (known as pace-of-change). We would not make a centrally set allocation to 'place' within the ICS. Existing allocations tools can be adapted to support ICS NHS bodies in making decisions about how to deploy resource to places.

An open book relationship between providers of NHS services, supported by improved cost data (PLICS), will give further transparency for stakeholders that the NHS is meeting its commitment to deploy resource according to need and tackle inequalities.

Full capital allocations will be made to the ICS NHS body, based on:

- the outcome of the 2022/23 capital settlement for operational capital, building on the arrangements initially implemented in 2020/21
- capital budgets being a combination of system-level allocations (operational capital), nationally allocated funds (for large strategic projects) and other national programmes
- the methodology being kept under review to ensure available capital is best allocated against need. We hope future allocations can be set over a multi-year, subject to the outcome of the next Spending Review.

Distribution of funds by the ICS NHS body

The ICS NHS body will agree how the allocation will be used to perform its functions, in line with health and care priorities set at a local level.

[14] An independent committee of academics, public health experts, GPs and NHS managers that makes recommendations on the preferred, relative, geographical distribution of resources for health services.

Money will flow from the ICS NHS body to providers largely through contracts[15] for services/outcomes, which may be managed by place-based partnerships or provider collaboratives.

The existing provider collaboratives for specialised mental health, learning disability and autism services have paved the way in taking on budgets through lead provider arrangements. In conjunction with ICS leaders, we will consider supporting provider collaboratives to take on further responsibility for use of resources to deliver population health outcomes.

The ICS NHS body will be able to commission jointly with local authorities under a section 75 joint commissioning arrangement, as CCGs can.

Spending will be part of a plan to deliver financial balance within a system's financial envelope, which would also be set by NHS England and NHS Improvement. This envelope covers expenditure across the whole system, including spending by NHS trusts/foundation trusts for services delivered for commissioners from outside the system.

Each ICS will have an agreed framework for collectively managing and distributing financial resources to address the greatest need and tackle inequalities in line with the NHS system plan, having regard to the strategies of the Partnership and the Health and Wellbeing Board/s. This is in line with the duty we expect to remain for the system to have regard for reducing health inequalities.

Financial rules will apply to ensure delivery of key national commitments, such as the Mental Health Investment Standard and the primary medical and community health services funding guarantee.

Based on these local priorities and national rules (including the National Tariff Payment System), the ICS NHS body will agree:

- priorities and outcomes to be achieved in plan against NHS budget (with clinical advice and with regard to ICS Partnership plan)
- the distribution of the NHS revenue allocation (both total financial value and service lines) to:

[15] The ICS NHS body will also be able to make grants to VCSE organisations and to NHS Trusts/FTs. In future, the ICS NHS body may wish to use its expected power to delegate its functions to statutory providers.

  - each place-based partnership as appropriate
  - each NHS provider (individually contracted or via a lead provider contract, including where operating as part of a provider collaborative)
  - contracts with other service providers
  - other collaboratives partnerships.
- A capital plan including how capital spend should be prioritised locally (developed through collective decision making across NHS providers, and with ability to co-ordinate with the estates and assets managed by local authorities).

The ICS NHS board and chief executive (AO) will be ultimately responsible for services under delegation arrangements with place-based partnerships or through lead provider contracts. They will need to put in place proportionate mechanisms to provide assurance on the spending of public money.

Setting budgets for places

The ICS NHS body will have the freedom to set a delegated budget for place-based partnerships to support local financial decisions to spend ICS NHS resources. However, it must adopt the principle of equal access for equal need and the requirements to reduce health inequalities. The ICS NHS body should engage local authority partners on the ICS NHS resources for the NHS services to be commissioned at place and support transparency on the spending made at place level. It should explain any variation from previous CCG budgets and enable the shared planning or pooling of NHS and local authority budgets, including stated minimum NHS contributions to Better Care Fund arrangements.

Budget allocated to and managed within a place (under the agreed schemes of delegation) might include:

- primary medical care
- other primary care as delegated/transferred from NHS England and NHS Improvement – dental, pharmaceutical, ophthalmology services
- community services
- community mental health including IAPT
- community diagnostics
- intermediate care

- any services subject to Section 75 agreement with local authority
- any acute or secondary care services that is has been agreed should be commissioned at place-level.

Financial and regulatory mechanisms to support collaboration

ICS NHS bodies will have a duty to co-operate with other NHS bodies, including NHS trusts and foundation trusts, and local authorities. They also have a duty to promote integration. These duties, combined with the new triple aim duty, should be a key driver for ensuring NHS ICS partners work together to meet the four purposes of the ICS with the resources available.

Collaboration in the NHS has accelerated in recent years and this is already supported by a wide range of enablers to ensure a shared investment in system objectives and plans.

Enablers already established, or expected to be established, through NHS England and NHS Improvement's system-by-default approach include:

- Setting system financial envelopes, which describe the funding available to spend in an ICS, including CCG allocations and national sustainability funding. These budgets will be based on population need and will support systems to work together to free up resources, which can be spent elsewhere in the system
- Proposals to establish an aligned payment and incentive (API) approach, in which fixed payments are set for an agreed level of planned activity; variable payments would also be agreed for activity above or below these plans. This should give the ICS NSH body, NHS trusts and foundation trusts greater certainty over payments and the agreed level of activity these payments will cover
- Inclusion of a System Collaboration and Financial Management Agreement in the NHS standard contract, which is a collaborative document aimed to ensuring NHS system partners work together to deliver shared financial objectives. The ICB, NHS trusts and foundation trusts will agree in advance ways of working and the risk management approach to dealing with unplanned pressures

- Change in oversight focus in the System Oversight Framework (SOF) which works with and through the system to tackle problems with an emphasis on system performance and greater autonomy for organisations with evidence of effective joint working.
- Guidance to be issued on provider governance to support providers to work collaboratively as part of ICSs to deliver system objectives. This will include an updated Code of Governance for NHS provider trusts, updated guidance on the duties of foundation trust governors, and updated memorandums for accounting officers of foundation trusts and NHS trusts. New guidance will be issued under the NHS Provider Licence that good governance for NHS providers includes a requirement to collaborate.

In addition to these policy developments, further enablers to support system collaboration are expected from the proposed legislation and policy, including:

- A common duty for ICS NHS bodies, NHS trusts and foundation trusts in relation to the triple aim, which requires them to have regard to the wider effect of their decisions in each of the three strands of the triple aim improving population health, quality of care and the use of resources
- Imposition of duties on the ICS NHS body to act with a view to ensuring system financial balance and to meet other financial requirement and objectives set by NHS England and NHS Improvement. This would also apply to NHS trusts and foundation trusts. This should mean that ICS NHS bodies, NHS trusts and foundation trusts have shared investment in the delivery of system financial balance and strong reason to collaborate to agree a system plan for meeting this; supported by a review of the NHS provider licence
- Powers to ensure organisational capital spending is in line with system capital plans. A review of the NHS provider licence in light of the new legislation and policy developments and specifically to support providers to work effectively as part of ICSs to deliver system objectives.

Services currently commissioned by NHS England and NHS Improvement

The legislation will enable the direct commissioning functions of NHS England and NHS Improvement to be jointly commissioned, delegated or transferred at an appropriate time to ICS NHS bodies.

NHS England and NHS Improvement is considering how it might shift some of its direct commissioning functions to ICS NHS bodies. Subject to discussions with systems and our Regions and further work on HR, our intention is to enable ICS NHS bodies to take on responsibility as soon as they are ready to do so after the enactment of legislation.

Commissioning of primary medical services is currently delegated to CCGs and will transition immediately into ICS NHS bodies when they are established. ICS NHS bodies might also take on primary dental services, general ophthalmic and pharmaceutical services commissioning.

Further work is taking place at national and regional levels to explore how the commissioning model for specialised services could evolve , in line with the safeguards and four principles set out in *Integrating Care: Next steps to building strong and effective integrated care systems across England*.

NHS England and NHS Improvement has a range of other direct commissioning functions including health and justice, armed forces and aspects of public health. Engagement with ICSs will continue to establish how they could take on greater responsibility for these services in future.

Data and digital standards and requirements

The standards and requirements for digital and data will be centred around the What Good Looks Like framework, which will set out a common vision to support ICS leaders to accelerate digital and data transformation in their systems with partner organisations. Based on consultation with a wide range of NHS and care stakeholders, the framework identifies seven success measures and will be published in the first quarter of 21/22.

We expect digital and data experts to have a pivotal role in ICSs, supporting transformation and ensuring health and care partners provide a modern operating environment to support their workforce, citizens and populations.

From April 2022, systems will need to have smart digital and data foundations in place. The way that these capabilities are developed and delivered will vary from system to system. Systems will locally determine the right way to develop these capabilities and to ensure they are available at system and place level, and across provider collaboratives.

Specifically, ICS NHS bodies are expected to:

- Have a renewed digital and data transformation plan that is embedded within the ICS NHS body plan and details the roadmap to achieve 'What Good Looks Like'; and enables a cross system approach to transformation, so that changes to models of care and service redesign involve digital and data experts working with partners from all relevant sectors.
- Have clear accountability for digital and data, with a named SRO with the appropriate expertise, (registered professional or with equivalent experience), underpinned by governance arrangements that have clear oversight and responsibility for digital and data standards and requirements for the ICS and enabling partner organisation programmes and services.
- Invest in levelling-up and consolidation of infrastructure, linked to the future ICS reference target architecture and data model, adopting a simplified cloud-first infrastructure that provides agility and frictionless cross-site working experience for the workforce.

- Implement a shared care record, that allows information to follow the patient and flow across the ICS to ensure that clinical and care decisions are made with the fullest of information.
- Ensure adherence by constituent partners to standards and processes that allow for interoperability across the ICS, and alignment to forthcoming national guidance.
- Enable a single co-ordinated offer of digital channels for citizens across the system and roll out remote monitoring technologies to help citizens manage their care at home.
- Cultivate a cross-system intelligence function to support operational and strategic conversations, as well as building platforms to enable better clinical decisions. This will require ICSs to have linked data, accessible by a shared analytical resource that can work on cross-system priorities.
- Agree a plan for embedding population health management capabilities and ensuring these are supported by the necessary data and digital infrastructure, such as linked data and digital interventions. Online PHM support can also be found at https://future.nhs.uk/populationhealth/grouphome and here Population Health Management - e-Learning for Healthcare (e-lfh.org.uk).

Arrangements should be co-ordinated across the NHS and local government, as well as between NHS organisations.

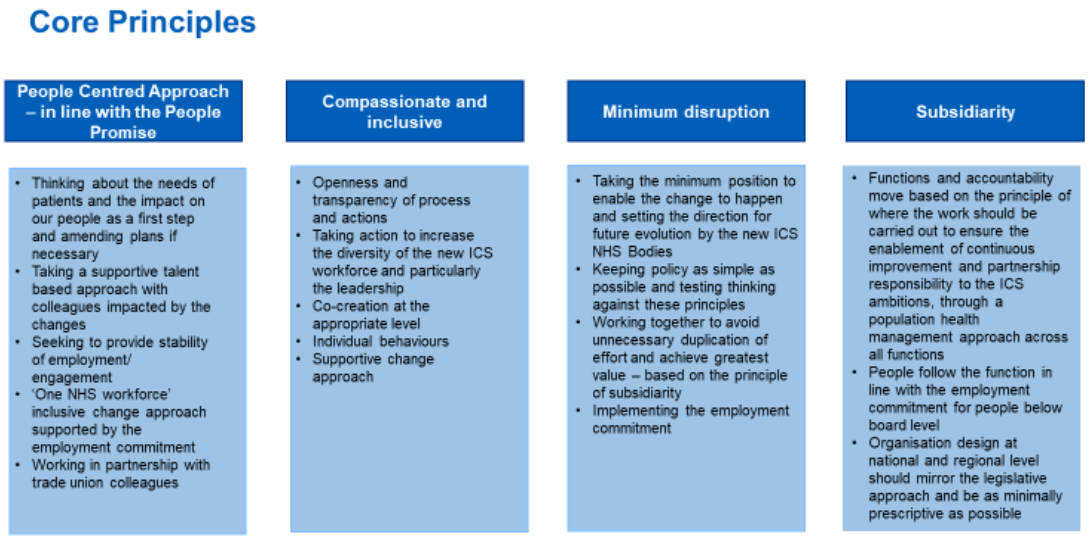
Managing the transition to statutory ICSs

We will work in partnership with systems, individual organisations affected, trade unions, voluntary organisations and central and local government to ensure the opportunities for improved outcomes for populations and improvements for our people are realised. We aim to create an environment that enables this change to take place with minimum uncertainty and employment stability for all colleagues who are involved.

The change and transition approach is guided by our Employment Commitment and a set of core principles designed to inform the thinking and actions of all colleagues throughout the process, acknowledging the wide variation in circumstances across systems.

> **The Employment Commitment**
>
> *"NHS people within the wider health and care system (below board level) affected directly by these legislative changes, including CCGs, NHS England and NHS Improvement and NHS providers, will receive an employment commitment to continuity of terms and conditions (even if not required by law) to enable all affected colleagues to be treated in a similar way despite a variety of contractual relationships. This commitment is designed to provide stability and remove uncertainty during this transition."*

The Employment Commitment is designed to minimise uncertainty and provide employment stability for people who will transfer directly from their employment or engagement directly into the statutory ICS NHS body. During the transition period the Employment Commitment asks affected organisations not to carry out significant internal organisational change and not to displace people. The commitment does not apply to those people in senior/board level roles who are likely to be affected by the new ICS Board structure and will have to go through organisational change as part of the abolition and establishment process.



Accountability for managing the change process will be with the current ICS and CCG leadership, with increasing involvement of the new leaders (eg chair, chief executive and others at board level) who may be appointed on a shadow or designate basis, pending the legislation.

