Monitor
Making the health sector work for patients

Wellington House
133-155 Waterloo Road
London SE1 8UG

T: 020 3747 0000
E: enquiries@monitor.gov.uk
W: www.monitor.gov.uk

2 December 2015

[redacted]

By email
[redacted]

Dear [redacted]

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

I refer to your email of 4 November 2015 in which you requested information under the FOI Act.

Your request

You made the following request:

I would like to see copies of the minutes, agenda and papers submitted to the last three meetings of Monitor's Clinical Advisory Forum.

Decision

Monitor holds some of the information that you have requested.

Monitor holds copies of the minutes, agenda and papers submitted to the previous two meetings of Monitor's Clinical Advisory Forum that took place prior to the date of your FOI request.

Monitor has decided to withhold some of the information that it holds on the basis of the applicability of the exemptions in sections 40 and 41 of the FOI Act as explained in detail below.

The attached Annex sets out the details of the relevant information that we hold and whether that information is to be disclosed (in whole or in part) or withheld from disclosure. Where information is being withheld, we have identified in the Annex those exemptions which we consider to be relevant, being one or more of sections 40 and 41 of the FOI Act.

Where we are able to disclose information to you, it will be provided to you electronically as identified by the document number in the Annex. The application of exemptions to the information referred to in the Annex is explained in the following paragraphs.

Reasons for decision

Section 40 – Personal information

Under section 40 of the FOI Act, information is protected from disclosure if it is personal data protected under the Data Protection Act 1998 ("the DPA"). Section 40(7) of the FOI Act provides that the relevant definition of personal data is that set out at section 1(1) of the DPA:

> *"personal data" means data which relate to a living individual who can be identified-*
>
> *(a) from those data, or*
>
> *(b) from those data, and other information which is in the possession of, or is likely to come into the possession of, the data controller,*
>
> *and includes any expression of opinion about the individual and any indication of the intentions of the data controller or any other person in respect of the individual.*

Some of the information in the documents is being withheld from disclosure under section 40(2) of the FOI Act on the grounds that it amounts to personal data and that the condition set out in section 40(3) is satisfied, namely that disclosure would amount to a breach of the data protection principles. This includes the names and contact details of junior and/or inward facing staff at Monitor, who have a reasonable expectation that their details would not be disclosed. This exemption is an absolute exemption and consideration of the public interest in disclosure is not required.

Section 41 – Information provided in confidence

Item 6 of the meeting held on 4 September 2015 includes a number of presentations that are exempt from disclosure under section 41 of the FOI Act as they contain information provided in confidence to Monitor. The section 41 exemption applies to information obtained from another person where its disclosure would give rise to an actionable breach of confidence. A breach of confidence will be actionable if a legal person is able to bring an action for the breach of confidence to court and the action is likely to succeed.

These presentations on agency and locum staffing have the necessary quality of confidence given that the information they contain is not readily available and is not trivial. These presentations were provided in circumstances giving rise to an obligation of confidence. We consider that the members of the Clinical Advisory Forum who gave these presentations would have a reasonable expectation that the information, views and data in them would remain private and would only be used by Monitor for the purposes of its regulatory activity. These presentations contain confidential information about the individual trusts to which they relate. We believe that disclosure of this information would constitute a breach of confidence actionable by those trusts.

Section 41 is an absolute exemption, so the application of the public interest test pursuant to section 2(2) of the FOI Act is not required. However, when determining whether an action for breach of confidence would be likely to succeed it is necessary to consider whether the public interest in favour of disclosure outweighs the interest in withholding the information. Where a duty of confidence exists there is a strong public interest in favour of maintaining

that confidence. Further, in order for the Clinical Advisory Forum to fulfil its role in advising Monitor it is important for the members of the Forum to be able to have free and frank discussions on clinical issues. It is our view that by disclosing the information provided to the Clinical Advisory Forum this may inhibit future provision of information to the Forum, which in turn would prevent the Forum from fulfilling its role in advising Monitor.

Having considered the material in respect of which this exemption would apply and given due weight to the relevant factors, we have concluded that the public interest is best served by withholding this information in this case.

Review rights

If you consider that your request for information has not been properly handled or if you are otherwise dissatisfied with the outcome of your request, you can try to resolve this informally with the person who dealt with your request. If you remain dissatisfied, you may seek an internal review within Monitor of the issue or the decision. A senior member of Monitor's staff, who has not previously been involved with your request, will undertake that review.

If you are dissatisfied with the outcome of any internal review conducted by Monitor, you may complain to the Information Commissioner for a decision on whether your request for information has been dealt with in accordance with the FOI Act.

A request for an internal review should be submitted in writing to FOI Request Reviews, Monitor, Wellington House, 133-155 Waterloo Road, London SE1 8UG or by email to foi@monitor.gov.uk.

Please note that this letter and the attached information will shortly be published on our website. This is because information disclosed in accordance with the FOI Act 2000 is disclosed to the public at large. We will, of course, remove your personal information (e.g. your name and contact details) from the version of the letter published on our website to protect your personal information from general disclosure.

Yours sincerely,

Stanley Silverman
Deputy Medical Director

ANNEX

No.	Document description	Decision	FOI Act exemption(s)
Meeting of the Clinical Advisory Forum held on 3 July 2015			
1	Agenda	Disclose	
2	Minutes	Disclose in part	40
3	Terms of Reference	Disclose	
4	Clinical Advisory Forum Launch Day Presentation	Disclose	
Meeting of the Clinical Advisory Forum held on 4 September 2015			
5	Agenda	Disclose in part	40
6	Minutes	Disclose in part	40
7	Item 4 Accident and Emergency Report	Disclose	
8	Item 6 Agency/Locum Staffing ("Agency and Workforce") Presentation	Disclose	
9	Locum Medical Staffing: Challenges and solutions in the real world (Heart of England NHS Foundation Trust)	Withhold	41
10	Nurse staffing: Managing supply and agency spend (King's College Hospital NHS Foundation Trust)	Withhold	41
11	Medical locums in Morecambe Bay (University Hospitals of Morecambe Bay NHS Foundation Trust)	Withhold	41
12	Why has Medical Agency Spend increased in the NHS? (Cabinet Office Implementation Unit)	Withhold	41
13	Agency/Bank staffing within STHFT (Sheffield Teaching Hospitals NHS Foundation Trust	Withhold	41

Monitor
Making the health sector work for patients

MEETING OF THE CLINICAL ADVISORY FORUM
FRIDAY 3 JULY 2015 at 1.00pm

BLACKWELL, WELLINGTON HOUSE, 133-155 WATERLOO ROAD LONDON SE1 8UG

AGENDA

1.	1.00	**Welcome and Apologies**		(oral item)
2.		**Declarations of Interest**		(oral item)
3.	1.05	**Clinical Advisory Forum - Terms of Reference** (attached)	Board Secretariat	CAF/15/01
4.	1.10	**Monitor's approach to clinical sustainability** (attached)	Hugo Mascie-Taylor, Stanley Silverman	(to be tabled)
5.	2.20	**Any other business**		
6.	2.30	**Close**		

The meeting will be preceded by an Induction (10.30-1.00) presented in the following order:

- *Welcome and introductions*
- *Role of the Clinical Advisory Forum*
- *Introduction to Linkedin network*
- *Lunch*

MINUTES OF A MEETING OF THE CLINICAL ADVISORY FORUM HELD ON 3 JULY 2015 AT 1.00 PM AT WELLINGTON HOUSE, 133-155 WATERLOO ROAD, LONDON SE1 8UG

Present:

Hugo Mascie-Taylor (Chair), Monitor (until item 4)
Ian Abbs, Medical Director, Guy's & St Thomas' NHS FT
Jag Ahluwalia, Medical Director, Cambridge University Hospitals NHS FT
Joy Akehurst, Director of Nursing & Quality, City Hospitals Sunderland NHS FT
Jackie Bird, Executive Director of Nursing & Quality, The Christie NHS FT
Andrew Catto, Executive Medical Director, Heart of England NHS FT
Hilary Chapman, Chief Nurse, Sheffield Teaching Hospitals NHS FT
Ruth Holt, Director of Nursing, South Tees Hospitals NHS FT
Peter Maskell, Medical Director, Kent Community Health NHS FT
Ruth May, Nurse Director (Monitor)
Tim Ojo, Executive Medical Director, Sussex Partnership NHS FT
Sean O'Kelly, Medical Director, University Hospitals Bristol NHS FT
Stephen Powis, Medical Director, Stephen Powis, Royal Free London NHS FT
Josie Rudman, Director of Nursing, Papworth Hospital NHS FT
Oliver Shanley Director of Quality & Safety, Hertfordshire Partnership NHS FT
Stanley Silverman, Deputy Medical Director (Monitor) (in the Chair from item 4)
Jane Viner, Director of Professional Practice, Nursing and People's Experience, South Devon Healthcare NHS FT
David Walker, Medical Director, University Hospitals of Morecambe Bay NHS FT
Geraldine Walters, Director of Nursing, Midwifery & Infection Control, King's College Hospital NHS FT

In attendance:

[redacted] Clinical Engagement Lead (Monitor)
[redacted] Governance Manager (Monitor)

Executive officers attended the meeting as detailed under specific agenda items below.

