Monitor

Making the health sector work for patients

Consultation on updates to the Risk Assessment Framework

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About Monitor

As the sector regulator for health services in England, our job is to make the health sector work better for patients. As well as making sure that independent NHS foundation trusts are well led so that they can deliver quality care on a sustainable basis, we make sure: essential services are maintained if a provider gets into serious difficulties; the NHS payment system promotes quality and efficiency; and patients do not lose out through restrictions on their rights to make choices, through poor purchasing on their behalf, or through inappropriate anti-competitive behaviour by providers or commissioners.

Across all areas of our work Monitor has a duty to enable better integration of services, both in healthcare and between health and social care, where this is in patients' interests. Monitor also seeks to encourage innovation and beneficial change through research and analysis to identify what works and what doesn't, and to stimulate better ways of working.

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Executive summary

In August 2013,[1] we published our 'Risk assessment framework' (RAF) for overseeing NHS foundation trusts under the rules set out in the Health and Social Care Act 2012.[2] The RAF sets out how we assess risk to the continuity of services and the risk of poor governance. The RAF enables us to identify potential concerns, which can lead us to either request further information from a foundation trust or to open an investigation. Further investigation is not automatic and a concern does not necessarily indicate a breach of the NHS Provider Licence.

We have used the RAF to monitor NHS foundation trusts since 1 October 2013. At publication, we said we would review later how the RAF works in practice and would adjust it if needed. We consider now is a suitable time to review the RAF following its first year of use. We are consulting on the following updates:

- introducing access measures for mental health services as proxies of governance
- introducing access and outcome measures for providers of high secure and medium secure mental health services as proxies of governance
- additional triggers for investigating financial risk at a provider to help ensure early identification and intervention for continuity of services risks.

We also intend to:

- rename 'quality governance' indicators 'organisational health' indicators and make their use clearer
- update terminology to take into account changes relating to new policies, such as the Care Quality Commission's (CQC) inspections regime
- make other clarifications, as already highlighted in the Foundation Trust Bulletin (FT Bulletin) in the course of the year (for example, additional exception reporting requirements which foundation trusts should advise Monitor on).

These changes apply only to foundation trusts. The RAF for independent providers was introduced on 1 April 2014 and therefore it is too early to review its operation. The way we monitor independent providers is unchanged at this stage. We intend to review the RAF for independent providers after it has been in operation for one year.

[1] We published in August 2013 in preparation for the framework coming in to effect from 1 October 2013

[2] Appendix C was updated in April 2014. More information can be found at www.gov.uk/government/publications/risk-assessment-framework-raf

The deadline for consultation responses is 5pm on 18 February 2015. To respond to the consultation please complete the survey at https://www.research.net/s/YYFZH35

After considering the feedback we will update and publish a revised RAF in March 2015. **The changes will take effect from 1 April 2015.**

Introduction

Monitor is required by the Health and Social Care Act 2012 to assess risks to the continued provision of NHS services, and publish guidance on action we may take if we identify risks. The RAF sets out how we will carry out these tasks.

We designed the RAF to be consistent with the Regulators' Code[3] and to be patient focused, evidence based, proportionate, transparent and co-operative.

We use the information we gather under the RAF to assess two areas:

- the risk to continuity of services (Continuity of Service licence condition 3)
- non-compliance with the NHS foundation trust governance condition (Foundation Trust licence condition 4).[4]

Monitor is seeking views on proposed updates to the RAF. These updates do not materially affect the information that foundation trusts are required to provide or the actions we will take.

Non-compliance with foundation trust governance condition

We propose:

- introducing access measures for mental health services as proxies of governance
- introducing access and outcome measures for high and medium secure mental health services as proxies of governance
- renaming 'quality governance' indicators 'organisational health' indicators and making their use clearer.

Risk to continuity of services

We propose consulting on additional triggers for investigating financial risk at a provider to help ensure early identification and intervention for continuity of services risks.

Below we have set out the proposed changes in each of these areas, and highlighted specific questions we would like interested parties to consider.

[3] See www.gov.uk/government/uploads/system/uploads/attachment_data/file/300126/14-705-regulators-code.pdf

[4] A copy of the NHS provider licence is at www.gov.uk/government/publications/the-nhs-provider-licence.

