NHS
Oxford University Hospitals
NHS Foundation Trust

**Trust Board Meeting in Public: Wednesday 10 May 2017**

**TB2017.52**

| **Title** | **Trust Management Executive Report** |
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| **Status** | For Information |
| --- | --- |
| **History** | This is a regular report to the Board |

| **Board Lead(s)** | **Dr Bruno Holthof, Chief Executive** | | | |
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| **Key purpose** | Strategy | **Assurance** | Policy | Performance |

## 1. Introduction

At the time of writing, and since the preparation of its last report to the Trust Board, the Trust Management Executive [TME] has met on the following dates:

- 16 March 2017
- 30 March 2017
- 13 April 2017
- 26 April 2017
- 28 April 2017; and
- 2 May 2017

and is also due to meet on

- 9 May 2017

These meeting dates reflect a revised schedule, under which TME will meet at least once a week up to the end of July 2017.

Provision has been made for this increased frequency of meetings to address the challenges facing the Trust in relation to quality, operational and financial performance.

The main issues raised and discussed at the meetings are set out below, and the Chief Executive will provide a verbal update on anything further to come out of the meeting held on 9 May 2017.

## 2. Significant issues of interest to the Board

Issues of interest highlighted for the Trust Board include the following:

i. TME has kept under review performance against quality standards, informed by consideration of the Quality Report (Month 11). Areas of quality performance upon which the Committee has focused include the following:

a. Measures to improve the timely availability of discharge summaries have been kept under review, including an initiative trialled in Surgery and Oncology [SUON] Division, that no discharge of a patient could take place without a discharge letter going with the patient. This had led to a significant improvement in the compliance rate reported on the Churchill site, and in the overall compliance rate for the SUON Division, and the initiative will be considered for roll-out in other divisions.

b. The process for assessment of harm to patients waiting 52 weeks for treatment has been reviewed. Whilst a detailed process was already in place to evaluate harm from cancer pathways over 104 days where risks of delayed treatment may be much greater, it was recognised that there was also a number of patients each month waiting longer than 50 weeks, with reasons for delays which included patient choice. It was further noted that this cohort of patients had usually undergone multiple reassessments of their clinical priority, and therefore, it was anticipated that there would be little harm attributed to this group.

A light touch three month review process is now being implemented for consultants to review clinical harm from waits of 50-52 weeks and to report this via the Divisional Medical Directors to TME. An evaluation paper is to be submitted to TME in July 2017.

c. TME received an update on progress that had been made to date in Medicines Management, following a second audit undertaken by the Trust's internal auditors in summer 2016. Although the action plan arising out of an earlier audit had been fully implemented, the summer 2016 audit identified 8 further recommendations, arising from the audit of 22 areas within the Trust. Actions plans drawn up for these areas to address the recommendations were reported to have been completed in 16 areas, and good progress made in the remaining 6 areas with 83-95% completion of required actions. Whilst commending the efforts made and improvement achieved, the importance of continuing focussed attention was re-iterated.

d. Regular report from the Clinical Governance Committee highlighted issues for TME's attention, including the fact that the recorded rates of dementia screening were not capturing the parallel use of historic paper assessments, particularly in acute medicine. The Divisional Director, Medicine, Rehabilitation and Cardiac [MRC] Division has been asked to follow up on moving towards "cognitive screening" to assess mental capacity, to be followed by a dementia referral as appropriate, as this is considered to be a more intuitive and accurate screening instrument.

ii. TME has kept financial performance under review over Months 11 and 12, in advance of report to the Board on financial performance up to year end at the meeting of the Board on 10 May.

iii. As was reported to the Board at its last meeting, review of the Trust's financial performance in the second half of 2016/17 revealed that, despite considerable efforts made by staff to improve productivity and recover the financial position, the situation deteriorated from Month 8 onwards.

Action was instituted to exert additional cost controls when the extent of the deterioration in the financial position in Month 8 became evident, and regular updates have been provided to TME on the implementation and effectiveness of actions aimed at delivering recovery to financial plan by year end.

Whilst Month 10 saw a recovery in the level of EBITDA[1], this was largely due to an increase in income, rather than a reduction in the cost base, and the level of EBITDA was not sustained through Months 11 and 12.

As is reported to the Board in the Report on Financial Performance up to 31 March 2017 [Paper *TB2017.49*], the Trust delivered a retained surplus of £1m and delivered £3.6m against the control total set by NHS Improvement [NHSI] which included Sustainability and Transformation funding. This means that the Trust has finished the year in a financial position that is substantially worse than hoped.

It is in part to meet the challenge to improve the underlying financial performance of the Trust that provision has been made for weekly meetings of TME.

[1] Earnings before tax, interest, depreciation and amortizatiion

iv. TME has also kept operational performance under review, informed by consideration of the Integrated Performance Report, and has scrutinised the detailed performance improvement plans that have been developed for:

- Urgent care (including performance against the 4 hour ED standard);
- Cancer (including performance against the eight cancer standards); and
- Referral to treatment (including performance against the 18 week RTT Incomplete standard).

v. Plans are being finalised to identify how existing capacity can be used to deliver additional activity, and what additional capacity would be required in terms of outpatients, diagnostics, theatre activity and associated staffing.

