North Cumbria University Hospitals NHS
NHS Trust

TRUST BOARD

Date of Meeting: 11/01/2011	**Enclosure:** 4
	Agenda Item No: 7
Title of Report: Chief Executive's Report	

Aims:

This report provides the Board with an update on key national and local announcements and policy developments that have emerged in the past month.

Summary:

The issues considered in this paper are:

- The Operating Framework for the NHS in England 2011/12
- Flu and Winter Planning
- Development of the Clinical Strategy
- Archbishop of York Visit

Specific implications for consideration (Financial/Workforce/Risk/Legal/Race Equality etc):

Financial	Outlines the Operating Framework requirements for the NHS in England 2011/12.
Workforce	No specific implications.
Other	No specific implications.

Recommendations:

That the Board notes the updates in this report.

Document previously approved by:

Not applicable. Report directly to the Trust Board.

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North Cumbria University Hospitals NHS
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TRUST BOARD
CHIEF EXECUTIVE'S REPORT
JANUARY 2011

1. INTRODUCTION

This report provides the Board with an update on key national announcements, policy developments, and issues significant to this Board.

2. THE OPERATING FRAMEWORK FOR THE NHS IN ENGLAND IN 2011/12

'A successful transition to the new system will require a tight grip to be maintained on current performance, financial stability and quality of service'.

The new coalition government published the health white paper 'Equity and excellence – Liberating the NHS' in July 2010. This document set out the plan for a new direction and system which is the most significant change to the NHS since its creation. A public consultation period followed between July and October and the Operating Framework for 2011/12 was subsequently published on 15 December 2010. The priorities set out in the framework need to be planned in conjunction with the NHS Constitution, the CQC assurance framework and Monitor's Compliance Framework. Legislation required to support the white paper will follow in the Health and Social Care Bill scheduled for January 2011.

Three key issues were highlighted during the consultation period;

- The unprecedented level of efficiency savings required over the next 4 years
- Significant reductions in management capacity planned
- The extent of the structural reform which is required

These three issues were thought to be the main risks associated with the transition period and were reflected in the response in the 2011/12 Operating Framework and the accompanying letter from Sir David Nicholson, Chief Executive of the NHS. The messages in these publications for all NHS bodies and their leadership teams are very clear. CEOs and NHS Boards are expected to balance competing agendas and priorities during the transition period by;

- Creating the conditions needed to ensure system reform will succeed
- Continuing to drive up quality and safety for patients
- Maintaining control of finance and performance through the QIPP challenge

The Framework sets out the transition arrangements for national and local systems covering the NHS Commissioning Board, the economic regulator, GP Commissioning Consortia and the development of the Foundation Trust pipeline for providers. The four year transition period will enable the new arrangements to be tested and refined using models for 'early adopters' such as GP Consortia Pathfinders including the locality commissioning groups in Cumbria. The focus on extending patient choice and information continues through quality standards and outcomes continue and the impact of the changes on workforce, training and education and informatics will be outlined in greater detail later in January 2011.

The quality and performance priorities will be underpinned by the NHS Outcomes Framework which will include key measures in April 2011 and new quality standards (est. 31 in total) will be published by the National Quality Board. Both developments will form the basis of the first mandate for the national NHS Commissioning Board. A summary of key performance indicators is attached to this report at appendix A.

The NHS Confederation summary outlines in greater detail the timelines for the system changes from 2011/12 onwards and the changes to the financial framework and governance arrangements.

A brief summary the key changes which will impact on local systems is shown below;

	Commissioners	Providers	NHS Finance
Key Developments 2011/12	• GP consortia pathfinders to be extended with delegated responsibilities • Consortia will not be responsible for PCT debt • Commissioning support units to be developed including SEs and JVs • £2 per head of population allocation for commissioning consortia • AWP introduced for community providers • Clearer separation of providers and commissioners • Revised standard contracts to support AWP • Contract to include FUNs and sanctions applied to data quality and completeness	• Marginal rate for emergency admissions retained (30%) • National efficiency requirement of 4% • Best practice tariffs extended and new tariffs introduced • National priority is VTE • Quality framework with 31 new standards from NICE • Baselines for Outcomes Framework established • Choose and Book revised to reflect contract requirements • SHAs continue to support FT pipeline until 2012/13 • Guidance on application of Right to Provide to NHS • Reporting MSA breaches from April 2011 • No reimbursement for readmissions within 30 days	• Aggregate surpluses carried over for 2011/12 excl. capital • Average growth in PCT allocations is 2.2% • PCTs to secure post discharge support using £150m re-ablement investment • £648m separate allocation to support health and social care integration • 2% PCT budgets allocated for non-recurrent investments and risk • Two year pay freeze for staff earning above £21k • Potential freeze for pay increments • Tariff changes for Designated Major Trauma Centres from April 2011 • 2% efficiency requirement embedded in tariff, HRG4 for A&E, new trim point and local reduced tariffs

