THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST

EXECUTIVE REPORT - CURRENT ISSUES

1. Executive Team

Particular attention is drawn to:

i) Preparation and state of readiness for Winter 2015/16.

ii) Navigating the evolving scenarios of policy directives and multi-factorial strategic/operational reach-in (regional and national).

iii) Caseload presentation arising out of the Northumbria Healthcare reconfiguration, post opening of the new Specialist Emergency Care Hospital, East Cramlington.

iv) Addressing the requirement to sustain financial stability and all this entails.

v) The escalating demand from an ever growing cohort of failing NHS providers to be underwritten via finite national bail out funding.

vi) The ever worsening crisis in North Cumbria and future interface with Newcastle upon Tyne as the regional supra-specialist provider.

vii) Care Quality Commission Whole Service Portfolio inspection scheduled 19th to 22nd January 2016.

viii) A raft of interrelated, problematical issues surrounding national Tariff (2016/17) and the risk of adverse consequential impact on leading specialist providers as exemplified by Shelford Group dialogue with Department of Health and NHS England.

ix) The recruitment challenge surrounding nursing staff vacancies.

x) Publication of the Annual Review incorporating the Statutory Annual Report and Accounts 2014/15.

xi) The ongoing challenge of the Newcastle Hospitals PFI and delivery of expectations in the public interest.

2. Key Impact Documents/Statements from Government/Regulators/Advisory Bodies/ Others

(i) Risk Assessment Framework (Monitor)

A consultation in June 2015 proposed a number of changes to the Risk Assessment Framework, aimed at strengthening the regulatory approach.

Arising out of the consultation, the changes in the updated Risk Assessment Framework include:

- Monitoring in year financial performance (income and expenditure margin) and the accuracy of planning.
- Combining a Foundation Trust's rating on these 2 measures with the existing elements of the CoS risk rating to produce a new single financial sustainability risk rating.
- Including a value for money governance measure within the existing governance rating.
- The requirement for all Foundation Trusts to submit monthly financial information via a monthly template.

In summary Monitor has advised:

"The changes we have made will enable us to act sooner where there are concerns about a Foundation Trust's financial sustainability and/or efficiency. However they will not lead to an automatic licence breach. They allow us to consider whether a potential investigation is necessary."

(ii) **A&E delays: Why did patients wait longer last Winter? (Monitor)**

Monitor published a paper on 3rd September 2015 which focused on the aggregate performance of A&Es against the four hour target since the third quarter of 2011, with a particular emphasis on Q3 2015/16 where it fell to its lowest percentage for a decade.

The following is to be noted:

- The aim of the report was to identify what factors caused the sudden decline in Q3 2014/15, and recommend actions that urgent care systems and national bodies could take to stop it from happening again this winter.
- Monitor's analysis suggests the decline in A&E performance can be explained by national systemic challenges, namely a Trusts inability to accommodate the increase in admissions from A&E departments generated by the increase in A&E attendances, and, to a lesser degree, blockages at other stages in the patient pathway.
- Staffing problems and the physical capacity of A&Es are not identified as having a significant contribution to the decline in A&E performance.
- Recommendations made to urgent care and national bodies include the prioritisation of:

    - Improving patient flows through urgent care systems to increase processing capacity.
    - Gaining a better understanding of the impact of social and community care.
    - Supporting local efforts to tackle challenges, e.g. through system resilience groups.

The Medical Director shall give an update at the meeting.

(iii) **The NHS in Five Years' Time (Dods)**

Parliamentary communications agency Dods has published a report which contains the results arising from a survey of 2,608 health workers' attitudes on the future of the NHS.

Key findings include:

- 48% said their role had been significantly impacted by financial constraints this year.
- 60% of health professionals see efficiency savings as their number one priority.
- 4% are confident the NHS will make savings of £22bn under NHS England Five Year Forward View by 2020.
- 42% agree that a move to a truly seven-day NHS would have a positive impact, although impact on resources is a widespread concern amongst the majority of respondents.
- Moves towards greater integration fall short on priority of NHS leadership, far lower than the ambition to make efficiency savings.
- 80% of health professionals surveyed said their organisation had insufficient resources to meet its current needs.