Estimated costings indicate that it will represent a very significant challenge to deliver elective activity in 2017/18 (outpatients/day cases/inpatients) at a level required to deliver the national RTT standard on a sustainable basis and simultaneously to avoid premium rate working during 2017/18.

vi. Other activity undertaken by TME has included:

a. Review of the arrangements for Phase 2 of OCCG’s consultation on Oxfordshire’s Health and Care Services;

b. Review of a presentation outlining the approach proposed on *Staff Engagement and the importance of Recognition;*

c. Review of the Draft OUH Quality Account 2016/17, and development of the quality priorities for 2017/18;

d. Review of the results of the Staff Survey 2016;

e. Monitoring of the implementation of internal audit recommendations;

f. Consideration of the draft report issued by the Care Quality Commission in March 2017, following unannounced inspection in October 2016.

3. Key Risks Discussed

i. TME has discussed the risks associated with achieving operational performance standards, in particular the constitutional standards relating to A&E performance, cancer care, and the 18 week Referral to Treatment standard;

ii. TME has considered the risks associated with financial performance, and has instigated a number of additional controls on pay and non-pay expenditure, in parallel with commissioning external support to implement a programme aimed at improving productivity over the short, medium and long term;

iii. TME has considered the risks associated with meeting the challenges to delivery of operational and financial performance standards, whilst ensuring the delivery of quality performance standards.

## 4. Key decisions taken

TME has taken key decisions to put into place immediate actions to control both pay and non-pay costs of the Trust, with the focus being on reducing costs in non-clinical areas, without causing any adverse effect on patient safety or the quality of patient care.

These key decisions include the following:

in relation to controls on non-clinical pay expenditure

- The cessation of recruitment to vacant Administrative & Clerical [A&C] posts in all divisions unless an offer has already been made and/or a start date agreed;
- The cessation of recruitment to all vacant posts in non-clinical divisions unless an offer has already been made and/or a start date agreed;
- The cessation of the use of temporary staff in non-clinical posts;
- The application of controls on non-clinical pay expenditure will be executed by a Panel (including representation of Executive Directors and Divisional Directors): the 'Control Panel for non-clinical pay expenditure';

  The *Control Panel for non-clinical pay expenditure* will undertake a weekly review of any requests seeking permission by exception to proceed with recruitment to a vacancy that arises in any non-clinical post (or, by exception, to the use of temporary staffing therein);

in relation to controls on non-clinical, non-pay expenditure

- The introduction of controls on non-clinical, non-pay expenditure, including the cessation of authority for any budget-holder to incur expenditure on non-clinical supplies;
- The application of controls on non-clinical, non-pay expenditure will be executed by a Panel (including representation of Executive Directors and Divisional Directors): the 'Control Panel for non-clinical non-pay expenditure';

  The *Control Panel for non-clinical non-pay expenditure* will undertake a weekly review of any requests seeking permission by exception to incur expenditure on non-clinical supplies. There will also be a mechanism for escalating any request that requires an answer sooner, on the basis that patient care might otherwise be adversely affected.

TME has instructed human resources to accelerate the recruitment of medical and nursing staff needed to meet the growing demand in urgent and elective services.

TME has also decided that assessments of the capabilities and capacity that exist throughout the organisation should be undertaken, to ensure that actions can be executed to meet the challenges to deliver quality, operational and financial performance standards.

Other key decisions made by TME have included:

a. Support to proceed with a full options analysis in relation to replacement of the Pharmacy Purchasing and Distribution Unit [PPDU], where the preferred option indicated was relocation of the PPDU to an off-site location at the Unipart Site Cowley (Unipart Logistics);
b. Approval to implement a reduction in the number of Critical Care beds on the Horton General Hospital [HGH] site, from 6 to 4, based on the fact that the numbers of patients requiring critical care at HGH have reduced over the past five years;
c. Approval to implement the new A-EQUIP model for the supervision of midwives across the Trust's Maternity services;
d. Support to proceed with recruitment in accordance with workforce plans presented by the Radiology Directorate, provided that finances are further reviewed in advance of any Advisory Appointment Committee held to appoint a consultant;
e. Support and endorsement of the approach proposed to staff engagement and recognition;
f. Agreement of Workforce Key Performance Indicators (KPIs) for 2017/18, subject to further revision in relation to the RAG banding.

## 5. Future Business

Areas on which TME plans to focus over the next three months include the following:

- Monitoring operational, financial and quality performance delivery at divisional level and, by exception, at clinical directorate level;
- Specifically implementing measures to control pay and non-pay expenditure, and monitoring their effectiveness;
- Monitoring execution of the performance improvement plans relating to urgent care, cancer, and RTT; scrutinising whether the actions taken are effectively addressing the causal factors identified;

## 6. Recommendation

The Trust Board is asked to note the contents of this paper.

**Dr Bruno Holthof**
**Chief Executive**

**May 2017**