Kingston Hospital NHS Trust

CHIEF EXECUTIVE'S REPORT

Trust Board **Part I**	**Item: 6**
25th April 2012	**Enclosure: C**
Purpose of the Report / Paper: To provide the Board with information on strategic and operational issues.	
For Noting ☒	**For Decision** ☐
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Recommendations & Action required by the Trust Board: The Trust Board is asked to note the report.	

Chief Executive's Report

Summary

1. This paper gives the Board an update on some of the key areas of activity that could impact upon the strategic development of the organisation. It also gives a brief outline of the operational environment and activity since the last Board meeting. A fuller operational update is given in the appendix.

    1) External environment – including plans for the authorisation of CCG's, an update on NW London Strategy & BSBV in SW London and a pension's update.
    2) Operational Update.

External Environment

The Transition and Implications for SW London

2. There are four authorisation timeline waves for Clinical Commissioning Groups (CCGs), beginning in June, July, September and October 2012. CCGs will confirm which application wave they wish to join by the end of April 2012 and the National Commissioning Board will confirm the authorisation pipeline in May 2012.

    The next steps in the national timeline for CCG authorisation is as follows:

    - April – August 2012: CCGs confirm commissioning support services, 360 degree assessments to capture partners' views and CCGs begin to apply for establishment and authorisation
    - October 2012 – January 2013: National Commissioning Board authorisation decisions will be made

3. Each CCG will be required to have its own constitution, financial management arrangements compliant with national requirements, a draft Joint Strategic Needs Assessment, a Joint Health and Wellbeing Strategy, an Organisational Development Plan, an SLA with their commissioning support organisation, draft commissioning intentions for 2013/14 and a 360° stakeholder survey report as part of the application for establishment submitted to the National Commissioning Board.

4. The aim will be to be authorised with as few caveats as possible. If conditions to authorisation are applied the commissioning function may be undertaken by another CCG or an organisation appointed by the National Commissioning Board.

    In SW London it is anticipated that the Kingston and Wandsworth CCGs will apply in the first waves.

5. Locally CCGs are developing their proposed leadership arrangements which will be put forward to the National Commissioning Board. Chairs have been elected for Kingston (Naz Jivani) and Wandsworth (Nicola Jones). Chairs for the remaining SW London CCGs are anticipated to have been elected by early May 2012. Accountable officers are less clear at this stage but it is expected that there will be an assessment process around June 2012.

6. SW London CCGs will be operationally responsible for their budgets from May 2012 and are expected to lead contracting negotiations next year. One commissioning support organisation providing services to CCGs in South London is planned, which is expected to operate in shadow form from October 2012 and will be hosted by the National Commissioning Board from April 2013. All SW London CCGs have indicated that they will be looking to buy at least the core offer, except for Kingston who are still working through their approach.

NHS Surrey – emerging CCGs

7. Dorking, East Elmbridge, Medlinc and Mid Surrey CCGs are coming together to form DEEMMS CCG from 1 April 2012. A Memorandum of Understanding has been developed with the new CCG which will enable them to take on 100% delegated responsibility for their allocated budgets from 1 April 2012. The four previous CCGs will become Commissioning Localities of DEEMMS and will remain with decision making delegated to their Locality Boards. Thus the principle relationship for Kingston Hospital will be with the East Elmbridge Commissioning Locality of DEEMMS and their Chair Dr Jill Evans.

8. Dr Jonathan Richards is the Chair of DEEMMS CCG and also Chair of the Dorking Commissioning Locality. Dr Claire Fuller is the Chair of Medlincs Commissioning Locality. The Mid Surrey Commissioning Locality Chair is yet to be confirmed.