(iv) **Transforming Urgent and Emergency Care Services in England – Safer, faster, better: good practice in delivering urgent and emergency care - NHS England (A guide for local health and social care economies)**

This document from NHS England is designed to help frontline providers and commissioners deliver safer, fast and better urgent and emergency care to patients of all ages, collaborating in UECNs to deliver best practice.

It sets out design principles drawn from good practice, which have been *"tried, tested and delivered"* successfully by the NHS in local areas across England. However, the guide should not be taken as a list of instructions or new mandatory requirements. Implementation should be prioritised taking into account financial implications and local context.

(v) **Establishing and implementing best practice to reduce unplanned admissions in those aged 85 years and over through system change (National Institute of Health Research)**

The National Institute for Health Research (NIHR) has released a study which seeks to identify system characteristics associated with higher and lower increases in unplanned admission rates in those aged 85 years and over; to develop recommendations to inform providers and commissioners; and to investigate the challenges of starting to implement these recommendations.

Key findings include:

- Between 2007/8 and 2009/10, average admission rates for people aged 85 years and over rose by 5.5% annually in deteriorating sites and fell by 1% annually in improving sites.

- In deteriorating sites, there were problems with general practitioner access, pressures on emergency departments and a lack of community-based alternatives to admission.

- The most striking difference between improving and deteriorating sites was not the presence or absence of specific services, but the extent to which integration within and between types of service had been achieved.

The final list of recommendations emphasises the importance of issues such as maximising integration of services; strategic leadership; and adopting a system-wide approach to reconfiguration.

(vi) **Agency Spending Rules (Monitor and Trust Development Authority)**

From 19th October 2015, Trusts subject to agency spending rules will have to secure nursing agency staff via approved framework agreements. Trusts must adhere to the rates published in the framework agreements for their chosen supplier.

All framework owners have been obliged to seek approval from Monitor and the Trust Development Authority by 14th September, before the final list is published on 17th September 2015.

(vii) **Background to the 2015 Spending Review (House of Commons)**

The House of Commons has issued a background document to the Spending Review, which will be announced on 25th November 2015.

Health features in this document as per the below:

- Spending 2015/16 for health stands at £116.6bn (the next biggest departmental spend is Education, at £58.2bn)
- The budget for the NHS (alongside schools spending, overseas aid and defence) is confirmed as protected – the following quote is from the Chancellor ie "[ring-fencing these areas is] an expression of the political desire by the Government to protect NHS spending, to protect schools spending and to hit our international development target. Much is made of the ring-fencing but, ultimately, it is just an expression of political will by Government and Parliament, these are areas of public spending that we want to relatively protect".
- The Government's commitment to increase spending on the NHS by £10bn in real terms by 2020/21 compared to the 2014/15 level is reiterated.

(viii) **The Chancellor's Choices: How to make the Spending Review as progressive as possible while still delivering a surplus (Institute for Public Policy Research IPPR)**

This report from the IPPR shows how the Chancellor could make the forthcoming spending reviews as progressive as possible – while keeping his promises to reach a surplus by 2019/20 and to avoid rises in national insurance, income tax or VAT.

Through detailed analysis of the figures, the IPPR indicates the Chancellor chose to protect social care; expand free childcare; protect education for 16-19 year-olds; support young people into work; and invest in housing, science, energy efficiency and also the *"Northern Powerhouse"* – whilst still reaching a surplus in 2019/20.

With regard to healthcare, the IPPR suggest that on top of the Government's plan to deliver an additional £8 billion to the NHS annually by the end of this Parliament, the Government should protect the revenue support grant to Local Authorities in flat cash terms in each of the four years from 2016/17 to 2019/20, in order to support adult social care. Transfers from the NHS to Local Authorities should continue, with the Better Care Fund sustained throughout the spending review period. Finally, whilst it is not earmarked for social care, the public health grant to Local Authorities should be protected in cash terms, and the ring fence removed, in order to give Local Authorities greater financial flexibility.

(ix) **National Maternity Review (NHS England)**

The online consultation is now live for the NHS Maternity Review. The review began its work in April this year to get a picture of the current state of maternity services across England and determine what can be done to improve these services. The consultation is available at the following link: https://www.engage.england.nhs.uk/survey/nhs-maternity-review.