Introducing access measures for mental health providers

Assessing NHS foundation trust governance

We use a range of information to assess whether a provider is well led and complies with the NHS foundation trust governance licence condition. This information helps us assign a governance risk rating. We assign a green risk rating to trusts where we have no concerns or that we are not investigating. When we have concerns and are investigating, we replace the green rating with a description of the issues and the steps we are taking to address them. We assign a red rating if we are taking regulatory action.

Performance against national access and outcomes standards forms part of our assessment of governance. We use 20 indicators that cover acute, mental health, community and ambulance providers[5] and that we consider are the best available proxies of governance. Material[6] or ongoing[7] underperformance against any of these indicators could indicate a governance concern and lead to further investigation at a trust.

To date, most national access targets have focused on acute providers and include A&E waiting times, referral-for-treatment waiting times and cancer referral targets. In mental health, the number of indicators that could be used as proxies of governance has been limited by a lack of existing standards. However, the proposed changes we are now consulting on reflect the government's decision to introduce new mental health access standards.

New mental health access measures

In early October 2014 the government announced two new access targets for mental health with a strong commitment to rolling out across the sector in 2015: [8]

- Two-week wait for receiving treatment from the early intervention in psychosis (EIP) programme. Providers will be required to treat 50% of patients within two weeks by April 2016.
- Referral-to-treatment target for Improving Access to Psychological Therapies (IAPT). Providers will be required to see 75% of patients within 6 weeks and 95% of patients within 18 weeks from April 2015.

We consider these access targets for mental health can have a similar function to the access targets we use as proxies for governance at acute providers. Therefore, we propose to introduce them as triggers for governance concerns at mental health

[5] The full list is in Appendix A of the RAF.
[6] That is, significant underperformance compared with the national standard
[7] That is, repeated underperformance across multiple quarters compared with the national standard
[8] See www.gov.uk/government/news/first-ever-nhs-waiting-time-standards-for-mental-health-announced

providers in the RAF. As these measures have only recently been announced there is still further work to be completed by NHS England to enable their rollout, and to ensure that they can be reliably used as regulatory tools without a significant risk of adverse unintended consequences. Therefore, we have looked at different options for introducing these standards into the RAF, on which we are seeking your views.

We will continue to liaise with NHS England throughout the consultation period to understand how their work is progressing on these new access measures and the impact, if any, on the options listed below.

EIP referrals

Mental health providers will be required to treat 50% of patients within two weeks of referral by April 2016. Work is underway at NHS England to determine several factors, including:

- the way in which progress towards the target will be defined and measured in 2015/16
- whether there will be a formal phased trajectory set by NHS England to help providers move towards the April 2016 target (such as setting lower thresholds for earlier achievement, eg 25% by September 2015)
- interim data arrangements for recording and monitoring this indicator in 2015/16 before permanent data is put in place through the Health and Social Care Information Centre for 2016/17.

As work continues in these areas, we have included three options for introducing this indicator to the RAF.

