

**Report to the Meeting of the**

BOD 28/2020

(Agenda item: 7)

# Oxford Health NHS Foundation Trust

# Board of Directors

**10th June, 2020**

**Chief Executive’s Report**

**For Discussion**

**Overview**

This will be my last report to the Board before I retire. During the last three months the focus has inevitably been on the Trust’s response to the Covid-19 pandemic, and our teams have risen magnificently and courageously to the challenges that has brought. In all sincerity I can say that there has been no greater privilege in my entire career than to serve with all my colleagues through the last three months. I am grateful to the Board for allowing me the opportunity to defer my retirement in order to do so. The Chairman and I have written to each member of staff in the Trust to express our gratitude and to explain what steps the Trust plans to take to deal with the next phase of the pandemic. I have appended that letter to this report.

I would also like to take this opportunity to welcome Dr Nick Broughton, my successor, who has now started with the Trust, which enables us to have a week during which we will handover the Chief Executive role. With that in mind I thought it might be worth this report offering some longer-term reflections on the period since I became Chief Executive of Oxford Health in 2012, following thirteen years as Chief Executive at South London and Maudsley.

One thing which struck me forcefully when I arrived was how thinly resourced mental health services were by comparison with my experience in South London. An element of that was to do with the level of morbidity, but it by no means explained the whole difference, and some essential elements of a properly developed local service – perinatal teams, comprehensive A&E liaison services, specialist ASD – were either entirely absent or so small as to be unable to begin to address the population health need. The inpatient bed base was, as it remains, one of the lowest per capita in the country. Inpatient staffing levels needed to be boosted, and the publication of the Francis report confirmed that should be the first priority, but it had to be done by reallocating resources within the existing funding; nothing additional was allocated to mental health.

There were some positives: my predecessor, Julie Waldron, had embarked on two much needed major capital developments to improve the fabric of inpatient mental healthcare, and I had the good fortune to be here when the new Highfield Unit and the Whiteleaf Centre were opened. Their foundations – literally – had been laid before my time. The Trust’s specialist services for Eating Disorders, Forensic Mental Health and CAMHS had deservedly high reputations and fulfilled and important regional role. Nevertheless it was impossible to avoid the impression that mental healthcare was of relatively low priority across the whole ‘south central’ area, and in some places, back in 2012, there was simply an attitude of denial when confronted with clear evidence of the shortfall in investment.

I have therefore spent much of the last eight years arguing the case for greater attention to and better investment in mental health services. That cause has been aided by growing national policy focus on the extent to which mental healthcare still needs to bridge a massive ‘treatment gap’ when compared with most physical illness. The Five Year Forward View for Mental Health, for example, set out as an target that the access rate to CAMHS services should increase from around 25% to around 35% - an ambitious uplift, but still leaving 65% without access. Whilst we have considerably exceeded that target access rate locally, ahead of time, the cost has been an increased pressure on clinicians in the service, and there is still unmet need and long waiting times for treatment.

More recently the NHS Long Term Plan has brought a welcome emphasis on investment in mental health services to enable them to catch up further, but much of what the plan sets out is additional to a ‘core’ local service, and so it must sit alongside efforts to get that on a stable and sustainable footing.

There has been some progress, first in Buckinghamshire, and most recently, following the work of the Shipman review, in Oxfordshire. In both cases however the achievement to date has been largely about properly funding activity which the Trust is currently providing in excess of what is it resourced to deliver, and that still leaves the requirement to bring the capacity of local core services up to a level which might reasonably be expected to serve the needs of the population. It is critically important therefore, as we noted at the last Board, that the agreement concluded in Oxfordshire in March also contains a clear commitment to bring mental health funding in line with the level of funding for acute and other elements of the healthcare system, given the operation of national allocation formulae. The responsibility to hold all parties to fulfilling that commitment in the years to come remains with the Board.

One of the successes of our work in mental health over the past eight years has been the growing collaboration with third sector partners, initially in the Oxfordshire Mental Health Partnership, but increasingly as the default approach to the provision of care. That collaboration has also been a feature of the Trust’s leadership of three mental health New Care Models, which have proved very successful in reducing the numbers of patients who are sent far away for specialist inpatient treatment.