NW London Strategy: Shaping a Healthier Future

9. The second stakeholder event held on 23 March 2012 set out the out of hospital strategy, the process and rationale for developing the options for reconfiguration and the criteria that will be used to evaluate them. Eight options are being worked up that deliver five major acute hospitals. It has been proposed that Northwick Park and Hillingdon should be major acute hospitals across all options to minimise the impact on access given that they are geographically remote. The remaining three major hospitals will be determined by geographical distribution to minimise the impact on local residents reflecting a choice between:

    - Hammersmith or St Mary's
    - Ealing or West Middlesex
    - Charing Cross or Chelsea and Westminster

10. A further stakeholder event is planned for 15 May 2012 to discuss the emerging plans for consultation.

11. The National Clinical Advisory Team will complete an independent assessment of the options in April 2012. The draft pre-consultation business case will be considered by the Cluster Board in May 2012 and the final version, together with a decision on whether to consult, will be considered in late June 2012. The Board will be kept informed of developments and any potential impact on the Trust.

BSBV Update

12. The sixth clinical report, covering Children's Services, will be published in early May 2012. These reports make recommendations on the number and future shape of services but are not site-specific. A scoring panel of over 60 people – public, clinicians, local authorities, directors of public health – will convene to score the non-financial aspects of the options for future hospital configuration on Wednesday 9 May 2012.

13. Croydon Council is seeking legal advice on the make-up of the scoring panel as they believe representation should be weighted to reflect the size of the local populations of each hospital, rather than the proposed equal balance from each borough. There has been recent coverage of this in the Croydon Guardian. The BSBV review team does not believe that weighting the panel per head of population would be the correct approach. There is no precedent for a population-weighted approach in the NHS or elsewhere in the BSBV programme. It is important to remember that the scoring panel is not a decision-making body and is only the first stage in the process to arrive at a final short list for consultation.

14. The Scoring Panel results will be combined with separate financial affordability appraisal results, which will be carried out in parallel by the BSBV Finance & Activity team (including Trust Directors of Finance). These combined results will be considered by the Clinical Strategy Group who will put forward a site-specific shortlist of options. The shortlist will then go to the BSBV Programme Board and the Joint PCT Boards, who will make the final decision on the shortlist of options to be formally consulted on with the public.

15. The Integrated Impact Assessment IIA will start in the pre-consultation stage and will be overseen by an independently chaired steering group. It will be informed by four separate impact assessments covering:

    - Health
    - Equalities
    - Travel
    - Environmental

16. The preparation of the IIA can begin once the shortlist of options has been agreed and are supported by finance and activity modelling. There will be three stages of publication:

    1. Initial pre-consultation document
    2. Mid-consultation document
    3. Final post-consultation version – submitted to Joint Boards and taking in consultation feedback

17. Formal public consultation is expected to start during the summer 2012 and the programme continues to be subject to scrutiny by the Joint Health Overview and Scrutiny Committee from all 6 local boroughs. The National Clinical Advisory Team (NCAT) and Office of Government Commerce (OGC) will be undertaking reviews of the programme during May 2012.

Pensions update

18. The issue of NHS and wider public sector pension reform is not yet resolved and further industrial action remains a risk. The Secretary of State has made a final offer which Trade Unions (TUs) are now responding to, or balloting upon. Unison has a ballot open that will close on 27 April 2012. The Royal College of Midwives is also consulting on the offer, as are other NHS unions. The Royal College of Nursing has decided not to consider any kind of industrial action for now following a February ballot on pensions (when 62% voted against and 32% for the offer) but will discuss next steps with other TUs after their ballots have concluded.

19. The British Medical Association is running a ballot between 14 and 29 May 2012 on industrial action, which it says would involve the withdrawal of all but urgent and emergency care.

20. Unite has rejected the final offer on pensions and announced on 17 April 2012 that it will hold a further day of industrial action on 10 May 2012. It has called on other public sector TUs to join this action. Outside of the NHS, the PCS is also taking action on this day affecting benefits and immigration offices. At the time of the last industrial action on 30 November 2011 the Trust had 37 Unite members, mainly in scientific, engineering and estates roles. It is possible that Unison and other health unions (other than the BMA) could also take action, provided they could give the proper 7 days' advance notice of numbers involved. The Trust will operate its contingency plans in discussion with our local TU representatives appropriate to any action notified.

