Agenda Item 1.v

Report to:	**Board of Directors**	**Date: 3 October 2019**
Report from:	**Chief Executive**	
Principal Objective/ Strategy and Title	**Chief Executive Report**	
Board Assurance Framework Entries	**Governance**	
Regulatory Requirement	**N/A**	
Equality Considerations	**None believed to apply**	
Key Risks	**N/A**	
For:	**Information**	

1. Purpose/Background/Summary

This report provides the Trust Board with a monthly update from the Chief Executive.

2. Summary of the NHS's recommendations to Government and Parliament

In February 2019 NHS England and NHS Improvement launched public and stakeholder engagement on proposals for NHS primary legislation, building on the outline proposals that arose from the NHS Long Term Plan process. On 24 June Parliament's cross-party Health and Social Care Select Committee published the findings of their parallel inquiry, which has helped shape NHS England and Improvement's response.

The report outlines a number of areas such as getting better value for money, increasing the flexibility of national NHS payment systems and integrated service provisions. At its core it recommends an NHS Bill should be introduced in the next session of Parliament. Its purpose wold be to free up different parts of the NHS to work together and with partners more easily. Once enacted, it would speed implementation of the 10-year NHS Long Term Plan.

The summary lists a number of points (the 'we' they refer to is NHS England and NHS Improvement):

- The Competition and Markets Authority's (CMA) roles in the NHS, as provided for by the Health and Social Care Act 2012 (2012 Act), should be repealed. There is strong public and NHS staff support for scrapping section 75 of the 2012 Act and for removing the commissioning of NHS healthcare services from the jurisdiction of the Public Contracts Regulations 2015. Taken together, these changes would remove the presumption of automatic tendering of NHS

healthcare services over £615k. Monitor's specific focus and functions in relation to enforcing competition law should also be abolished.

- The triple aim duty should reflect the need to engage local communities and build on the existing duties of local authorities and CCGs to engage patients and citizens, to collaborate in the performance of their functions, to integrate care delivery, and to improve the health and wellbeing of residents. Successful implementation of the NHS Long Term Plan requires the NHS to forge strong links with its communities, citizens and local government partners, not just to improve the planning and delivery of NHS services, but to promote physical and mental health and wellbeing, support the design of healthy communities, tackle inequalities, connect people better to relevant local community assets, and act as anchor institutions. We did not hear of specific NHS legislative barriers that hinder community co-production. Instead it may be possible to embed the principles of community co-production more clearly within the main text of the NHS Constitution.
- The Select Committee agreed that NHS commissioners and providers should be newly allowed to form joint decision-making committees on a voluntary basis, rather than the alternative of creating Integrated Care Systems (ICS) as new statutory bodies, which would necessitate a major NHS reorganisation. We propose that NHS England and NHS Improvement should not have any new and additional powers of intervention in relation to such committees beyond those that exist in relation to CCGs and NHS providers. The law should make it permissible for NHS England and NHS Improvement's regional teams to participate for example in relation to specialised commissioning. It is also important to note that we propose to maintain current statutory duties to assess and report on Clinical Commissioning Groups (CCG) performance, and to oversee providers, albeit in ways that better reflect system working and the new triple aim duty.
- Joint committees should be flexible enough to serve two different and distinct purposes. The first purpose is to enable closer collaboration and decision making between separate providers. The second is to assist and further the work of ICS which will cover the whole of England.
- Closer collaboration between commissioners and providers is essential for implementing the NHS Long Term Plan. Every CCG governing body must presently include a clinician from an NHS provider but only from outside that CCG's area. This restriction should be lifted. Closer collaboration and decision making between NHS commissioners and providers also brings increased risks of conflicts of interest which will need managing through updated NHS England and NHS Improvement statutory guidance. Application of the new procurement regime should continue to be reserved to the CCG and not be delegable to the ICS joint committee.
- Whilst we are only making proposals for NHS legislation, we also agree with the Select Committee that closer collaboration with and from local government is needed. Health and Wellbeing Boards will continue to have an important role in assessing local needs and developing joint health and wellbeing strategies. And local authorities should not only be able but actively encouraged to join ICS joint committees. Their full membership would greatly assist implementation of the NHS Long Term Plan, whilst not introducing a new local government veto over the NHS's discharge of its own financial duties: for example, in making budgetary decisions about how best to live within a system level NHS commissioner and provider resource limit set by Parliament.