The requirement to advocate for mental health has not, I hope, been at the expense of community services. In fact, in my interactions with the wider health and care system, more than 80% of the time is spent in discussion about community services, which is one of the reasons why somebody needs to draw proper attention to mental health. It should be said however that for a long time the principal focus of much of that system wide discussion about community services has been about their role facilitating discharges from acute services, and into community hospital beds. That too is now beginning to change and there is thankfully a growing recognition that more focus needs to be given to how community services and primary care work together systematically to support patients in the community and to prevent the need for them to go to hospital in the first place.

The establishment of three Emergency Multidisciplinary Units (or RACU in the case of Henley) has been an important step forward in building the infrastructure to support that. The model of care developed at Townlands Hospital in Henley, in conjunction with the Royal Berkshire Hospital, has demonstrated the range and extent of specialist healthcare which can be brought out of the acute setting and much closer to local communities, and how community hospitals without inpatient beds can enable frail elderly people who need a period of bed based care can be supported by outreach into local care homes.

Our growing collaboration with GP Federations, and latterly with the nascent Primary Care Networks is fundamental to this work, which is now reinforced by the national ‘Ageing Well’ programme. The last three months have shown how effective working together in this way can be as we have tackled Covid-19, and I am confident that the Board’s decision to appoint Dr Ben Riley as Managing Director for Primary and Community Care will help to build on the innovation and fresh thinking which that experience, so difficult in many ways, has nevertheless brought about.

One of my principal reasons for coming to Oxford Health was that it seemed to me there were great opportunities to foster clinical academic collaboration, and to bring to local healthcare the benefits of working with what was already back in 2012 rated as the world’s best medical school. I knew from my experience in south London how valuable an asset that could be if cultivated effectively by both parties. Again there were some foundations to build on, but I think that over the last eight years considerable progress has been made in establishing a centre for research in mental health and primary, community and social care which will bring great benefits to clinical practice and training locally and internationally for decades to come.

The establishment of the CLAHRC (now the ARC) was the start, but has since been followed by our involvement in a very active and successful AHSN, the designation of the Oxford AHSC (now Oxford Academic Health Partners), and the creation of what is still only the second mental health Biomedical Research Centre in the country. The attachments to this report describing how they have risen to the challenge of Covid-19 demonstrates both the skill and versatility and the importance of this powerful partnership. I would like to pay particular tribute to Professor John Geddes, Head of the Department of Psychiatry and the Trust’s R&D Director, who has made an enormous contribution to this achievement.

Nothing is more emblematic of the priority accorded to mental health over past decades in this part of the world than the fact that the main inpatient base for adult care in Oxfordshire is in buildings at the Warneford Hospital which will shortly be 200 years old. Much of the rest of the mental health estate has now been improved, and the contrast with the facilities in Buckinghamshire is now stark, so it is imperative that the situation is addressed. The success of the clinical academic collaboration offers opportunities which are available to very few other NHS Trusts to progress that goal. The Strategic Outline Case approved by the Board in April for the redevelopment of the Warneford, creating a new hospital, expanded research facilities, a hub for the development of life sciences for neuroscience and psychiatry, and the establishment of a new postgraduate college for medicine and related disciplines is therefore hugely important for the future.

I have tried to foster the spirit of partnership and engagement in the way in which the Trust works as an organisation, and while there is undoubtedly still much more to do, I hope that internally and externally there have been some signs of that making a difference. The establishment of Oxford Healthcare Improvement is a key piece of infrastructure, but more work is needed to embed the learning it brings across our services and into our partnership working. I hope that we have raised the importance of addressing inequality as part of our core agenda; the ‘Linking Leaders’ events have allowed us systematic and serious consideration of a wide range of dimensions of inequality. As current events in the world around us show all too clearly, we still have much more work to do to build a culture in which everyone feels truly included. We have significantly stepped up the means we have for involving patients and carers and for understanding better their experience of care. The future of healthcare will, I remain convinced, be more and more about a joint endeavour between practitioners, patients and carers, rather than the traditional model of doing something ‘to’ or ‘for’ people, and I hope that the last eight years have left the Trust better equipped to support that approach.