1. **Welcome and apologies**

1.1 Apologies for absence had been received from Andy Brogan (Executive Director of Clinical Governance & Quality, South Essex Partnership University NHS Foundation Trust) and David Evans (Medical Director, Northumbria Healthcare NHS Foundation Trust).

2. **Declarations of interest**

2.1 No interests were declared.

3. **Clinical Advisory Forum – Terms of Reference (CAF/15/01)**

3.1 The Clinical Advisory Forum (CAF) noted the proposed Terms of Reference. The Chair invited the members to consider these further outside the meeting and circulate their comments ahead of the next meeting of CAF in September 2015.

4. **Monitor's approach to clinical sustainability**

i.) Part 1

4.1 The Nurse Director (Monitor) asked CAF members for their views on how to best inform Monitor's Patient and Clinical Engagement Directorate's work in relation to agency nurse staffing. CAF members welcomed Monitor's initiative and emphasised the value of the proposed work.

4.2 With regard to nurse staffing, CAF members identified a number of issues that could be addressed through Monitor's work. These included the use of agency staffing and workforce planning at national level. Consideration was given to the culture of working as a full time agency nurse and its impact on the resource implications on NHS foundation trusts (NHSFTs). The impact of medical shortfalls on workforce planning was noted. The need for trusts to develop long term workforce planning strategies was considered. The potential implications of poor workforce planning on quality and finances at NHSFTs was noted. The need to develop new models of care to address issues in relation to poor quality of care and staffing levels in community care was emphasised. The role of CAF in informing the debate on agency staffing at national level was noted.

4.3 With reference to agency staffing, consideration was given to the underlying causes of the increasing use of temporary staff at NHSFTs in the context of a post-Francis (Public Inquiry) rise in demand following safe staffing initiatives. The roles and responsibilities of the commissioners and NHSFTs in helping the sector reduce its agency spend were discussed. The guidelines published by the National Institute for Health and Care Excellence on safe staffing for nursing in adult inpatient wards in acute hospitals was noted. Monitor's ongoing work with NHS Trust Development Authority to help tackle the issues of concern at national level was considered. The challenges faced by local health economies (LHE) where hospital services were topped up by stealth rather than designs were discussed. The need for Monitor to develop an integrated risk assessment function to address such issues was emphasised. The advantages and disadvantages of implementing reconfigurations in the interests of patients were discussed in this context. The benefits anticipated from Monitor's regulatory role in relation to system leadership were discussed. CAF members noted the value of supporting the front line at NHSFTs and emphasised the need to develop guidance to provide support to nurses.

ACTION: RM

ii.) Part 2

4.4 Stanley Silverman (Deputy Medical Director (Monitor)) introduced the presentation which set out CAF's role, how it could work in practice and Monitor's approach to clinical sustainability. Monitor's role in relation to system leadership and sustainability was considered. The significance of Monitor's interventions on commissioners and their potential impact on LHE was emphasised. The use of regulatory frameworks was noted.

5. Any other business

5.1 There was no other business.

Close

To: Clinical Advisory Forum

For meeting on: 3 July 2015

Agenda item: 3

Report by: [redacted] Governance Manager

Report on: Clinical Advisory Forum Terms of Reference

Summary:

As this is the first formal meeting of the Clinical Advisory Forum (CAF), this report presents the Committee with its Terms of Reference

Recommendations:

The CAF is recommended to adopt the proposed Terms of Reference attached as an Annex to this paper.

Public Sector Equality Duty:

Monitor has a duty under the Equality Act 2010 to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations between people from different groups. In relation to the issues set out in this paper, consideration has been given to the impact that the recommendations might have on these requirements and on the nine protected groups identified by the Act (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, gender and sexual orientation).

This report is not likely to have any particular impact upon the requirements of or the protected groups identified by the Equality Act.

Exempt information:

None of this report is exempt under the Freedom of Information Act 2000.

BACKGROUND

Role of CAF

1. CAF should provide independent senior clinical input to the work of the Patient and Clinical Engagement (PCE) Directorate. It will form an important component of Monitor's patient and clinical engagement strategies, helping to inform:

    - a better understanding of the clinical impact of Monitor's work;
    - the appropriate use of the regulatory levers available to Monitor; and
    - delivery of Monitor's wider strategic objectives[1].

CAF Proposed Membership and Attendees

2. The Committee shall be made up of:

    - Medical Director and Executive Director of Patient & Clinical Engagement Hugo Mascie-Taylor (Chair), Monitor
    - Medical Director, Ian Abbs, Guy's & St Thomas' NHS FT
    - Medical Director, Jag Ahluwalia, Cambridge University Hospitals NHS FT
    - Executive Medical Director, Andrew Catto, Heart of England NHS FT
    - Medical Director, Peter Maskell, Kent Community Health NHS FT
    - Executive Medical Director, Tim Ojo, Sussex Partnership NHS FT
    - Medical Director, Sean O'Kelly, University Hospitals Bristol NHS FT
    - Medical Director, Stephen Powis, Royal Free London NHS FT
    - Medical Director, David Walker, University Hospitals of Morecambe Bay NHS FT
    - Director of Nursing & Quality, Joy Akehurst, City Hospitals Sunderland NHS FT
    - Executive Director of Nursing & Quality, Jackie Bird, The Christie NHS FT
    - Executive Director of Clinical Governance & Quality, Andy Brogan, South Essex Partnership University NHS FT
    - Chief Nurse, Hilary Chapman, Sheffield Teaching Hospitals NHS FT
    - Director of Nursing, Ruth Holt, South Tees Hospitals NHS FT
    - Director of Nursing, Josie Rudman, Papworth Hospital NHS FT
    - Director of Quality & Safety, Oliver Shanley, Hertfordshire Partnership NHS FT
    - Director of Professional Practice, Nursing and People's Experience, Jane Viner, South Devon Healthcare NHS FT

[1] Making sure public providers are well led; making sure essential NHS services are maintained; making sure the NHS payment system promotes quality and efficiency; making sure procurement, choice and competition operate in the best interests of patients; promoting change through high quality analysis and debate, and by encouraging innovation; making sure Monitor is a high performing organisation.

- Director of Nursing, Midwifery & Infection Control, Geraldine Walters, King's College Hospital NHS FT

3. The following officers will be in attendance at CAF meetings:

    - Deputy Medical Director (Monitor);
    - Director of Nursing (Monitor); and
    - Board Secretariat (Monitor)

Reporting to Monitor's Executive Commttees

4. The Medical Director and Executive Director of Patient & Clinical Engagement will be responsible for the information provided to Monitor's Executive committees on the activities of the CAF.

Conclusion

5. CAF members are asked for any comments that they might have on this report and the Committee's Terms of Reference (attached here as an Annex to this paper)

Monitor
Making the health sector work for patients

CLINICAL ADVISORY FORUM TERMS OF REFERENCE

1. Purpose

1.1. The Clinical Advisory Forum (CAF) exists to provide independent senior clinical input to the work of the Patient and Clinical Engagement (PCE) Directorate. It will form an important component of Monitor's patient and clinical engagement strategies, helping to inform:

- a better understanding of the clinical impact of Monitor's work;
- the appropriate use of the regulatory levers available to Monitor; and
- delivery of Monitor's wider strategic objectives[2].

2. Membership

2.1. The CAF shall comprise up to 19 members. The Medical Director (Executive Director of Patient and Clinical Engagement) shall act as the Chair of the CAF. In his absence the Deputy Medical Director or Nurse Director shall act as Chair.

2.2. The membership of the CAF will consist of up to nine medical directors and nine chief nurses of NHS foundation trusts (NHSFTs). Members of the CAF shall be appointed by the Chair of the CAF following an open invitation for applications. Representatives from a broad cross-section of trusts will be sought including acute, mental health, community and ambulance trusts. Whilst members of the CAF are appointed as individuals in their own right and not as representatives of their employer or professional body, when a member ceases to be a board member of an NHSFT trust their membership of the CAF will also cease.

2.3. Appointments to the CAF shall usually be for a period of up to three years and are unlikely to be extended for further periods.

2.4. Only members of the CAF have the right to attend CAF meetings. Other individuals may be invited by the Chair of the CAF to attend all or part of any meeting as and when appropriate and necessary.

[2] Making sure public providers are well led; making sure essential NHS services are maintained; making sure the NHS payment system promotes quality and efficiency; making sure procurement, choice and competition operate in the best interests of patients; promoting change through high quality analysis and debate, and by encouraging innovation; making sure Monitor is a high performing organisation.

3. Secretary

3.1. A member of the Board Secretariat shall act as the secretary to the CAF.

4. Frequency of Meetings

4.1. The CAF shall meet every two months, according to business requirements.

5. Notice of Meetings

5.1. Meetings of the CAF, other than those regularly scheduled as above, shall be summoned by the secretary of the CAF at the request of the Chair. Due regard will be given to notice periods required by those clinicians who still have clinical commitments.

