

# Report to the Meeting of the

**BOD 23/2018**

(Agenda item: 5)

# Oxford Health NHS Foundation Trust

# Board of Directors, 28th February 2018

**Chief Operating Officer’s Report**

**For Consideration and Discussion**

**Executive Summary**

This paper provides a narrative of key issues being managed by the Operational Management Team (OMT).

**Governance Route/Approval Process**

Regular monthly report straight to Public Board. Also shared for information purposes with the Extended Executive Team and Capital Programme Board.

**Recommendation**

The Board is asked to consider and discuss this report.

**Author, Title & Lead Director:** Dominic Hardisty, Chief Operating Officer

It is believed that there are no issues that need to be referred to the Trust Solicitors.

This report relates to or provides assurance and evidence against all seven Strategic Objectives of the Trust.

**Quality**

**Oxfordshire system-level CQC inspection**.As will have no doubt been discussed in the Chief Executive’s report, the Oxfordshire health and care system has now received its CQC system inspection report on the state of care for over 65s. Unusually I have included the key recommendations below, since I believe them to be a key theme that we and system partners must continue to return to in the months and years ahead.

* System leaders must improve how they work together to plan and deliver health and social care services for older people in Oxfordshire. While doing so a review of people’s experiences must take place to target improvements needed to the delivery of health and social care services, bringing people back to the forefront of service delivery.
* System leaders must address and create the required culture to support service interagency collaboration and service integration.
* The older people’s strategy must be reviewed and the results implemented into an updated Joint Strategic Needs Assessment. As part of the older people’s strategy, the draft frailty pathway should be implemented and evaluated to include those underrepresented in society.
* System leaders should undertake more evaluation of the actions taken by teams and individuals during times of escalation and learning should be shared with system partners to encourage learning and continuous improvement.
* System leaders must evaluate their winter plans and pressures throughout the year to ensure lessons learned are applied when planning for increased periods of demand.
* System leaders should review and strengthen the approach to managing the care market so that providers are aware of future requirements, particularly in respect of domiciliary care, end of life care and care for people living with complex mental health issues. A proactive approach to market management is required to ensure a sustainable care market.
* System leaders must implement the STP’s joint workforce strategy and work with the full range of care providers to support a competent, capable and sustainable workforce.
* System leaders must review how people flow through the health and social care system including a review of pathways so that there are not multiple and confusing points of access. Pathways should be well defined, communicated and understood across the system.
* System leaders should ensure that housing support services are included within multidisciplinary working, especially in relation to admission to and discharge from hospital, to enable early identification of need and referrals.
* System leaders should conduct a review of commissioned services to consider design, delivery and outcomes, to improve the effectiveness of social care assessments and reduce and avoid duplication. On completion, the criteria for each service should be circulated to system partners and social care providers to ensure resources are used effectively.
* System leaders should review methods used to identify carers eligible for support so that they are assured that carers are receiving the necessary support and have access to services.
* System leaders should ensure that better advice, information and guidance is offered to people funding their own care.
* Continue to embed the trusted assessor model.
* System leaders must continue to engage with people who use services, families and carers when reviewing strategies and integrated systems and structures to ensure these are co-produced.
* Engagement and partnership working with the VCSE sector should be reviewed to improve utilisation.

It is important that we all stop and reflect on what this means for the older people of Oxfordshire: can we in good conscience say that we are all working together to serve our public well? CQC’s conclusion is that we are not. More of the same will not work, so we need what our regulators NHSI have called a ‘system reset’.

I and colleagues are working on a detailed action plan in response to the report, which is due in early March. I will share the highlights from this action plan in next month’s report.

**Trust Well Led inspection.** Again as will have no doubt been covered in the Chief Executive’s report, we have now been notified that our Well Led Review will take place in mid-April, will unannounced inspections of up to six of our core services to take place over the next month. Inspectors have already visited our learning disability ‘step down’ service, and preparations are in full swing to ensure that we are both as welcoming and transparent as possible when CQC arrive.

CQC also recently completed a Mental Health Act inspection of our inpatient mental health wards. Whilst we await the draft inspection report, informal feedback was that they were impressed with what they found, particularly given known staffing constraints. All of the staff involved are to be commended for their exemplary efforts to continue to provide safe, effective care at all times, whatever the pressures.

**Adult wards.** We remain concerned about acuity across our mental health pathways. We have also recently written to Oxfordshire CCG to express our concern about rising activity levels in community services and proposing a relaxation in our assessment window for non-emergency patients. Staff, particularly in the City Team, report that demand cannot be met without these steps: the performance team are currently undertaking a more granular analysis of the data in order to understand these trends and the drivers for them.