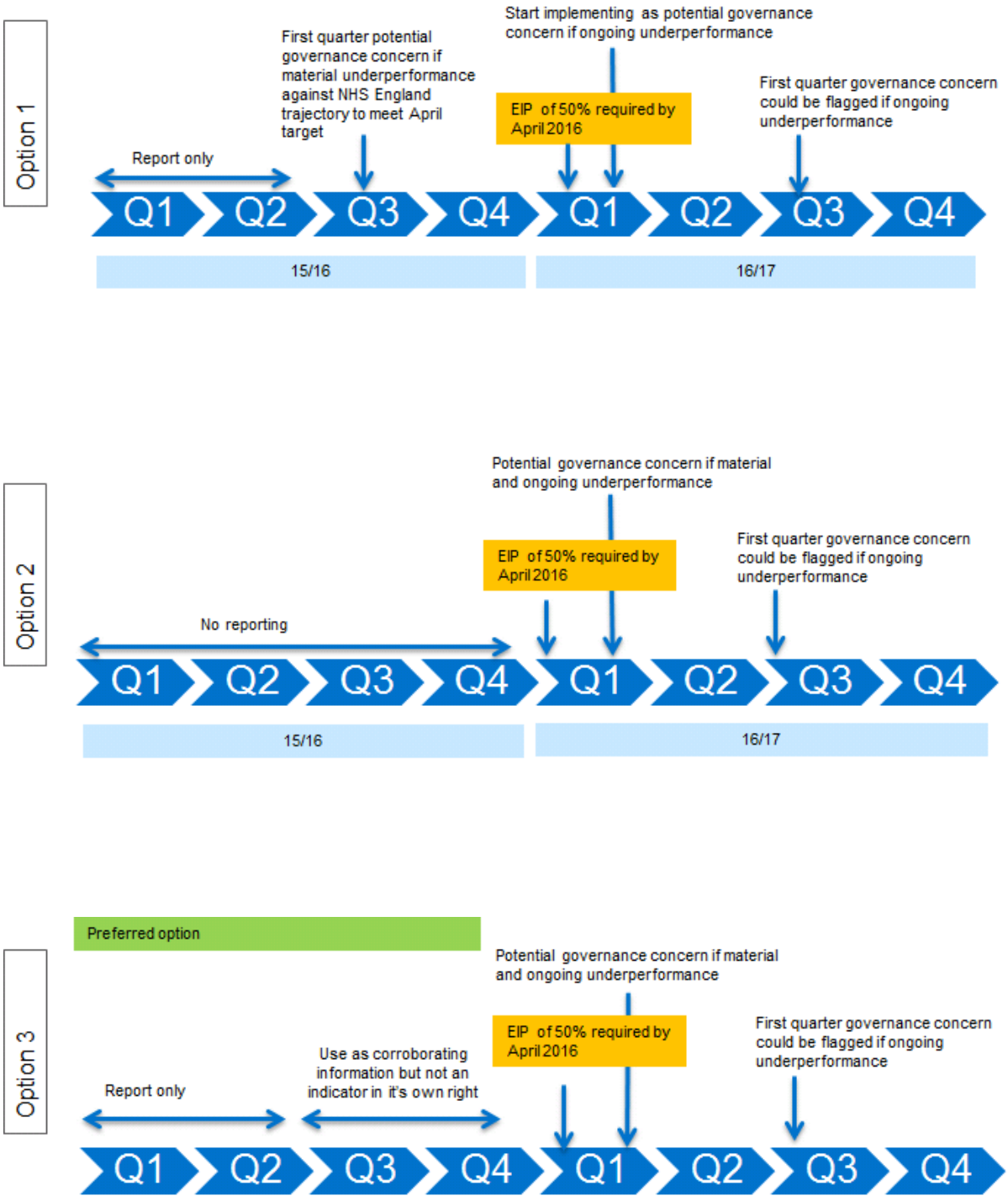
- **Option 1:** Bring the EIP measure into the RAF during 2015/16 ahead of the formal date for 50% achievement. This would be the fastest option and could help to ensure the sector is ready for April 2016. However, it would require NHS England to set a formal phased trajectory for providers to move towards the April 2016 target. It also depends on adequate interim IT arrangements being in place to collect and monitor the data throughout 2015/16 before permanent arrangements are put in place.
    - Quarterly reporting and monitoring to start from 1 April 2015. However, for the first two quarters of 2015/16 we would only collect the information and would not investigate if a provider fails to meet the target.
    - From Q3 2015/16, we could investigate if a provider materially misses the phased target trajectory set by NHS England.
    - Once the requirement is formally in place (from Q1 2016/17), we may investigate if a provider either materially fails to meet the target or

repeatedly misses the target consecutively (eg for three financial quarters in a row). At this point, this would match the approach we currently take with similar measures for acute providers. Q3 2016/17 is therefore the first time we could investigate a provider for failing on an ongoing basis (three quarters in a row).