5.2. Unless otherwise agreed, notice of each meeting confirming the venue, time and date together with an agenda of items to be discussed and any supporting papers, shall be circulated to each member of the CAF and any other person required to attend, no later than five working days before the date of the meeting.

6. Conduct of Meetings

6.1. Except as outlined above, meetings for the CAF shall be conducted in accordance with the provisions of Monitor's Rules of Procedure.

7. Minutes of Meetings

7.1. The secretary shall minute the proceedings of all meetings of the CAF, including recording the names of those present and in attendance.

7.2. Draft minutes of meetings shall be circulated promptly to all members of the CAF and, once agreed, made available to all members of Monitor's Executive Committee.

8. Duties

8.1. The primary role of the CAF will be to act as a critical friend to the PCE Directorate and, in particular, to inform, challenge and review:

8.1.1. The ongoing development of Monitor's patient and clinical engagement strategies;

8.1.2. The delivery of the PCE Directorate's work programme and the advisory activities it undertakes;

8.1.3. The clinical impact of Monitor's work.

8.2. Members will provide advice on Monitor's work as required. Appendix 1 provides an overview of the type of work that the forum may be involved in.

8.3. Members may be asked individually for advice related to their area of expertise, or may be asked to form a collective view on a more general area.

8.4. A sub-group of CAF members may be formed to advise on a particular case or project.

9. Other matters

9.1. The CAF shall:

9.1.1. Have access to sufficient resources including co-option in order to carry out its duties, including access to the Board Secretary for assistance as required;

9.1.2. Be provided with appropriate and timely training, both in the form of an induction programme for new members and on an ongoing basis for all members.

July 2015

Appendix 1 – Types of work

The following list provides some examples of the type of work that forum members may be asked to advise on.

1. *Making sure public providers are well-led*
   - Monitor's Risk Assessment Framework and other aspects of the regulatory regime
   - Development and other support available to FTs

2. *Making sure essential services are maintained*
   - Contingency planning
   - Whole health economy approaches

3. *Making sure the NHS payment system promotes quality and efficiency*
   - Long-term pricing strategy and associated research, development and evaluation projects

4. *Making sure procurement, choice and competition operate in the best interests of patients*
   - Parties benefit cases (mergers)
   - Clinical and service aspects of conduct cases (provider and commissioner)
   - Clinical and service aspects of market investigation references and reviews

5. *Promoting change through high quality analysis and debate, and encouraging innovation*
   - Initiatives/ studies e.g. design and implementation of new models of care

Monitor

Making the health sector work for patients

Clinical Advisory Forum Launch Day

July 2015

GOV.UK/monitor

Welcome and thank you!

Purpose of today:

- To get to know each other
- To discuss to role of the Clinical Advisory Forum and how it might work in practice
- To discuss a live issue for the Monitor team

Why does Monitor need more clinical input?

Support better decisions

Improve regulatory effectiveness

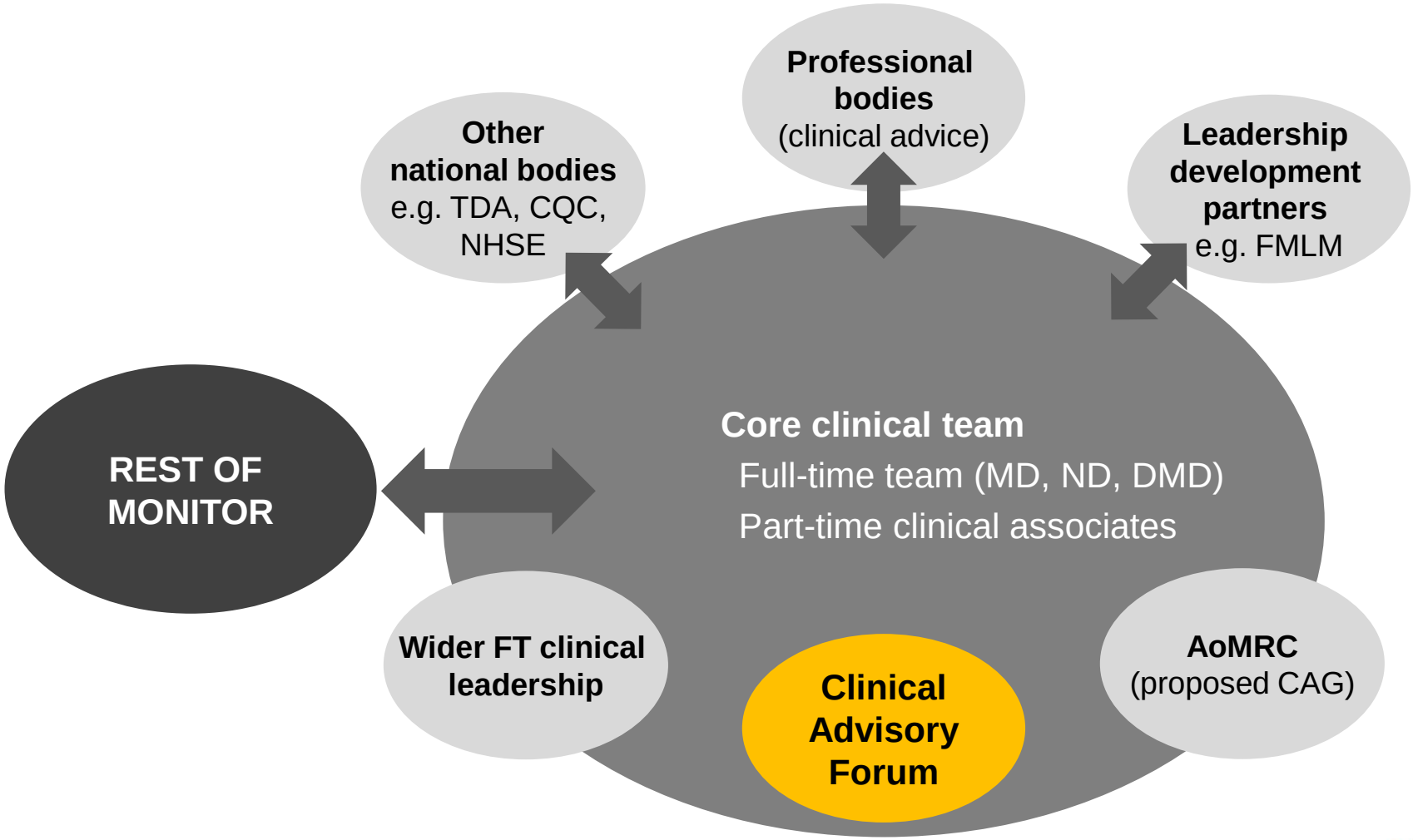
Gain legitimacy	Influence the sector	Improve awareness of Monitor's role and work

Monitor
Making the health sector work for patients

Role of the clinical team

- An accessible clinical “sounding board” – this includes the CAF
- Help linking up with/ procuring specific external clinical expertise
- Senior clinical support to provide direct “hands on” challenge to regulated organisations
- At a corporate level, access to a network of senior clinical leaders
- Driving Monitor’s clinical agenda

Our structure and wider clinical engagement



Monitor
Making the health sector work for patients

Role of the Clinical Advisory Forum

- A formally constituted group providing advice to the clinical team and wider organisation
- Representation from both executive medical directors and chief nurses from a wide range of providers
- A flexible approach as our work programme develops – we may decide to co-opt members and set up task and finish groups

Subject areas where we might look to involve the Forum

- Core elements of the clinical team's agenda e.g. development support for MDs/ CNs
- Our approach to contingency planning and success regime interventions
- Long term pricing strategy and associated projects
- Patient benefit cases and other CCD investigations – this will potentially be a big part of the Forum's work programme
- Policy and research projects

Introducing the FT medical directors and chief nurses LinkedIn group

- Our first discussion point: What training/ development/ shared learning support do you need more access to?

Current issues/ concerns/ policy developments

- Nurse staffing & agency controls

- New commissioning approaches and new models of care – suggest scheduling for a future meeting

Monitor's approach to clinical sustainability

- NCEPOD's review of GI bleeding: Time to get control
  - Published today and available on NCEPOD's website

Why GI bleeding?