2. Operational Update

21. The high levels of activity experienced in February 2012 have continued into March 2012. A&E attendances were up 7% on March 2011. There were large numbers of high acuity patients as well as significant numbers of patients with more minor ailments. Despite this increased activity the emergency department continued to achieve the 95% target of patients being seen and treated within four hours.

22. All elective activity continued as plan as well as the extra patients being treated following the investment of the winter access initiative funding. All eight referral to treatment waiting time standards were achieved.

23. Improved utilisation of Choose and Book slots is now being seen following the review of the Directory of Services and increased capacity across the specialities. Slot issues have also reduced from 16% in February 2012 to 6% in March 2012. A communication plan is being developed to further engage GP's in using choose and book. Slot availability and utilisation continues to be monitored on a daily basis.

24. The February 2012 cancer performance was affected by the half term break and the small numbers of patients treated in some categories. This is reflected in greater detail in the performance report.

25. The process for signing off budgets commenced. Budget holders have met with the Chief Operating Officer and Deputy Director of Finance to sign off their budgets for 2012/13. This has involved a review of their budgets and confirmed understanding and sign up to local cost improvement programmes.

26. As part of the Trusts Emergency Planning programme many staff across the Trust participated in an Emergo Exercise. This allowed the organisation to test its major incident plan with external support. The feed back from the exercise was very positive allowing staff to test their preparedness for a major incident in a safe environment. There were many lessons learnt which will be shared through the formal report.

27. The London Cardiovascular Arrhythmia Project Team undertook an Arrhythmia Assurance Visit (Stroke and Cardiovascular Service) on the 26th March 2012. The review team feed back was positive although there are some areas of improvement. A formal report and action plan is awaited.

Appendix 1

Contents

1. Operational Reports from Divisions

1.1 Division of Women and Child Health
Divisional Director Report, Dr Andy Winrow

28. The Maternity Unit delivered 5924 babies in the year 2011 / 12 of whom 5823 were NHS deliveries. This compares with a total number of deliveries of 5874 in the preceding financial year. Although the caesarean section rate has fluctuated, the rate has been as low as 25.9% (February 2012). The Division is pleased that the renegotiated KPI for caesarean sections has increased the permitted percentage to 28% and, in the light of NICE guidance that has impacted on women's perspective regarding choice of operative delivery, there will not be a financial penalty associated with the caesarean section rate.

29. Further work between the Maternity team and the Business Information team has helped clarify the Trust's position regarding compliance with the requirement to book the majority of pregnant women within 12 weeks and 6 days. Following discussion, the criteria for inclusion in this data was redressed with exclusion of those who booked elsewhere then transferred their care to Kingston and those who choose to book later than the time limit specified. In doing so, this brought the Trust in line with other local providers. This revision has shown that Kingston Hospital is compliant with > 90% of women booked within the specified time limit. This has been clarified with the commissioners at the Clinical Quality Review Meeting and is due for review at the Maternity Services Liaison Committee in June (at commissioner request).

30. The Division underwent a mock CNST assessment as a prelude to determining the feasibility of proceeding for a full CNST level 2 assessment in the summer or autumn. The assessment highlighted several areas of inadequate compliance predominantly in linking current safe clinical practice to the exact requirements as specified in our extensive policies. The Division is completing a rigorous gap analysis to determine the practicality of still proceeding for formal assessment in June of whether further time is required to ensure success when examined.

31. The Gynaecology Department has participated in the discussions regarding the reconfiguration of the surgical centre. The resulting plan continues to localise gynaecology services together that is important for maintenance of quality and to support the Division's productivity plans. The Division's still plan for the Assisted Conception Unit to transfer from Queen Mary's Roehampton to the Kingston site in June.

32. The Paediatric Department has been reviewing the possible impact of the recommendations arising from both the Children's Working Group of '*Better Services Better Value (BSBV)'* and the pan-London Health Care Programme review of Paediatric Emergency Care. The output from both programmes is similar and will require formalisation of extended working hours in the department above the current level of consultant presence. The recommendation from *BSBV* relating to the number of in-patient paediatric units in South West London remains controversial.

