Today’s discussion

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A new PM, a new chancellor

- No dedicated No.10 health SpAD
- Health is no different to police or defense
- Free at the point of use remains
- If the answer from STPs is reconfiguration then you’ve got to be kidding
- The government gave NHS £10bn, “more than its leaders asked for”. If you wanted more then you should have said (though NHSE did...).
“In fact safer care doesn't cost more, it costs less. Every time a patient has a fall, or picks up a bedsore or catches an infection they stay in hospital for longer, costing the NHS more.... When you look at our safest hospitals, our best schools and our top police forces and you see it's not about the level of funding, but the quality of leadership.”

Autumn statement

• Emergency revenue boost for primary care and social care that is ‘dual-keyed’ by secondary care

• Capital rescue for both longer term (e.g. infrastructure fund, asset-backed bonds, cost of production) and short-term (e.g. maintenance capital and refurbs)

• Credible financial re-plan from now to 2020/21

• Commission to think about 2020-2040 health and care needs, how to fund them and choices entailed

• Assume no more revenue, small capital help, social care to be bailed out first
• **Fall in the pound** affecting procurement and social care workforce

• **Great repeal act** will transcribe EU law into English law, with Lords input into issues such as procurement, competition, EWTD

• **Cavendish Coalition** focussing on recruitment and retention of the health and care workforce
Without sounding too ungrateful...

The Government has committed to train up to an additional 1,500 students through medical schools for the academic year 2018/19.

“Yes. There will be staff here from overseas in that interim period - until the further number of British doctors are able to be trained and come on board”

- Will HEE have the money to fund the clinical placements?
- Will the doctors be in the specialties we need?
- Will they come online soon enough?
- Will the parallel action on self-funded nurses bring us into balance?
- Impact on current/future overseas doctors?
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### Performance as challenged as we’ve seen it

#### % of patients seen in Type 1 (Major) A&Es, by provider

<table>
<thead>
<tr>
<th>Q4 2013/14</th>
<th>Q4 2014/15</th>
<th>Q4 2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Q1 STF access targets</strong></td>
<td>89</td>
<td><strong>PMs first winter. Increasing pressure on departments under most pressure e.g. A&amp;E special measures, mandated ward rounds</strong></td>
</tr>
</tbody>
</table>
Manifesting in extremis as closures

Stafford hospital suspends 'unsafe' children's A&E

NHS trust temporarily closes service for under-18s owing to lack of 'professionally trained and experienced staff'

A Staffordshire hospital has suspended its A&E service for children after senior staff said it was "not currently clinically safe".

Grantham hospital A&E closure trial 'will waste police time'

© 16 August 2016  Lincolnshire

Grantham & District Hospital Accident & Emergency Emergency Care Centre Main Hospital Outpatient Department

Chorley MP's fury over extended A&E closure
And window beds
The state of provider finances

How confident are you about achieving your financial control total?

<table>
<thead>
<tr>
<th>Confidence Level</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very confident</td>
<td>30%</td>
</tr>
<tr>
<td>Fairly confident</td>
<td>32%</td>
</tr>
<tr>
<td>Neither confident or not confident</td>
<td>27%</td>
</tr>
<tr>
<td>Not very confident</td>
<td>11%</td>
</tr>
<tr>
<td>Not at all confident</td>
<td></td>
</tr>
</tbody>
</table>

*n = 84*

Q1 2015/16 | Q1 2016/17
---|---
Aggregate provider deficit (£m) | -930 | -461
STF support | -450

Reported deficit

**Our take**

- Final 2016/17 provider deficit ‘number’. HMT aim in firebreak year was no deficit. NHSE want -£250m. NHSI best estimate is -£580m with Q1 y/e f/cast of -£660m.
- We think it’s going to be a scramble to get to -£580m. Privately we think -£700-900m more credible
- Vital to get as close to -£580m as possible: fend off “incompetent providers”; 17/18 run rates; NHSI
Capital not on the same page

- **£4.8bn**: Cash budget for total NHS capital over this parliament
- **£4.3bn**: Forecast provider capital spend in 2016/17
- **£3.7bn**: Provider capital spend in 2015/16
- **£2.7bn**: Provider capital budget in 2016/17
The view from the centre

Q2 looking okay at M5 and we must tell a good story

Don’t reprofile – cover downside in the narrative

The provider sector MUST balance in 2017/18

Pathology, back office and Carter motoring

Ratchet up control totals to make up for any slippage
Someone asked me if the glass is half full or half empty.

I told them I don’t even have a glass.

NHS ALB Finance Director
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Noble intentions in the planning guidance...