- **Option 2:** Slowest implementation of the EIP measure into the RAF with no regulatory use of the measure in 2015/16. However, it would not rely on interim IT arrangements, so reduces the risk of data reliability issues.
    - Quarterly reporting and monitoring to start from 1 April 2016.
    - From Q1 2016/17 we would potentially investigate if a provider underperformed against the target on a material or ongoing basis.
    - Q3 2016/17 is therefore the first time we could investigate a provider for failing on an ongoing basis (three quarters in a row).
- **Option 3:** This is an intermediate solution between options 1 and 2. The measure would be used as a formal trigger from April 2016 and would only be considered as a wider corroborating factor during 2015/16.
    - Quarterly reporting and monitoring to start from 1 April 2015. However, for the first two quarters we would only collect the information and would not investigate if a provider fails to meet the target.
    - During Q3 and Q4 2015/16 we would use very poor performance against the standard as a corroborating indicator if there are other governance concerns, but would not investigate based on EIP alone. For this reason, this option does not necessarily depend on NHS England introducing a phased trajectory for the target, although it might be helpful.
    - From Q1 2016/17 we would potentially investigate if a provider underperforms against the target on a material or ongoing basis.
    - Q3 2016/17 is therefore the first time we could investigate a provider for failing on an ongoing basis (three quarters in a row).

Option 3 is our preferred option as it allows the timely introduction of the measure into the RAF but recognises the further work needed to ensure adequate reporting and assurance systems are in place.

Figure 1: How the different EIP options would work in practice



Question 1: Do you agree that we should use the EIP measure as an indicator of potential governance concerns?

Question 2: Do you agree with our proposal to implement option 3?

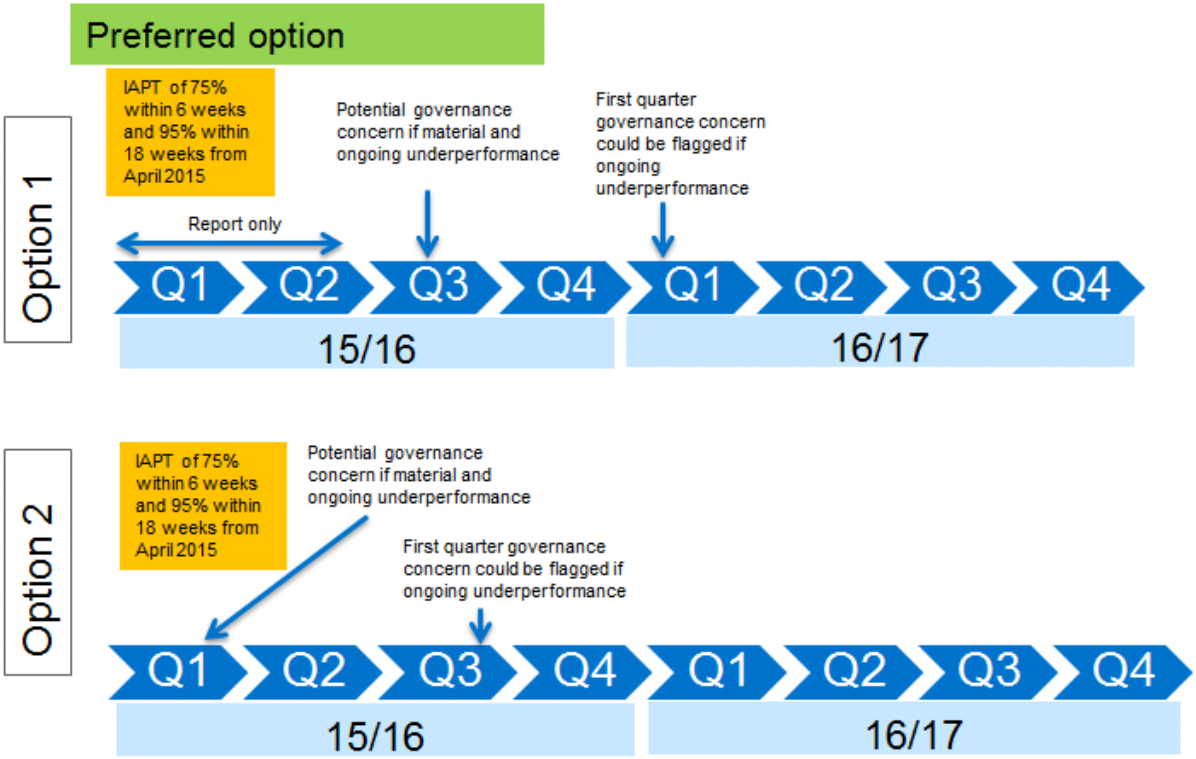
IAPT referrals

Mental health providers will be required to see 75% of patients referred for IAPT treatment within 6 weeks and 95% of patients within 18 weeks from April 2015. NHS England is considering the period for implementation and the systems needed to record and monitor progress against the indicator. However, it is our understanding that the issues are less extensive than for EIP, and the IAPT measures should therefore be introduced into the RAF fairly swiftly. There are two options on which we are seeking views:

- **Option 1:** Allows some time to refine monitoring and reporting before we might investigate a potential breach.
    - Quarterly reporting and monitoring starts from 1 April 2015.
    - From Q3 2015/16, we may investigate a provider if they underperform against the target on a material or ongoing basis.
- **Option 2:** Would be the quickest implementation, but would not allow any time for monitoring issues to be resolved before use as governance trigger.
    - Quarterly reporting and monitoring starts from 1 April 2015.
    - From Q1 2015/16, we may investigate a provider if they underperform against the target on a material or ongoing basis.

Option 1 is our preferred option as it allows the timely introduction of the measure into the RAF but allows a short period of time to ensure the reporting and assurance systems are effective before the indicator is used as a formal trigger for governance concerns.

Figure 2: How the different IAPT options would work in practice.



Question 3: Do you agree we should use the IAPT measure as an indicator of potential governance concerns?

Question 4: Do you agree with our proposal to implement option 1?

Monitoring NHS foundation trusts that provide high secure and medium secure mental health services

Providers of high secure mental health services

In 2013, the Secretary of State for Health agreed that providers of high secure mental health services (HSS) could apply for foundation trust status. There are three providers[9] in England that deliver HSS.

Performance against selected national access and outcomes standards forms part of our assessment of governance risk for foundation trusts. Therefore, in preparation for the potential authorisation of HSS providers we have identified a selection of national metrics that could act as proxies of governance at HSS providers. These indicators were identified during summer 2014 in consultation with the National Oversight Group,[10] a group of stakeholders that provides oversight and assurance of the high secure system.

A new indicator for the RAF should be:

- **provider specific**. While we seek to support the overall NHS system, we regulate individual organisations, and use underperformance to consider regulatory action.
- **well defined**. Our approach needs to be consistent and transparent, so failure must be based on the same clear, well-defined criteria.
- **clear thresholds**. We need a target that performance is compared against to indicate an issue.
- **timely**. Poor performance needs to be reflected in a timely way so that we can consider action as soon as appropriate and proportionate (ie the measure reflects recent performance and there is not a significant time lag between reporting and performance).

The extent to which the potential indicators meet these criteria and are ready to introduce into the RAF varies and only the most suitable indicators will be included. We are therefore consulting on each indicator and seeking sector views on the suitability of our intended next steps.

[9] West London Mental Health NHS Trust (Broadmoor hospital), Nottinghamshire Health and Care NHS Trust (Rampton hospital) and Mersey Care NHS Trust (Ashworth hospital).

[10] The National Oversight Group includes representation from the Department of Health, Welsh Government, Ministry of Justice, National Offenders Management Service, NHS England, NHS commissioners, high secure services providers and other experts.

Proposed indicators for consultation

- **Maintain HSS bed occupancy at or below 93%**. This could be a suitable governance proxy because it indicates the provider's ability to manage capacity and resources. It is reported by HSS providers quarterly, although there is no penalty or reward if the target is missed or met.

- **Percentage of patients not having a full health check every 12 months**. This could be a suitable governance proxy because it is linked to overall patient care management at the provider. Patients are required to have health checks as part of the standard contract and this measure is reported quarterly to NHS England. Providers should achieve 0% and exceptions must be reported to NHS England. Work is ongoing to determine the minimum standards that would define a full health check. For these reasons, rather than asking providers to report on this measure quarterly, we could ask providers to exception report against this measure where 0% is not met.

- **Health check assessment not carried out within 24 hours of admission to HSS**. This measure is also linked to the overall patient care management so it could be a useful governance proxy. Patients are required to have health checks as part of the standard contract and this measure is reported quarterly to NHS England and providers should achieve 0%. As with the health checks above, work is ongoing to agree the scope of the health assessments. For these reasons, rather than asking providers to report on this measure quarterly, we could ask providers to exception report against this measure where 0% is not met.

Questions 5, 6 and 7: For each proposal we want to know your views on whether we should include this measure as a proxy for governance for HSS providers. What are your views of the pros and cons of including each option in the RAF?