33. With the end of the financial year, the income for the Division has improved considerably with the favourable £166k in month reducing the previous adverse income projection to an end of year deficit of £36k. Pay costs continue to be adversely affected by the significant amount of maternity leave within the Division that includes 17.63 WTE in midwifery. A paediatric consultant is due to also leave on maternity leave in the next few months. There are no new senior appointments within the Division.

1.2 Division of Ambulatory Care
Divisional Director Report, Dr John Wong

34. The Division has completely reviewed and overhauled their Risk assessments, meetings and monitoring to reflect the Trust's Risk agenda. The Division now identifies a few – maximum of 3 – good practice messages from the Division's Risk meetings to cascade to all staff. The intention is to spread good ideas and guidelines that can possibly be used in all departments.

35. In Health Records, following the special project of filing loose notes, a recent audit of patient records has shown a marked improvement. The challenge is to embed this behaviour by emphasising that it is every staff's responsibility to file notes properly. The project is continuing till summer.

36. In Pathology the department is reviewing OrderComms. at the pilot sites to enable roll out into the Community. Pathology very much support extending this initiative and are expecting good uptake in general practice. At this juncture the Division are also reviewing the Radiology module of OrderComms.

37. The Divisional Manager for Ambulatory care is leading the implementation of the action plan that has been developed following the Outpatient survey. This will address the systems and processes that underpin Outpatient services and improve the patient experience.

38. Finally the Division has ended the last year in positive financial balance. This is accompanied by the Division coping with an increased workload in all departments.

1.3 Divisional of Medicine and A&E
Divisional Director Report, Dr Sarah Evans

39. Preparation for the Easter weekend provided the division with opportunity to close twenty beds on Derwent Ward. This closure was the culmination of the huge amount of work undertaken to improve daily discharges and reduce length of stay within the medical unit. A number of ward changes have been made to accommodate this closure. These include the provision of six haematology beds on Blythe Ward, the increase by four of care of the elderly beds on Keats Ward and the interim transfer of the stroke therapy room to Elliott Ward.

40. Changes to the skill mix of nursing staff within the medical unit have begun with an increase in the nurse to health care assistant ratio on night shifts and the provision of the supervisory sister on the day shifts. A number of nurses recruited in Northern Ireland are expected to start in May and June and the division has also had a huge response to the recent advert for nursing posts. Once in post it will be possible to increase the nurse to health care ratio during the day.

41. The work of the patient pathway programme board has resulted in further improvements within the division. A pilot to extend the occupational therapy support in the Emergency Department proved highly successful in avoiding further admissions and has therefore been commissioned for 2012. Work on developing an electronic board for the recording of the patient's status on the ward, including expected date of discharge has progressed and the recording of ambulatory patients, who attract an ambulatory tariff commenced on 1st April 2012.

42. The staff consultations have now ended and the process of slotting staff into available posts has been completed. The staff who have been impacted by the changes have been provided with as much support as possible by the management teams and every effort is now being made to find suitable alternative employment for this small group of staff.

43. The division has continued to maintain improved performance of the pay budget and has worked closely with budget holders over the last month on the management of the non pay budget. This has included the provision of more detailed information on the costs of individual items, the review of stock on the wards, and the reinforcement of the criteria for the requesting of ambulance transport.

44. Three of the new emergency department consultants have commenced in post. The division has also been successful in securing support for the appointment of a third consultant cardiologist who will work at Kingston and at St. George's Hospital in developing this service.

1.4 Division of Surgery & Critical Care
Divisional Director Report, Mr Roland Morley

45. As part of the Productive Operating Theatre Project a comprehensive review of stock management is being undertaken. A stock take is planned to identify those items of stock that are no longer required, optimal levels of items that should be kept on the shelf and management of the stock to create efficiencies in storage and ordering.

46. A Measures workshop has been held in March which will inform the development of a dashboard to reflect the improvements achieved through The Productive Operating Theatre.