Each ICS should make initial arrangements to manage the transition and ensure that there is capacity in place ready for implementation of the new ICS body. Plans should be agreed with regional NHS England and NHS Improvement teams.

Each ICS should ensure that planning adequately addresses the implications of organisational development implications as operations evolve from the current into the future configuration. This should be explicitly based in the local context.

It is important to note that any plans are subject to the passage of the legislation. Systems cannot pre-empt the decision of Parliament on whether to approve a bill or how it is to be amended. While plans can be made, systems should not take decisions or enter into arrangements which presume any legislation is already in place or that it is inevitable it will become law, before the Parliamentary process has been completed.

The overarching aim is to ensure and enable:

- the safe transfer of functions into the ICS NHS body (ie existing statutory functions that are to be exercised by the ICS NHS body) and prepare for the ICS body to take on new functions as appropriate
- the smooth transition of our people (ie legally compliant, with minimum disruption).

The indicative outputs expected in every ICS over the course of the transition period in 2021/22 are set out below. This is subject to legislation and other factors (including pending decisions on ICS boundaries in some areas).

By end Q1 Preparation	• Update System Development Plans (SDPs) against the key implementation requirements (functions, leadership, capabilities and governance) and identify key support requirements. • Develop plans in preparation for managing organisational and people transition, taking into account the anticipated process and timetable, and any potential changes to ICS boundaries and the need to transform functions to support recovery and delivery across the ICS.
By end Q2 Implementation	• Ensure people currently in ICS Chair, ICS lead or AO roles are well supported and consulted with appropriately. • Carry out the agreed national recruitment and selection processes for the ICS NHS body chair and chief executive, in accordance with guidance on competencies and job descriptions issued by NHS England and NHS Improvement. This will reflect the expected new accountabilities and responsibilities of ICS NHS bodies. • Confirm appointments to ICS Chair and chief executive. Subject to the progress of the Bill and after the second reading these roles will be confirmed as designate roles. • Draft proposed **new** ICS NHS body MoU arrangements for **2022/23**, including ICS operating model and governance arrangements, in line with the NHS England and NHS Improvement model constitution and guidance. • Plan for CCG teams to only operate at sub-ICS level where the SDP confirms that the ICS plans to establish a significant place-based function at that footprint. • Begin due diligence planning.
By end Q3 Implementation	• Ensure people in impacted roles are well supported and consulted with appropriately.

	• Carry out the recruitment and selection processes for designate finance director, medical director, director of nursing and other board level role in the NHS ICS body, using local filling of posts processes. • Confirm designate appointments to ICS NHS body finance director, medical director and director of nursing roles and other board and senior level roles. • ICS NHS bodies and ICS Partnerships to be ready to operate in shadow form. • Engagement on local ICS Constitution and governance arrangements for ICS NHS body and ICS Partnership.
By end Q4 Transition	• Ensure people in affected roles are consulted and supported. • Continue the recruitment and selection processes for all other designate ICS NHS body senior roles, including place-level leaders and non-executive roles, using local filling of posts processes. • Confirm designate appointments to any remaining senior ICS roles (in line with our relevant guidance) so that as much of the ICS NHS executive board and other senior leadership is ready (subject to formal decisions on appointments after the legislation is in place/in force). • Complete due diligence and preparations for staff and property (assets and liabilities, including contracts) transfers from CCGs and other NHS staff transfers to new ICS NHS body in line with our guidance. • Commence engagement and consultation on the transfer with trade unions. • Complete preparations to shift our direct commissioning functions to ICS NHS body, where this is agreed from 1 April 2022. • Ensure that revised digital, data and financial systems are in place ready for ‘go live’. • Submit the ICS NHS body constitution for approval and agree the 2022/23 ICS MoU with NHS England and NHS Improvement, setting out key elements of how the new ICS NHS body and ICS Partnership will operate in the future, in accordance with guidance to be issued by NHS England and NHS Improvement.

NHS England and NHS Improvement is working with a range of stakeholder groups, including a newly formed ICS Transition Partnership Group, which is a sub-group of the national Social Partnership Forum, to make available a range of resources and guidance to support the transition. The following documents will be published in support of this document:

- Change and Transition approach – core principles – setting the tone for how the change should be approached by affected organisations.
- Employment Commitment Guidance – which builds on the commitment made in the FAQs published on 11 February 2021 and sets out what 'board level' means in this context. This also sets out the national support and senior level support that is available for colleagues affected by these changes.

After the legislation is introduced, we will publish further resources and guidance to support people transition planning and implementation.

Conclusion

As we move into the next phase of system development, we must capture and build on the spirit and practice of partnership now embedded across the NHS local councils, the VCSE sector and beyond. We continue to face an unprecedented challenge as a health and care system, but ICSs offer a clear way forward.

Strengthening local partnerships through ICSs is one of the most important and exciting missions in the public sector today. We would like to thank colleagues in every part of every system for your continued efforts to pursue it. This is an opportunity to deliver better care and population health; to ensure services treat us all as individuals and respond to our increasingly complex health and care needs. It is also an opportunity to work in partnership with local residents in new ways, removing even more of the traditional barriers to joined-up, personalised care and support.

Building on the achievements of system leaders over several years, the further ‘transformation by necessity’ prompted by the pandemic provides a platform for ongoing improvement of relationships, services and outcomes. Working together through ICSs will allow us to seize these opportunities, ensure our health and care systems are fit for the future and that we achieve world class health outcomes for our whole population.

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This publication can be made available in a number of other formats on request.

Publication approval reference: PAR642

Report to Trust Board	
Report Title	**Integrated Performance Report - June 2021**
Report from	Jon Spencer - Chief Operating Officer
Prepared by	Performance And Information Department
Previously discussed at	Trust Management Committee / Management Executive
Attachments	

Brief Summary of Report

The Integrated Performance Report highlights a series of metrics regarded as Key Indicators of Trust Performance and cover a variety of organisational activities within Operations, Quality and Safety, Workforce, Finance, Research, Commercial and Private Patients . The report uses a number of mechanisms to put performance into context, showing achievement against target, in comparison to previous periods and as a trend. The report also identifies additional information and Remedial Action Plans for KPIs falling short of target and requiring improvement.

Executive Summary

The IPR for June 2021 shows that there has been a significant increase in the number of referrals being received per month such that the rate is now at 90.6% of the average seen in 2019/20. The level of elective and outpatient activity being undertaken has also increased to 90.5% and 95% respectively against the 2019/20 position. Although the level of emergency attendances has increased, this is still only sitting at 63% of the level seen prior to the pandemic. This will continue to be monitored for the next couple of months to determine whether it settles into a permanent reduction in attendances.

The Trust again met all non-RTT national targets including the 4 hour A&E standard, 28 day cancer standard and percentage of diagnostic waiting times less than 6 weeks. We remain on plan to treat all patients who have waited over 52 weeks by the end of next month and made good in month progress in treating 19% of the patients who had been waiting over 18 weeks.

The performance against the average call waiting time has deteriorated against last month's performance and remains below the required target of 2 minutes. Daily analysis of the performance of the service indicates that it is able to perform to an acceptable standard on days when it is fully staffed and the Netcall system is performing well, but is susceptible to a sudden dip in performance where there is either short term sickness absence within the administrative team or the Netcall system is unavailable due to network downtime. Actions are being taken to address these matters and the Doctor Doctor system continues to be rolled out to a greater number of patients.

The Trust had a single never event which is being investigated at present. The investigation is due to be completed by early September and a more detailed update will then be provided to the Board on the learning from this incident. The time taken to respond to complaints fell below the required target of 25 days due to 4 complaints taking longer than the allocated time to investigate. It is unusual for this to have occurred in a single month and therefore that performance will return to an acceptable standard from next month.

Although the Trust's appraisal compliance is not quite meeting the 80% standard, performance is on an upward trajectory and is now only 0.4% short of the required standard. Managers have been asked to ensure that a date is set for any outstanding appraisals so that the target is achieved next month.

Action Required/Recommendation

The report is primarily for information purposes but will inform discussion regarding how the Trust is performing against its key organisational measures. This may in turn generate subsequent action.

For Assurance	X	For decision		For discussion		To Note	

Context - Overall Activity - June 2021

		June 2021	19/20 Mth 1-11 Average	Year To Date
Accident & Emergency	A&E Arrivals (All Type 2)	5,261	8,230	15,256
	Number of 4 hour breaches	7	124	11
Outpatient Activity	Number of Referrals Received	10,919	12,051	29,671
	Total Attendances	48,933	51,427	136,503
	First Appointment Attendances	10,748	11,392	29,422
	Follow Up (Subsequent) Attendances	38,185	40,035	107,081
Admission Activity	Total Admissions	2,969	3,281	8,255
	Day Case Elective Admissions	2,709	2,944	7,510
	Inpatient Elective Admissions	81	102	210
	Non-Elective (Emergency) Admissions	179	235	535

These figures are not subject to any finance or commissioning business logic. They present all activity, whether chargeable or not

Moorfields Eye Hospital NHS Foundation Trust

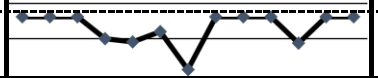
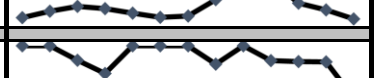
NHS

Service Excellence (Ambitions)

June 2021

Operational Metrics

** RTT Figures Provisional for June 2021, ratings will be re-introduced once initial recovery plan has been completed*
*** Figures Provisional for June 2021*

Metric Description	Reporting Frequency	Target	Rating	RAP Pg	Previous Period	Current Period	13 Month Series	Year to Date
Cancer 2 week waits - first appointment urgent GP referral	Monthly	≥93%	G		100.0%	100.0%		100.0%
Cancer 14 Day Target - NHS England Referrals (Ocular Oncology)	Monthly	≥93%	G		98.8%	98.8%		97.9%
Cancer 31 day waits - Decision to Treat to First Definitive Treatment	Monthly	≥96%	G		100.0%	100.0%		100.0%
Cancer 31 day waits - Decision to Treat to Subsequent Treatment	Monthly	≥94%	G		100.0%	100.0%		100.0%
Cancer 62 days from Urgent GP Referral to First Definitive Treatment	Monthly	≥85%			100.0%	n/a		100.0%
Cancer 28 Day Faster Diagnosis Standard	Monthly	≥75%	G		100.0%	100.0%		85.7%
18 Week RTT Incomplete Performance *	Monthly	≥92%			75.4%	80.3%		75.3%
RTT Incomplete Pathways Over 18 Weeks *	Monthly	≤1608 (Avg. 2019/20)			8162	6624		
52 Week RTT Incomplete Breaches *	Monthly	Zero Breaches			111	17		307
A&E Four Hour Performance	Monthly	≥95%	G		100.0%	99.9%		99.9%
Percentage of Diagnostic waiting times less than 6 weeks **	Monthly	≥99%	G		100.0%	100.0%		99.3%

Where issued for a metric, the page number of the Remedial Action Plan (RAP) can be found in column 'RAP Pg'

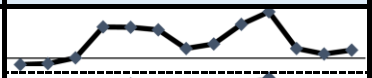
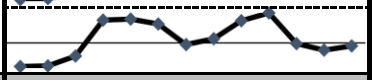
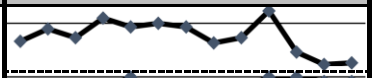
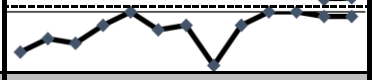
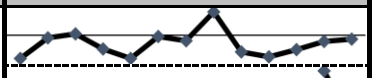
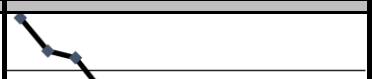
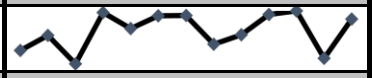
Moorfields Eye Hospital NHS Foundation Trust

NHS

Service Excellence (Ambitions)

June 2021

Operational Metrics

Metric Description	Reporting Frequency	Target	Current	RAP Pg	Previous Period	Current Period	13 Month Series	Year to Date
Average Call Waiting Time	Monthly	≤ 2 Mins (120 Sec)	R	4	162	205		
Average Call Abandonment Rate	Monthly	≤15%	G		11.4%	13.4%		13.2%
Median Clinic Journey Times - New Patient appointments	Monthly	≤ 95 Mins (tbc)	G		72	73		75
Median Clinic Journey Times -Follow Up Patient appointments	Monthly	≤ 85 Mins (tbc)	G		84	84		84
Patients Waiting For Follow-Up KPI - to be defined	Monthly	tbc			*In Development*			n/a
Theatre Cancellation Rate (Non-Medical Cancellations)	Monthly	≤0.8%	G		0.62%	0.69%		0.57%
Number of non-medical cancelled operations not treated within 28 days **	Monthly	Zero Breaches	G		3	0		3
Mixed Sex Accommodation Breaches	Monthly	Zero Breaches	G		0	0		0
Percentage of Emergency re-admissions within 28 days following an elective or emergency spell at the Provider (excludes Vitreoretinal)	Monthly (Rolling 3 Months)	≤ 2.67%	G		0.64%	1.41%		
VTE Risk Assessment	Monthly	≥95%	G		96.9%	99.2%		98.6%
Posterior Capsular Rupture rates (Cataract Operations Only)	Monthly	≤1.95%	G		1.07%	0.97%		0.97%

Where issued for a metric, the page number of the Remedial Action Plan (RAP) can be found in column 'RAP Pg'

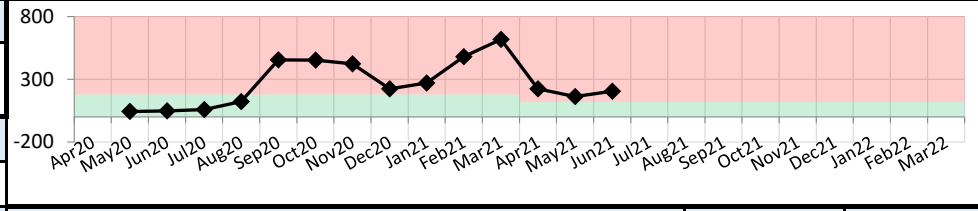
Remedial Action Plan - June 2021

Domain	Service Excellence (Ambitions)		
Lead Manager	Alex Stamp	Responsible Director	Jon Spencer

