

# Report to the Meeting of the

**CoG 28/2017**

(Agenda item: 10)

# Oxford Health NHS Foundation Trust

# Council of Governors

**13 September 2017**

**Chief Executive’s Report**

**For: Information/Approval**

As I pointed out in my report also to the Board of Directors, the NHS’s emergency planning and resilience have been tested over recent months with the cyber-attack, the terrorist attacks and the Grenfell tragedy, and we have sought to draw relevant local lessons from those events. Other local issues which continue to command attention include demand and capacity issues and the potential impact on the Oxfordshire contract risk share which remains of concern. More positively the contracts and transfer agreements with regard to Oxfordshire Learning Disability services to support the planned transfer date concluded as planned with staff and services successfully transferring on 1st July.

**Local issues**

1. **Financial Plan FY18**

The detail of our performance is included in the finance report, but the headline financial result for the four month period to the end of July 2017 is an Income & Expenditure surplus of £0.5m, which is £0.1m adverse to plan. However, this includes £1.3m of one-off benefits which when excluded results in an underlying deficit position of £0.8m, which is £1.4m adverse to plan. The underlying adverse position is mainly due to a shortfall in delivery of CIP together with other pressures in services and in particular agency spend. The forecast year-end position is a surplus of £2.2m which is in line with the plan of £1.8m plus an additional £0.4m of Sustainability & Transformation funding received for last financial year which is excluded from performance against the Trust’s control total. This position includes £1.9m of Sustainability & Transformation funding (STF) for this financial year.

Based on the year-to-date results the Trust’s overall Use of Resources risk rating would be a ‘2’, however, the Agency metric is rated as a ‘4’ because spend on agency staff was 50% above the ceiling set by NHSI resulting in an override to cap the Trust’s rating at a ‘3’. The Trust continues to work hard to address spend on agency and will receive support from NHSI’s expert in this area (September/October) to establish if there is anything else the Trust can do to reduce its reliance on same.

1. **FY18 – contract/risk share governance**

There has been some progress with implementation of the agreed mitigations of the £18m largely activity based risk outlined in the contractual agreement between ourselves, OUH and Oxfordshire CCG, but much still needs to be done. However, progress on this continues to be significantly behind where it needs to be. I have reiterated to both other parties the Trust's position that the Trust will not commit to any additional expansion of the quantum or nature of the existing risk share agreement, which is predicated on implementation of the agreed list of mitigations as an inherent part of that agreement. That includes, specifically, any additional costs associated with the Referral to Treatment (RTT) backlog identified by regulators at OUH. As previously advised, OUH is required to prepare a revised activity plan for NHSI but the impact of this on the assumptions made back in December will need to be assessed to see if it represents a fundamental change; more importantly it needs to be set in the context of the much greater financial risks identified in the contract. In reality the rate limiting factor is most likely to remain as the availability of workforce to sustain levels of activity.

DTOCs remain a challenge across the system, with a significant detrimental effect on the Average Length of Stay for patients in community hospitals. The system has implemented a range of initiatives designed to mitigate the impact of this, but the Trust's leadership team remain extremely concerned about the situation. We have recently tabled some additional proposals of our own to system partners - these are currently being debated by the system. What is clear is that 'doing nothing' is not an option, so we remain keenly focused on solving the problem. However, we are currently largely reliant upon our partners to do this for us due to the structure of current commissioning and provider arrangements.

1. **Musculoskeletal (MSK) Contract**

As I have previously explained to Governors, the process of procurement for these services poses a significant workforce risk in an area which is key to mitigation of one of the most salient RTT risks. I explained I had set out our concerns to the CCG Chief Executive, but the contract has since been awarded to the private sector (Healthshare). I also explained that when we were able, greater certainty would be afforded our staff and patients.

We are on track for transferring the MSK service on 1st October as follows:

***Patient letters*** have been sent to all patients who are currently active with the service and any new referrals that have been received by the service. The letters have included contact information for Healthshare and a contact number within the current service if the patient does not want to transfer their data to the new provider. We are also contacting patients by text where possible.

***New patient referrals*** – as from 1st September it has been agreed with commissioners and Healthshare that any new referrals will be sent direct to Healthshare who will triage and treat the new referral.

***The current service*** will stop providing clinics from 15th September and will run emergency clinics up to 22nd September in order to prepare for transferring the services on 1st October.

***Patients’ information*** – there are two phases planned for transferring patient records. The first was completed on 5th September, and the second is planned for the end of September.

***Estates*** – the Trust has formally written to the commissioner and Healthshare and confirmed that notice has been served on NHS PS in Chipping Norton, Henley and Bicester. Healthshare will liaise directly with NHS PS regarding these buildings. Healthshare acknowledge that Oxford Health will continue to provide Podiatry from Townlands in Henley.