- NHS Improvement's proposed power to direct mergers between foundation trusts (FTs) was rejected by the Select Committee, NHS Providers and the NHS Confederation. It was also discussed, and not supported, by the NHS Assembly. It should not be included in the draft Bill.
- The proposed power for NHS Improvement to set annual capital spending limits for NHS FTs should also be circumscribed on the face of the Bill as a narrow 'reserve power' only. Each use of the power should only apply to a single named FT individually and automatically cease at the end of the current financial year. The newly merged NHS England and NHS Improvement should be required to explain why use of the power was necessary; describe what steps it had taken to avoid its use; and also include the response of the FT. To ensure transparency, this information would be published.

3. Operational performance

3.1 Hospital Optimisation

I am pleased to report that Theatre 6 opens in October as planned. Theatre is staffed and a new theatre timetable in place. Opening of all of Critical Care and ward beds needed to support the vital expansion of capacity will be challenging but the teams have a number of imaginative mitigations in place to cover gaps in the rota until new recruits are in post. The increase of 20% in surgical capacity provides what is needed to draw surgical activity through, reduce waiting lists and address IHU and RTT performance.

The next phase of work follows three strands; outpatients, nursing roster reviews and Cath lab and theatre flow. The diagnostic phase of activity recovery in Outpatients is complete and although the work undertaken by Meridian Productivity has not identified any new issues it has evidenced the diagnosis and the scale of the opportunity. Meridian is proposing a 13 week intervention that they would deliver on behalf of the Trust and this is currently being considered. The roster review on Critical care and staffing review on the fourth floor has also been completed and actions identified to improve roster compliance and adjust staffing levels. Work on flow through our treatment areas continues and offers further productivity opportunities as it progresses.

3.2 Specialist Clinical Frailty Network

The Specialist Clinical Frailty Network was set up by NHS England in 2018 to explore identification of frail patients in specialist services and also to develop tools for their management. The Trust has engaged with the Network and run frailty projects in the first two pilot waves, with TAVI being in wave 1 and Critical care in wave 2. The strap line shared by the projects is "Just because we can, doesn't mean we should". At the celebration event on 24th September both projects presented their findings and the Critical Care project won the competition for best project in the Critical Care category. Building on this success and the lessons learnt from both projects the Trust plans to roll out frailty assessment across all pathways.

4. Financial performance

4.1 Finance and activity update

The Trust's year to date (YTD) position excluding the land sale is a deficit of £2.7m which is favourable to plan by £0.8m. Total clinical income is below plan YTD by £1.4m, with the Guaranteed Income Contracts (GICs) providing £1.8m of protection to the income position, therefore the underlying income position is £3.2m below plan, a marginal improvement for the last two months.

This lower activity is driven by 7.7% less admitted activity than planned YTD and 8.7% lower Outpatient activity than planned.

Pay costs are adverse to planned levels and have not fluctuated in line with the reduced activity. The Trust had 251 WTE vacancies which were offset by temporary staffing costs.

4.2 CIP

Non-pay costs are favourable to plan, reflecting the lower activity in consumables, non-utilisation of revenue contingency (required to offset the CIP gap) and underspends on the NPH transition programme.