Average Call Waiting Time

Target	Rating	YTD	Previous Period	Current Period
≤ 2 Mins (120 Sec)	Red	n/a	162	205

Divisional Benchmarking (Jun 21)	City Road	North	South	Other
	n/a	n/a	n/a	n/a



Previously Identified Issues	Previous Action Plan(s) to Improve	Target Date	Status
Despite still underperforming, the trend continues to improve. We continue to be understaffed in the Contact Centre and have a member of staff on extended sick leave impacting the number of staff able to answer calls especially at peak times on a Monday and Tuesday (with 2 Bank Holiday Mondays this month).	Progress with recruitment of staff for Contact Centre. Regular contact with Bank to review suitable candidates. Looking into B2 apprenticeship candidates for the Booking/Contact Centre as well as B2 technicians that Bank may have access to. Staff absense now being recorded on daily stats.	Jul 2021	In Progress (Update)
A number of issues with Netcall and the issue log not working have impacted on staff being able to answer and action calls.	Netcall problems are recorded and reported. We are in the process of building and about to trial a new issue log system, which will generate tickets, similar to other help desks. IT issues now being records on daily stats.	Jul 2021	In Progress (Update)
High numbers of patients calling to confirm booked appointments.	The Patient Portal rollout and provision of appointment confirmation via text messages should reduce these call volumes.	Jul 2021	In Progress (Update)

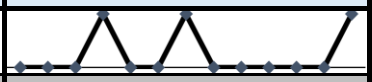
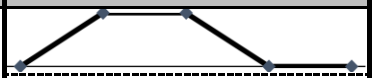
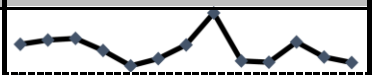
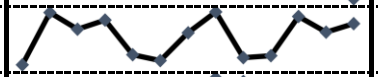
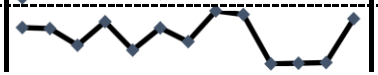
Reasons for Current Underperformance	Action Plan(s) to Improve Performance	Target Date
Despite still underperforming, the trend continues to improve. We continue to be understaffed in the Contact Centre and have a member of staff on extended sick leave impacting the number of staff able to answer calls especially at peak times on a Monday, Tuesday and Friday.	Progress with recruitment of staff for Contact Centre. Regular contact with Bank to review suitable candidates. Looking into B2 apprenticeship candidates for the Booking/Contact Centre . Use demand/capacity tool to identify resource required to plan extended opening hours/weekend operation Staff absence now being recorded on daily stats.	September 2021
A number of issues with Netcall and the issue log not working have impacted on staff being able to answer and action calls.	Netcall problems are recorded and reported. We are in the process of building and about to trial a new issue log system, which will generate tickets, similar to other help desks. IT issues now being records on daily stats.	September 2021
High numbers of patients calling to confirm booked appointments.	The Patient Portal rollout and provision of appointment confirmation via text messages should reduce these call volumes.	September 2021

Moorfields Eye Hospital NHS Foundation Trust

NHS

Service Excellence (Ambitions)

June 2021

Quality and Safety Metrics								
Metric Description	**Reporting Frequency**	**Target**	**Rating**	**RAP Pg**	**Previous Period**	**Current Period**	**13 Month Series**	**Year to Date**
Occurrence of any Never events	Monthly	Zero Events	R	7	0	1		1
Endopthalmitis Rates - Aggregate Score	Quarterly	Zero Non-Compliant	G		0	0		
MRSA Bacteraemias Cases	Monthly	Zero Cases	G		0	0		0
Clostridium Difficile Cases	Monthly	Zero Cases	G		0	0		0
Escherichia coli (E. coli) bacteraemia bloodstream infection (BSI) - cases	Monthly	Zero Cases	G		0	0		0
MSSA Rate - cases	Monthly	Zero Cases	G		0	0		0
Inpatient Scores from Friends and Family Test - % positive	Monthly	≥90%	G		94.9%	94.5%		95.1%
A&E Scores from Friends and Family Test - % positive	Monthly	≥90%	G		93.6%	92.3%		93.2%
Outpatient Scores from Friends and Family Test - % positive	Monthly	≥90%	G		93.4%	93.6%		93.6%
Paediatric Scores from Friends and Family Test - % positive	Monthly	≥90%	G		92.9%	95.9%		94.0%

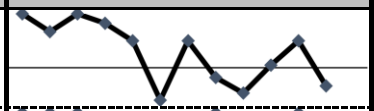
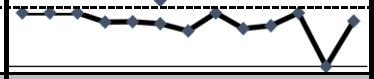
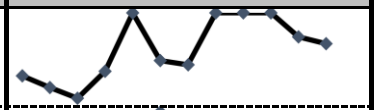
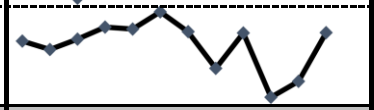
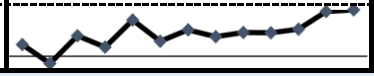
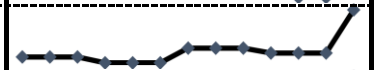
Where issued for a metric, the page number of the Remedial Action Plan (RAP) can be found in column 'RAP Pg'

Moorfields Eye Hospital NHS Foundation Trust

NHS

Service Excellence (Ambitions)

June 2021

Quality and Safety Metrics								
Metric Description	**Reporting Frequency**	**Target**	**Current**	**RAP Pg**	**Previous Period**	**Current Period**	**13 Month Series**	**Year to Date**
Summary Hospital Mortality Indicator	Monthly	Zero Cases	G		0	0		0
NHS England/NHS Improvement Patient Safety Alerts breached	Monthly	Zero Alerts	G		0	0		
Percentage of responses to written complaints sent within 25 days	Monthly (Month in Arrears)	≥80%	R	8	90.0%	73.3%		84.4%
Percentage of responses to written complaints acknowledged within 3 days	Monthly	≥80%	G		80.0%	97.0%		94.9%
Freedom of Information Requests Responded to Within 20 Days	Monthly (Month in Arrears)	≥90%	G		98.0%	97.4%		97.8%
Subject Access Requests (SARs) Responded To Within 28 Days	Monthly (Month in Arrears)	≥90%	G		93.9%	98.2%		95.9%
Number of Serious Incidents remaining open after 60 days	Monthly	Zero Cases	G		0	0		0
Number of Incidents (excluding Health Records incidents) remaining open after 28 days	Monthly	tbc			145	150		
Research Metrics								
Median Time To Recruitment of First Patient (Days)	Monthly	≤ 70 Days	R	9	61	111		
Percentage of Commercial Research Projects Achieving Time and Target	Monthly	≥65%	G		75.0%	100.0%		80.0%
Total patient recruitment to NIHR portfolio adopted studies (YTD cumulative)	Monthly	≥1800			443	1218		1997
Proportion of patients participating in research studies (as a percentage of number of open pathways)	Monthly	≥2%	G		5.1%	5.2%		

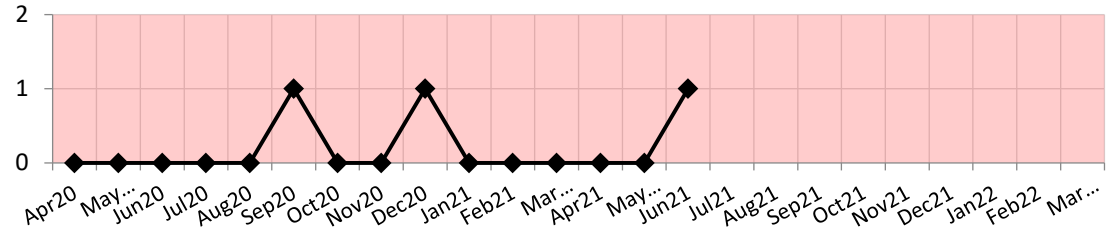
Where issued for a metric, the page number of the Remedial Action Plan (RAP) can be found in column 'RAP Pg'

Remedial Action Plan - June 2021

Domain	Service Excellence (Ambitions)		
Occurrence of any Never events	Lead Manager	Julie Nott	Responsible Director	Ian Tombleson

Target	Rating	YTD	Previous Period	Current Period
Zero Events	Red	1	0	1

Divisional Benchmarking (Jun 21)	City Road	North	South	Other
	1	0	0	0



Previously Identified Issues	Previous Action Plan(s) to Improve	Target Date	Status
No Outstanding Issues or Actions			

Reasons for Current Underperformance	Action Plan(s) to Improve Performance	Target Date
One new Never Event has been reported in accordance with national and trust policy. The incident relates to the placement of a radioactive plaque on the incorrect lesion (correct eye). All external notifications have been completed.	The investigation is on-going (due for completion and submission by 6 September)	September 2021

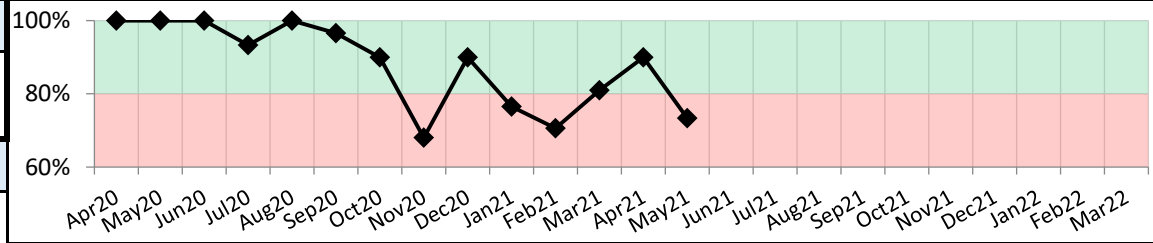
Remedial Action Plan - June 2021

Percentage of responses to written complaints sent within 25 days (Month in Arrears)

Domain	Service Excellence (Ambitions)		
Lead Manager	Tim Withers	Responsible Director	Ian Tombleson

Target	Rating	YTD	Previous Period	Current Period
≥80%	Red	84.4%	90.0%	73.3%

Divisional Benchmarking (May 21)	City Road	North	South	Other
	71.4%	66.7%	100.0%	n/a



Previously Identified Issues	Previous Action Plan(s) to Improve	Target Date	Status
No Outstanding Issues or Actions			

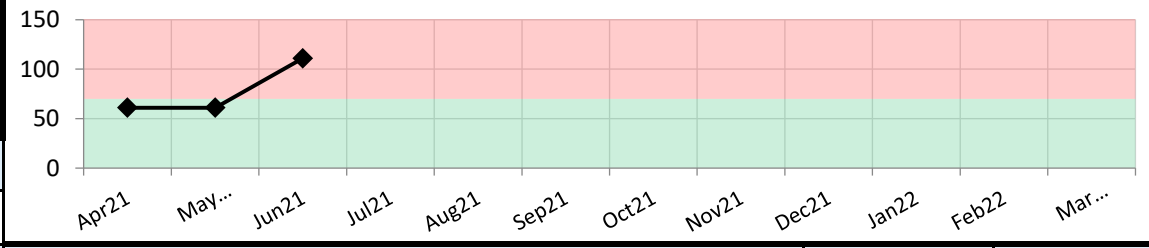
Reasons for Current Underperformance	Action Plan(s) to Improve Performance	Target Date
15 complaints were received in May. Of these, four exceeded their response date (two for North and two for City Road). This was due to the length of time taken to investigate the concerns - divisional submission of the complaints for review and signature exceeded the trust breach date.	Regular reminders are sent to teams about deadlines. Managers for complaints in the North and City Road divisions have been specifically reminded that complaints investigations must be returned to the complaints team on, or before the Divisional response date to avoid timescale breaches.	July 2021

Remedial Action Plan - June 2021

Domain	Infrastructure & Culture (Enablers)		
Median Time To Recruitment of First Patient (Days)	**Lead Manager**	**Julian Hughes**	**Responsible Director**	**Sir Peng Tee Khaw**

Target	Rating	YTD	Previous Period	Current Period
≤ 70 Days	Red	n/a	61	111

Divisional Benchmarking (Jun 21)	City Road	North	South	Other
	n/a	n/a	n/a	n/a



Previously Identified Issues	Previous Action Plan(s) to Improve	Target Date	Status
No Outstanding Issues or Actions			

Reasons for Current Underperformance	Action Plan(s) to Improve Performance	Target Date
A number of research studies were delayed due to the COVID-19 pandemic. Studies in set-up during the COVID-19 pandemic were held in set up and not opened until COVID-19 restrictions were lifted. This prolonged the time from site selection to first patient recruit. Staff availability on site also delayed organisation of the site initiation visit to get studies opened. Patient attendances to clinic were also reduced during this period which severely limited the number of eligible patients that could be approached to participate in the research studies.	As COVID-19 restrictions are lifted and patient appointments in the hospital increase, this will increase the number of eligible patients seen for recruitment to clinical trials. Studies are also no longer being held in set-up, and are being opened more quickly which will reduce the time to recruit the first patient. Note the data reflects the studies in set up for 12 months from April 2020, and so are the worst affected by COVID-19.	December 2021

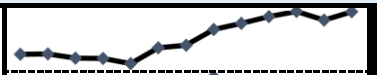
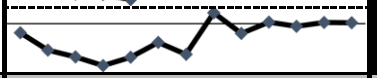
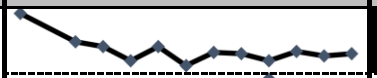
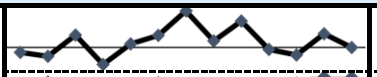
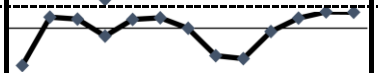
Moorfields Eye Hospital NHS Foundation Trust