In January our out of area placements increased, partly as a result of increased presentations and acuity, but also due to a loss of operational focus on flow. In February we have re-energised the very successful work that was undertaken on this issue about a year ago by running a ‘Perfect Week’ and ensuring that we capture learning from this and re-embed it across our service leadership.

**Learning disabilities acuity.** We have had to support some learning disability patients dealing with particularly challenging situations. I am delighted that both our mental health and LD teams have done an outstanding job of rising to these challenges. However, we continue to live with the legacy of historic deficits in service provision, and do not yet have a firm inpatient proposition that will be right for this very vulnerable patient group. Oxfordshire is not of a scale to be able to support a safe, effective and caring ‘assessment and treatment’ unit for LD. Nonetheless, we continue to need some kind of very personalised alternative either to admission to a general mental health ward or to an out of area placement, albeit that we are funded for such placements within our baseline.

**CAMHS PICU.** We have submitted an outline proposal to NHS England for a CAMHS PICU to be built adjacent to the Highfield Unit on the Warneford Campus in Headington. This includes new emergency ‘front door’ provision for young people.

We are also considering the additional provision of a dedicated 18-25 ward within our footprint to support very unwell patients in managing the transition from being a young person to becoming an adult.

**Awards.** I am delighted to inform you that Amber Ward in Buckinghamshire has now also received its AIMS accreditation meaning that all three older adult wards now have AIMS accreditation. I have also been talking with some of the team recently about visiting some other older exemplary adult wards so that we can raise the bar for our own provision: I fear that we have not always served these patients as well as we should despite the best efforts of staff, and it may well be that we need to invest in improved facilities for these patients who have very complex physical and mental health needs.

**Stroke rehabilitation beds.** I can now confirm that these beds have all moved to Abingdon ahead of schedule. The move was extremely well managed, which is a credit to all of the staff involved.

**Fire safety.** A specific concern was escalated about one of our buildings in Aylesbury. Extensive work with the landlord during the month has confirmed that those using the building are safe, and will be made even safer once planned improvements have been fully completed.

**People**

**Appointment of Deputy COO.** I am delighted to announce the appointment of Pauline Scully as Deputy COO. This is fundamentally an acknowledgement of her experience, seniority within my and the executive team, her passionate advocacy for mental health and her exemplary role modelling of ‘compassionate leadership’. From a personal point of view this will also, in time, give me more headroom as Pauline and I share responsibilities out between us. In her first year I intend to ask her to focus on leading our work on the Five Year Forward View for Mental Health, and to work with HR and L&D colleagues to develop a leadership framework (and supporting suite of materials, training and events) for all leaders in the Trust. We want to become a ‘go to’ Trust for emerging NHS leaders: by raising our game in this way we will raise the game for the entire organisation, all our staff, and those that we provide care for.

**Consultation.** The majority of Service Directors and half of the Clinical Directors have now been appointed substantively, with remaining selection and appointment processes to complete by the second week of March. This means that we are running slightly behind on our schedules, but we hope to make up some of this by running Phases 2 and 3 (Heads of Service and Directorate Support Services) more or less in parallel. Even if all changes are not completed by the end of March (which is likely) I would propose that we begin to report using new Directorate structures from 1st April, so that we are able to provide a full financial year of data rather than making changes mid-year.

**Joint meetings with HR leads**. A huge amount of work continues in this area but we all remain concerned that the things we are doing will be ‘necessary but not sufficient’ in order to rise to our workforce challenges.

I attended on Stuart’s behalf an Oxfordshire system workshop on healthcare support workers. It has been agreed that a system-wide approach is the best way of shoring up recruitment, and a County-wide recruitment campaign is under way, leading interested applicants to a single recruitment portal for all employers from the statutory, voluntary and private sectors.

At this event I also received from a participant a fascinating analysis of the cost of living in Oxfordshire. This suggests that, for lower-paid staff – who make up some 70% of the health and care workforce and at least 30% of the health workforce – current levels of pay do not reflect the cost of living in Oxfordshire, particularly the cost of housing. The research-based UK Minimum Income Standard developed by Joseph Roundtree Foundation (JRF) and others, suggests that a single adult needs to earn £23, 325 a year to achieve a minimum acceptable standard of living in Oxfordshire. This requirement is based on one-bed accommodation. For accommodation with two bedrooms, the minimum household income requirement rises to at least £37,000, for three-bed accommodation at least £50,000.

We await the outcome of national pay negotiations which have been reported may go some way towards addressing this by proposing a minimum NHS wage. If they do not – or if the proposed minimum wage is insufficient for workers to be able to live and work in Oxfordshire – then we will have a strategic choice to make about whether we should implement such an approach on our own behalf. We have been lobbying regionally for the NHS ‘High Cost Living Areas Allowance’ to apply to Oxfordshire but this has not so far been supported since many other trusts do not seem to face the same pressures that we do.