5. Workforce update

5.1 Compassionate and Collective Leadership Update

The team's work to build a compassionate and collective leadership culture for the Trust is ongoing. Using the terms compassionate and collective leadership in the title of the programme helps us promote the meaning of these terms:

- Compassionate leadership, this is hard to define in one sentence, but it is a spectrum of behaviours that makes someone compassionate, i.e. actively listening to people, and empathising, positively including everyone, which in turn nurtures trust, engagement and psychological safety/wellbeing.
- Collective leadership, also known as inclusive or collaborative leadership. This means a type of culture where staff at all levels are empowered as individuals and in teams to act to improve care within and across trusts - 'leadership of all, by all and for all'.
- Please visit the intranet pages to learn more, particularly if you can spare a few minutes to watch a video on compassionate and collective leadership in healthcare by Professor West, Kings Fund: http://papsvrintra/papworthonline/cultureleadership/index.asp?id=2539

A series of focus groups and a survey is currently being undertaken, the results of the work will be reported later in the year, alongside conclusions gained from the other workstreams that when considered together will give us a revealing picture of how close we are to our goal of creating a culture where compassionate and collective leadership can thrive.

5.2 Brexit update

The Trust EU Exit Board meets bi-weekly ramping up in line with preparation for the likelihood the UK will now be leaving the EU without a deal on 31 October 2019. Representatives from Royal Papworth including procurement, contracts emergency planning and executive attended the regional workshop held in Cambridge on the 16th September and is actively producing sit rep reports to the regional and national EU emergency preparedness teams. Currently our EU exit board is reporting a 'green overall state of readiness' keeping a close eye on any changes impacting our score in particular Staffing, Medicines, R & D, Overseas visitors, Consumables and radioisotopes.

5.3 Flu vaccination campaign

We will be launching the flu campaign this week. This year as the vaccine is being provided to the hospital in three batches over an eight week period, we plan to regulate demand with clinical staff being targeted first and non-clinical staff (also

covering the House) being covered later in the roll out. Our target this year is to vaccinate 80% of patient facing staff. This is up on last year's target but still very much achievable, and importantly, 80% gives us herd immunity.

6 Annual Members Meeting

6.1 Governor Elections 2019: Results announced

We announced the results from our recent Governor Elections at our Annual Members' Meeting, held at the Cancer Research UK Cambridge Institute on Wednesday 18 September 2019. A breakdown of the results can be accessed here.

7 STP Joint Clinical Group.

The Joint Clinical Group is comprised of all Medical and Nursing Directors in Cambridgeshire and Peterborough STP organisations; it has been tasked with providing a strong clinical voice as the STP addresses the challenge of reaching financial stability. RPH has accepted leadership roles in Respiratory Medicine and Cardiology both within the JCG but also in its sub-group the Clinical Communities Forum. In Cardiology, the RPH vision is for one service that permits the maximum amount of care close to home while also using facilities in a coordinated manner. There is a critical need for RPH to support partner organisations so that no patient in the STP is deprived from access to 24/7 consultant cardiology.

8. News and updates

8.1 Organ Donation Week 2019

During Organ Donation Week from Monday 2 September to Sunday 8 September, Royal Papworth Hospital NHS Foundation Trust and NHS Blood and Transplant urged people to talk to their families about organ donation to increase the number of lives that can be saved or transformed by an organ transplant. Next year, the law around organ donation is changing in England. Known as Max and Keira's Law, from spring 2020, all adults in England will be considered as having agreed to donate their own organs when they die unless they record a decision not to donate or are in one of the excluded groups.

8.2 Staff cheer on Sgt. Elizabeth Marks at London 2019 World Para Swimming Championships

Some of the Critical Care team that looked after Paralympic swimmer Sgt. Elizabeth Marks at Royal Papworth Hospital in 2014 were invited to surprise her and cheer her on at the London 2019 World Para Swimming Championships yesterday, where she won gold in the S7 100m backstroke.

8.3 Cancer patients highly rate care at Royal Papworth

Royal Papworth Hospital has been rated one of the best hospitals in the country for its cancer care. In the 2018 National Cancer Patient Experience Survey published this week, the Trust received an overall score of 9.3 out of 10 and scored highly across a range of criteria including92% of respondents said that, overall, they were always treated with dignity and respect while they were in hospital.

Recommendation:

The Board of Directors is requested to note the content of this report.