The consultation is open to women who have been pregnant and supported by the NHS, to their husbands or partners, friends and family members. Also healthcare professionals, charities and representative organisations as well as commissioners of Maternity Services can input. The consultation will be open until 31st October 2015. All comments will are set to contribute to the Review's recommendations, which it is understood shall be published in December 2015 on the NHS England website.

(x) **Proposals for Whistleblower Guardian (Care Quality Commission)**

The Care Quality Commission has set out proposals for how to establish a *"national guardian"* for NHS whistleblowers. Under the plans the role will answer to the CQC's Chief Executive but the guardian's independence will be protected and they would have the freedom to criticise the regulator *"if they feel it is necessary".* The creation of an *"independent national officer"* to oversee and review the treatment of NHS whistleblowers was one of the main recommendations of Sir Robert Francis' Freedom to Speak Up Review, and it was announced earlier this month that the officer would be based in the CQC.

While the guardian will be able to identify incidences where whistleblowers have not been properly treated and suggest remedies, the role will not have the statutory powers to make Trusts comply with them. Under the CQC's proposals, the position would be appointed and managed by its Chief Executive, and the appointing panel would include representation from NHS England, Monitor and the NHS Trust Development Authority. To preserve the guardian's independence, they would sit outside the CQC's Executive Team, and their reports would not have to be signed off by the CQC or the other arm's length bodies.

(xi) ***"Devo Manc"* to be subject to national regulation**

Leaders of the much vaunted Greater Manchester devolution project have accepted that national bodies will still be responsible for regulating NHS services in the region. However, the Interim Chief Officer for the project has said there will still need to be a *"new regulation model"* for the region, with input from local leaders. In essence this would entail regulators, including Monitor and the Care Quality Commission, taking a broader health system approach, rather than focusing on the performance of an individual provider. *"Frustration"* with current models is spoken of and discussions are taking place with Monitor and the CQC over new arrangements. Councils and the NHS in Greater Manchester had initially sought to lead the regulation of NHS providers in the area. However, the wording around this was refined in the final Memorandum of Understanding with NHS England. In July 2015, an amendment to the Devolution Bill saying regulatory or supervisory functions could not be transferred from national bodies was passed in the Lords. It is not expected that Greater Manchester will seek different performance targets, as it will still be subject to the NHS Constitution et al.

(xii) **Northumberland CCG set to hand over to 'Accountable Care Organisation'**

As part of a national Vanguard inspired initiative and in what is being heralded as a first in the NHS, Northumberland Clinical Commissioning Group is working towards handing over its budget and nearly all of its functions to a provider led ie an *"Accountable Care Organisation" (ACO).* The proposal is part of Northumberland CCG's work to overhaul its models of care and contracting. This would clearly represent a very substantial reduction of the CCG's functions, and a radical move away from the current commissioner/provider divide. The plan is to establish a Special Purpose Vehicle (SPV) organisation, to which both the CCG and primary care budgets for the geography in question would be delegated.

The SPV would be akin to an ACO and similar to the provider networks being developed in the United States to take on substantial delegated risk and responsibility for the planning and funding services for defined population catchments. It is understood the SPV would be jointly governed by Northumbria Healthcare NHS Foundation Trust together with representatives of Primary Care, Public Health, and others in the area. It is understood governance per sé is being designed to ensure that population health needs and out of hospital care are prioritised. The expected start date for the new model is April 2017. However, some elements may be run in shadow form in 2016.

Impact and consequences in relation to '*North of Tyne'* as a whole are being addressed, albeit may prove to be rather problematical under the given circumstances.

The Chairman will lead discussion on the key issues that most understandably beckon from the perspective of the impact on the local health economy.

(xiii) **Strategy and Business Plan for 2016-21 (Care Quality Commission)**

The CQC is running a web survey to generate informal input to their strategy and business plan for 2016-21. The three key areas it is focusing on in the plan are: how providers use the resources available to them to deliver high-quality care; factors that affect quality outside individual providers; and refining the CQC regulatory model to make it more efficient and effective. A full consultation on the strategy will be published in early 2016.

(xiv) **Managing Conflicts of Interest in NHS Clinical Commissioning Groups (National Audit Office)**

The National Audit Office has found that some 1,300 NHS Clinical Commissioning Group Board members were susceptible to conflicts of interest, as they were also doctors in active Primary Care practice.