NHS

People (Enablers)

June 2021

Workforce and Financial Metrics

Metric Description	Reporting Frequency	Target	Rating	RAP Pg	Previous Period	Current Period	13 Month Series	Year to Date
Workforce Metrics								
Appraisal Compliance	Monthly	≥80%	R	11	77.3%	79.6%		
Information Governance Training Compliance	Monthly	≥95%	G		95.1%	95.1%		
Staff Turnover (Rolling Annual Figure)	Monthly	≤15%	G		9.6%	9.7%		
Proportion of Temporary Staff	Monthly	RAG as per Spend			10.4%	10.9%		10.2%
Financial Metrics								
Overall financial performance (In Month Var. £m)	Monthly	≥0	G		1.02	0.01		0.05
Commercial Trading Unit Position (In Month Var. £m)	Monthly	≥0	G		0.41	0.40		1.06

Where issued for a metric, the page number of the Remedial Action Plan (RAP) can be found in column 'RAP Pg'

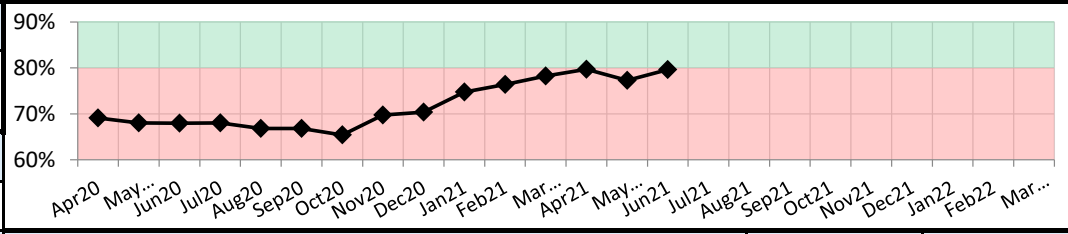
Remedial Action Plan - June 2021

Domain	People (Enablers)		
Lead Manager	Bola Ogundeji	Responsible Director	Sandi Drewett

Appraisal Compliance

Target	Rating	YTD	Previous Period	Current Period
≥80%	Red	n/a	77.3%	79.6%

Divisional Benchmarking (Jun 21)	City Road	North	South	Other
	n/a	n/a	n/a	n/a



Previously Identified Issues	Previous Action Plan(s) to Improve	Target Date	Status
Compliance dipped over the last month from 83%. From following up on actions over the last month. I am now sending out Monthly MAST reports which incudes Appraisal data, but It seems Appraisal only reports has had more of an impact in driving up complinace.	The development of support and guidance for virtual appraisal is on-going and a process of reminder emails to managers is now in operation. HR Business Partners are communicating appraisal rates with Divisional Management Teams on a monthly basis. The learning and development team are also providing additional support to managers to undertake appraisals remotely and have implemented an action plan including: • Monitoring expiries and sending reminders to staff and managers with weekly escalation where there is no response. We will be attaching objective setting guidelines to the reminder email to support managers • Undertaking analysis to understand reasons for non-compliance eg absence, workload and reporting this back to the HRBPs • Where training requirement linked to the e-appraisal tool is identified, the team offer 121/small group coaching. • L&D team are taking a targeted approach within corporate services to drive up lower % compliance by sending non-standard reminders to managers with staff requiring appraisal and a deadline for completion - Friday 14th May. This reflects opportunities for face to face appraisals as corporate staff increasingly return to the office. This will be monitored by L&D. • We are also proposing to launch an appraisals awareness week supported by communcation team in the next few weeks. This would focus on post-COVID reset and review of objectives. • Re-introduced Appraisal only reporting to managers who have staff who are non - compliant in appraisal. This was working but was merged in with overall complinace reproting and thus causing a dip.	Jul 2021	In Progress (Update)

Reasons for Current Underperformance	Action Plan(s) to Improve Performance	Target Date
Issues as above	In addition to the above: • Compliance is going up and has increased at a steady pace of 2.3 % from last month. Therefore we will continue with our current approach – including identifying hot spots and working with the managers to offer support and unblock issues.	July 2021

Moorfields Eye Hospital NHS Foundation Trust

NHS

Agenda item 07

Finance report

Board of directors 22 July 2021

Report title	Monthly Finance Performance Report Month 03 – June 2021
Report from	Jonathan Wilson, Chief Financial Officer
Prepared by	Justin Betts, Deputy Chief Financial Officer
Link to strategic objectives	Deliver financial sustainability as a Trust

Executive summary

All NHS organisation were issued with revised control totals for the first six months of the year referred to as 2021/22 H1. The revised £4.85m surplus has been increased further to £6.55m reflecting a £1.7m contribution from Elective Recovery Funded (ERF) activity subject to NCL confirmation. There is no current guidance surrounding the 2021/22 H2 financial regime.

For June the Trust is reporting :-

- **a £0.53m surplus** (£6.95m deficit YTD) prior to funding support;

- Additional support funding consists of:-
  - £0.08m Elective Recovery Funding;
  - £0.24m Block income funded values above activity levels; and
  - £1.01m Additional NCL COVID support funding.

- **Resulting in a £1.87m surplus** post support (£4.42m surplus YTD);

- Activity delivery and costs are below historical budgeted levels resulting in current block income values exceeding the cost value of activity being undertaken in June;
- Activity is slightly greater than the 80% expectation to receive Elective Recovery Funding (ERF) and the Trust is reporting £3.28m of ERF income within the year to date position;
- Ongoing support funding, and ERF distribution is subject to and awaiting NCL confirmation.

Compared to plan, the Trust is reporting:-

Financial Performance £m	Annual Plan	In Month			Year to Date			
		Plan	Actual	Variance	Plan	Actual	Variance	%
Income	£268.7m	£25.6m	£23.2m	(£2.5m)	£70.3m	£69.3m	(£1.1m)	(2)%
Pay	(£142.5m)	(£11.4m)	(£11.4m)	(£0.0m)	(£33.7m)	(£33.4m)	£0.3m	1%
Non Pay	(£110.1m)	(£11.6m)	(£9.1m)	£2.5m	(£29.9m)	(£29.1m)	£0.8m	3%
Financing & Adjustments	(£9.5m)	(£0.8m)	(£0.8m)	(£0.0m)	(£2.4m)	(£2.4m)	(£0.0m)	(0)%
CONTROL TOTAL	**£6.5m**	**£1.9m**	**£1.9m**	**(£0.0m)**	**£4.4m**	**£4.4m**	**£0.0m**	

Quality implications

Patient safety has been considered in the allocation of budgets.

Financial implications

Delivery of the financial control total will result in the Trust being eligible for additional benefits that will support its future development.

Risk implications

Potential risks have been considered within the reported financial position and the financial risk register is discussed at the Audit Committee.

Action Required/Recommendation

The board is asked to consider and discus the attached report.

For Assurance		**For decision**		**For discussion**	✓	**To note**	✓

Moorfields Eye Hospital NHS Foundation Trust

NHS

Monthly Finance Performance Report
For the period ended 30th June 2021 (Month 03)

Presented by	Jonathan Wilson; Chief Financial Officer
Prepared by	Justin Betts; Deputy Chief Finance Officer Amit Patel; Head of Financial Management Lubna Dharssi, Head of Financial Control Richard Allen; Head of Income and Contracts

Monthly Finance Performance Report

For the period ended 30th June 2021 (Month 03)

Key Messages

Statement of Comprehensive Income

2012/22 Financial Plan	The Trust has received a £6.55m surplus Control Total for the first half of 2021/22, referred to as H1. This has been increased from the original £4.85m target to reflect a further £1.70m contribution from Elective Recovery Fund (ERF) activity.

Financial Position
 	
£1.87m surplus Including support
	For June the Trust is reporting:-
	
	• **a £0.53m surplus** (£6.95m deficit YTD) prior to funding support;
	• Additional support funding consists of:-
	  • £0.08m Elective Recovery Funding;
	  • £0.24m Block income funded values above activity levels; and
	  • £1.01m Additional North Central London COVID support funding.
	
	• **Resulting in a £1.87m surplus** inclusive of the above (a cumulative £4.41m surplus);

Income £1.34m ahead of plan pre support	Total trust income is £1.34m more than plan, driven by the rebasing of plans submitted to NHS Improvement and England:- • Commissioned Clinical **income gains of £0.49m**; (£4.43m losses YTD) • Other Clinical activity **income gains of £0.43m**; (£0.22m YTD) • Commercial **income gains of £1.22m**; (£1.61m YTD) • Research **income losses of £0.57m**; (£0.71m YTD) and • Other **income losses of £0.23m;** (£0.38m YTD). Directly commissioned activity income, if reimbursed by normal contracting arrangements, would total £15.04m compared to a plan of £14.55m - £0.49m favourable to plan, although this is inclusive of £0.62m of high cost Voretegene treatments..
Expenditure £2.49m ahead of plan (pay, non pay, excl financing)	Pay costs are break-even in June against the revised plan. Overall pay is up £0.3m compared to May driven by a higher use of bank and agency support to undertake activity. Non pay costs were £2.51m favourable to plan in June, due to the plan rebasing. Cumulative non-pay budgets are £0.8m under-spent reflecting lower Oriel activity against plan.

Statement of Financial Position

Cash and Working Capital Position	The cash balance as at the 30th June 2021 was £69.6m, an increase of £1.2m since the end of March 2021 which in line with expectation. The trust will also be reviewing performance against the Better Payment Practice Code (BPPC) for the quick payment of creditor invoices in line with national expectation.
Capital (both gross capital expenditure and CDEL)	Capital spend to 30th June 2021 totalled £1.6m against a plan of £3.0m as operational teams focused recovery planning around increasing patient activity. Capital is forecast to be in line with plan and will be revised as projects are further developed and refined.
Use of Resources	Current use of resources monitoring remains suspended.

Trust Financial Performance - Financial Dashboard Summary

FINANCIAL PERFORMANCE

Financial Performance £m	Annual Plan	In Month Plan	In Month Actual	In Month Variance	In Month %	In Month RAG	Year to Date Plan	Year to Date Actual	Year to Date Variance	Year to Date %	Year to Date RAG
Income	£268.7m	£25.6m	£23.2m	(£2.5m)	(10)%		£70.3m	£69.3m	(£1.1m)	(2)%	
Pay	(£142.5m)	(£11.4m)	(£11.4m)	(£0.0m)	(0)%		(£33.7m)	(£33.4m)	£0.3m	1%	
Non Pay	(£110.1m)	(£11.6m)	(£9.1m)	£2.5m	22%		(£29.9m)	(£29.1m)	£0.8m	3%	
Financing & Adjustments	(£9.5m)	(£0.8m)	(£0.8m)	(£0.0m)	(2)%		(£2.4m)	(£2.4m)	(£0.0m)	(0)%	
CONTROL TOTAL	**£6.5m**	**£1.9m**	**£1.9m**	**(£0.0m)**	(0)%		**£4.4m**	**£4.4m**	**£0.0m**		
Memorandum Items											
Research & Development	(£1.40m)	(£0.11m)	£0.01m	£0.12m	109%		(£0.35m)	(£0.23m)	£0.11m	33%	
Commercial Trading Units	£5.74m	£0.37m	£0.77m	£0.40m	877%		£0.86m	£1.92m	£1.06m	123%	
ORIEL Revenue	(£2.25m)	(£0.20m)	(£0.02m)	£0.18m	88%		(£0.88m)	(£0.19m)	£0.69m	78%	

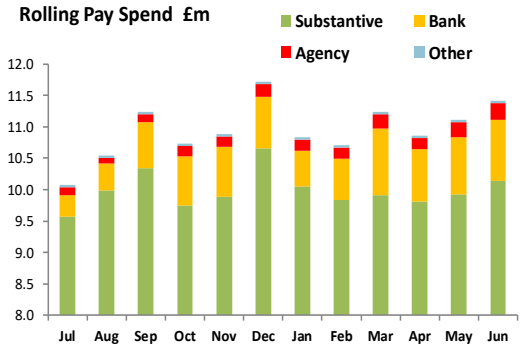
INCOME BREAKDOWN RELATED TO ACTIVITY

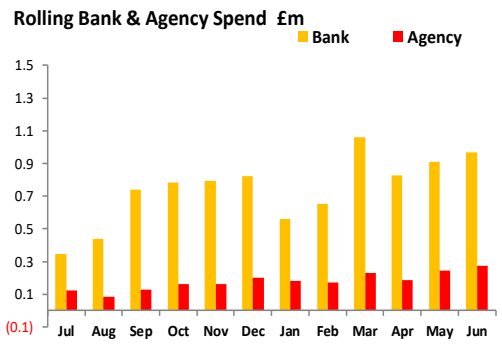
Income Breakdown £m	Annual Plan	Year to Date Plan	Year to Date Actual	Year to Date Variance	Year to Date RAG	Forecast Plan	Forecast Actual	Forecast Variance
NHS Clinical Income	£140.0m	£35.2m	£29.4m	(£5.8m)		-	-	-
Pass Through	£35.9m	£8.9m	£10.2m	£1.3m		-	-	-
Other NHS Clinical Income	£9.9m	£2.3m	£2.6m	£0.2m		-	-	-
Commercial Trading Units	£35.2m	£7.6m	£9.2m	£1.6m		-	-	-
Research & Development	£15.9m	£4.1m	£3.4m	(£0.7m)		-	-	-
Other	£12.8m	£3.4m	£3.0m	(£0.4m)		-	-	-
INCOME PRE TOP-UP	**£249.7m**	**£61.6m**	**£57.9m**	**(£3.7m)**		**-**	**-**	**-**
ERF/COVID Top up funding	£19.0m	£8.7m	£11.4m	£2.6m		-	-	-
TOTAL OPERATING REVENUE	**£268.7m**	**£70.3m**	**£69.3m**	**(£1.1m)**		**-**	**-**	**-**