- Common medical emergency
- 85000 cases per annum in UK
- 10 per hour
- Reports of poorly resourced services
- Management has changed dramatically in line with increasing specialisation and technology

Method

• England, Wales, NI: 1st January-30th April 2013	4,780
• Up to 5 cases per trust • > 4 units RBC transfused	1,077
• Ano-rectal bleeding excluded	769
• Questionnaires returned	618
• Photocopied notes received	596
• Cases peer reviewed	485

Areas considered

- Risk stratification
- Admission pathways
- Diagnostics and interventions
- Outcomes
- Governance

Risk stratification

- 88% of trusts had guidance for UGI
- 25% for LGI
- Risk assessments done in 36% of UGI

Admission pathways

- 97% NEL admissions
- 60% admitted because of GI bleed
- 40% developed GI bleed as in patient
- 14% UGI managed by Gastro or GI bleed team
- 50% LGI managed by surgeons

Diagnostics and interventions

- Delays in OGD [80% of those in shock by 24hours: NICE standard = 100% in 2hours]
- Many endoscopists not skilled in essential areas. Many units not JAG approved
- Poor access to IR (30% of admitting trusts IR on site with on call rota, 45% of others had a formal network arrangement
- Good access to surgery

Outcomes

- Overall hospital mortality rate 24%
- 14% if admitted with bleeding, 38% if already IP
- 22% developed at least 1 complication
- 23% had a rebleed
- 58% had a rebleed plan in place

Governance and improvement

- < half deaths discussed at an M and M meeting
- Clinical lead UGI 60%, LGI 38%
- MDT discussion 8%
- Audit of guideline compliance 81% - 32%
- Massive transfusion policy 100%
- Potential for improvement identified locally 7%
- Potential for improvement identified by NCEPOD reviewers 44%

Overall shortfalls

- Facilities
- Compliance with guidelines and policies
- Clinical leadership and decision making
- 24/7 service
- Governance
- Audit, reflection and learning

Principal recommendations

- GI bleed patients admitted only to hospitals with endoscopy, surgery, ITU, anaesthesia on site 24/7 and IR 24/7 on site or formal network
- Other patients need to have the above available 24/7 on site or by a network
- All GI bleeds managed by a GI bleed team (can have diverse membership) with a lead clinician responsible for pathways and governance
- Patients with a major bleed to be discussed with duty consultant within 1 hour (including current in patients)
- A rebleed plan to be documented with every diagnostic or therapeutic intervention.

So what?

- Patients
- Individual clinicians
- Providers (and their boards)
- Commissioners
- GMC/ NMC
- CQC
- Monitor/ TDA

A.O.B. and Close

Monitor
Making the health sector work for patients

Monitor
Making the health sector work for patients

MEETING OF THE CLINICAL ADVISORY FORUM
FRIDAY 4 SEPTEMBER 2015 at 10.30am

BLACKWELL, WELLINGTON HOUSE, 133-155 WATERLOO ROAD LONDON SE1 8UG

AGENDA

1.	10.30	**Welcome and Apologies**		(oral item)
2.		**Declarations of Interest**		(oral item)
3.	10.35	**Minutes and matters arising from the meeting held on Friday 3 July 2015** (attached)	Board Secretariat	CAF/15/02
4.	10.40	**Accident & Emergency Report** (attached)	[redacted]	CAF/15/03
5.	11.30	**CAF Update**	Hugo Mascie-Taylor	(oral item)

LUNCH & INFORMAL DISCUSSION (12.30-1.30pm)

6.	1.30	**Agency/ Locum Staffing** (to follow)	[redacted]	CAF/15/04
7.	3.55	**Any other business**		
8.	4.00	**Close**		

MINUTES OF A MEETING OF THE CLINICAL ADVISORY FORUM HELD ON 4 SEPTEMBER 2015 AT 10.30AM AT WELLINGTON HOUSE, 133-155 WATERLOO ROAD, LONDON SE1 8UG

Present:

Hugo Mascie-Taylor (Chair), Monitor (in the Chair until item 6)
Andy Brogan, Executive Director of Clinical Governance and Quality, South Essex Partnership University NHS FT
Andrew Catto, Executive Medical Director, Heart of England NHS FT
Hilary Chapman, Chief Nurse, Sheffield Teaching Hospitals NHS FT
Peter Maskell, Medical Director, Kent Community Health NHS FT
Ruth May, Nurse Director (Monitor) (in the Chair from item 6)
Sean O'Kelly, Medical Director, University Hospitals Bristol NHS FT
Josie Rudman, Director of Nursing, Papworth Hospital NHS FT
Oliver Shanley Director of Quality and Safety, Hertfordshire Partnership NHS FT
Jane Viner, Director of Professional Practice, Nursing and People's Experience, South Devon Healthcare NHS FT
David Walker, Medical Director, University Hospitals of Morecambe Bay NHS FT
Geraldine Walters, Director of Nursing, Midwifery and Infection Control, King's College Hospital NHS FT
Dawn Wardell, Chief Nurse, Dudley Group NHS FT

In attendance:

[redacted] Digital Engagement Strategy Manager (Monitor) (until item 5)
[redacted] Associate Medical Director: Medicine (Monitor)
[redacted] Clinical Engagement Lead (Monitor)
[redacted] Senior Economist (Monitor) (until item 5)
[redacted] Associate Medical Director: Urgent and Emergency Care (Monitor)
[redacted] Implementation Adviser, Implementation Unit, Cabinet Office (item 6)
[redacted] Economic Analyst (Monitor) (until item 5)
[redacted] Associate Medical Director: Mental Health (Monitor)
[redacted] Senior Adviser, Implementation Unit, Cabinet Office (item 6)
[redacted] Governance Officer (Monitor) (until item 6)
[redacted] Clinical Fellow (Monitor)
[redacted] Clinical Fellow (Monitor)
[redacted] Governance Manager (Monitor)

Executive officers attended the meeting as detailed under specific agenda items below.

1. Welcome and apologies

1.1 Apologies for absence had been received from Jag Ahluwalia (Medical Director, Cambridge University Hospitals NHS FT), Jackie Bird (Executive Director of Nursing

and Quality, The Christie NHS FT), David Evans (Medical Director, Northumbria Healthcare NHS Foundation Trust), Ruth Holt (Director of Nursing, South Tees Hospitals NHS FT), Tim Ojo (Executive Medical Director, Sussex Partnership NHS FT), Stephen Powis (Medical Director, Royal Free London NHS FT) and Stanley Silverman (Deputy Medical Director (Monitor)).

2. Declarations of interest

2.1 No interests were declared.

3. Minutes and matters arising from the meeting held on Friday 3 July 2015 (CAF/15/02)

3.1 The minutes of the Clinical Advisory Forum (CAF) meeting on 3 July 2015 were approved and the matters arising were noted.

3.2 Consideration was given to the proposed Terms of Reference (ToR) of the CAF, which had been circulated to the members in advance of the meeting. The CAF resolved to agree that the proposed ToR should be approved.

3.3 It was noted that Alison Tong, Dorset County Hospital, would replace Ruth Holt, South Tees Hospitals NHS Foundation Trust, on the CAF for future meetings.

4. Accident and Emergency Report (CAF/15/03)

4.1 [redacted] (Associate Medical Director: Urgent and Emergency Care) introduced the presentation which set out the Economics team's work in relation to the drivers of the decline in accident and emergency (A&E) performance against the 4-hour waiting time target in 2014/15. It was noted that the econometric model upon which the analysis had been based had been built using only national data. Consideration was given to the various factors that had affected A&E performance and it was emphasised that these were not wholly within the control of the relevant hospital or emergency department. CAF members noted that when addressing this issue in the longer-term, all contributing factors would need to be considered.

4.2 CAF members discussed the findings of the Economics team's work, which had identified a marked increase in both the number of attendances to A&E and emergency admissions in 2014/15. Consideration was given to the potential impact of people's behaviour and expectations on both the attendance rate and A&E performance as a whole. It was noted that further work would be undertaken to investigate whether the increase in attendances could be attributed to a specific demographic. There was a discussion in relation to the main determinates in the econometric model and the various factors that affected A&E performance. CAF members considered the potential impact of clinical decisions, system processes, leadership and culture on A&E performance. The importance for clinical leadership to drive system change and good practice was emphasised. Consideration was given to the impact of patient acuity on the findings of the work.

4.3 CAF members considered the questions raised by the Economics team in relation to the dissemination of the findings through the clinical community. The ways to actively involve the clinical community in sector initiatives were discussed. The value of disseminating the findings through the clinical community was emphasised. It was considered that the use of established medical journals and other literature in addition to meetings with system partners and local system resilience groups would be the most effective way of communicating these findings and promoting system-wide engagement. CAF members proposed that a toolkit should be designed for local providers to enable them to compare local data and national data to contextualise their performance and position on a national scale.

4.4 Consideration was given to the work that Monitor had done to support and promote clinical leadership in relation to the various ongoing sector initiatives. The CAF highlighted the importance of ensuring an open dialogue was available, both in clinical peer groups and between clinicians and Monitor, to discuss the aim of these initiatives and their projected outcomes.

5. CAF Update (oral item)

5.1 The Nurse Director (Monitor) provided an oral update in relation to the nurse revalidation process that was currently being undertaken in Monitor and across the NHS foundation trust sector. CAF members recognised the importance for all providers to adhere to this process.

5.2 CAF members discussed the Department of Health (DH)/NHS England's proposals in relation to NHS services being available seven days a week. Consideration was given to the feasibility of the proposed standard with regard to emergency admissions and the target performance in relation to this. Whilst CAF members were broadly content with the proposed standard, it was noted that it was context specific and would not be applicable in all clinical situations. The importance of ensuring this standard applied to all emergency admissions, including mental health and community hospitals, was emphasised. Some minor drafting comments were proposed and the CAF confirmed it was content for these to be submitted to DH.

