Paper 1505141

BOARD PAPER - NHS ENGLAND

Title: Chief Executive's report
By: Simon Stevens, CEO
Purpose of paper: • Update on the work of the Chief Executive since taking up post on 1 April 2014. • Information on a number of NHS England priorities not covered elsewhere on the agenda. • Record of several urgent actions taken since the last Board meeting.
Actions required by Board Members: • To note, and to discuss various items referred to herein.

NHS ENGLAND CEO's REPORT TO THE BOARD

1. My first five weeks

On April 1st when I took up post I said that - alongside my immediate official duties - I wanted to get out-and-about around the country to listen and chat with a wide cross section of people served by, and working for, the NHS. So here's how I've been spending part of my first few weeks.

I've met patients, carers and NHS staff - in Newcastle, Salford, London, Durham, Leeds, Birmingham, Oldham, Wakefield, and Manchester, amongst others. I've met children living with cancer, 96 year old stroke patients, new mums, young men with severe mental health problems, expert carers, angry relatives, longstanding whistleblowers, victims of domestic violence helped in extraordinary ways by health service professionals, and dozens of other people with inspiring, energising and just occasionally frustrating and upsetting stories about their interactions with the NHS.

In doing so I've had the opportunity to visit GP practices, acute mental health teams, local hospitals, local councils, community nurses, midwives and therapists, several major teaching hospitals, and several highly innovative third sector providers. One way or another I've now met with leaders from around three quarters of England's 211 CCGs, as well as with three Academic Health Science Centres, a clinical senate, and the Academic Health Science Network covering Merseyside and the North West Coast.

I've appeared before the Health Select Committee; launched our new 'commitment to carers' strategy; and addressed the annual conference of NHS Clinical Commissioners, and the NHS England Industry Council. I've chaired the NHS Equality and Diversity Council (where we heard from Roger Kline about workplace race equality and the 'snowy white peaks' of NHS leadership); the NHS Leadership Academy board (where we agreed its 2014/15 plan and discussed future strategic direction); and the NHS IQ board (ditto). I have also - to state the obvious - spent significant time with staff across NHS England as well as with our partners in other NHS bodies and across government, discussing immediate priorities and our broader strategic agenda.

So, all told, a stimulating and educational five weeks. Thank you to everyone who has helped organise these exceptional discussions and visits. I'm looking forward to the many others now planned.

2. Performance

Providers are rightly now taking significant steps to ensure safe staffing following the findings of the Francis and Keogh reviews. In the round, 2014/15 is expected to be more financially challenging than last year. Other areas of current attention include:

- *18 week RTTs*. More concerted action is urgently now needed by providers and commissioners to ensure that the NHS continues to meet the public's

legitimate expectation of acceptable waiting times for admitted patient care. This is something that NHS England (hand in glove with Monitor, TDA and DH) will be emphasising over the coming weeks.

- *Better Care Fund planning*. In June last year the Government announced that an additional £1.9 billion would be deployed from CCGs in 2015/16 as a catalyst for improved services at the interface of health and social care. In principle this initiative is welcome. At its meeting in March, the Board received a paper on progress, and I will provide a verbal update at this meeting on developments since then. At local level, Health & Wellbeing Boards have been tasked with developing BCF plans. Initial review shows that further work is needed to help ensure plans are realistic and that local hospitals are engaged

- *Mental health services*. Work is underway to ensure IAPT rollout and dementia diagnosis is on track, and that baseline measures are in place to assess the extent of parity of esteem and the action subsequently needed. Attention is also now being given to ensuring that commissioning models and priorities for 2015/16 better reflect the parity of esteem imperative than was the case in prior years.

- *Learning disabilities commissioning*, post-Winterbourne View. As has been publicly reported elsewhere, this has clearly been deeply problematic, and consideration now needs to be given to a new approach that places more control and direction in the hands of the people affected, their carers, and the expert advocacy and voluntary organisations involved. We hope to begin these discussions very soon.

- *Specialised commissioning.* Overspends in this area last year served to pre-empt needed investments in primary and mental health services this year. I have asked Paul Watson to lead an internal taskforce to better grip this issue over the next 90 days, in advance of more fundamental changes which I intend to make by mid-year, in conjunction with CCGs and other stakeholders.

3. Co-commissioning primary care

One year in to the new commissioning system there do appear to be tangible gains from much greater clinical involvement in planning and funding decisions by CCGs. But for maximum impact we also need to ensure that the three-way division of labour between primary care commissioning, local hospital and community health service commissioning, and specialised commissioning does not inhibit a unified population-based approach. In particular, if we want to better integrate care outside hospitals, and properly resource primary, community and mental health services - at a time when overall funding is inevitably constrained - we need to make it easier for patients, local communities and local clinicians to exercise more clout over how services are developed.

CCGs have now argued that one route to doing so is to give them greater influence over the way NHS funding is being invested for their local populations. Equally, it is obvious that CCGs are still young organisations at different stages of

development and with different local needs, so rather than specifying a one-size-fits all solution for how to do this, we have invited CCGs themselves to come back to us with their ideas by June 20th.

However to be clear: we will not recommend to the NHS England Board any such arrangements be authorised unless and until there is transparent and fair governance in place - with a continuing oversight role for NHS England – which safeguards against conflicts of interest. CCG expressions of interest will also need to meet a number of tests including showing how these new arrangements would advance care integration, raise standards and cut health inequalities in primary care, all in the context of the CCG's five year plan for its local NHS services.