**Contracts and Funding**

There is no change to the situation reported at the last Board. Covid-19 has effectively suspended progress on closing out the FY20 commissioning contracts and completion of the FY21 contracts. Following the agreement in early March, following mediation, with Oxfordshire CCG to the increased level of investment in mental health services the contractual details have not yet been finalised and we continue to hope that this delay will not have any material impact. It remains important that we proceed with completion of the contract as soon as the Covid-19 situation allows. For Buckinghamshire and Swindon, Wiltshire and Bath and North East Somerset, the main contract details have been agreed but progress to complete the contracts continues to be suspended. For mental health services across all of our contracts the matter of the Mental Health Investment Standard additional funding and the Mental Health Transformation funding, both key elements of the NHS Long Term Plan, has yet to be clarified. It is not yet known when the funds will be available which puts at risk the delivery of planned improvements within the financial year; clarification from NHSE/I is being urgently sought.

Transition from the prototype New Care Models, for Forensic, CAMHS and Eating Disorders, to the new Provider Collaboratives, has been postponed at least until 1 October 2020 due in part to Covid-19 but also due to some critical outstanding contractual matters. Discussions have recommenced to determine whether an October start is at all feasible.

**Local issues**

1. **Financial Performance FY21: Month 1, April 2020**

The financial plan that was submitted to NHSE/I for FY21 was for a £2.8m surplus, however, this included a late adjustment of £2.8m additional cost improvement (CIP), as OHFT’s contribution to closing the deficit in the consolidated BOB ICS financial plan, and £2.7m financial recovery funding (FRF). The underlying OHFT financial plan is for a £2.8m deficit.

The financial regime that has been implemented as a result of Covid-19, and which is initially applicable to the period April to July, is designed to ensure that all trusts breakeven and hence will have sufficient liquidity to remain a going concern. This has meant that in April a breakeven position was reported. Additional costs of £1.6m incurred due to Covid-19 have been recharged to NHSE/I. The underlying OHFT financial position for April was a small surplus, slightly better than the submitted plan. There are a number of uncertainties around these financial arrangements, most notably the lack of transparency around the additional funding of the Mental Health Investment Standard and the service transformation investments. However, the usual financial controls and scrutiny remain in place.

1. **People: Recruitment and Retention**

I will speak specifically to the matter of our Covid-19 response at the meeting, but significant effort continues to ensure we regularly communicate with our staff and leaders around Coronavirus. We have:

* Continued a programme of webinars;
* produced a key messages update email now twice weekly for all staff;
* answered hundreds of questions from staff, managers and staff representatives;
* continued ongoing development of FAQs on our intranet;
* improved our wellbeing pages with quick links on a wide range of practical and emotional support tools etc;
* A two stage Risk Assessment process has been developed – firstly an online screening tool (paper version for those unable to access online) and secondly a more thorough Personal Risk Assessment which examines the role, risks, mitigations available and adjustments required. This is to be done by line managers with staff in higher risk occupations or categories, including age, ethnicity, underlying health conditions and pregnancy. The intention is to provide support and tailored decisions rather than blanket approaches to risk assessment and decisions about whether people can work.
* Further discussions with our three staff equality networks (race, disability and LGBT+) have taken place to better understand the impact on groups of staff who may have particular needs or additional support requirements. Another round of these discussions is planned for 10 June 2020 and we will act accordingly with support and improvements;
* Good dialogue with staff representatives including via the usual meetings and supplemented by a weekly call with the Chief Nurse and HR Director to ensure we are aware of and responding to issues highlighted by staff side;
* Recruitment work is continuing at a good pace and plans are being developed for a phase two advertising campaign to build on the work done so far, and capitalise on the goodwill towards the NHS and the economic downturn impacting some other sectors of the economy. Our Learning and Development capability gives us a strong base to “grow our own” staff, hiring those with no previous health or care experience and training them through our apprenticeship or other programmes.

Communication with staff will need to remain a high priority and we continue with regular briefing notes, FAQs, and updates as well as listening events. As referenced earlier I have appended the letter to each member of staff acknowledging their magnificent efforts and updating them on various important aspects of the crisis including testing, risk assessment and recovery.

1. **COVID-19 response**

As referenced above, I will devote much of my oral update to the Board on the impact of and response to this international emergency.

We have faced Covid-19 for nearly three months now. But if the initial peak of cases is now gradually beginning to decline, we are entering a new and different phase, bringing its own risks and challenges. We must be very careful to avoid any recurrence of the virus spreading rapidly. This next phase may go on for quite a long period of time, and we will need to find a way to operate as normally as possible while still taking a comprehensive range of extraordinary measures to protect against the virus and to minimise the possibility of any further resurgence.