We have also considered whether the proportion of patients admitted to HSS within 14 days of eligibility could be an effective proxy of governance concerns. Our understanding is there is not a defined national target; however, providers do report against this and consider that it could be a good proxy for governance concerns.

Question 8: Should we include the proportion of patients admitted to HSS within 14 days of eligibility as an indicator now? What are your views on this indicator as a governance proxy in the future?

We can also investigate a trust when third-party reports or complaints suggest a governance concern. As the National Oversight Group has an oversight and assurance role for high secure services, we consider it appropriate to add the group as an example of a third-party reporter, who may provide exception reports or information that could trigger a governance concern.

Question 9: Should we include the National Oversight Group as an example third-party reporter?

Question 10: Are there any other suitable indicators for HSS that meet our criteria and could be effective governance proxies?

Monitoring providers of medium secure services

Providers of medium secure services (MSS) can already be authorised as foundation trusts; currently 17 foundation trusts deliver medium secure services. As we are introducing a number of new indicators for HSS, to ensure consistency and proportionate treatment across providers we have also considered whether the same indicators are applicable to MSS providers. Of the indicators highlighted above for HSS, the following indicator could also be applied to MSS:

- percentage of patients having a full health check every 12 months.

Question 11: What are your views of including the above indicator for MSS services as well as HSS?

We have not currently identified any additional robust capacity or access-related indicators that could be used as governance proxies and that are provider specific, well-defined, timely and have clear thresholds. Therefore, we welcome any suggestions of indicators for medium secure providers that could be considered a good proxy of governance and are related to access or capacity management and meet these criteria.

Question 12: Do you agree with the principle of introducing additional access and outcomes measures for MSS to ensure they are treated proportionally with HSS?

Question 13: Are there any other suitable indicators for MSS that meet our criteria and could be used to identify potential governance concerns?

Clarifications to the quality governance indicators

We use the RAF to assess whether a trust's governance meets the standards expected in the governance conditions of their licence. Where there is evidence that a foundation trust is failing to meet the requirements of the licence condition we may investigate to determine if there has been a breach of the governance licence condition. We use a governance risk rating to describe our views of a trust and the risk of potential breach of the licence condition. This rating is based on information from several areas. The current RAF sets out the categories that can be indicators of governance concerns:

- CQC judgements of the quality of care provided

- performance against selected national access and outcomes targets that are considered good proxies of governance
- information and reports from third parties
- selection of quality governance indicators
- degree of risk to continuity of services or other aspects of financial governance.

Table 1 sets out examples of the principal quality governance indicators that we look at.

Table 1: Quality governance indicators (or organisational health indicators)
Patient metrics • patient satisfaction
Staff metrics • high executive turnover • staff satisfaction • sickness/absence rate • proportion of temporary staff • staff turnover
Aggressive cost reduction plans

We consider these indicators can be more helpfully described as **'organisational health indicators'** because more of them are more representative of how an organisation is managed, rather than specifically attributable to quality governance. In addition, there is occasionally confusion between our Quality Governance Framework[11] and the quality governance indicators in the RAF; changing the name would resolve any potential confusion.

We also think it would be helpful to make clear how we use these indicators when considering whether or not there is a governance concern at a trust.

We are unlikely to take regulatory action based on performance against these indicators alone. There are three ways in which we tend to use these organisational health indicators:

i. **During monitoring** – to be considered in conjunction with other governance concerns (such as ongoing breaches of a trust's referral to treatment, cancer or A&E targets) and therefore may be used as a corroborating factor.

[11] More information about Monitor's quality governance framework can be found here.

ii. **During an investigation** – to help to start to diagnose causes of poor performance (including culture).

iii. **During an investigation or once a trust has been found to be in breach of their licence** – to help assess our level of confidence in a trust's ability to turn around performance.