5.3 An oral update was provided in relation to the Migration Advisory Committee (MAC). Consideration was given to the proposal for nursing to be included on the MAC's shortage occupation lists. CAF members confirmed they were content with this proposal and considered that a letter should be sent from HM Treasury to the MAC outlining the financial pressures associated with nurse staffing across the sector.

5.4 An oral update was provided in relation to recruitment in the Patient and Clinical Engagement directorate at Monitor. CAF members' discussed the level of activity on the LinkedIn page that had been established for use by clinical staff across the sector and the effectiveness of this networking tool.

5.5 The Executive Director of Patient and Clinical Engagement provided an oral update in relation to the closer collaborative working between Monitor and the NHS Trust Development Authority. Consideration was given to CAF members' views on the most effective operating structure for the integrated organisation. It was requested that Ed

Smith, Chairman, should attend a CAF meeting to discuss the integration of these organisations.

ACTION: HMT

5.6 An oral update was provided in relation to the work being undertaken by the Patient and Clinical Engagement directorate at Monitor. CAF members confirmed they were content to provide assistance to the directorate as appropriate.

6. Agency/Locum Staffing (CAF/15/04)

6.1 The CAF considered the following presentations:

- Locum Medical Staffing: Challenges and solutions in the real world (Andrew Catto)
- Nurse staffing: Managing Supply and Agency Spend (Geraldine Walters)
- Agency/Bank Staffing within Sheffield Teaching Hospitals NHS Foundation Trust (Hilary Chapman)
- Medical Locums in Morecambe Bay (David Walker)
- Why has Medical Agency Spend increased in the NHS? (Implementation Unit, Cabinet Office)

6.2 It was requested that Ian Cummins, Chief Executive, Health Education England, should attend a CAF meeting to discuss issues relating to training the future clinical workforce.

7. Any other business

7.1 There was no other business.

Close

Monitor

Making the health sector work for patients

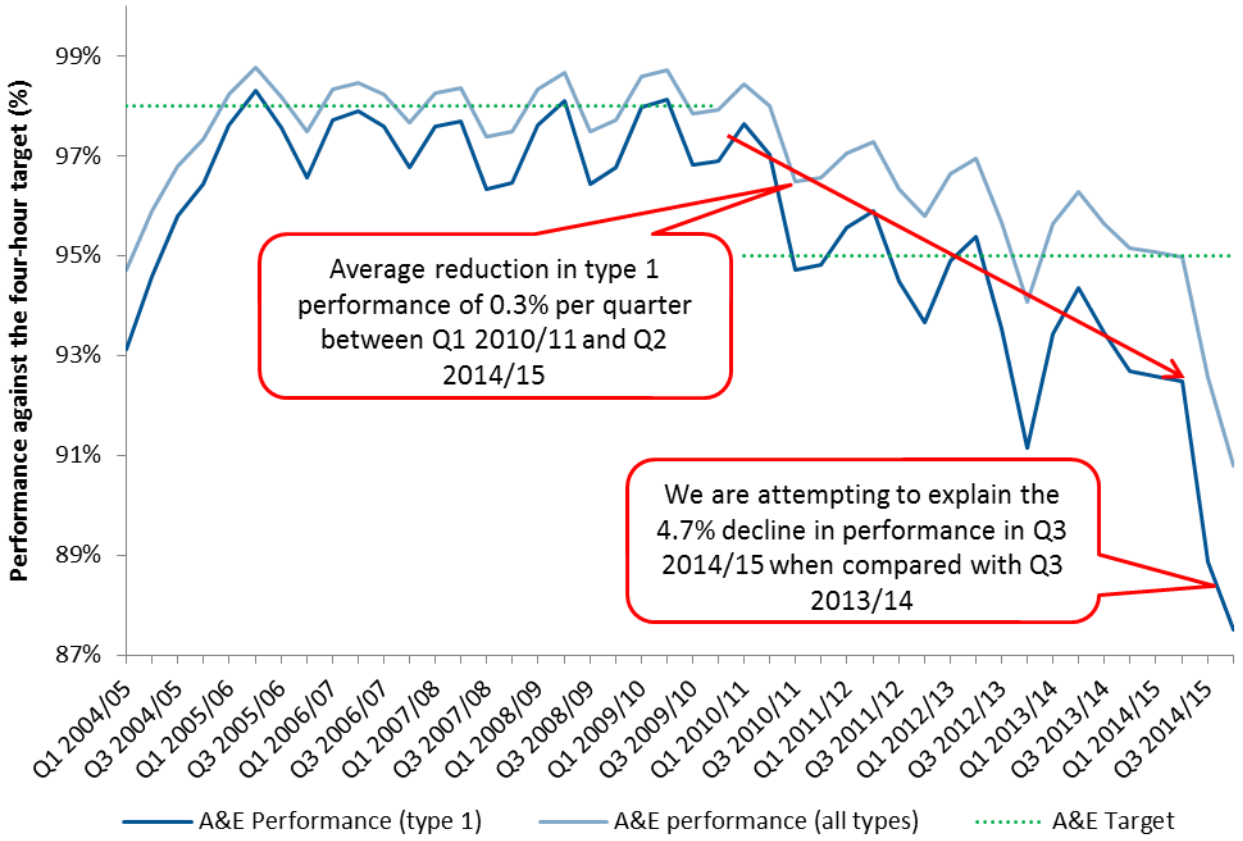
A&E delays: why did patients wait longer last winter?

Clinical Advisory Forum
4th September 2015

GOV.UK/monitor

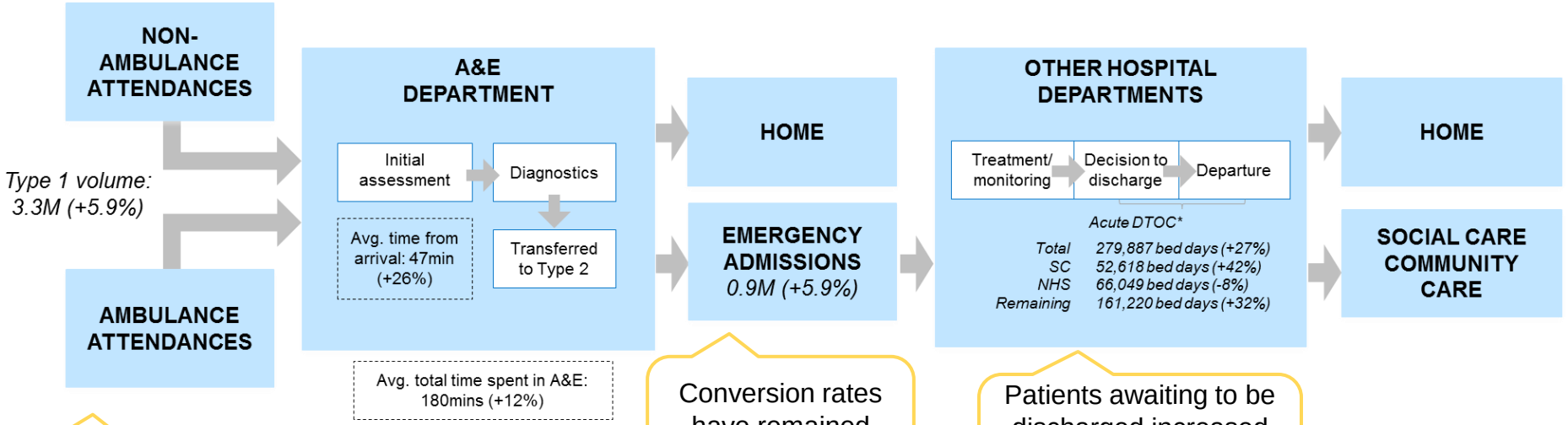
We know that 2014/15 marked a sharp decline in A&E performance against the 4-hour waiting time target

National performance against the A&E four-hour target, quarterly, 2004/05 – 2014/15



Our project question: *'What are the specific factors that may have driven the decline in A&E performance against the 4-hour target in 2014/15? Given these drivers, what actions by trusts and national bodies are likely to be most effective in helping to avoid these problems in the future?'*

A&E performance is determined by factors within and beyond the immediate control of the hospital



Hospitals received 5.9% more Type 1 attendances than in Q3 13/14

Some trusts include both Type 1 and Type 3 attendances.

Conversion rates have remained constant (27.9%)

Patients awaiting to be discharged increased by 27.0% from Q3 13/14 to Q3 14/15

This is delayed transfers of care (DTOC) reported by **acute providers only** and we have broken these down into three categories for the purposes of our analysis:

- Social care DTOC caused by social care organisations.
- NHS DTOC caused by NHS organisations.
- Remaining DTOC - social care DTOC caused by NHS organisations; NHS DTOC caused by social care organisation; and DTOCs that were caused by a combination of *both* social care and NHS organisations.

Note: All figures quoted are for the period Oct-Dec 14/15.