It is of interest that the investigation also found that commissioners who are not medical practitioners have potential conflicts of interest when they have financial or other interests in organisations that provide local health services.

(xv) **Multi-dimensional Performance Assessment using Dominance Criteria (Economics of Social and Healthcare Research Unit)**

This report outlines the difficulties in judging hospital performance as the following:

- There is no single measure of performance as hospitals have different objectives that they are expected to achieve, e.g. access, safety and affordability.
- People might value the above objectives differently, which makes it difficult to construct an overall measure of performance that everybody would be happy with.

(xvi) **Improving Length of Stay – what can hospitals do? (The Nuffield Trust)**

The Nuffield Trust, in conjunction with Monitor, has published a report which aims to find the best ways to improve quality of care across the health system in light of recent pressures on urgent and emergency care.

In summary, the report identifies significant opportunities to reduce length of hospital stay through improvements in internal processes and the development of alternative services and draws attention to the following principles of good practice:

- Focus on flow.
- Getting the basics right, eg creating standardised pathways for common patient types that are based on evidence and clinical consensus complemented by structured Ward rounds.
- Maintaining a rapid pace for decision-making and patient progress.
- Ensuring active support for discharge seven days a week.

(xvii) **CQC Ratings replace Foundation Trust status as '*definition of success'* (Secretary of State for Health)**

The mark of quality for an NHS provider is no longer the Foundation Licence but the award of a *'good'* or '*outstanding'* rating by the Care Quality Commission.

The Secretary of State has made it clear that he was making the attainment of one of the CQC's highest ratings the *"single definition of success"*. The possibility has also been floated that there could be statutory change to make the freedoms given to Foundation Trusts available to any Trust that is rated *'good'* or '*outstanding'.*

(xviii) **'Too many Trusts in the NHS' (Secretary of State for Health)**

The Secretary of State has heralded that there are *"too many Trusts in the NHS"* and a need to *"up the pace of work on hospital chains and other provider reforms".* These comments come amid renewed interest in the so called *'chains'* in both Government as well as NHS England whom it is understood are selecting sites for its *'Acute Care Collaboration Vanguard'.*

In 2014, the Dalton Review (Salford Royal NHS Foundation Trust inspired) advocated a range of organisational forms for NHS Providers including hospital chains; Moorfields style single service chains; and management franchises.

It is to be noted that Salford Royal NHS Foundation Trust and the Wrightington, Wigan and Leigh NHS Foundation Trust have submitted a bid to NHS England's national Vanguard scheme to *'kickstart'* the *'chain initiative'*.

(xix) **North Cumbria Success Regime Programme Board (NHS England)**

A Programme Board has been established to oversee the initiative taken by NHS England to bring about high quality, safe services which are clinically and financially stable.

Newcastle Hospitals are seen to be a stakeholder in this quest.

(xx) **Complaints about Acute Trusts 2014-15 (Parliamentary and Health Service Ombudsman)**

The report provides details of the number of complaints received for each Trust, the outcomes of these complaints and the reasons which led people to complain. In 2014-15 the PHSO upheld 44% of investigations into complaints about Acute Trusts.

The PHSO advises:

"*As part of the drive to provide transparency to people about the complaints that we handle, we want boards to see regular data about complaints so they can identify themes and recurring problems and take action. This is why I am pleased to be publishing the second in our series of regular publications outlining the insight we have drawn from our complaints data, broken down by Trust.*

We believe all complaints offer an insight into how Trusts are performing. However, there are many factors that influence the number of complaints that

different health organisations receive. This includes (but is not limited to) the size of the organisation, the specialisms it deals with, patients' demographics and ease of access to a complaints service. If complaints data is to be useful and encourage learning, it is important that this context is taken into account".

The information contained within the report is not designed to rank Trusts on the basis of their complaints information or assess the performance of individual organisations when it comes to handling complaints.

However, the data does pose some interesting questions, and the PHSO is of the belief it will enable Trusts to better explore their approach to handling complaints. For instance, why are some Trusts seven times more likely to have a clinical episode turn into an investigated complaint than others?

Sir Leonard Fenwick
Chief Executive
17th September 2015