The Trust has confirmed which GP Practices are currently used for provision of services and Healthshare will work with practices to secure clinic space as required. Healthshare have also informed us that they will liaise direct with the appropriate parties to secure clinic space at Faringdon Medical Centre.

Healthshare have accepted the Trust’s offer of using the clinic space at Wallingford Hospital subject to agreeing Heads of Terms and contract. Healthshare have declined the offer made by the Trust relating to interim clinical accommodation arrangement for 1 month in Abingdon, Witney, Wantage and Didcot. Apart from the space at Wallingford, Healthshare have not shared with the Trust where they will be holding clinics for patients from 1st October.

***Equipment*** – the Trust is considering options to place MSK equipment with other services in the Trust, transfer it to the new provider or auction it.

***Staff Consultation*** has not yet concluded as there are some outstanding queries raised by staff; the Trust is working with Healthshare to conclude these queries raised.

1. **IM&T - Digital Strategy Update:**

As previously reported, the Trust is one of seven organisations chosen to go forward and receive up to £5million of funding over the next 3.5 years to accelerate digital health initiatives in mental health services.  The Trust will need to match this funding.  Based on the Trust’s long term financial plan there is sufficient matched funding already reserved.

Our GDE programme will consist of five project areas, each of which will contain multiple work-streams. The five project areas are listed below:  
  
a)    Expanded Electronic Health Record (EHR)  
b)    Records Sharing  
c)    Advanced Analytics  
d)    Patient Facing / Self-Management  
e)    Enabling Infrastructure

In addition to the above there will be on-going cross-project activities focused on ‘soft’ enabling elements.  These will consist of: up-to-date IG policies and procedures; information sharing agreements; collaborative working with partner organisations and user training.  The GDE programme elements form the basis of the Trust’s Digital Strategy and offer a tremendous opportunity to support care delivery with digital solutions.  However, to achieve this outcome the Trust will need to invest significant time and effort from a wide body of colleagues across all areas.

With this in mind the current EHR Programme in the Trust will develop into a broader Digital Strategy Programme.  This new Programme Board will be comprised of senior clinical and non-clinical Trust colleagues, as well as representatives from NHS Digital and key suppliers where appropriate.  The Digital Strategy Programme will oversee the portfolio of projects and activities, and will be responsible for ensuring the expected benefits are delivered.

The Chief Operating Officer is attending the September Council meeting, as was requested at the last meeting, and we will be happy to answer governor questions with regard to the feedback machinery on which we rely in order to understand the impact of change on our clinical staff and our patients. Our safety walkaround programme commencing in September will, amongst other lines of enquiry, see our non-executive and executive directors hear first-hand how implementation of our EHR programme is working in the areas visited.

1. **Workforce: Nurse Recruitment and Retention**

The Council is familiar with the significant staff shortages across England, most notably amongst clinical staff such as nurses, doctors and paramedics, with demand for services and demands on staff increasing.   Given this national situation, and to address our own concerns locally, we are concentrating on decisions and oversight of opportunities available to newly qualified nurses primarily by creating accelerated routes of progression and career pathways and considering what support is available to develop their clinical, managerial and leadership skills and experience.  A structured approach will enable assessment of competence supporting professional development; job rotation mechanisms will be evaluated within the programme of work as well as the potential for the introduction of appropriate reward and incentive frameworks.  Furthermore, we have commenced discussions about whether we should take a new approach to agency use in non-registered roles such as HCAs where we spend nearly £3million per year. Implementation will require further planning and risk assessing before we can begin consulting and involving stakeholders.

Our HR Director will attend the November Council of Governors’ meeting to describe the Trust’s workforce strategy and implementation plans.

1. **Wave 2 New Care Model Applications for Tertiary Mental Health Services**

The Council has been advised that we were successful in our bid to lead a Wave 2 New Care Model for Adult Eating Disorders with Avon and Wiltshire Partnership Trust, 2Gether, Berkshire Healthcare NHS FT, Weston Area NHS Trust, Southern Health NHS FT, Dorset Healthcare Trust and Priority/Partnerships in Care.

The plan is for go-live in April 2018 and the ambitions of the Model are to:

* Reduce length of Stay
* Reduce out of area placements
* Increase repatriation of patients (closer to home)
* Increase numbers of patients in treatment
* Improve patient/carer experience
* Enhance working with 3rd Sector partners
* Reduce expenditure on inpatient beds

Plans are now in train for data validation and resourcing along with development of the Project Group and the establishment of the network.   A business plan, management agreement and the necessary contract variation agreement are being developed to accord with go-live.

1. **New Care Model – Forensic services**

We are now in the second quarter of implementation of the Thames Valley and Wessex New Care Model. The team continues to work with NHS England and other members of the network to validate patient level and financial information.  Procedures are in place for clinical leaders across the network to effectively oversee admission and discharge processes and in the coming quarter further work will be done to standardise these across the network.  In addition, the network is working with Response to identify ways of increasing supported housing capacity.