RAG Ratings Red > 3% Adverse Variance, Amber < 3% Adverse Variance, Green Favourable Variance, Grey Not applicable

PAY AND WORKFORCE

Pay & Workforce £m	Annual Plan	In Month Plan	In Month Actual	In Month Variance	Year to Date Plan	Year to Date Actual	Year to Date Variance	% Total
Employed	(£141.1m)	(£11.3m)	(£10.1m)	£1.1m	(£33.3m)	(£29.9m)	£3.4m	89%
Bank	(£1.0m)	(£0.1m)	(£1.0m)	(£0.9m)	(£0.2m)	(£2.7m)	(£2.5m)	8%
Agency	£0.0m	£0.0m	(£0.3m)	(£0.3m)	£0.0m	(£0.7m)	(£0.7m)	2%
Other	(£0.5m)	(£0.0m)	(£0.0m)	£0.0m	(£0.1m)	(£0.1m)	£0.0m	0%
TOTAL PAY	**(£142.5m)**	**(£11.4m)**	**(£11.4m)**	**(£0.0m)**	**(£33.7m)**	**(£33.4m)**	**£0.3m**	





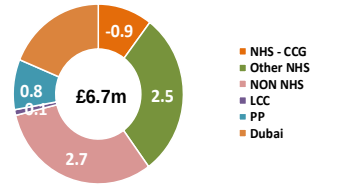
CASH, CAPITAL AND OTHER KPI'S

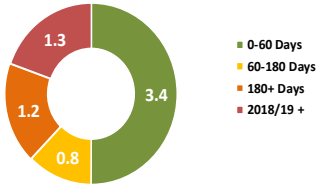
Capital Programme £m	Annual Plan	Year to Date Plan	Year to Date Actual	Year to Date Variance	Year to Date RAG	Forecast Plan	Forecast Actual	Forecast Variance
Trust Funded	(£17.2m)	(£0.9m)	(£0.4m)	(£0.5m)		-	-	-
Donated/Externally funded	(£0.5m)	-	£0.0m	(£0.0m)		-	-	-
TOTAL	**£17.7m**	**£0.9m**	**£0.4m**	**(£0.5m)**		**-**	**-**	**-**

Key Metrics	Plan	Actual	RAG
Cash	69.5	69.6	
Debtor Days	45	25	
Creditor Days	45	48	
PP Debtor Days	65	49	

Use of Resources	Plan	Actual
Capital service cover rating	-	-
Liquidity rating	-	-
I&E margin rating	-	-
I&E margin: distance from fin. plan	-	-
Agency rating	-	-
OVERALL RATING	**-**	**-**

Net Receivables/Ageing £m





Trust Income & Expenditure Performance

FINANCIAL PERFORMANCE

Statement of Comprehensive Income £m	Annual Plan	In Month Plan	In Month Actual	In Month Variance	In Month %	In Month RAG	Year to Date Plan	Year to Date Actual	Year to Date Variance	Year to Date %	Year to Date RAG
Income											
NHS Commissioned Clinical Income	175.90	14.55	15.04	0.49	3%		44.05	39.62	(4.43)	(10)%	
Other NHS Clinical Income	9.86	0.85	1.28	0.43	51%		2.35	2.57	0.22	10%	
Commercial Trading Units	35.22	2.15	3.37	1.22	57%		7.62	9.23	1.61	21%	
Research & Development	15.92	1.98	1.41	(0.57)	(29)%		4.15	3.43	(0.71)	(17)%	
Other Income	12.84	0.95	0.73	(0.23)	(24)%		3.41	3.03	(0.38)	(11)%	
Total Income	**249.74**	**20.49**	**21.82**	**1.34**	**7%**		**61.58**	**57.89**	**(3.69)**	**(6)%**	
Operating Expenses											
Pay	(142.54)	(11.40)	(11.42)	(0.02)	(0)%		(33.69)	(33.40)	0.29	1%	
Drugs	(38.44)	(3.57)	(4.00)	(0.43)	(12)%		(9.39)	(9.86)	(0.47)	(5)%	
Clinical Supplies	(21.70)	(1.47)	(2.12)	(0.65)	(44)%		(4.54)	(5.09)	(0.55)	(12)%	
Other Non Pay	(49.99)	(6.55)	(2.97)	3.58	55%		(15.96)	(14.12)	1.84	12%	
Total Operating Expenditure	**(252.68)**	**(22.99)**	**(20.50)**	**2.49**	**11%**		**(63.58)**	**(62.47)**	**1.11**	**2%**	
EBITDA	*(2.94)*	*(2.51)*	*1.32*	*3.83*	153%		*(2.00)*	*(4.58)*	*(2.58)*	(129)%	
Financing & Depreciation	(10.08)	(0.84)	(0.83)	0.01	1%		(2.53)	(2.52)	0.00	0%	
Donated assets/impairment adjustments	0.61	0.07	0.04	(0.02)	(36)%		0.16	0.15	(0.01)	(6)%	
Control Total Surplus/(Deficit) Pre ERF/Block and Top Up Payments	**(12.41)**	**(3.28)**	**0.53**	**3.81**	**116%**		**(4.36)**	**(6.95)**	**(2.59)**	**(59)%**	
Elective Recovery Funding	10.86	3.80	0.08	(3.72)			4.68	3.28	(1.40)		
Block funding in excess of activity	-	-	0.24	0.24			-	5.06	5.06		
COVID Top Up Payments	8.10	1.35	1.01	(0.34)			4.05	3.03	(1.02)		
Control Total Surplus/(Deficit) Post ERF/Block and Top Up Payments	**6.55**	**1.87**	**1.87**	**(0.00)**	**(0)%**		**4.37**	**4.41**	**0.05**		

Commentary

Operating Income

£1.34m ahead of plan pre support

Clinical activity levels recorded were 86% for Daycase and 89% for Outpatients during June compared to 2019/20 levels. If the trust was reimbursed under activity-based contracting arrangements, income would have totalled £15.04m – inclusive of £0.62m of high cost Voretegene treatments recorded in month. The underlying position was £0.24m below block funded levels.

Other notable income variances include:-

- Commercial Trading income was £1.22m favourable due to the re-basing of the plan. Cumulative income is £1.6m above plan;
- Other NHS Clinical Income is £0.43m favourable, due to increased retrospective income gains at Bedford due to data delays;
- Research was £0.57m adverse driven by a correction to grant activity which is mirrored in non-pay;

Employee Expenses

£0.02m below plan

Total pay costs were break-even in month reflecting the revised plan submission.

- Bank and agency costs totalled £1.24m in June (85% of June 2020 levels) and £0.26m (26%) respectively - higher than October – December 2020 levels;
- Cumulative temporary staff costs are £0.16m (16%) higher than October – December 2020 averages;
- Increases are concentrated within Medical, Scientific and Clinical Support staff groups.

Non Pay Expenses

£2.51m above plan

(non pay and financing)

Non pay costs were £2.51m favourable to plan reflecting the revised plan submission (£2.3m). Cumulative non-pay is £0.82m favourable, the main points for the non-pay position are:-

- Drugs was adverse by £0.43m due to two Voretegene treatments totalling £0.62m;
- Clinical supplies were £0.65m adverse primarily due to the revised plan (£0.59m). Cumulative clinical consumables expenditure is proportional to 2019/20 levels;
- Oriel is underspent by £0.69m;

Trust Patient Clinical Income Performance

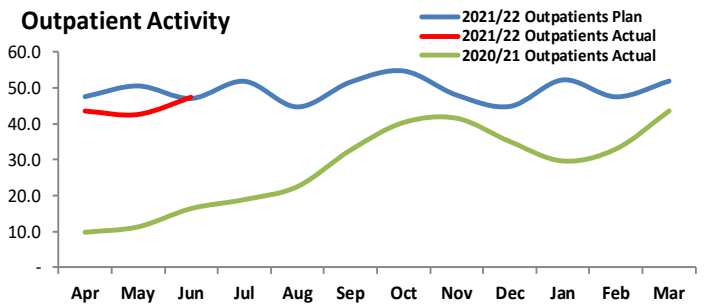
PATIENT ACTIVITY AND CLINICAL INCOME

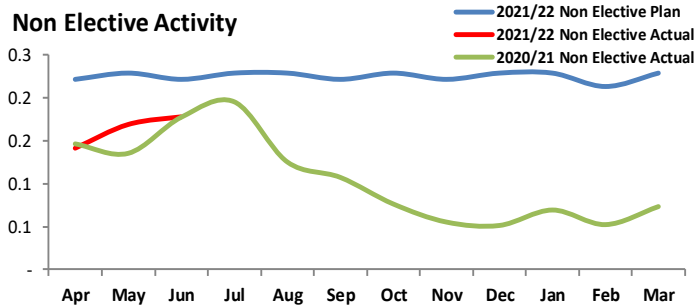
Point of Delivery	Activity In Month				Activity YTD				YTD Income £'000			
	Plan	Actual	Variance	%	Plan	Actual	Variance	%	Plan	Actual	Variance	%
AandE	8,118	5,261	(2,857)	65%	24,624	15,259	(9,365)	62%	£3,846	£2,390	(£1,455)	62%
Daycase / Inpatients	3,166	2,723	(443)	86%	8,487	7,609	(878)	90%	£9,490	£8,895	(£595)	94%
High Cost Drugs	4,889	4,832	(57)	99%	13,108	14,049	941	107%	£9,831	£10,192	£361	104%
Non Elective	229	178	(51)	78%	694	488	(206)	70%	£1,352	£1,013	(£339)	75%
OP Firsts	11,391	9,941	(1,450)	87%	30,539	27,267	(3,272)	89%	£5,225	£4,597	(£627)	88%
OP Follow Ups	42,121	37,454	(4,667)	89%	112,947	106,120	(6,827)	94%	£11,579	£10,326	(£1,252)	89%
Other NHS clinical income									£1,106	£769	(£337)	70%
Total	69,914	60,389	(9,525)	86%	190,399	170,792	(19,607)	90%	£42,428	£38,182	(£4,246)	90%

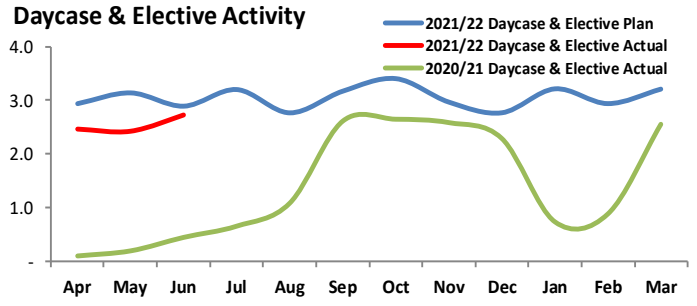
Income Figures Excludes CQUIN, Bedford, and Trust to Trust test income.

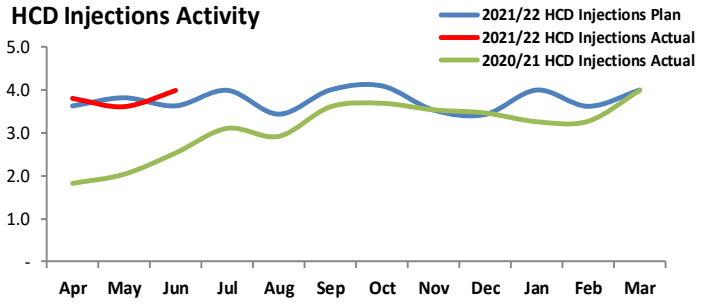
RAG Ratings Red to Green colour gradient determined by where each percentage falls within the range

ACTIVITY TREND









Commentary

NHS Income

NHS Patient Clinical activity income in June was £15.04m if reimbursed via normal activity based contracting arrangements. Notable activity levels include:-

Inpatient activity
- The Trust achieved 86% of baseline activity levels in June (a reduction from 87% in May);

Outpatient Activity
- The Trust achieved 89% of baseline activity levels in June (a reduction from 90% in May);

High Cost Drugs
- The Trust achieved 99% of baseline activity levels in June (a decrease from 103% in May);

Activity Plans

2019/20 activity levels (pre-COVID) are being used nationally as a proxy to report organisations return and recovery to pre pandemic levels of activity during 2021/22.

The charts to the left demonstrate the in year activity levels compared to previous years, highlighting the material shift in activity as a result of COVID, and the pace of recovery towards pre-COVID activity levels. The 2021/22 plan level represent 2019/20 delivered levels of activity.

Elective Recovery Fund (ERF)

Inpatient and Outpatient activity are included within the national Elective Recovery Fund (ERF) calculations, with an expectation of 80% achievement in June. From July this is expected to be increased to 95%.

- The Trust will receive £3.3m ERF funding for the year to date period as activity exceeded the expected levels, however it is now forecast to achieve £3.9m in H1 versus the originally planned £10.8m. It is anticipated that the planned surplus for the first six months will be adjusted to take account of the above.