Other System Developments	• PCTs remain statutorily responsible until April 2013 forming clusters by June 2011 to consolidate capacity (managed consolidation) and reduce running costs during this period • SHAs remain accountable for leading transition and operational delivery during 2011/12 • The NHS Commissioning Board (NHSCB) will be established in shadow form during 2011/12 • The model for Health and Wellbeing Boards will be developed based on pathfinders with the aim having shadow arrangements in place nationally by the end of 2011/12 • All PCTs to divest community services by April 2011 • Running costs of the NHS will be reduced from £5.1bn to £3.7bn (45%) during the period of the spending review – including anticipated savings on functions transferred to the NHSCB • Gradual removal of controls on existing FTs with the staged introduction of the new regulatory regime • Relationship between NHS Commissioning Board, Monitor and CQC will be set out in greater detail with CQC key role in maintaining quality and safety during the transition period • MARS will be extended and include pre-authorised MARS to ensure capacity during the transition period

The key changes beyond 2011/12 include;

- 2012/13 SHAs abolished when the NHS Commissioning Board takes on formal statutory functions and authorises GP Consortia from April 2012
- PCTs abolished on 31 March 2013 when GP consortia are authorised and commissioning support units move to social enterprise and joint venture arrangements
- Choice will be extended to GP practice from April 2012
- The new system of economic regulation will be introduced from April 2012 with Monitors new licensing role which will extended further to price setting by 2013/14 onwards
- 2012/13 the dedicated Provider Development Agency will be established to oversee completion of the FT pipeline which is scheduled for April 2014
- Health and Wellbeing Boards will assume statutory responsibilities from April 2013
- Shadow allocations for Public Health for Local Authorities from 2012/13
- Final budget for running costs for Commissioning Consortia is expected to be £25-£35 per head of population by 2014/15

Delivering change while maintaining performance against the QIPP challenge will be dependent on the flexibility of local systems and their ability to work across boundaries. This will be essential if local changes are to achieve the low running costs in the new system expected at the start and ensure they remain low in line with national projections.

The Board should be aware that further details on specific aspects of implementation and guidance will follow in the near future including;

- Development of our local pathfinder GP consortia and their commissioning plans and priorities for 2011/12
- Governance requirements and arrangements for GP Commissioning Consortia (early 2011)
- The first NHS Outcomes Framework (January 2011) incorporating Quality Accounts
- National Quality Board guidance on maintaining quality and safety, early warning systems, due diligence continuity for successor bodies, provider guidance on strengthening governance etc. (early 2011)
- DH advice for FTs on key issues and steps required to achieve FT status (January 2011)
- New NHS Standard Contract and guidance including simplified clauses re process
- Information Strategy (early 2011)
- Improving Outcomes Strategy for Cancer (to be confirmed)
- Publication of PbR Guidance for 2011/12 (early 2011)

During this period of substantial change all NHS organisations are expected to ensure there are rigorous processes in place to ensure quality and safety is maintained and that the quality impact of planned changes are thoroughly assessed. In addition local systems are expected to maintain the improvements made to date such as waiting times, reductions in HAIs and QIPP targets will continue to be monitored centrally. Any under-performance will trigger proportional action which could include intervention from the centre.

There is an expectation that plans are integrated at a local level (reflecting QIPP requirements) and are geographically based rather than functionally based. Each locality is therefore expected to have a clear strategic vision for improvements in quality and productivity and plans to ensure they support the transition to the new system and delivery of the NHS Operating Framework. SHA plans will therefore be reviewed by the DH by the end of March 2011 to ensure they meet a series of assurance tests for implementing the operating Framework.

3. DEVELOPMENT OF THE CLINICAL STRATEGY

Board members will be aware of the current position and planned work in relation to the development of the Trust's Clinical Strategy. Specific work will be taken forward during January 2011 with PCT colleagues and GP Clinical Leads to align commissioning intentions to the future service models of care across primary and secondary care. The key driver for this is to ensure we have a viable clinical and financial strategy across North Cumbria.

4. FLU – WINTER PRESSURES

Our hospitals faced a very busy time over the Christmas and New Year holiday period with increased emergency admissions due to influenza and other winter viruses. Staff worked extremely hard in difficult circumstances to ensure patients were treated safely and efficiently.

NHS North West is releasing weekly figures to the public on numbers being treated in hospital for flu, by region. As of 5 January, the number of people with flu in critical care beds in Cumbria and Lancashire stood at 26. Across the North West as a whole, there were 108 flu patients in critical care beds.

Like all hospitals, we have plans in place to increase the number of critical care beds if necessary. Hospital trusts operate as a regional and national network so that they can offer support to each other and make sure that anyone who needs an intensive care bed can get one.

On 5 January NHS North West asked all hospitals across the region, including our own in Cumbria, to postpone some routine non life-threatening surgery as part of normal winter plans that allow staff to concentrate on the most poorly patients. Through the media our Trust has apologised to those patients whose elective surgery has been cancelled and promised that these operations will take place as soon as possible.