Along with many Trusts providing mental health and learning disability services, Oxford Health has played a key role throughout the pandemic by transforming care, both to maintain services and respond to the significant challenges presented by the COVID-19 pressures.

We have been quick to adapt, supporting the acute sector by providing support and setting up such as mental health 24/7 emergency service access lines. We have accelerated discharge through our community services, reduced avoidable admissions with enhanced crisis care, and moved many home-treatment models and clinical services online.

However, we must ready ourselves for the pressure our mental health services will continue to face in the weeks and months ahead, given a predicted surge in demand for mental health care as lockdown eases. Activity in many mental health services has either not reduced as significantly as in other areas of the NHS or has been met through new forms of support often in the community. Mental health providers are already beginning to report a significant increase in demand and the severity of new referrals, so there are more challenges ahead of us.

The size and complexity of the challenge facing us as we seek to meet pent up demand, and the predicted surge in new demand cannot be underestimated and will require effective and careful prioritisation. Our demand and capacity work will help shape requirements for services, as well as support to invest in the data and analysis to understand what changes prompted by the pandemic have added value and need to be locked in, and where recovery and restoration of services is needed.

Key to meeting the extra demand will be ensuring that the required expansion in service provision is fully and promptly funded, on a sustainable basis. This funding must reach the frontline services that need it most, including core community mental health services, but also social care and key services provided by the voluntary sector.

The pandemic has exacerbated the significant workforce challenges we were already facing and so close attention to workforce planning will be paramount and we will need to ensure staff get the time they need to rest and recover given the toll the pandemic response has taken on them.

I reported last time that we would undertake a new, more detailed and comprehensive programme of screening and risk assessment of all staff in relation to Covid-19. That has already taken place and covered a range of factors which evidence suggests may convey greater degrees of risk including age, obesity, underlying health conditions and, especially in the light of the concerns which have been identified nationally, being from a BAME background.

I wish to thank everybody again for the outstanding efforts that have been made in helping us to respond and to keep caring for those that need us. As we all try to balance the impact of Covid-19 on our personal life and our work, it is essential that we think of our own health and that of our colleagues as much we do that of our patients.

1. **CEO Stakeholder meetings and visits**

Since the last board meeting, key stakeholders with whom I have met, visits I have undertaken and meetings that I have attended have included:

* Health Gold Covid-19 Update – *twice weekly*
* Daily Covid-19 Partnership Group update
* MH/LDA Covid-19 response weekly webinar for Trust CEOs
* CAMHS Consultants & senior leadership meeting
* South East MH LDA Cell & system leads *weekly*
* Provider CEOs catch up calls *twice weekly*
* COVID-19 top team webinar
* BOB ICS MH Delivery Board
* Warneford Strategic Business Case
* SE Leaders call with Anne Eden *weekly*
* Warneford Review
* Warneford Park Steering Group
* TVLRF Strategic Recovery Coordinating Group *Weekly Telecon*
* OCCG The role of the primary care/community services group
* COVID-19 top team webinar
* NHSEI South East Regional Roadshow – second phase
* Bucks County Council – Assistant Director Social Care Interviews
* AHSN Emergency Mental Health Covid learnings meeting
* Informing our response to *Covid-19* by research
* Warneford Park Steering Group
* CE Restoration and Recovery Working Group - *fortnightly*
* OCC Home First & Admissions Avoidance
* CCG/OH agreement – meeting with OMHP CEOs
* ARC Strategy Board
* SE MH Deep Dive
* OCA Project Board meeting
* Oxford AHSN Board
* BOB ICS Mental Health Delivery Board
* Warneford Park – OCC/Quod meeting
* Oxfordshire Digital Strategy Group
* BOB ICS System Leaders Group

1. **Research & Development (R&D)**
   1. **R&D and COVID-19**

I attach two papers detailing the impressive range of research activity on Covid-19 undertaken in the BRC and the ARC. My thanks to Professor John Geddes and Professor Richard Hobbs for their work in leading this.