- Stability & planning certainty with two years
- Early timetable to avoid protracted contracting process
- Break out of the zero sum game with system control totals
- STF back loaded

- Not as stable and transparent as it appears e.g. hidden efficiencies of increased control totals, CQC fees, clinical placements, CQUIN
- Christmas contract deadline assumes a realistic offer (not -4m vs 26m), and means rushed internal processes and governance
- Do clinical, operational, STP plans align e.g. pathology?
- CCGs frustrated over 1% hold back, MH pass through, no transformation
- Happy families, marginal electives, doing the right thing fine up to a point
## STPs – the good points

- Few could object to place-based planning, conversations, co-ordination
- Started conversations we’ve never had before in the NHS
- Started conversations with social care for the first time
- Provided the place we needed for service change
- Starting to tackle the wicked long-standing problems
- Turbo-charged the right plans, even if some are dusty
- Sub-regions make sense where there are ‘lots of places’ for place-based plans
## STPs – the challenges

### Purpose
- **What is the STP there for?** Planning exercise, delivery or performance management (new metrics)?
- Does the STP work for us, or do we work for the STP?
- Are we talking about the right things e.g. end of life care vs. pathology joint ventures
- **If have to balance finances then magical thinking needed on demand assumptions**
- Who would be an STP leader?

### Engagement
- **Who speaks for primary care?** LMC? Charismatic GP Federation leader?
- How do you engage a local authority?
- Governance and accountability
- **Clinical engagement and internal comms**
- Very acute-focused in most places, when non-acutes potentially speak LA and primary care more easily

### Process
- Do we need to accelerate some plans and let others follow?
- **What are the secret filters e.g. capital & political noise? Real disappointment on capital**
- ‘Don’t worry’ about competition not credible
- Storing up legal & public challenges
- **What is the question you are putting to the public?**
STPs – so far not a comms masterpiece
STPs – your views

Percentage of stakeholders you think are engaged or very engaged in your STP process

- Your trust: 53.6%
- CCGs: 44.7%
- Other NHS Providers: 36.8%
- Local authorities: 10.6%
- GPs/Primary Care: 2.0%
- Patient groups/public: 0.7%
- Third sector: 0.0%
- Private sector: 0.0%

(n = 153)

Is this open place-based planning, or closed NHS place-based planning?
STPs – your views

- Returning the local health economy to financial balance
- Moving care into the community
- Acute reconfiguration
- Addressing unwarranted variation in quality
- Integrating health and social care
- Investing in more preventative ways of working

- Set criteria for what STP is here to talk about
- Private briefings for elected council members have gone down well
- Ignore anyone who tells you not to talk to a clinician, MP or member of the public
- Book meetings with your provider counterparts every Friday afternoon
- Hull and West Mids developing STP-wide estates strategy focused on repurposing as an easier sell for public and politicians
- An Oxford specialist nurse: Oxfordshire looking at standard T&Cs for staff across health and social care, joint bank, joint recruitment, joint training
STPs – next steps for us

National oversight group e.g. few go fast

Survey to handle expectations and share good ideas

Practical tools e.g. MoUs, examples of how decisions are delegated, consequences of not playing ball
New care models update

Steady progress in the vanguards and in developing new models outside the vanguard programme

STPs expected to act as vehicles for wider spread of new care models but important for localities to be able to align different footprints

Concerns around future funding: dedicated vanguard funding moves to mainstreaming through transformation and sustainability fund

Increasing recognition that this is a 7-10 year journey not a quick fix
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Regulatory sitrep – everyone is special

16
Trusts are in quality special measures

5 for now
Trusts are in financial special measures

13
Trusts are in success regime areas

65%
Of rated trusts are rated ‘requires improvement’ or ‘inadequate’ by the Care Quality Commission (CQC)

129
Good

69
Requires improvement

8
Inadequate

15
Outstanding

Frimley (27)
Salford (15)
West Sussex ()
Northumbria (18)
Newcastle (39)
West Sussex ()
NTW ()
Liverpool H&C ()

All data correct as of Oct 2016
Single oversight framework

- **Removed**
  - EBITDA
  - Quality metrics e.g. never events

- **Added**
  - Agency spend brought forward
  - Penalised for control totals

- **Still to come**
  - Carter metrics
  - Capital controls

- **Process**
  - Nov publication
  - CQC../pipeline
CQC State of Care 2016

Many health and care services in England are providing good quality care, despite a challenging environment, but substantial variation remains.

Some health and care services are improving, but we are also starting to see some services that are failing to improve and some deterioration in quality.

Will we be sensitive to the current context? Of course, as far as possible, but we are a quality regulator, the bar does not move on quality. If the current funding envelope means that most of providers will be rated requires improvement, then that’s the rating we will give.
“Since we know that, in all sectors, providers with better overall ratings tend to score better in terms of being well-led, this suggests a link between good leadership, good financial management and higher quality ratings.”
How do you feel?