The current position in relation to demand and capacity continues to be reviewed on a daily basis across the North West as part of initiating the winter plans.

5. ARCHBISHOP OF YORK VISIT

West Cumberland Hospital hosted a visit by the Archbishop of York, John Sentamu, on 17 November 2010. The Archbishop met staff who had helped with the response to last year's major incidents (the Keswick School bus crash and West Cumbrian shootings) and thanked them for their efforts. He also met some of the taxi drivers affected by the shootings, in the hospital chapel.

Dr Sentamu also took the opportunity to review the plans for the redevelopment of the hospital, particularly in relation to how they will cater for spiritual needs, and spoke with members of the New Hospital Project Team to receive an update on the scheme.

6. RECOMMENDATION

The Trust Board is requested to note the report.

Carole Heatly
CHIEF EXECUTIVE

Appendix A

Annex

Integrated performance measures for national oversight

	Headline measures	Supporting measures
Quality (Safety, Effectiveness & Patient Experience)	• HCAI measure (MRSA & CDI) • Patient experience survey[2] • Referral to Treatment waits (95th percentile measures) • MSA breaches • A&E Quality Indicators (5 measures)[1] • Ambulance quality (Cat A response times) • Cancer 2 week, 62 day waits (2 aggregate measures) • Emergency Readmissions	• MRSA – delivery of objective • VTE Risk assessment • Ambulance quality indicators (all other measures)[1] • Cancer waits (all 9 measures) • Community services • Access to NHS dentistry • PROMS scores • Mental health measures (EI, CR/HT, CPA, IAPT) • Smoking Quitters • Breast screening • Cervical screening test results • Referral to Treatment waits (median wait measures) • People with Long Term Conditions feeling independent and in control of their condition • Emergency admissions for Long Term Conditions • CDI – delivery of objective • % deaths at home (inc care homes) • A&E quality indicators (all other measures) • Stroke indicator • Carers breaks • Staff engagement[2] • Maternity 12 weeks • Low value procedures • Breastfeeding at 6-8 weeks • Bowel screening • Diabetic retinopathy screening • Coverage of NHS Health Checks • Safeguarding
Resources (Finance, Capacity & Activity)	• Financial forecast outturn & performance against plan • Financial performance score for NHS Trusts[3] • Delivery of running cost targets • Progress on delivery of QIPP savings • Acute Bed Capacity • Non elective FFCEs • Numbers waiting on an incomplete Referral to Treatment pathway • Health visitor numbers • Workforce productivity	• Total pay costs • Year to date financial position • Delivery of 2% recurrent headroom • Underlying financial position of PCTs and NHS Trusts • Daycase rate • GP written referrals to hospital • First outpatient attendances following GP referral • Elective FFCEs • Ambulance Urgent & Emergency Journeys • Staff absences • Clinical staff numbers • Redundancy numbers • Total workforce (WTEs) • NHS Trusts Breakeven duty • PCT legacy debt position • Length of stay (Acute and MH) • Delayed Transfers of Care (Acute & MH) • Other referrals for a first outpatient appointment • All first outpatient attendances • A&E attendances • Community activity • Temporary staffing costs • Management numbers
Reform (Commissioner, Provider & building capability and partnership)	• FT pipeline • Transforming Community Services (TCS) successfully achieved • GP Consortia progress and transfer of relevant functions NHS CB/LAs • Establishment of PCT clusters • Choice • Information to Patients • Competition	**Provider development:** % of orgs progressing along pipeline to milestones agreed between SHA, trust and DH % of organisations behind expected position along the FT pipeline by over 3 months. % of organisations behind expected position along the FT pipeline by over 3 months that are in the unsustainable providers categorisation Uptake of community services Right to Request scheme and forecast uptake in Right to Provide % (value) of community and mental health services by PCT subject to Any Willing Provider **TCS:** Extent of completion of TCS programme – separation and divestment of provider services **GP Consortia:** % of GPs (a) in pathfinder consortia and (b) in pipeline to become pathfinders % of PCT commissioning spend delegated to GP practices Running costs per head of pop. delegated from PCTs to consortia for start up costs **NHS CB:** Has SHA completed full analysis of current levels of staffing and arrangements for those region-wide (SHA and PCT) functions, which will transfer to the NHS CB? **Choice:** Bookings to services where named consultant led team was available (even if not selected Proportion of GP referrals to first OP appointments booked using Choose and Book Trend in value/volume of patients being treated at non-NHS hospitals. **Information:** % of patients with greater control of their care records **Capacity & Capability:** Secure leadership capacity in critical posts in PCTs, clusters and SHAs

1 Suites of measures – a drop in performance on a single indicator may not trigger intervention as long as there has been no worsening in performance of the suite overall.
2 Monitored through local data collections as well as national annual survey 3 The finance domain score for NHS Trusts in the NHS Performance Framework.