Trust Statement of Financial Position – Cash, Capital, Receivables and Other Metrics

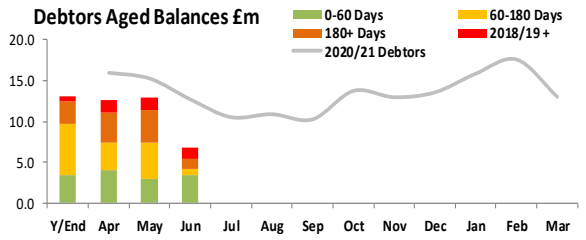
CAPITAL EXPENDITURE

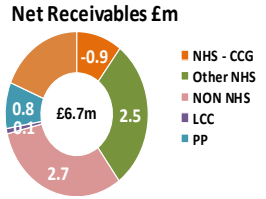
Capital Expenditure £m	Annual Plan	In Month Plan	In Month Actual	In Month Variance	Year to Date Plan	Year to Date Actual	Year to Date Variance
Estates - Trust Funded	0.9	0.1	0.0	(0.1)	0.1	0.0	(0.1)
Medical Equipment - Trust Funded	3.8	0.2	0.1	(0.1)	1.5	1.2	(0.3)
IT - Trust Funded	1.2	0.2	0.2	0.1	0.5	0.2	(0.4)
ORIEL - Trust Funded	2.6	0.2	0.1	(0.1)	0.6	0.3	(0.4)
Dubai - Trust funded	0.4	0.1	0.0	(0.1)	0.1	0.0	(0.1)
Other - Trust funded	8.3	0.1	-	(0.1)	0.1	-	(0.1)
TOTAL - TRUST FUNDED	**17.2**	**0.9**	**0.4**	**(0.5)**	**3.0**	**1.6**	**(1.4)**
Covid/Donated/Externally funded	0.5	-	(0.0)	(0.0)	-	(0.0)	(0.0)
TOTAL INCLUDING DONATED	**17.7**	**0.9**	**0.4**	**(0.5)**	**3.0**	**1.6**	**(1.4)**

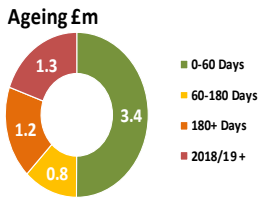
Capital Funding £m	Annual Plan	Secured	Not Yet Secured	% Secured
Planned Total Depreciation	8.3	8.3		100%
Cash Reserves - B/Fwd cash	6.0	6.0		100%
Cash Reserves - Other (ICS)	4.5	4.5		100%
Capital Loan Repayments	(1.8)	(1.8)		100%
TOTAL - TRUST FUNDED	**17.0**	**17.0**	**-**	**100%**
Donated/Externally funded	0.3	0.3		100%
Donated/Externally funded	0.2	-	100%	0%
TOTAL INCLUDING DONATE	**17.3**	**17.3**	**-**	**100%**

RECEIVABLES

Net Receivables £m	0-60 Days	60-180 Days	180+ Days	2018/19 +	Total
CCG Debt	(0.0)	(0.9)	(0.0)	0.0	(0.9)
Other NHS Debt	0.9	0.9	0.1	0.6	2.5
Non NHS Debt	0.9	0.2	0.9	0.6	2.7
Commercial Unit Debt	1.6	0.5	0.2	0.1	2.4
TOTAL RECEIVABLES	**3.4**	**0.8**	**1.2**	**1.3**	**6.7**







STATEMENT OF FINANCIAL POSITION

Statement of Financial Position £m	Annual Plan	Year to Date Plan	Year to Date Actual	Year to Date Variance
Non-current assets	-	103.2	103.2	-
Current assets (excl Cash)	-	21.0	21.0	-
Cash and cash equivalents	-	69.5	69.6	0.0
Current liabilities	-	(55.7)	(55.7)	-
Non-current liabilities	-	(36.0)	(36.0)	-
TOTAL ASSETS EMPLOYED	**-**	**102.0**	**102.0**	**0.0**

OTHER METRICS

Use of Resources	Weighting	Plan YTD	Score
Capital service cover rating	20%	-	-
Liquidity rating	20%	-	-
I&E margin rating	20%	-	-
I&E margin: distance from financial	20%	-	-
Agency rating	20%	-	-
OVERALL RATING		**-**	**-**

Commentary

Cash and Working Capital

The cash balance as at the 30th June 2021 was £69.6m, an increase of £1.2m since the end of March 2021, in line with expectation.

Capital Expenditure

Capital spend to 30th June 2021 totalled £1.6m against a plan of £2.4m, whilst operational teams refocused on accelerator plans and activity recovery.

Capital is forecast to be in line with the Trust's internal plan but will be refined as projects are further developed and refined.

Use of Resources

Use of resources monitoring and reporting has been suspended.

Receivables

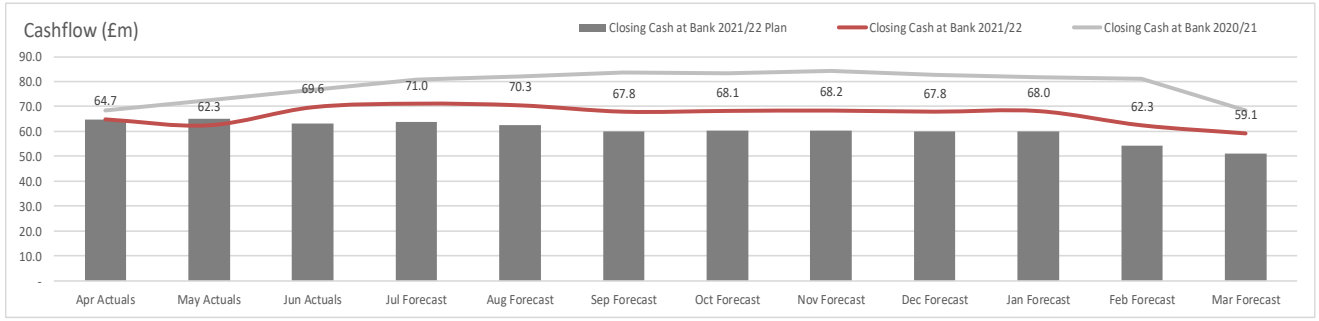
Receivables have reduced to £6.7m since the end of the 2020/21 financial year, and £6.3m from June, due to payments, primarily from NHS Trusts due to effective credit control.

Payables

Payables totalled £15.3m at the end of June, a reduction of £11.9m since March 2021. The reduction is mainly attributable to significant capital spend in March this year.

Cash Flow

Cash Flow £m	Apr Actuals	May Actuals	Jun Actuals	Jul Forecast	Aug Forecast	Sep Forecast	Oct Forecast	Nov Forecast	Dec Forecast	Jan Forecast	Feb Forecast	Mar Forecast	Outturn Total	Jun Plan	Jun Var
Opening Cash at Bank	**68.4**	**64.7**	**62.3**	**69.6**	**71.0**	**70.3**	**67.8**	**68.1**	**68.2**	**67.8**	**68.0**	**62.3**	**68.4**		
Cash Inflows															
Healthcare Contracts	15.4	16.4	16.0	15.4	15.4	15.4	15.4	15.4	15.4	15.4	15.4	15.4	186.5	13.7	2.3
Other NHS	1.6	0.3	7.2	1.5	1.4	1.5	1.5	1.4	1.4	1.4	1.4	1.5	22.0	1.5	5.7
Moorfields Private/Dubai	3.6	3.5	3.9	3.2	3.1	3.4	3.6	3.8	2.9	3.7	3.5	3.8	42.0	3.1	0.8
Research	1.1	0.9	1.8	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	12.4	1.0	0.8
VAT	0.6	0.2	0.3	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	4.7	0.4	(0.1)
PDC	-			-	-	-	-	-	-	-	-	0.3	0.3	-	0.0
Other Inflows	(0.1)	0.6	0.5	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	2.3	0.2	0.3
Total Cash Inflows	**22.2**	**22.0**	**29.5**	**21.6**	**21.4**	**21.8**	**22.0**	**22.1**	**21.2**	**22.1**	**21.8**	**22.5**	**270.3**	**19.8**	**9.7**
Cash Outflows															
Salaries, Wages, Tax & NI	(9.6)	(9.8)	(9.8)	(9.6)	(9.6)	(9.6)	(9.6)	(9.6)	(9.6)	(9.6)	(9.6)	(9.6)	(115.4)	(9.6)	(0.2)
Non Pay Expenditure	(13.5)	(11.5)	(11.0)	(8.7)	(10.1)	(10.9)	(10.1)	(10.3)	(9.6)	(10.2)	(10.0)	(10.7)	(126.6)	(8.7)	(2.3)
Capital Expenditure	(1.7)	(2.1)	(0.1)	(0.3)	(0.3)	(1.2)	(0.4)	(0.5)	(1.2)	(0.5)	(5.8)	(1.3)	(15.3)	(0.8)	0.7
Oriel	(0.3)	(0.1)	(0.6)	(0.3)	(0.2)	(0.6)	(0.2)	(0.2)	(0.1)	(0.1)	(0.1)	(1.8)	(4.7)	(0.2)	(0.3)
Moorfields Private/Dubai	(0.8)	(0.8)	(0.9)	(1.3)	(1.2)	(1.3)	(1.5)	(1.4)	(1.2)	(1.4)	(1.3)	(1.4)	(14.5)	(1.2)	0.3
Financing - Loan repayments	-		-	-	(0.6)	(0.8)	-	-	-	-	(0.6)	(0.8)	(2.8)	-	-
Dividend and Interest Payable	-		-	-	-	(0.1)	-	-	-	-	-	(0.3)	(0.3)	-	-
Total Cash Outflows	(25.8)	(24.3)	(22.3)	(20.2)	(22.1)	(24.4)	(21.7)	(22.0)	(21.6)	(21.8)	(27.5)	(25.8)	**(279.6)**	(20.5)	(1.8)
Net Cash inflows /(Outflows)	(3.7)	(2.4)	7.2	1.4	(0.7)	(2.6)	0.3	0.1	(0.4)	0.2	(5.7)	(3.2)	-	(0.7)	7.9
Closing Cash at Bank 2021/22	**64.7**	**62.3**	**69.6**	**71.0**	**70.3**	**67.8**	**68.1**	**68.2**	**67.8**	**68.0**	**62.3**	**59.1**	**59.1**		
Closing Cash at Bank 2021/22 Plan	64.7	64.9	63.2	63.7	62.4	59.8	60.2	60.3	59.9	60.1	54.4	51.1	51.1		
Closing Cash at Bank 2020/21	68.4	72.7	76.7	80.8	82.0	83.6	83.3	84.3	82.6	81.6	81.1	68.4	68.4		



Commentary

Cash flow

The cash balance at the 30th June is £69.6m, slightly higher than forecast due to effective credit control resulting in payments from other NHS bodies.

The current financial regime has resulted in block contract payments which gives some stability and certainly to the majority of cash receipts. The Trust currently has 105 days (prior month: 94 days) of operating cash.

June saw a cash inflow of £7.2m against a plan of £0.7m outflow due primarily to timings of receipts.

Moorfields Eye Hospital NHS Foundation Trust

NHS

Agenda item 08
Learning from deaths Q1 21/22
Board of directors 22 July 2021

Report title	Learning from deaths
Report from	Louisa Wickham, medical director
Prepared by	Julie Nott, head of risk & safety
Link to strategic objectives	We will pioneer patient-centred care with exceptional clinical outcomes and excellent patient experience

Executive summary

This report provides an update regarding how we learn from deaths that occur within Moorfields defined by criteria (see Annex below) as set out in trust policy. It is a requirement for all trusts to have a similar policy.

The trust has identified 0 patient deaths in Q1 2021/22 that fall within the scope of the learning from deaths policy. The investigation into the death of the patient that occurred during Q3 2020/21 concluded during Q1. Following the Inquest in relation to the death of this patient, held in April 2021, the trust was issued with a Prevention of Future Deaths (PFD) report and received a separate enquiry and request for information from the Care Quality Commission. Responses were provided to both HM Coroner and the CQC during June 2021, in accordance with the required timescales. The action plan is in the process of being implemented, including the sharing of learning with divisions and clinical services.

Quality implications

The Board needs to be assured that the trust is able to learn lessons from serious incidents in order to prevent repeat mistakes and minimise patient harm.

Financial implications

Provision of the medical examiner role for Moorfields may have cost implications for the organisation.

Risk implications

If the trust fails to learn from deaths there is clinical risk in relation to our ability to provide safe care to patients, reputational risk, financial risk of potential litigation and legal risk to directors.

Action Required/Recommendation

The Board is asked to receive the report for assurance and information.

For Assurance	✓	**For decision**		**For discussion**		**To note**	✓

Learning from deaths Board paper

This report satisfies the requirement to provide the trust board with an update regarding compliance with, and learning from, the NHS Improvement learning from deaths agenda.

The Q1 2021/22 data, as at 9 July 2021, is shown in table 1 below.

Indicator	Q2 2020/21	Q3 2020/21	Q4 2020/21	Q1 2021/22
Summary Hospital Mortality Indicator (as reported in the IPR)	0	0	0	0
Number of deaths that fall within the scope of the learning from deaths policy (see annex 1)	0	1	0	0
% of cases reviewed under the structured judgement review (SJR) methodology/ reviewed by the Serious Incident panel	N/A	100	N/A	N/A
Deaths considered likely to have been avoidable	N/A	0*	N/A	N/A

Table 1

Learning and improvement opportunities identified during Q1

- The learning and improvement opportunities identified during the investigation into the Q3 2020/21 patient death were not confined to the surgical procedure. In addition to the learning associated with the procedure, and the peri- and post-operative monitoring requirements that have been subsequently identified as being necessary for patients undergoing an endoresection procedure, the investigation highlighted the following as areas in which improvements could be made:
    - Recording of next of kin information for admitted patients
    - Use of name stamps in health records (to identify the clinician making the entry)
    - Provision of written patient information as part of the consent process, and documentation of this
    - Accurate recording of risk factors in the venous thrombo-embolism (VTE) assessment
    - Review of the pre-assessment content when a procedure changes following completion of the assessment.

  A LIFEline (shared learning) bulletin was developed for this incident and shared with staff.

Medical examiner (ME) role (update)

Work with UCLH, in relation to the provision of a ME service for Moorfields at City Road and Moorfields Private, remains on-going. A number of policy amendments are required and a data sharing agreement is to be established.