The date for ceasing to use agency healthcare support workers has now been moved to mid-May for quality and operational reasons.

**Time to Change.** We publicly announced our commitment to something called Time to Change, which is a national programme to raise awareness of mental health amongst employers. This also requires us to review and improve our own approach to employee mental health, which is something that we are all delighted to re-commit to.

**Sustainability**

**Oxfordshire urgent care system.** The urgent care system remains under enormous pressure and we remain in a state of high escalation. This has included using a bonus system to reward staff for working extra shifts and using high cost and off framework agencies, which is not something that we normally favour. However, I have taken the view that we should prioritise quality over money at this difficult time, albeit that the CCG have agreed to cover our cost pressures for the period.

Fundamentally, as discussed under the CQC System Inspection section of my report above, we need a completely new way of delivering urgent care across the system. We have made a number of detailed proposals to the CCG and OUH for how we would do this, as well as signaling a willingness to scale up our domiciliary care provision to become a county-wide provider at scale if we are awarded a suitable contract. A full review of the OUH HART service is also under way, since it has now become clear to all system partners that the current arrangements are not sustainable.

**Contracting.** As will no doubt be discussed in the finance section of the Board, the annual contracting round is upon us. Whilst there is more money next year than expected before the budget, pressures across the system are also very severe. Whilst we are confident that we can secure a higher level of funding next year it is likely that this will be absorbed entirely into existing cost pressures, which means very little room for developing our services. In addition, despite a recognition by commissioners of the importance of the Mental Health Five Year Forward View, this needs to be balanced with demands from tariff-based acutes. It is clear that a new approach to contracting will be required that moves the onus for resolving these dilemmas from commissioners to providers (or ‘Integrated Care Systems’ which is the new language being used nationally).

As mentioned above, we have in particular proposed a new way of contracting for urgent care services to Oxfordshire CCG which aligns with this direction of travel. It remains to be seen what their appetite for devolution of budgets really is.

**Finances.** As will no doubt be discussed in the finance section of the Board, we continue to recognise that full delivery of CIPs will not be possible this year, and that there is a high degree of risk contained in next year’s financial plan. Nonetheless it is important that we maintain robust plans for saving money where we can, and I believe that all (well perhaps most) of the necessary machinery to do this is in place. As discussed last month the key areas of focus for next year will be:

* Agency spend;
* Non-pay;
* New business; and
* Developing a new suite of productivity tools to inform future decision-making.

**Joint enterprise.** A draft business plan and Shareholders’ Agreement has now been shared with partners and needs to be brought before the Board. I would propose that we circulate this electronically following the Board, taking comments virtually from Board members in the subsequent fortnight, so that we can hopefully bring a suitable final version to March Board.

**Strategic planning.** As discussed at the recent Board Strategy Day we are now refreshing our Strategy and Business Plan. It is healthy to do this every couple of years, since the context is continually changing and our understanding of what we need to do becoming more nuanced as we all learn how better to shape our response to the demands upon us.

**Tenders.** We have a small number of tenders under way at the moment including one for a new autism service for Oxfordshire which is being submitted with a suitable voluntary sector partner and one for Individual Placement Support (IPS).

**Mental health social care.** We have now produced a draft options appraisal on older adults’ social care provision in Oxfordshire which is being shared with Oxfordshire County Council. I remain concerned that OCC’s approach may not result in the best solution for staff and patients, albeit that I fully understand their frustrations with the historic model. The real question is ‘which solution gives us the best chance of improving things’ so as to align with the CQC System Inspection Report: I remain to be convinced that splitting an existing multi-disciplinary team is the best answer.

**Oxfordshire Transformation Programme.** Oxfordshire CCG has reviewed Phase 1 of the Oxfordshire Transformation Programme with a view to incorporating stakeholder feedback and learning from the experience. Alongside this, the CQC System Inspection has emphasised the need for better health and social care planning and an overarching vision and strategy for health and care in Oxfordshire.

The CCG has stated that it intends to progress with the next phase in a very different way, listening and trying to move forwards by consensus with residents and patients at local level. The goal will be to bring together organisations’ individual strategies to ensure that we have one over-arching strategy, owned by the Health and Wellbeing Board. Further announcements are anticipated in the coming weeks.

**Exec to exec with South Central Ambulance.** A positive exec to exec was held with SCAS. I was unable to attend personally, but have separately had a number of extremely positive discussions with SCAS representatives about improving partnership working on both sides. They are good people.

**Dominic Hardisty, 26th February 2018**