47. The project for bringing together the acute medical and surgical emergencies on the 3rd floor of the Surgical Block is progressing and the first stage is being progressed for completion at the end of April. This includes pre-assessment moving to Roehampton Wing, Jasmine moving to the pre-assessment area on the 4th floor and MGPU moving into the area vacated by Jasmine. At the same time Isabella ward will move to the 4th Floor and be amalgamated with the surgical elective and post-operative wards.

48. An operational plan is being developed by all Divisions to detail the patient pathways through the two newly created areas. The move will help facilitate ambulatory pathways for both medical and surgical patients and will enable a surgical admission on the day area to be created on the 4th Floor.

49. The Dental laboratory closed this month and the area will be utilised to provide space to bring together the administrative functions of both the oral surgery and ENT/Audiology departments. This should improve efficiencies for both departments and introduce some cross cover to provide a better service.

50. The Specialities have submitted their proposals for the administrative structures to support their clinical practice and are awaiting the outcome of the Patient Access consultation to enable this work to go forward. This will support the achievement of the 18 week target for the specialities by enabling a more robust process across the patient pathway from referral through to treatment.

51. The final part of implementing the Divisional restructure, agreed in November 2011, can now progress following the completion of the consultations within other Divisions. Interviews for the Speciality pathway managers will be completed by the end of this month. The gaps within the operational management structure have had an impact on the Division and its ability to move forward with the work streams as quickly as required.

52. The Division had an adverse position in month of £143k but has ended the year with a favourable variance against plan of £25k. This month there has been an increase in both pay and non pay expenditure. There have been high levels of over performance on Daycase and Elective activity particularly in Pain management and Orthopaedics. Ophthalmology experienced the highest monthly activity over performance all year in Outpatient attendances with 3,199 attendances in month.

53. Ms Vasuki Sivagnanavel, Consultant Ophthalmologist with an interest in Medical Retina, joined the Trust on April 2nd. This is her first consultant appointment and she has been working in this speciality at Moorfields Eye Hospital, London for the past 6 years.

2. Communications Update

Projects

54. The Team have been working on a number of campaigns and projects since the last Trust Board meeting in March 2012. These have included; coordinating a programme of non-executive and executive walkabouts throughout the Hospital, preparation of a Hospital-wide communications strategy for the 2012 Olympic Games, GP engagement including the coordination of a Radiology event on 18 April, preparation of patient information leaflets, PR preparation for International Nurses Day, preparation for a PR event to promote the new commitments, standards and behaviours into the organisation, developing communications plans to support elements of the commercial strategy, promoting and coordinating the monthly staff awards, website updates and improvements and supporting the executive team to prepare for the Hospital's Foundation Trust application and to compile the quality assurance governance review. The team is working on the final draft of the 2011/12 annual report, ready for submission. On a daily basis the team also monitors news sites, progresses our social media (Twitter and Facebook) and compiles staff emails/updates.

Press activity

55. The team has received 7 enquiries from the local and national press since mid-March 2012. The main press enquiries were about job cuts, hospital savings and the cath lab. Press statements were prepared and distributed regarding these matters. We have also received 1 filming and 1 audio recording request and are meeting with a film production company to discuss filming options.

56. Three proactive positive press releases were written and distributed, regarding two separate ex Kingston Hospital patient relatives undertaking fundraising for the hospital and two Kingston Hospital doctors returning from performing cataract surgery for charity in Bangladesh. Media monitoring has also been undertaken and the new press grid is being utilised to provide a better analysis of our media coverage.

Overall, the coverage received since the last Board meeting has been fairly positive or neutral with 12 stories printed in the press. In this time, 5 positive press stories were generated by proactive press releases prepared by the team. A correction for the inaccurate ambulance handover story was also printed in the local paper.

Membership and Events

57. The total number of public members now stands at over 4,750, which means we are well on track to achieve our target of 5,000 public members by June 2012. We also have continued to build links with local groups including Kingston Lesbian, Gay, Bisexual, Trans (LGBT), Kingston Youth Council and others. The Communications and Membership Manager now also looks after the Trust's 230+ volunteers, following the retirement of the Voluntary Services Manager.