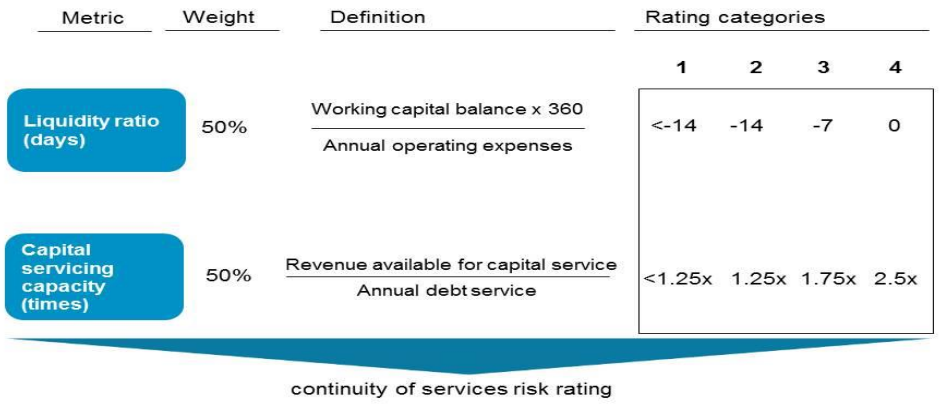
Additions to the financial risk rating

Calculating continuity of services risk

We use a continuity of services risk rating to assess financial risk at providers of commissioner requested services. The continuity of services risk rating incorporates two common measures of financial robustness:

- **liquidity:** days of operating costs held in cash or cash equivalent forms included wholly committed lines of credit available for drawdown
- **capital servicing capacity:** the degree to which the organisation's generated income covers its financing obligation.

Figure 3: How the continuity of services risk rating is calculated



We consider launching an investigation when a trust has a continuity of services rating of 1 or 2.

The information we collect on continuity of services is monitored and assessed regularly and by exception. Each year we use a provider's submitted plans to calculate the continuity of services risk rating quarterly over the coming years. During the year, providers report actual performance quarterly and we compare the projected continuity of services risk rating with actual financial performance and update the rating as necessary. We can also assess the impact of ad hoc or

exception events that could have a material impact on the financial impact of a provider.[12]

Potential changes to how we assess continuity of services risk

There is significant financial pressure on foundation trusts and there are an increasing number of providers that may be at risk of breaching the continuity of services requirements now and in the near future. At times, it may be appropriate for Monitor to investigate a potential issue earlier, especially where earlier intervention could prevent further deterioration or help resolve issues more easily.

Introducing an additional trigger for identifying financial concerns at a trust

As the overall continuity of service risk rating is weighted equally between liquidity and capital servicing capacity, a strong rating on one measure could mask a significant risk in the other. We may not be able to investigate despite there being a clear indication of forthcoming financial issues that may risk the future continuity of services. Therefore, we propose introducing an override mechanism that will allow us to investigate where a trust's liquidity *or* capital service capacity represents a significant financial risk. Currently, where a trust has a liquidity risk rating of 4 and a capital servicing capacity of 1, so its overall continuity of service risk rating is 3, we may ask for additional information on a monthly basis, but we are unlikely to investigate the trust unless the continuity of service risk rating dropped to 2. However, under the proposed changes, a trust with a capital servicing capacity or liquidity rating of 1 would be considered a material financial risk in its own right and could trigger an investigation, even if the trust's overall risk rating were 3.

As with all other triggers for investigation in the RAF, this trigger would highlight a concern we may wish to investigate, it does not mean we will automatically investigate or take regulatory action. In each case, we consider the licence holder's circumstances and the context of the possible breaches before investigating if a breach has occurred.

Question 14: Do you see any significant downsides or do you object to the introduction of a trigger for investigation where a trust has the highest risk rating of 1 on either liquidity or capital service ratio (regardless of overall continuity of service rating)?

The RAF currently states that we can act on the basis of current and prospective continuity of service risk at a provider. Prospective risk is based on the information provided in a trust's forward plan. The RAF also allows us to subject a licence

[12] Further information on how we calculate the continuity risk rating can be found in Chapter 3 of the 'Risk assessment framework'.

holder's forward plan to a detailed stage of analysis and scrutiny before publishing their risk ratings.

The quality of submitted forward plans can vary substantially, so we have been working with the sector to help build capability in forward planning.[13] Poorer quality plans are less likely to adequately reflect the potential future risk to continuity of services at a provider and could mask financial concerns that may have led us to investigate sooner. Therefore, to help address this issue, we propose to update the RAF to clarify that the detailed analysis of a trust's forward plan could, for example, include testing the forward plans against different scenarios and assumptions (ie stress testing plans) and that where the quality of a trust's overall forward plan is considered poor after stress testing, we may investigate.