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

The most recent update from the AHSN is provided below:

* The Oxford AHSN response to Covid-19: The Oxford AHSN is supporting our partners in the NHS and social care in responding to the challenges posed by the unprecedented Covid-19 pandemic. We have refocused our work using our experience in sourcing innovation, sharing expertise and connections to support our partners across the region in delivering an effective response. The research and innovation priorities of workforce, use of digital/AI technology, mental health and multimorbidity that emerged from the NHS needs survey last year have proved to be highly relevant in responding to the pandemic.
* Earlier work we had carried out in digital and diagnostic innovation has enabled rapid regional and national rollout of innovation to support the response to the pandemic. One example is the rollout of Sleepio, a digital therapy programme improving health and wellbeing through better sleep, initially part of the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System workforce programme, which has now been made available free to all NHS staff in England with thousands already using it.
* Our chief executive Professor Gary Ford has written a blog about the unprecedented response from the NHS, supported by AHSNs and others: <https://www.oxfordahsn.org/news-and-events/news/the-pandemic-has-shown-the-nhs-can-adopt-and-drive-change-rapidly/>
* More details of the AHSN’s Covid-19 response – including case studies and resources – can be found on our website at: <https://www.oxfordahsn.org/our-work/covid-19/>
* Farewell to Stuart: At its meeting on 28 May the Oxford AHSN Board passed on its best wishes to Stuart Bell. Stuart led the development of NHS-academic partnership working in mental health in the region and is a former chair of the AHSN’s R&D oversight group.

1. **National and Regional issues and transformation developments**

A helpful digest of national and legal issues and guidance emerging since the last report is routinely on the Board’s agenda. Other key developments worthy of reference are as included below:

* 1. **System Integration in BOB**

The BOB ICS Bulletin is appended to my report for Board’s reference which highlights the latest with regard to continued partnership working, strong clinical leadership and the efforts of all colleagues to address challenges.

Despite the positives of collaboration across the ICS during the pandemic so far, the extent of the impact of Covid-19 on staff across the system and our local communities is still being felt and our understanding increases each day – we have seen colleagues lose their lives and our BAME communities have been particularly affected by Covid-19.

The bulletin highlights that addressing these and other issues, restoring services and “resetting” the health and care system will need to be a joint, collaborative effort with health and social care, staff and local communities. The pandemic has also enabled a lot of innovation to happen with new ways of working, new ways of supporting patients and new collaboration between services – restoration and rebuilding plans need to take this into account, as well as ensure that vigilance on the COVID-19 response is maintained.

With this in mind, the System Leaders Group has agreed to set up a Restoration and Recovery Board, that enables this work to be done and to ensure linkages with the recovery efforts of all partners within the Thames Valley Local Resilience Forum.

1. **Consultant appointments**

There have been three consultant appointments since my last report. On the panel were: Mark Hancock, Medical Director; Vivek Khosla, Clinical Director and Tina Malhotra, Associate Medical Director.

Appointed candidates:

1. Dr Arif Ahmed was appointed to a consultant psychiatrist post with Chiltern AMHT. Arif has been working with us as a locum consultant since March 2018 following successful completion of his higher training with the Trust. In addition to Arif’s medical degree from Sree Siddhartha Medical College, Bangalore, India, he also joins us with a post-graduate diploma in Psychiatric Practice from the University of Hertfordshire.
2. Dr Owen Curwell-Parry was appointed to a consultant psychiatrist post with Aylesbury AMHT at the Whiteleaf Centre. Owen is currently an ST6 trainee with the trust and is due to achieve his CCT in August 2020. Owen has been a trainee of the trust for many years, completing both his core and higher training with us. Owen has both a degree in medical sciences and a medical degree from the University of Oxford.
3. Dr Alison Lennox was appointed to a consultant psychiatrist post with the Buckinghamshire Adult Autism Diagnostic and Intervention Service and ADHD service. Alison has been working for the Trust since completion of her higher training with us, based with South AMHT working across our Wallingford and Abingdon sites. Alison has a real interest in neurodevelopmental disorders and has completed training in the treatment of adults with ADHD and an the ADOS-2 course to improve her knowledge of the assessment of these disorders. Alison completed a bachelor of arts in 2006 and a master of arts from the University of Cambridge, and competed her medical degree with University College London, she also has a Postgraduate Certificate in Teaching and Learning for Health Professionals (PGCert) from the University of Bristol.

**Recommendation**

The Board is invited to ratify the consultant appointments and to note this CE report seeking any necessary assurances arising from it or any appendices.

**………and finally**

I would like to thank the Board and my Executive colleagues for all their support and encouragement over the last eight years, and especially Martin Howell and David Walker, the two Trust Chairs under whom I have had the privilege to serve.

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