One national medical examiner update publications has been released by NHS Improvement since the Q4 report:

- June 2021 https://www.england.nhs.uk/wp-content/uploads/2021/06/June-2021-NME-bulletin-.pdf

Annex 1

Included within the scope of this Policy:

- All in-patient deaths;
- Patients who die within 30 days of discharge from inpatient services (where the Trust becomes aware of the death);
- Mandated patient groups identified by the NQB Learning from Deaths guidance including individuals with a learning disability, mental health needs or an infant or child;
- The death of any patient who is transferred from a Moorfields site and who dies following admission to another provider hospital;
- The death of any patient, of which the trust is made aware, within 48 hours of surgery;
- All deaths where bereaved families and carers, or staff, have raised a significant concern about the quality of care provision by Moorfields;
- Deaths of which the trust becomes aware following notification, and a request for information, by HM Coroner;
- Persons who sustain injury as a result of an accident (e.g. a fall down stairs) whilst on Trust premises and who subsequently die;
- Individual deaths identified by the Medical Examiner or through incident reporting or complaints or as a result of the Inquest process;

Excluded from the scope of this Policy:

- People who are not patients who become unwell whilst on trust premises and subsequently die;

Moorfields Eye Hospital NHS Foundation Trust

NHS

Identifying the work supporting achievement of our strategic objectives

July 2021

This pack

1. Following the Board strategy day, this pack highlights on a page the work we have agreed to focus on (slide 4)
2. It suggests a possible priority for the programmes as a whole (slide 5) – on which we would invite views (slide 5)
3. It proposes a guide for decision making on the forward shape of the network (slide 6 and 7)
4. And outlines that the programmes are necessarily at different stages of development re a 5 year plan and the first year of activity (slide 8).

Strategic objectives

A focus on Excellence

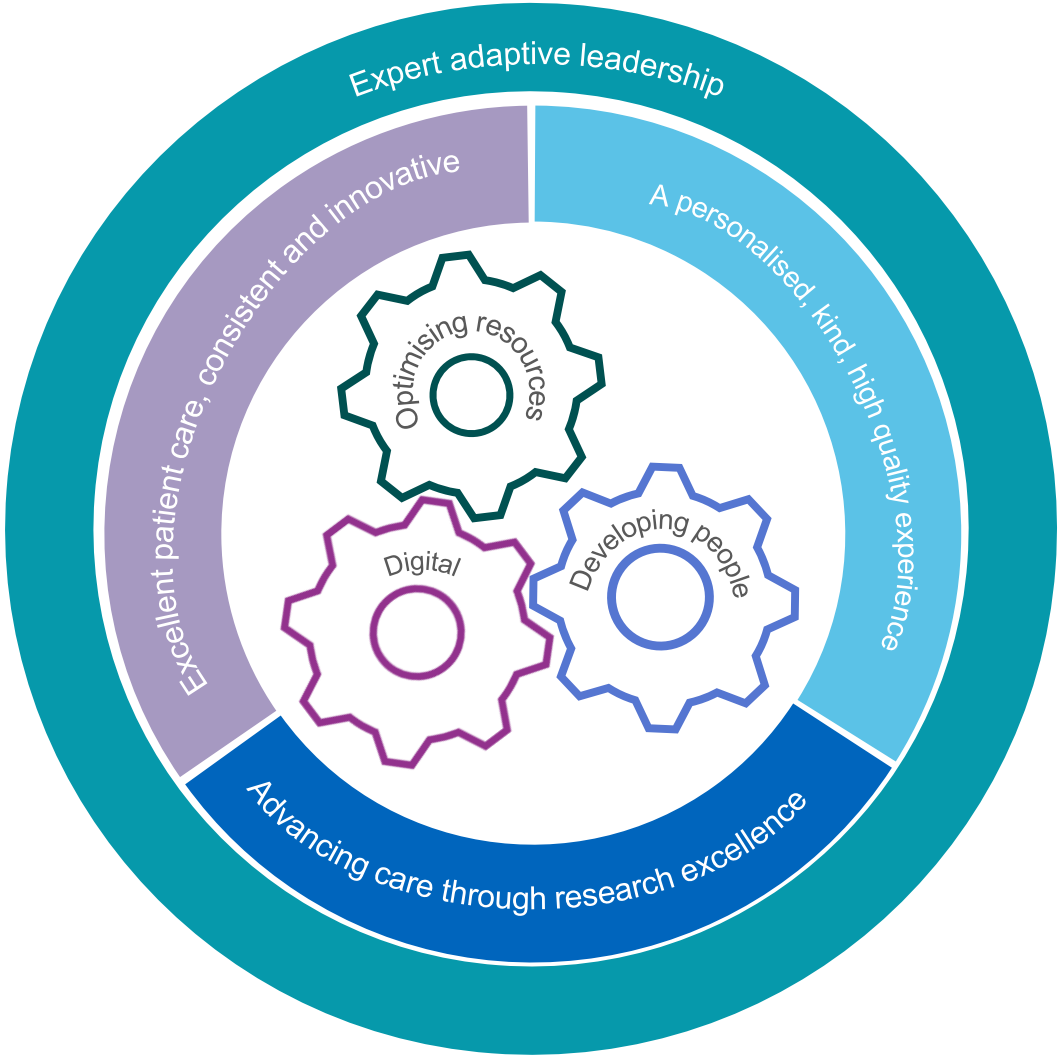
1	Excellent patient care that is safe, consistent and innovative
2	A personalised, kind, high quality experience for patients and staff
3	Advancing care through research excellence

Fundamental enablers

4	Supporting all our people to realise their potential and be heard and valued in delivering the best eye care.
5	Embracing and integrating digital opportunities.
6	Optimising our resources, achieving better value for money and making the most of commercial opportunities.

Our role in the system

7	Expert, adaptive leadership

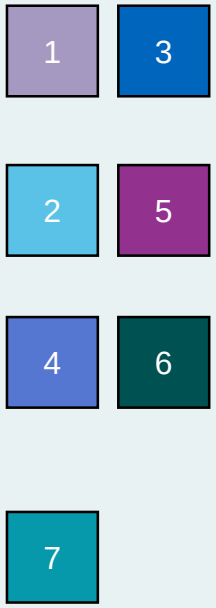


An Outcomes & Activities Dashboard: What we have said we want to do as an organisation

	1.	2.	3.	4.	5.	6.	7.
1	Infrastructure and culture for consistency and improvement	Improve patient systems and processes (e.g. booking centre)	Growth in scientific research & BRC	Getting the Basics Right; improving compliance	Systems resilience and reliability	Improved management information and financial awareness	Expert leadership and collaboration; sharing advice and guidance
2	Network design to agreed principles (consolidation, access)	Improve customer experience through targeted focus on the most vulnerable.	Expand time given over to health services research	HR Improvement: adding more value	Clinical informatics, AI and automation	Network optimisation for efficiency	Planning and co-ordinating care delivery in London
3		Consistently kind, high quality staff experience.	A research-oriented innovative mindset (& more people across the whole network doing research)	Workforce Transformation and Career Development	Our digital front door / public-facing care interface	Cost savings programmes	
4				Education and Training (tbc) and training NHS/specialty leaders		Commercial / private patient activity	

Assessing priority and desired levels of oversight: 5 guiding statements

In terms of what we know of our ambition, does the following feel right?



1. Continued assurance on maintaining our position and visible improvements being made re: excellence in research and outcomes (our north star areas, critical to our purpose)
2. Digital and experience as significant and known programmes that require investment (digital emphasis in year 1, with investment in complementary experience activity from year 2)
3. People and value – significant efforts needed, but comparatively less board attention required to affect the desired changes. Regular assurance on progress on both, particularly private patient income, and on rolling out changes to the network as per agreed design.
4. Leadership – check in every six months. Might need more steers/intervention at political crunch points on the emergent commissioning infrastructure across London.
5. We have developed governance in place for most of the stated areas of activity (e.g. digital, research, people, finance.)

Our focus for the network in this strategic horizon is…

1. Consolidating our network according to the agreed building blocks we have identified, potentially in partnership with others, in our existing populations.

2. Considering approaches from other providers – we will not actively seek growth but will review proposals from organisations seeking short term mutual aid and/or longer term partnership

3. Considering expansion of our reach through digital means, such as online services and triage.

Decision-making framework

Our north star:

Positively contributing to eye care by implementing new service models and delivering applied research

Conditions:

When making strategic decisions we will consider the extent to which our choices impact on the following:

1. Enable us to work towards becoming a £300m turnover organisation with a presence in at least 5 ICSs.
2. Allow us to strengthen the existing service we provide to our served populations, in line with our strategic objectives (e.g. expanding research opportunities)
3. Receive support from the relevant NHS trust board(s) and ICS leadership
4. Enable growth of our commercial businesses

Maturity of plans: what we know now, versus what will be emergent (1 year vs 5 year plans)

Each strategic area is positioned differently in respect of a one year and five year view, which is to be expected.

- For example, we have a developed view of network consolidation and our approach to cost savings and improved outcomes over five years, though we are still determining the priority for year 1 taking account of politics, positioning benefits and cost.

- We have strong one year plans for experience, research, developing people and digital. For experience, early work will be in developing our processes, with investments likely in year 2, for significant realisation in 3,4,5.

- Leadership is a five year influencing programme, though there are early opportunities to formalise positions as ICSs and their governance and financial flows become more apparent in year 1/2.

Moorfields Eye Hospital NHS Foundation Trust

NHS

Agenda item 10
BAF summary update
Board of directors 22 July 2021

Report title	BAF and corporate risk register – Q4 2020/21 and Q1 2021/22
Report from	Helen Essex, company secretary
Previously discussed at	With individual risk owners, audit and risk committee
Link to strategic objectives	The board assurance framework links to all strategic objectives

Brief summary of report

The trust's corporate risk register is the means by which the management executive holds itself to account and defends its patients and staff as well as the trust. It helps to clarify what risks are likely to compromise the trust's strategic and operational objectives and assists the executive team in identifying where to make the most efficient use of their resources in order to improve the quality and safety of care. Along with the board assurance framework, this should support the creation of a culture which allows the organisation to anticipate and respond to adverse events, unwelcome trends and significant business and clinical opportunities.

Quality implications

The trust must have a robust approach to risk management in order to maintain the highest standards of quality care provided to patients. Identification and mitigation of risk is an important tool in being able to manage events that could have an impact.

Financial implications

There are no financial implications arising from this paper.

Risk implications

As detailed in the paper.

Action Required/Recommendation.

The audit committee is asked to note the report and discuss risk updates.

For Assurance	✓	**For decision**		**For discussion**	✓	**To note**	

Board assurance framework executive summary report
January 2021 – June 2021 (Q4 2020/21 and Q1 2021/22)

1. BAF analysis and summary of changes

The top-rated risks to achieving the strategic objectives are as follows:

1. Impact of Covid-19 in all areas of the trust and on the wider system as a whole.
2. Delivery of our long-term plan for a new centre for research, education and clinical care.
3. Financial impact of COVID and future planning.
4. Recovery of clinical services.
5. Robust workforce planning.
6. Staff health and wellbeing.
7. The impact of a 'no deal' Brexit.
8. Attraction of sufficient research funding.

All have been identified as risks that will have a significant impact on the delivery of patient care, the patient and staff experience, the financial sustainability and reputation of the trust or a combination of these. The identified areas are those that require the most focus from the Board in terms of scrutiny and provision of assurance from the executive team. Particular attention is also being given to those risks that are not wholly within the trust's control to mitigate and a strategy developed as to how to manage such external factors.

1.1 Amendments made in these quarters

The risk relating to Covid-19 has fluctuated due to the changing nature of the pandemic. It was reduced in the latter half of 2020 but then increased again due to the impact of the second wave and lockdown. The current position is that the risk is at a 12 (4x3) and has remained at this level for two quarters as work continues to increase emergency and elective activity to previous BAU levels.

The risk relating to **workforce planning** has increased from 12 (4x3) to 16 (4x4) due to the need to expedite progress in making sure the workforce is fit for purpose in light of new models of care being developed and resource/time required in undertaking the clinical workforce modelling. The people committee will monitor progress.

The risk relating to staff **health and wellbeing** has decreased from 16 (4x4) to 12 (4x3) due to a number of initiatives put in place for both redeployed and other staff, the establishment of the health and wellbeing subgroup and plans for additional staff surveys to monitor progress outside the formal staff survey.

Oriel from 5x4 (20) to 5x3 (15) – although risks to the delivery of the overall project remain high, the success of the resolution to grant application was an important milestone and the robust monitoring of other critical path deadlines provides some assurance and mitigation that the risks are being well managed.

Commercial activity (from 5x3 (15) to (4x3) 12 – strong performance in both UK and UAE means risk is mitigated although performance measures will be kept under close review and recent approval for new capacity and infrastructure will have an impact.

Cyber security (from 4x4 (16) to 4x3 (12) – remediation action plan has been completed and although the risk should remain high on the agenda there is regular monitoring of mitigating actions and 'standards met' submission of DSP Toolkit and green/amber audit provides assurance that procedures in place continue to be as robust as possible.

1.2 Risks added in these quarters

If the trust's **Digital infrastructure** fails to provide robust resilience and adequate performance, then treatment of patients may be compromised through either a lack of access to digital patient and administrative data, or a slowness of information delivery that reduces patient throughput enough that some patients may need to re-book and return for their treatment. This risk has been rated as a 4x4 (16).

1.3 Risks removed in these quarters

The risk relating to Brexit has been moved to the corporate risk register for quarterly monitoring as there has been little movement is presenting no significant impact at this stage. The issue of visibility of numbers of overseas visitors has been raised by the finance committee and will be taken through that agenda. Other elements of this risk relate to workforce and supplies.

1.4 Emerging concerns from the corporate risk register

A number of risks have been escalated from divisional and corporate services risk registers and are under consideration for inclusion.

These risks primarily rate to specific issues within clinical support services departments and IT resilience.