Everything’s happening all at once: STP deadlines, planning guidance, shortened contracting round, SOF segmentation, control totals, junior doctors, winter.

I am a long standing CEO of a well performing organisation with a strong historical track record of delivering performance targets and the finances and I have a good and stable board.

How do I feel? I feel vulnerable. And if I feel vulnerable in this position then God help others in less fortunate positions.
The goal

The reality

Don Berwick
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Workforce issues

- Rolling junior doctor strikes off
- Consultant contract negotiations on slow down
- Agenda for change changes on back burner
- Brexit uncertainty
- Uncertain impact of end of bursaries
- New ways of working and care models
- CQC and NHSI aligned on safe and sustainable staffing?
- Leadership pipeline and new roles e.g. managing directors in chains
- Coded signs that HEE no longer planning for balance by 2020/21

Headed for a slow-motion car crash without a clear consistent and aligned message on:

1. **Staffing-quality-finance balance** - ugly and difficult decisions on paybill will have inevitable impact on quality and consequences for current Gov’t narrative of platinum quality supported by intensive inspection process and workforce growth.

2. **Strategy & planning** – are STPs and LWABs the vehicles for grappling with consequences of new care models and u-bend funding?
Junior doctors next steps

Is this contract safe? On paper yes... But in practice? In practice there has been no groundwork laid for the expanded roles of educational supervisors, no realistic investment in the Guardian role in many trusts, and the financial pressures on hospitals right now are mounting. I simply cannot see hospitals having the will, the manpower or investing the resources to make this work.

Source: Junior Doctor Blog

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**British Medical Association: Trusts: reconsider contract timetable**

UK Stakeholder - Press Releases

NHS trusts in England should delay implementation of the new junior doctor contract until a number of non-negotiable contractual requirements are in place and agreement is reached on a new contract.

EPA junior doctors committee chair Ellen McCourt has written to trusts to highlight the areas which, if not in place, would represent an immediate breach of contract.

They include the guardian of safe working hours, a local equalities impact assessment and an established system of exception reporting.

Trusts were recommended by the Government to introduce the new contract, starting with specialty trainees 3s and above in obs and gynae this month, but they are not subject to a legal requirement.
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Good morning, what are you here for? Hold on, you’re a GP trainee? Would you like a:

• Locum post tomorrow
• Permanent locum post
• Salaried GP
• Partnership
Further to the fact that four out of five Directors say that providers are facing financial difficulty now, there is continued evidence from our survey of actual failure within the provider market in the last 6 months, affecting at least 65% of councils and thousands of individuals as a consequence.
### Some positives

<table>
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<th>Red</th>
<th>Blue</th>
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</table>
| • Trusts starting to employ their own social care workforce (e.g. Ipswich)  
• Trusts buying their own care beds permanently or semi permanently in commercial nursing / care homes (e.g. Oxford)  
• Trusts creating their own in house on site nursing home type step down beds  
• Trusts buying or creating their own off site nursing homes (e.g. Wolverhampton, East Kent)  
• Trusts taking over the provision of social services (Salford, Wirral & Northumbria) | • A good time to be putting in an offer to primary care, particularly if you can take on some of the estate cost or risk  
• Federations providing one voice to either deal with or be taken over by  
• LLPs formed to take on c10 practices and lists of 100,000 patients. Employing health coaches in primary care doing health promotion, diet, exercise, nutrition  
• Complex care hubs up and running to support daily data updates on acute activity and do proactive in-reach and virtual clinics for high cost cohorts |
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**Main Findings**

- Policies and procedures often in place, but challenges around consistent practice and lessons not always learned or shared across their organisations.
- Evidence of external checking or validation of data security arrangements and culture of learning from others.
- Systems and protocols were not always designed around the needs of frontline staff – resulting in potentially insecure workarounds.
- Move away from paper patient record is helping but electronic data security procedures need to improve as risks are higher.

**Recommendations**

- Leadership should demonstrate clear ownership and responsibility for data security.
- Staff should have the right information, tools, training and support to allow them to do their jobs effectively while still being able to meet their responsibilities for handling and sharing data safely.
- IT systems and all data security protocols should be designed around the needs of patient care and frontline staff.
- Data security audit and external validation should be strengthened to a level similar to those assuring financial integrity and accountability. CQC assessment framework and inspection approach will include assurance that appropriate internal and external validation against the new data security standards have been carried out.
Wachter review

Key points:
• The level of ambition is right but it will take more time and investment than you think
• ‘Return on investment’ from digitisation is not just financial
• It is better to get digitisation right than to do it quickly
• Digital aspirations which are locally driven
• It’s a process not an end point

Main recommendation:
• All trusts should be largely digitised by 2023 but it should be phased process
• More money should be available, funding linked to a viable local implementation/improvement plan
• Clinical input at the heart of digital transformation through appropriate leadership by professional, trained clinician-informaticists at the trusts
• Ensure interoperability as a core characteristic to promote clinical care, innovation, and research