We tested 10 high-level hypotheses across the A&E pathway to help us explain the decline

Increase in the number and profile of attendances and admissions	H1	Nationally there was a higher number of A&E **attendances** and this had a negative impact on A&E performance against the four-hour target
	H2	Nationally there was a higher proportion of **sicker people attending** A&E and this had a negative impact on A&E performance against the four-hour target
	H3	Nationally there was a higher proportion of **people attending A&E via ambulance** and this had a negative impact on A&E performance against the four-hour target
	H4	Nationally the **variability of attendances** patterns (in terms of the time and date of arrival) changed and this had a negative impact on A&E performance against the four-hour target
	H5	Nationally there was a higher number of people **admitted via A&E** and this had a negative impact on A&E performance against the four-hour target
	H6	Nationally there was a higher proportion of **sicker people admitted** via A&E and this had a negative impact on A&E performance against the four-hour target
Changes in the capacity of the A&E department	H7	Nationally A&E departments had more **problems** with their **staff related resources** and this had a negative impact on A&E performance against the four-hour target
	H8	Nationally A&E departments had more **problems** with their **non-staff related resources** (e.g. IT, diagnostics) and this had a negative impact on A&E performance against the four-hour target
Changes in the capacity of the rest of the hospital	H9	Nationally **other hospital departments** had more problems **working effectively** with the A&E department and this had a negative impact on A&E performance against the four-hour target
	H10	Nationally other hospital departments had higher rates of **bed occupancy** and this had a negative impact on A&E performance against the four-hour target

We looked at

National data to explore trends and patterns of each potential driver

+

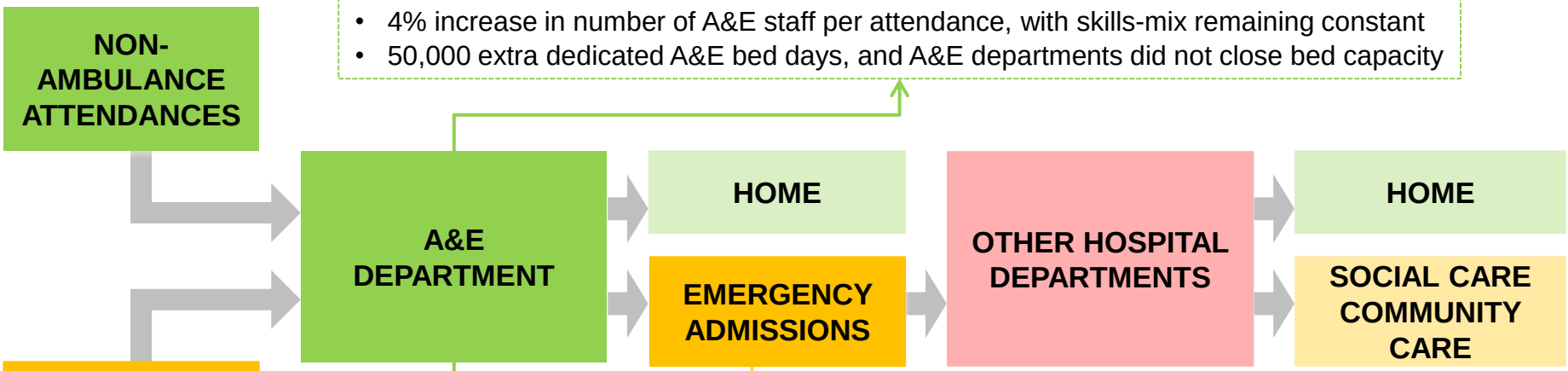
Econometric model to identify the relative impact of each potential driver

+

Trust survey to collect information not available in national sources

A&E departments kept pace with the increase in demand but they may be unable to sustain this in the medium-long term

A&E departments increased capacity to meet growing demand
- There was a high 5.9% increase in both A&E attendances and emergency admissions
- Patients' sickness has remained constant or registered a marginal increase*
- Conversion rate has remained constant (27.9%)
- 4% increase in number of A&E staff per attendance, with skills-mix remaining constant
- 50,000 extra dedicated A&E bed days, and A&E departments did not close bed capacity



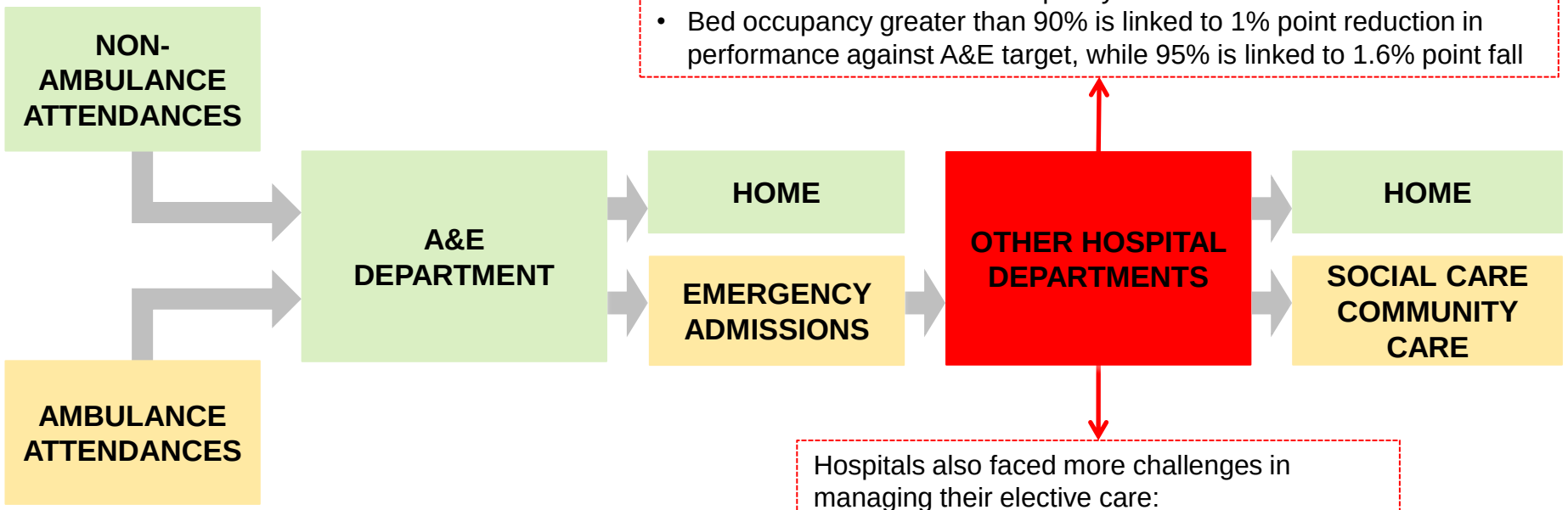
However, this will be challenging to sustain:
- Growth in A&E attendances, reduction in inpatient bed capacity and issues with patient throughput will compound strain on A&E departments
- A&E staff are facing an increasingly diverse range of activity - growth in type 3 attendances and the number of admitted patients receiving treatment in A&E

- No impact on A&E waiting target decline in Q3 2014/15
- Limited/unknown impact on A&E waiting target decline in Q3 2014/15
- Considerable impact on A&E waiting target decline in Q3 2014/15

*We have used different proxies for acuity as there is no perfect measure of degree of "sickness"

A key cause of the decline in Q3 2014/15 is linked to difficulties in absorbing the increase in admitted patients from A&E

- In Q3 14/15 hospitals were running at very high utilisation levels (≈90%) leaving little room to absorb any change in demand
  - This was 1.9 percentage points higher than in Q3 13/14
  - 72 trusts had bed occupancy >90%
- Bed occupancy greater than 90% is linked to 1% point reduction in performance against A&E target, while 95% is linked to 1.6% point fall



Hospitals also faced more challenges in managing their elective care:

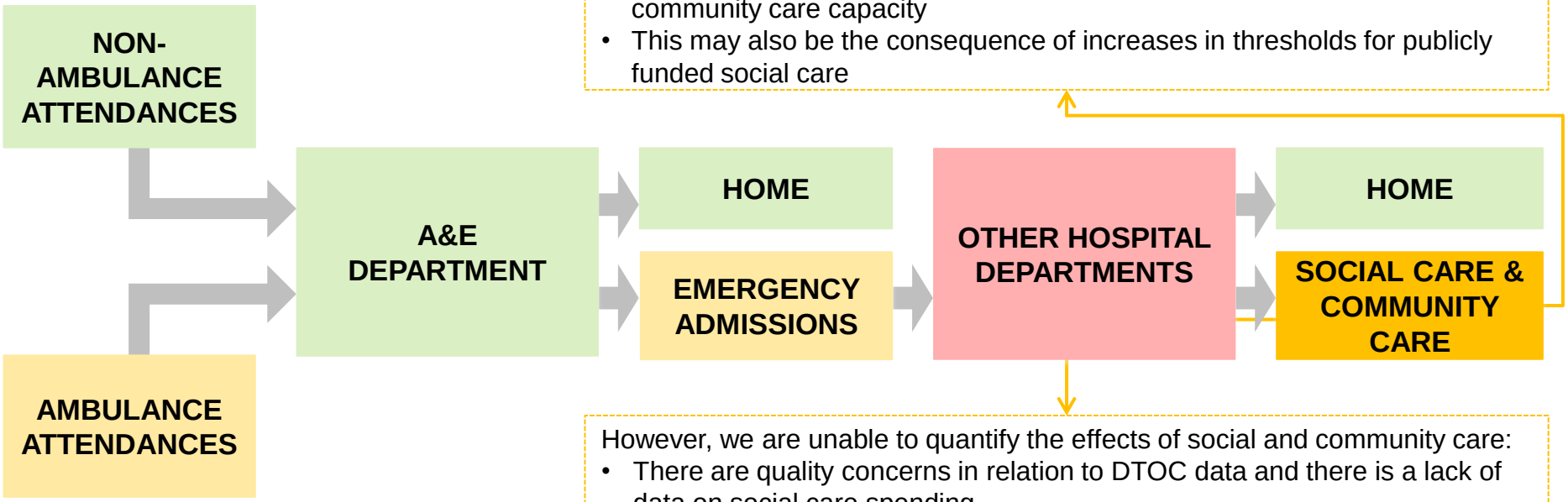
- Increased cancellations of urgent elective operations (+25.4%)
- Overall elective activity levels down 2% on Q3 13/14