Board Assurance Framework (BAF)

June 2021

Risk Scoring Matrix and Colour Codes					
	Likelihood				
Consequence	1. Very Unlikely	2. Unlikely	3. Likely	4. Very Likely	5. Almost Certain
5. Catastrophic	5	10	15	20	25
4. Major	4	8	12	16	20
3. Moderate	3	6	9	12	15
2. Minor	2	4	6	8	10
1. Negligible	1	2	3	4	5

Risk score:	Strategic Outcome:	Risk description:	Lead:	Lead Committee/s:
16	We will have an infrastructure and culture that supports innovation	If the trust's **Digital infrastructure** fails to provide robust resilience and adequate performance, then treatment of patients may be compromised through either a lack of access to digital patient and administrative data, or a slowness of information delivery that reduces patient throughput enough that some patients may need to re-book and return for their treatment.	Chief information officer	Capital scrutiny committee and management executive
16	We are able to deliver a sustainable financial model	**Financial Regime -** national guidance has set out the Operational Planning framework for 1st April- 30th September 2021/22 only (referred to as H1). Guidance surrounding H2 is not expected until August 2021 subject to HMT negotiation. Current H1 plans have been derived at System ICS level with Provider allocations.	Chief financial officer	Management executive
16	We will attract, retain and develop great people	If the trust does not have a **robust workforce plan** in place then there will be staff shortages and skill gaps leading to insufficient numbers of staff available in key areas and a subsequent impact on the quality of patient care, pressure on staff and a decrease in morale which will affect both the staff and patient experience.	Director of workforce & OD	People committee
15	We will have an infrastructure and culture that supports innovation	If the key assumptions behind **Oriel** are not achieved then there may be insufficient capital and resources available leading to a failure to be able to deliver a new facility that is fit for purpose and improves the patient and staff experience.	Director of strategy & business development	Capital scrutiny committee
15	We will be at the leading edge of research making new discoveries with our partners and patients	If the trust cannot attract sufficient **research funding** to maintain its position then its capacity to conduct appropriate research will diminish leading to an inability to compete effectively for funding and a significant risk to the trust brand and reputation in the field	Director of R&D	Strategy and commercial committee BRC monitoring group
12	All strategic objectives	If the trust is unable to appropriately manage the impact of the **Covid-19** virus there will be an impact in a number of areas including significant harm to staff and patients, significant financial risk both in the short and long term, reputational risk, workforce impact and system working risk.	Chief operating officer	Recovery oversight committee
12	We will be enterprising to support and fund our ambitions	If the **growth in commercial activity** is not to plan then there will not be sufficient revenue generated leading to pressure on trust finances elsewhere and a lack of ability to effectively compete in the market and to continue to provide high quality NHS services to patients as well as having an impact on the assumptions for Oriel.	Chief financial officer	Strategy & commercial committee
12	We will pioneer patient-centred care with exceptional clinical outcomes and excellent patient experience	If the **recovery of clinical services** post-COVID does not ensure timely access to ophthalmic care for both new and existing patients then this may lead to patient harm, reputational risk and potential financial risk through litigation.	Medical director	Quality & safety committee
12	We will attract, retain and develop great people	If the trust fails to put in place sufficient support for staff and processes/procedures to manage **staff health and wellbeing**, both during and after the pandemic, then this will lead to increased stress and sickness absence, poor staff engagement with the organisation, poor recruitment and retention and an impact on staff morale.	Director of workforce & OD	People committee
12	We will have an infrastructure and culture that supports innovation	If there is a successful **cyber-attack** then the trust may suffer from a loss of service and/or corruption of data leading to poor patient care or experience, loss of income and damage to reputation.	Director of quality and safety	Audit and risk committee

Moorfields Eye Hospital NHS Foundation Trust

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Agenda item 11
Report of the audit and risk committee
Board of directors 22 July 2021

Report title	Report of the audit and risk committee
Report from	Nick Hardie, chairman, audit and risk committee
Prepared by	Helen Essex, company secretary
Link to strategic objectives	We will have an infrastructure and culture that supports innovation We are able to deliver a sustainable financial model

Brief summary of report

Attached is a brief summary of the audit and risk committee meeting that took place on 13 July 2021.

Action Required/Recommendation.

- The Board is asked to NOTE the report of the audit and risk committee and gain assurance from it.

For Assurance	✓	**For decision**		**For discussion**		**To note**	✓

AUDIT AND RISK COMMITTEE SUMMARY REPORT – 13 JULY 2021	
Governance	• Quorate – Yes • Attendance (membership) - 100%
Current activity (as at date of meeting)	***Internal audit*** • The plan has been drafted and shared with the executive as a group but meetings with individual directors will take place shortly and the plan will then be finalised. • It was agreed to move the job planning audit to the middle of 22/23 as it affects a number of different areas. • The committee asked to see a specific audit on patient communication which has been a recurring theme. • There is one overdue recommendation on the tracker which relates to the SBS contract but this has been updated. ***External audit*** • Grant Thornton has already issued opinions on the financial statements and no further issues have been raised. • The vfm report will be finalised and audit certificate issued today to allow the accounts to be laid before parliament prior to the AGM. • Three key areas are under review; financial sustainability, governance and economy, efficiency and effectiveness arrangements. • There are no significant weaknesses identified but there will be minor improvement points moving forward. • Recurring themes are Covid, Oriel and the move towards increased system working and what that means for the trust. ***Salary overpayments*** • The action plan contained 13 key actions of which seven have been completed and six are ongoing. • There were a number of system barriers in place to completing the action on full manager self service so this has been amended. • Work needs to be done on putting job plans in place for optometrists as well as putting in dedicated resource for the optometry and medical side of the plan. • A payroll specialist will be put in place who will be able to identify where the overpayment has occured and other process issues have been established that should reduce the number of payments. • Now that there is more confidence about systems, processes and manager training there will be a focus on accountability for those areas where errors are high as well as a tightening of dispute processes. • There is still a way to go in relation to seeing an improvement in managers effectively managing transactional HR issues, and there are still a number of legacy problems to be managed. • Focus in future will be on trends and late leavers. ***Physical security audit*** • The committee discussed the extent to which the numbers on instances of abuse are taken at face value, noting that the number of patients coming in to the hospital is lower. • However, previous quarter results from June to August 2020 show 100,000 fewer visits in comparison to 2019 with only a minimal difference in the number of reports. • Verbal abuse figures are also similar despite a 50,000 difference in the number of patients seen. These figures relate to verbal abuse, racial abuse and other threatening behaviour.

- There has been a significant increase in the regularity of cases, partly due to Covid restrictions such as only allowing a certain number of patients in at any one time, not allowing relatives, social distancing, queues outside the building, etc.
- Pathways in place are causing issues although they are in place to keep people safe.
- Extra guards have been put on the doors to help protect staff and volunteers.
- A training package is in place for staff in conflict resolution and de-escalation and volunteers will be using this.

Job planning

- The trust is in the process of identifying an SRO that has the requisite level of skills and experience.
- The first round of job plans are now on e-job planning, so we are able to get to a more granular level of detail. Guidance will be produced that sits alongside the policy in order to avoid having to change the policy on a regular basis.
- Business partners in each division are incorporating job planning into reporting and audit, and in particular those job plans in excess of 12 PAs.
- A clear action plan will be developed once the new medical staffing lead is in place.
- The committee was clear that it is important to get as close as possible to 100% of job plans signed off.

Medical records update

- The outsourcing attempt was less than optimal.
- Moves have been made to move towards a paper-lite organisation and make a step change in reducing paper.
- The preparatory work was not done in order to provide a seamless transition from the previous system and to make information available to clinicians.
- A longer piece of work is being done with teams as to how to progress the digital agenda and specify team by team as to how they store their information in the longer term.
- The use of paper notes needs to be phased out over time but the critical point is making sure the new system is better for users than the old system.

Costing audit

- NHSI/E ask that trusts submit individual costs from the previous financial year and oversee a rolling programme of audits.
- Audits are undertaken by an external organisation and all trusts are selected once every three years in order to provide assurance that cost submissions have been prepared in accordance with relevant costing guidance.
- The trust received substantial assurance and an action plan will be developed and submitted by the end of August.
- There was nothing unexpected in terms of the recommendations.

Board assurance framework

- The risk relating to Oriel has been partly mitigated due to the resolution to grant planning decision.
- Although there are still a significant number of risks to the project there is robust governance in place to oversee the key milestones/critical path items.
- Discussion took place over the Brexit risk and it was agreed that it would be useful to separate out risks relating to workforce and supplies, as research funding is already a separate item.
- The underlying deficit was discussed at the finance committee and it will be critical to keep under close review what is likely to happen in H2 and beyond.

	Counter fraud report • A plan has been developed that covers Q2 – 4 and all required activities that will be needed to demonstrate compliance with the new standards and the team that will be delivering the service. • The most significant task is the completion of the fraud and bribery risk assessment. • The team has met with various trust officers and communications, and has already received a referral so lines of communication are open. • Other key areas of focus are finance, estates, IT, procurement as well as the management of maintenance contracts. • In relation to cyber security the hard control environment comes from IT but the team will work on the soft control environment, raising staff awareness, etc. • An update is awaited from the counter fraud authority on the ongoing cases.
Key concerns	• Operational resilience of SBS and response times/accuracy of reporting. • Potential conflict from 19 July when there is an announcement that mask-wearing will be relaxed outside hospitals, need a very clear communication from the top as to what measures will be put in place. • Important to get a clinical lead and medical HR lead in place for job planning as soon as possible to keep momentum going. • Stability of IT in relation to medical records and paper-lite which has already been raised as an issue. • Risk in having sufficient numbers of staff in network sites to handle notes in the temporary period.
Items for discussion outside of committee	• The sign-off process for job plans is an area that needs finalising, with a process that involves services, divisions and executive sign-off. • Risks escalated from the City Road divisional risk register relate to sterile services, the eye bank and pathology, all of which will be reported through to QSC as part of the City Road update next week.
Date of next meeting	• 12 October 2021

Moorfields Eye Hospital NHS Foundation Trust

NHS

Agenda item 12
Report of the people committee
Board of directors 22 July 2021

Report title	Report of the people and culture committee
Report from	Vineet Bhalla, chairman, people and culture committee
Prepared by	Helen Essex, company secretary
Link to strategic objectives	We will have an infrastructure and culture that supports innovation We will attract, retain and develop great people

Brief summary of report

Attached is a brief summary of the people and culture committee meeting that took place on 29 June 2021.

Action Required/Recommendation.

Board is asked to:

- Note the report of the people and culture committee and gain assurance from it.

For Assurance	✓	**For decision**		**For discussion**		**To note**	✓

People & culture committee summary report – 29 June 2021

Governance	• Quorate – Yes • Attendance – 100%
Discussion points	***Workforce strategy*** • The committee discussed the progress of board objectives • 23 priorities were previously agreed at the October board. Four are complete, 14 in progress and five are due to start. • Critical path activity will determine the common risks issues and themes that the committee will discuss. • There are risks in terms of delivery when there are unforeseen events that have an immediate impact such as a pandemic, the accelerator programme with pay and reward work and ICS implications. • Resource has been put in place to fill key posts and the workforce team is in a much better position in terms of strategic capability. • ICS level priorities are likely to impact funding although the trust is not as dependent on the ICS for delivery as other trusts. • The trust will continue to do what is best for MEH and raise the profile of ophthalmology but must to continue to work in a collaborative way. • The agile working project team has looked at the definition of staff and reviewed policies and support changes. • Space has to be used safely and within social distancing guidelines so it is not possible to bring all staff back full time. • There is broad agreement that transformation themes are the right ones and will be aligned with the CIP programme. • Central transformation resource will support the change programmes in the trust. • Digital implementation will include changes to the workforce for digital medicine. • Other key areas of focus will be learning from best practice, consistency of approach, patient experience and learning from diagnostic hub pathways. • Discussion took place on how to make decisions around roles that cut across work streams and how to put appropriate governance in place. • Priorities are coming from the divisions, services as well as central. All views need to align, with inconsistencies escalated for improvement. • An update will be provided at the next meeting on particularly difficult issues and how they will be resolved. • The importance of having cultural conversations with staff and understanding the value of the staff along each pathway was highlighted. • Workforce features in a number of CIP schemes and they are the changes divisions want to make locally. ***Subgroup updates*** **Workforce transformation** • The next meeting will focus on HEE funding and alignment to training needs, infrastructure of CPD and the apprenticeship strategy. **EDHR steering group** • An engagement officer is now in place who focus on ethnic priorities and career progression as well as developing the staff networks and building the work plan for EDI. **Health and wellbeing group** • Strategic objectives have been developed and the strategy drafted. • There is a focus on mental, physical and emotional wellbeing, including the metrics.

	• The strategy links to the national agenda and NHS people plan and will be completed in August. ***Vision statement*** • The purpose is to establish where workforce is trying to get to, alongside the work of the board on the Trust strategy. • Three key themes: 1. Open and values driven culture 2. Being the best place to work 3. Being at our best through getting the basics right • Agreed to make sure that the language is clear and expectations can be met so need to narrow the focus on the key areas of need. • More focus should be given to disability and diversity throughout. • Discussion took place on career progression and how we might let people partner with other organisations. • There was broad support for the areas, but need to sharpen the message and have clear metrics in place to demonstrate progress. ***Education and training prioritisation*** • There has been a large piece of work to build a database on what courses and modules are available that can then be mapped with skill groups. • Customer service and de-escalation training should be a priority. • Need to be clear about where the responsibility sits (i.e. with education or HR) • A CPD (Continuing Professional Development) manager may be required to work with departments and the education system/UCL. • Protected time for learning should be included and link to quality and safety. • A centralised multi professional learning academy/faculty is something that we would aspire to.
Key concerns	• Ongoing alignment and ownership of all cross-organisation initiatives affecting the workforce • Effectiveness of the CPD agenda in the absence of a broader skills based organisation model • Impact of various funding cuts
Discussions outside the committee	• EDI policy to be developed with a focus on inclusion. • Ensuring Quality and Safety of services are maintained during the implementation of workforce strategy
Date of next meeting	• 14 September 2021