• Global Digital Exemplars – “to inspire others by really showing how information technology can deliver both improved patient outcomes and enhance business efficiencies.”
  • Salford Royal Hospitals NHS Trust
  • Wirral University Teaching Hospital NHS Foundation Trust
  • City Hospitals Sunderland NHS Foundation Trust
  • Royal Liverpool and Broadgreen University Hospitals NHS Trust
  • West Suffolk NHS Foundation Trust
  • University Hospitals Birmingham NHS Foundation Trust
  • Luton & Dunstable University Hospital NHS Trust
  • Royal Free London NHS Foundation Trust
  • Oxford University Hospitals NHS Foundation Trust
  • Taunton and Somerset NHS Foundation Trust
  • University Hospitals Bristol NHS Foundation Trust
  • University Hospitals Southampton NHS Foundation
What is NHS Providers doing

**Engagement and relationships**
- NHS Digital
- NHS England

**Raising the profile of member issues regarding the informatics agenda**
Submission to the lords committee on transformation and sustainability

**Potential collaboration with LGA, ADASS NHSCC and NHS Confederation to showcase achievements, highlight barriers and disseminate “how to” tips on the use of technology as an enabler to integrate care.**
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What has changed since we last met

Q1 Finances better than expected but not ‘good’ & financial reset package announced

Second-cut STPs and financial plans being developed as governance questions raised. STP plans now increasingly ‘out in the open’.

Junior doctors reject proposed contract, phased implementation but trusts under pressure

Brexit, new Prime Minister, new cabinet, Jeremy Hunt remains as Secretary of State for Health

NHSI Standard Oversight Framework consultation and segmentation
A decreasing appetite for honesty at a time when hard choices need to be made

A more porous membrane to support integrated commissioning and integrated provision

The additive primacy of systems

A re-emerging addiction to scale
Promoting a national debate
It’s so important to have a core narrative. DLCG told councils there is no more money, so shrink the offer, and from top to bottom of councils they get it and work accordingly (inc. 15% price cuts to our NHS services).

But DH simply says we need to get more efficient, so the board feels squeezed, and a health visitor gets busier, but there isn’t that core narrative of a 15% cut means fewer contacts, shorter contacts.

NHS community trust finance director
Welcome to Chester

- Rolling out new software and hardware solution to develop a realtime air traffic control system to give oversight on their assets, staff and patients.
- Staff will have lapel badge to track activity, patients have fitbit style bracelets, kit and beds RFID’d like in Wolverhampton
- Will all be linked to PAS systems and staff scheduling system so you can do the Lord Carter work of aligning the demand and staff supply curves
- Unit of staffing will now be more than a ward and you can start thinking about staffing more flexibly across specialties
- Lots of talk about chains, but more thought needed on how you connect them culturally, in governance terms, in data terms, and operationally – this will help with the operational connection and data
Welcome to Alder Hey Children’s Hospital

• “The client and architect have created something special here.” (RIBA, 2016)

• Listened to children who wanted access to fresh air, gardens, natural lighting

• A drawing by 15-year-old Eleanor Brogan impressed architects and inspired their final design
Welcome to London Ambulance Service

Good SAM App alerts people with medical training that there is a nearby emergency. Helps provide early life-saving interventions prior to arrival of emergency services.

Matches skills with need in real time in the real world.

You’re never more than 15 feet from a rat, a potential date, or CPR, in London.
• Guys, our core business is to run a hospital, and we’re not very good at it.

• Serious incident lead and clinical audit lead in same room but not on the same planet

• Flush out the bad apples. Managers and clinicians who have been cute and stayed below the radar being harmfully incompetent

NHS Trust Strategy Director
DTOC is an issue we will never solve. We are the worst in the country. Perhaps the STP will solve it….Then new CEO said let’s buy capacity – we can afford it, and we can’t afford not to. 60 care support workers directly employed from career fairs aimed outside health & social care sector, who provide social care in people’s homes after discharge from hospital. Bought intermediate care beds. Reduced DTOC significantly.

Let’s find our 300 keenest people and ask for a 2 minute smartphone selfie video on what their improvement idea is. 600 minutes of improvement. Lots of popcorn.
This year our conference focuses on how the NHS provider sector can stay fighting fit and continue to deliver the world-class standards of care we are so rightly proud of.

Our event will be the best opportunity for senior leaders of provider organisations to come together in 2016 to share learning, celebrate success and be inspired.

Confirmed speakers include the chief executives of CQC, NHS England and NHS Improvement.

Delegates can take advantage of group discounts of up to 25%.

Please see our website for further details and to book your place:

www.nhsproviders.org/2016
Q&A

THANK YOU