We are leading work to develop the New Care Model in Eating Disorders working with regional partners. A network meeting is scheduled for September to develop the model of care and drafts of the business plan and management agreement will be available by October with the aim of submitting for Board sign-off in November. Formal ‘go-live’ of this network will be in April 2018.

1. **Southern Health – Learning Disability (LD) services**

All service and transaction contracts were successfully concluded at the end of June and staff, patients and services transferred as planned on 1st July.  Heads of Terms were signed with regard to the Slade site and agreement was reached to support signing of Heads of Terms with NHS England concerning the Evenlode service to include the development longer term of a forensic pathway and the associated capital developments at the Littlemore site.

All of the LD teams received a warm welcome to the Trust and inductions have progressed well.  Morale is reported to be high and the local press responded positively to the transfer.

1. **Academic Health Science Centre (AHSC)**

The Oxfordshire AHSC Board has discussed the need to begin planning for reaccreditation of the Oxford AHSC which we anticipate will begin in 2018.  This will be addressed in more detail at the next AHSC Board meeting and at a specially convened away day in early 2018.

1. **Academic Health Science Network (AHSN)**

As part of more regular updates on matters concerning our AHSN, the latest information is outlined below:

AHSNs have proved their worth and will be relicensed for another five years from 2018, NHS England has confirmed. More details here: <http://www.oxfordahsn.org/news-and-events/news/future-of-academic-health-science-networks-secured-for-five-more-years/>

AHSNs will share £39m to identify and spread new innovations and better ways of working. More details here: <http://www.oxfordahsn.org/news-and-events/news/ahsns-to-receive-39m-to-assess-benefits-of-new-technologies/>

The Life Sciences Industrial Strategy published on 30th August – with a foreword from Prof Sir John Bell – identifies important roles for AHSNs. More details here: <http://www.ahsnnetwork.com/life-sciences-industrial-strategy/>

The Oxford AHSN is sponsoring ten places for lay contributors to attend an international conference on empathy in Oxford on 24th October. More details here: <http://www.oxfordahsn.org/news-and-events/news/oxford-funding-10-places-on-the-oxford-empathy-programme-international-colloquium/>

1. **National and Regional issues**

It is worth noting that a number of leaders across the regulatory landscape are changing, most notably: Ed Smith departs NHSI shortly, followed in the autumn by Jim Mackey.  Mike Richards retired from the CQC in July and NHS England is being ‘restructured for delivery’ alongside planned changes with regard to CQC inspections and fresh guidance regarding new care models and ‘new complex providers’, and changes to NHSI’s Single Oversight Framework.  More locally, both David Smith and Jo McManners leave Oxfordshire CCG at the end of the calendar year.

1. **Sustainability and Transformation ‘Partnerships’ (STPs) and local transformation**

As previously highlighted, the Trust is working with the Buckinghamshire system to develop an Accountable Care System (ACS) in collaboration with GP federations, the Acute/Community Trust (BHT) and councils and commissioners.   Work is developing at pace.  The Trust has set up its own internal working group which I chair, and which will help accelerate the delivery of plans to improve integration of health services to deliver better value care. The intention is to create and implement the necessary frameworks and controls to have an ACS up and running from 1st April 2018 and in shadow form from October 2017.

A Buckinghamshire ACS Partnership Board has been established to provide strategic direction to inform the development of accountable care across the Buckinghamshire system.  As the Chief Executives’ leadership forum for setting the strategic direction and a clear vision for the health and care system across Buckinghamshire, it replaces and therefore supersedes the Healthy Bucks Leaders’ Group.   A memorandum of understanding with NHSE and partnership final form terms of reference and compact agreements will be recommended by the Partnership Board for adoption by each organisation’s Board and will be presented to our September Board meeting for approval.

Progress with an Oxfordshire ACS is slower, but partners have reaffirmed commitment. The Trust is however pleased that its plans for a joint venture arrangement with the GP Federations is maturing well and I am happy to expand at the meeting if helpful.

The outcome of the Phase 1 consultation is now known and the HOSC have indicated their intentions to refer obstetric changes to the Secretary of State, accepting other elements of the proposal with the exception of the number of bed closures to be delayed pending improvements in the DTOC situation.

Discussions with regard to the future of STPs and funding, alongside the national recruitment process for the appointment of STP leads are seeing renewed focus, and again I am happy to answer questions at the meeting given the interest shown in the STP/BOB at your last Governor Forum. What is certain is that the Trust needs to extract the learning from Phase 1 for its Phase 2 process and I intend to hold open discussions as soon as possible in advance of the formal process such that we can protect communities and support wider understanding of the impetus for change so we can develop solutions together.

**Recommendation**

The Council of Governors is invited to note the report and to seek any assurances arising from it.

**Lead Executive Director: Stuart Bell, Chief Executive**