4. An NHS five year 'forward view'

Following NHS England's Call to Action last year, CCGs and health care providers were asked to develop their five year outline plans by the end of June. In taking an initial look at where this work has got to, it strikes me that in a number of geographies we are going to need to take a more fundamental look at how care models might evolve beyond our traditional ways of delivering services. In doing so, we're going to have to challenge some now outmoded assumptions about how best to support patients both in and out of hospital. And given both the heterogeneity of the populations we serve and the different legacy patterns of health care provision across the country, we need to promote and welcome new solutions which may vary from place to place.

All of this is, of course, playing out against the backdrop of an extremely tough financial position, so we need an honest but creative process for considering what realistically the NHS can and cannot do under alternative sets of constraints over the next five years or so. To that end I set out for the Health Select Committee our intention to use the extended five year planning process to help publicly answer the questions - by the late Autumn - 'What are the further things the NHS can do now to put itself on a sustainable footing, and where will that take us? And what are the constraints that would need to be relaxed, and the enablers that need to be put in place to help get us there?' I look forward to further discussing this process with the Board and with our partners.

5. NHS England's organisational fitness and scope

One year in, this an appropriate time to take stock of what NHS England is doing and how it is doing it. I expect the result will be a few incremental adjustments to our organisational structure, management processes, core commissioning capabilities, and focus of effort. I've asked Karen Wheeler (who I've appointed as our National Director for Transformation and Corporate Operations) and Ros Roughton to support a rapid first phase of this work. This will focus on better alignment between our national directorates; ensuring we have the people to support our core functions; and ensuring that NHS England's inherited diverse set of activities are an appropriate fit with our mission. I will give a short update on this work at the Board meeting.

6. Transparent conduct of NHS England business

NHS England has set new standards for openness and transparency in all of its operations, compared with what went before. And I've set myself and our organisation the goal in everything we do of 'thinking like a patient, and acting like a taxpayer'. We meet as a board in public, are publicly set goals through a democratically-accountable Mandate, and maintain and publish declarations of interest for all Non-Executive and Executive Directors. NHS England already publishes information on expenses incurred by national directors and we hold a register of gifts and hospitality received. One additional transparency step we will now take – similar to the practices of government departments – is to routinely publish information on the chief executive's and executive directors' business meetings with external non-public sector organisations.

7. Urgent actions taken since the last meeting of the Board

Four 'urgent actions' were undertaken since the last meeting, as set out in the Annex to this paper. They were:

- approval of business case for the merger of the Royal Free and Barnet & Chase Farm Trusts;
- approval of Strategic Outline Case for the Health & Justice Information Services;
- approval of Outline Business Case for NHS 111 Telephony re-procurement;
- approval of delegated authority to the Chief Financial Officer to underwrite

Simon Stevens, CEO
9 May 2014

Annex to Chief Executive's report

Name of urgent action	Lead national director	Overview	Details	Board members approved	Date to be reported to Board
Barnet and Chase Farm	Paul Baumann	Business case for the acquisition of Barnet & Chase Farm Trust by Royal Free London NHS Trust	The business case seeks approval to commit £12m of the NHS England central provider support budget in 2014/15 to support this transaction and for NHS England to sign the Heads of Terms.	Malcolm Grant (Chairman) David Nicholson (Chief Executive) Ed Smith (Chair of the Finance and investment committee) Moira Gibb (Non-executive Director	15 May 2014
Health & Justice Information services	Paul Baumann	Strategic Outline Case for the Health & Justice Information Services at a projected whole life cost of £53.5 million).	It is essential that work on the Outline Business Case for phase (1), the national integrated primary care (replacement) service for the residential estate, proceeds without delay to ensure that a replacement service for the residential estate can be procured and delivered by July 2016 when the current contract expires.	Malcolm Grant (Chairman) David Nicholson (Chief Executive) Ed Smith (Chair of the Finance and investment committee) Moira Gibb (Non-executive Director)	15 May 2014
NHS 111 telephony re-procurement	Paul Baumann	Outline Business Case for the 111 Telephony re-procurement	Chair's Action to approve the Outline Business Case for the 111 Telephony re-procurement at a projected whole life cost of £33.3 million. The timeline to achieve this re-procurement is challenging, and any slippage will impact on the set up and test phase and create a significant risk of loss of business continuity for the NHS 111 service.	Malcolm Grant (Chairman) David Nicholson (Chief Executive) Ed Smith (Chair of the Finance and investment committee) Moira Gibb (Non-executive Director)	15 May 2104

Name of urgent action	Lead national director	Overview	Details	Board members approved	Date to be reported to Board
NHS Direct	Paul Baumann	Underwriting legacy liabilities to services we commission that have been transferred from NHS Direct to HSCIC.	NHS Direct was dissolved on 31 March 2014 with exit costs being funded by the DH for services which ended on that date. Three NHS Direct services transferred to HSCIC and will continue to be commissioned by NHS England. Urgent action was approved to give Paul Baumann delegated authority to underwrite exit cost liabilities for these services up to a maximum of £2.79m.	Malcolm Grant (Chairman) Moira Gibb (Non-executive Director) Barbara Hakin (National Director: Commissioning Development) Ed Smith (Non-executive Director)	15 May 2014