- No impact on A&E waiting target decline in Q3 2014/15
- Limited/unknown impact on A&E waiting target decline in Q3 2014/15
- Considerable impact on A&E waiting target decline in Q3 2014/15

50% of trusts also reported reductions in capacity of social and community care services to be a key issue, but we could not quantify the effect

Hospitals had more difficulties in transferring patients awaiting discharge to out-of-hospital settings:

- DTOCs increased by 27%
- Trusts surveyed suggest this was the result of reductions in social and community care capacity
- This may also be the consequence of increases in thresholds for publicly funded social care



However, we are unable to quantify the effects of social and community care:

- There are quality concerns in relation to DTOC data and there is a lack of data on social care spending
- In addition, DTOCs account for only 4% of total available bed days, so reduction in social/community care capacity could only partially explain high bed occupancy rates

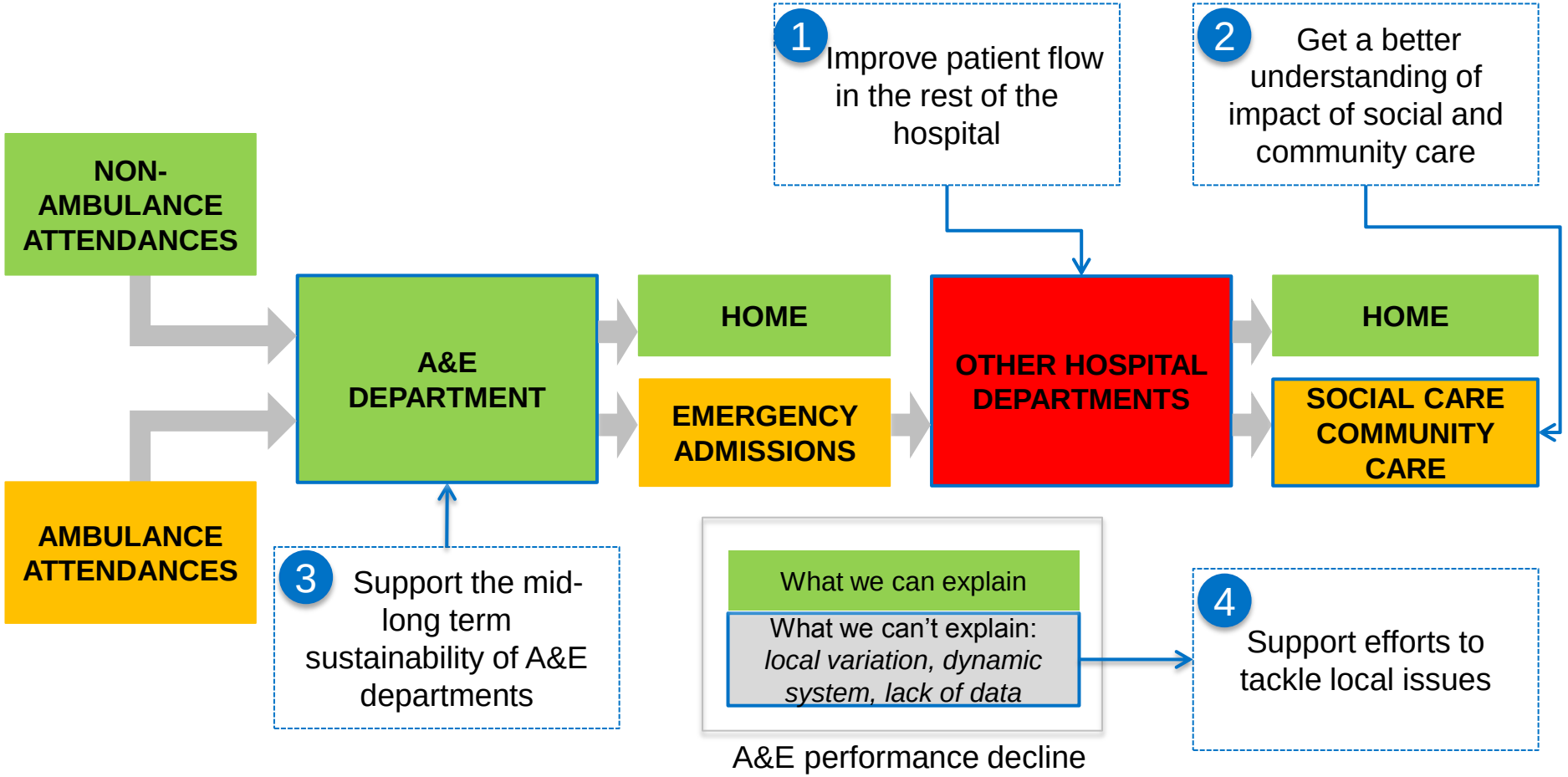
- No impact on A&E waiting target decline in Q3 2014/15
- Limited/unknown impact on A&E waiting target decline in Q3 2014/15
- Considerable impact on A&E waiting target decline in Q3 2014/15

*DTOC: Delayed Transfers Of Care

We rejected some hypothesis as drivers of the decline in A&E performance against the target

			Explain the decline in 14/15	Confidence in the evidence
Increase in the number and profile of attendances and admissions	H1	Nationally there was a higher number of A&E **attendances** and this had a negative impact on A&E performance against the four-hour target	NO	
	H2	Nationally there was a higher proportion of **sicker people attending** A&E and this had a negative impact on A&E performance against the four-hour target	NO	
	H3	Nationally there was a higher proportion of **people attending A&E via ambulance** and this had a negative impact on A&E performance against the four-hour target	YES	
	H4	Nationally the **variability of attendances** patterns (in terms of the time and date of arrival) changed and this had a negative impact on A&E performance against the four-hour target	NO	
	H5	Nationally there was a higher number of people **admitted via A&E** and this had a negative impact on A&E performance against the four-hour target	YES	
	H6	Nationally there was a higher proportion of **sicker people admitted** via A&E and this had a negative impact on A&E performance against the four-hour target	NO	
Changes in the capacity of the A&E department	H7	Nationally A&E departments had more **problems** with their **staff related resources** and this had a negative impact on A&E performance against the four-hour target	NO	
	H8	Nationally A&E departments had more **problems** with their **non-staff related resources** (e.g. IT, diagnostics) and this had a negative impact on A&E performance against the four-hour target	NO	
Changes in the capacity of the rest of the hospital	H9	Nationally **other hospital departments** had more problems **working effectively** with the A&E department and this had a negative impact on A&E performance against the four-hour target	NO	
	H10	Nationally other hospital departments had higher rates of **bed occupancy** and this had a negative impact on A&E performance against the four-hour target	YES	

Where could we focus our efforts next?



- No impact on A&E waiting target decline in Q3 2014/15
- Limited/unknown impact on A&E waiting target decline in Q3 2014/15
- Considerable impact on A&E waiting target decline in Q3 2014/15

Many initiatives have already started

1 Improve patient flow in the rest of the hospital

- NICE is currently developing service guidance on “Acute medical emergencies in adults and young people”, which will cover service organisation and delivery across the NHS.
- The ‘Moving Care Closer to Home’ project will publish a report in early September that highlights the importance of improving inpatient flow.
- The ‘Productive Models of Elective Care’ research team will soon publish a report that identifies opportunities to improve productivity through models of elective care.

2 Get a better understanding of impact of social and community care

- NHS England with the support of DH and NHS Improvement has reviewed the Delayed Transfers of Care (DTOC) guidance to improve the quality and consistency of providers’ reporting in this area
- NAO are scoping a value for money study looking at the discharge of patients from acute hospitals. This is likely to have a focus on how delayed transfers of care are managed and monitored locally, and how DH and its arm’s length bodies are supporting health and social care bodies to minimise delays.
- NHS England’s UEC Review Programme have launched an ‘Out-of-Hospital Urgent Care’ programme which will include roll-out of an integrated NHS 111 service, improved coordination between the Independent Care Sector and the NHS, and development of community based care models.