Question 15: Do you have any comments you would like us to take into account regarding the stress testing of plans?

Other clarifications

During the course of the year, we have published clarifications on sections of the RAF in our monthly FT Bulletin.[14] We intend to include these clarifications in this update of the RAF. We also intend to update the RAF to take into account changes that have happened with respect to various policies that have been updated during the year, for example the introduction of the new CQC inspection regime, the well-led framework, and mergers and acquisitions policies. These clarifications are generally minor wording changes and updates to how we present the RAF, to bring it up to date with current policies and terminology.

Under the governance condition we also intend to update the wording of the RAF to make it clearer that we can investigate material as well as ongoing underperformance against national outcome and access targets.

Question 16: Are there any other updates or clarifications that you consider are necessary to the RAF? If so, please outline why you think the changes are necessary. Please provide supporting evidence for the proposed change where possible.

[13] We recently published a strategy development toolkit to support all NHS providers in developing clear and well thought-out strategies. Please see: www.gov.uk/government/publications/strategy-development-a-toolkit-for-nhs-providers.
[14] Please see the full list of FT Bulletin publications at the Monitor website: www.gov.uk/government/collections/nhs-foundation-trusts-correspondence-from-monitor

Responding to the consultation and next steps

How to respond to the consultation

We ask all interested parties and stakeholders to respond to the consultation by **5pm on 18 February 2015.** To respond to the consultation please use the following link: https://www.research.net/s/YYFZH35

Question 1: Do you agree that we should use the EIP measure as an indicator of potential governance concerns?

Question 2: Do you agree with our proposal to implement option 3?

Question 3: Do you agree we should use the IAPT measure as an indicator of potential governance concerns?

Question 4: Do you agree with our proposal to implement option 1?

Questions 5: Should we include maintaining bed occupancy at or below 93% as a proxy for governance for HSS providers? What are your views of the pros and cons of including this option in the RAF?

Question 6: Should we include the percentage of patients not having a full health check every 12 months as a proxy for governance for HSS providers? What are your views of the pros and cons of including this option in the RAF?

Question 7: Should we include the percentage of patients not having a full health within 24 hours as a proxy for governance for HSS providers? What are your views of the pros and cons of including this option in the RAF?

Question 8: Should we include the proportion of patients admitted to HSS within 14 days of eligibility as an indicator now? What are you views on this indicator as a governance proxy in the future?

Question 9: Should we include the National Oversight Group as an example third-party reporter?

Question 10: Are there any other suitable indicators for HSS that meet our criteria and could be effective governance proxies?

Question 11: What are your views of including the above indicator for MSS services as well as HSS?

Question 12: Do you agree with the principle of introducing additional access and outcomes measures for MSS to ensure they are treated proportionally with HSS.

Question 13: Are there any other suitable indicators for MSS that meet our criteria and could be used to identify potential governance concerns?

Question 14: Do you see any significant downsides or do you object to the introduction of a trigger for investigation where a trust has the highest risk rating of 1 on either liquidity or capital service ratio (regardless of overall continuity of services rating)?

Question 15: Do you have any comments you would like us to take into account regarding the stress testing of plans?

Question 16: Are there any other updates or clarifications that you consider are necessary to the RAF? If so, please outline why you think the changes are necessary. Please provide supporting evidence for the proposed change where possible.

If you have trouble accessing the survey link above please email RAF@monitor.gov.uk.

Confidentiality

You can request to keep your name and/or organisation confidential and excluded from the published summary of responses on the online form. If you send your response by email or post, please do not forget to tell us if you wish your or your organisation's name to be withheld from any published documents.

If you would like any part of the content of your response (instead of or as well as your identity) to be kept confidential, please let us know and make it obvious by marking in your response which parts we should keep confidential. We will do our best to meet your request, but because we are a public body subject to freedom of information legislation we cannot guarantee that we will not be obliged to release your response even if you say it is confidential.

Next steps

After considering the feedback provided through this consultation we will update and publish the revised RAF in March 2015. **The changes will take effect from 1 April 2015.** If the updates require changes to the annual planning review templates or the quarterly reporting templates we will issue an update to each as appropriate and notify trusts of the changes as soon as feasible.

Monitor

Making the health sector work for patients

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