3 Support the mid-long term sustainability of A&E departments

- NHS England, DH and PHE are working together on a national Services Information Campaign to reduce emergency care pressures; local NHS organisations will be able to join up with this campaign.
- A new Emergency Care Data Set (ECDS) is being developed, which should enable providers and commissioners to better plan and monitor the delivery of emergency care.
- NHS England’s UEC Review Programme are developing guidance for commissioners on Urgent Care Centres, Emergency Centres and Emergency Centres with specialist services

4 Support efforts to tackle local issues

- DH, Monitor, TDA and NHS England are setting up an Emergency Care Improvement Programme (ECIP) to help the most challenged urgent care systems, with a focus on patient flow.
- The ‘Safer, Faster, Better’ guide for delivering UEC services will be published, which will be a practical summary of good-practice design principles for local health communities to adopt.

Questions to the group

- How can we best disseminate the findings through the clinical community?
- How can the clinical community get actively involved in current initiatives?

Monitor

Making the health sector work for patients

Agency and workforce

CAF

4 September 2015

GOV.UK/monitor

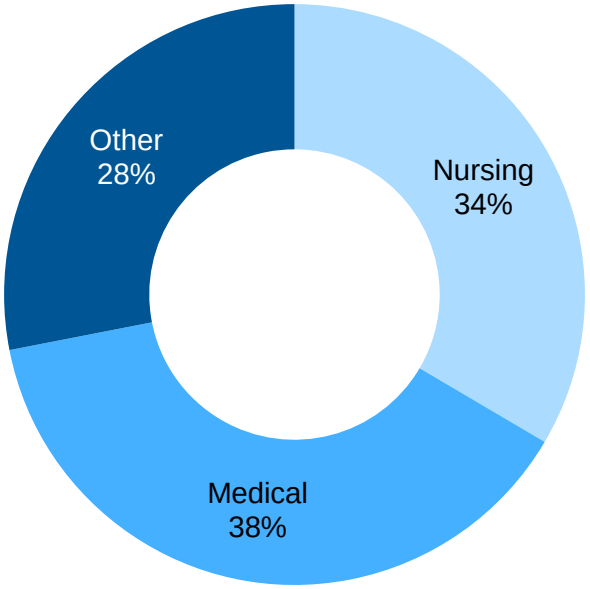
In 2014/15, NHS providers spent £3.3 billion on temporary staff

Agencies can play an important role in the healthcare sector to meet unforeseen peaks in demand.

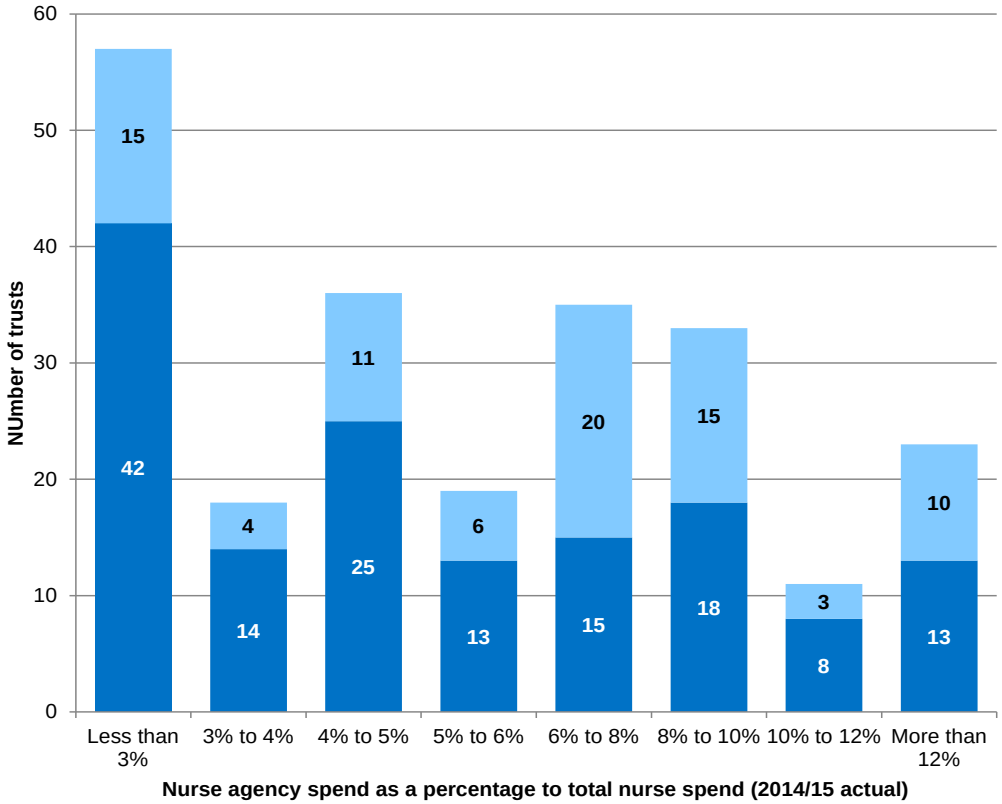
However, spending has risen rapidly year-on-year, compounding financial pressures

And there can be quality issues - agency nurses can be less familiar trust's procedures, and trusts with high temporary staff usage tend to have poorer patient experience ratings.

Agency spending 2014-15, all trusts



Nursing agency spend as % of total nursing spend, by trust



A broad programme is being put in place to support effective staffing

Supply side

- HEE's Workforce plan for England 2015/16 describes how supply is forecast to grow by 23,000 full-time equivalents by 2019
- DH and the Chief Nursing Officer for England also have workforce programmes for increasing the supply of nurses in the short to medium term
- Discussions continue in relation to health care worker immigration restrictions

Demand side

- We will soon collect all the safer staffing guidance in one place
- Aim to ensure staffing requirements take into account patient acuity and dependency, outcome measures and professional judgment - rather than relying on simple staff/patient ratios.
- We launched new agency spending rules on 1 September

Trust support

- The Agency Intensive Support Team provides a range of assistance to trusts depending upon the requirements of the individual provider.
- Activities include active diagnosis of workforce problems, sharing best-practice and delivering practical on-site support to fill capacity and capability gaps

Agency Intensive Support Packages

The team

- The Agency Intensive Support Team was established during the summer of 2015.
- The team forms part of an NHS wide initiative to address the agency staffing challenge. Other workstreams led by the DH, HEE and NHS England are working to increase the supply of staff; e.g the return to practice initiative
- The team will provide practical help and guidance to help trusts manage their temporary staffing by providing practical help and guidance, share best practice and fill skill-gaps in certain circumstances

The AIST model provides 3 separate support packages, depending upon the needs of the trust:

1) Advisory support (light touch)	2) Remote/desk-based support (light touch +)	3) Hands-on/Onsite support
Available to all FTs	Available to all FTs	Available for targeted FTs
Example activities: • Provision of agency diagnosis toolkit • 1:1 teleconference with FTs to provide initial steer on deployment of toolkit • Sign-posting the FT to other good practice FTs to encourage the sharing of innovative ideas • Providing technical advice on temporary staffing issues • Acting as a link to updates on system responses to agency and workforce issues	*Example activities:* • AIST challenge/review of FTs diagnostic assessment • AIST challenge/review of FTs action plan • AIST challenge/review of implementation • Provision of benchmarking information	*Example activities:* • AIST supported deployment of diagnosis toolkit • AIST supported diagnosis and action planning • AIST supported implementation (see the slide 6 for the approach)

This week, Monitor/TDA launched rules for agency spend, covering nurses, midwives health visitors & support staff

1. Spending ceilings

Trusts have been set trajectories for agency nursing spend as a % of their total nursing spend staff spend.

2014/15 nursing agency spend	Band	Q3 & Q4 2015/16 ceiling	2016/17 ceiling	2017/18 ceiling	2018/19 ceiling
Under 3%	A	3%	3%	3%	3%
3% to 4%	B	3%	3%	3%	3%
4% to 5%	C	4%	3%	3%	3%
5% to 6%	D	5%	4%	3%	3%
6% to 8%	E	6%	5%	4%	3%
8% to 10%	F	8%	6%	4%	3%
10% to 12%	G	10%	8%	6%	4%
Over 12%	H	12%	10%	8%	6%

These come into effect from 1 October.

2. Use of approved frameworks

From 19 October all agency nurses must be procured through approved frameworks.

Framework owners must apply to Monitor/TDA by 14 September

Frameworks will be approved considering a range of value for money and quality criteria.

If a trust can get a better deal off framework then it can apply for non-framework approval.

The rules include mechanisms for local managers and clinical leaders to override them under exceptional circumstances in the interests of patient safety. Trusts must report this to Monitor/TDA.

Next steps

Price caps will be developed and announced later in 2015. We want to engage with regional or sub-regional stakeholder groups in setting the price caps.

Rules for other staff groups (including doctors) are also being developed.