# CHIEF EXECUTIVE’S REPORT

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**For:** Information ☒  Assurance ☐  Discussion and input ☒  Decision/approval ☒

**Sponsor (Executive Lead):** Chief Executive

**Author:** Executive Team

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**Recommendations:**

The Council of Governors is asked to **note** and discuss the updates provided in the report.
Chief Executive’s Report
September 2015

1. Summary

This paper provides the Council of Governors with an update on some of the key areas of activity that could impact upon the strategic development of the organisation.

2. External Environment

2.1 Integration

*Development of detailed proposals for the provision of integrated out of hospital care in Richmond*

Richmond CCG have identified the Trust together with Hounslow and Richmond Community Healthcare NHS Trust, Richmond General Practice Alliance and West Middlesex University Hospital NHS Trust as the ‘Most Capable Providers’ to form an alliance and develop proposals to deliver integrated out of hospital services from April 2016. The Most Capable Provider (MCP) assessment process will run until the end of December 2015, followed by a period of contract negotiation and mobilisation. Commissioners had indicated that failure to meet the required criteria at key gateways will trigger a competitive dialogue process. A Memorandum of Understanding, approved by the Board in June 2015, was judged by the CCG to have met the criteria to pass the governance qualification stage.

The Partners will now focus on developing detailed proposals to deliver integrated out of hospital health and social care, for submission to commissioners in the Autumn. At this stage Richmond CCG has agreed a budget of £250k to support providers in delivering this. Three dialogue sessions were held with the CCG and providers during July 2015 to discuss elements of the outcome based commissioning contract including the scope of services, a discussion on outcomes, financial and contractual principles. Governance arrangements have been established and a Programme Director has been recruited to lead the detailed programme of work.

*Kingston Integration*

Similarly, the Trust is working closely with the CCG, Kingston Council, Kingston GP Federation, Your Healthcare, South West London and St George’s Mental Health Trust to transform out of hospital services as part of the Kingston Co-ordinated Care project. A Programme Board and Design Team have been established to redesign pathways which will then be tested in two phases to ensure that they are effective in practice. A project that engaged with customers in Kingston and staff to develop the case for change and build on previous insights is complete. Work on preparing for the commissioning and contracting changes required to deliver the new operating model is being progressed in parallel.
2.2 Secretary of State Speech – Making Healthcare More Human-Centred And Not System-Centred

The Secretary of State in July set out the government’s 25 year vision for a patient-led, transparent and safer NHS. The announcements made emphasise transparency, choice, empowered patients and local decision making and signal a move away from a target driven culture to one of learning and improvement, with an overall ambition for the NHS to become the world’s largest learning organisation.

Changes to the regulation architecture and renewed focus on improvement:

- NHS Improvement will be the new operating name for a jointly led NHS Trust Development Authority and Monitor. This will be chaired by Ed Smith, currently Vice-Chair of NHS England, supported by Ara Darzi as a new non-executive director. Recruitment for a chief executive of NHS Improvement will commence immediately and will be completed by the end of September.

- The safety function currently at NHS England and led by Dr Mike Durkin will transfer to NHS Improvement. NHS Improvement will also host a new Independent Patient Safety Investigation Service.

- Introduction of an international buddying programme; initially five NHS trusts will be buddied with Virginia Mason in Seattle, with an expectation to develop further international partnerships in the future.

Changes to the consultant contract to enable a seven-day NHS:

- The opt out clause for weekend working will be removed from the consultant contract for newly qualified hospital doctors. Doctors currently in service will still be able to exercise weekend opt-outs, but the off-contract payments for this activity will be reformed.

- The British Medical Association (BMA) was offered a six week window to discuss and agree the changes with the government.

Leadership capacity in the NHS:

- The government accepted in principle the recommendations from the Rose report ‘Better leadership for tomorrow’. This included a suggestion that the functions of the Leadership Academy come under the purview of Health Education England (HEE).

Proposals relating to patient safety, quality of care and patient choice:

- Improving incentives for staff to speak out against poor quality care in the NHS.

- Establishment of an independent agency to investigate patient safety incidents to be hosted by NHS Improvement.

- Modernisation of the supervision of midwifery.
• GPs will be asked to inform patients of the Care Quality Commission rating and waiting time data at hospitals.

• NHS England will develop proposals for introducing meaningful patient choice and control over their care offered in services for maternity, end of life care and long term conditions.

3. Internal Environment

3.1 Monitor Investigation

The Foundation Trust regulator Monitor has launched an investigation into the Trust’s A&E performance and financial sustainability. The Trust has managed its finances very well for many years and has some of the best clinical outcomes in the country, but in line with the rest of the NHS, the amount paid for each patient is reducing and the Trust has also absorbed some costs that were previously paid for nationally, this includes the Hospital IT system which costs £2m per year. The Trust has had some issues in meeting the A&E four hour wait target since November 2014 and has implemented a ‘faster flow, safer care’ operations transformation programme focused on improving the flow of patients through the Hospital, as well as working closer with community and CCG partners to deliver care in the most appropriate setting for patients.

Monitor has started to examine how and why the A&E performance and financial issues have occurred, test the Trust’s thinking on solutions and help to identify other possible options. Monitor will help the Trust to explore further ways in which the Trust can work with other local NHS organisations so as to continue to provide patients with quality services and to improve performance. The Trust very much welcomes this investigation and has been working with Monitor to look in detail at some of the challenges and how to support the Trust to plan for long term recovery and sustainability.

3.2 Improving and sustaining cancer performance

Nationally 2014/15 was a challenging year for commissioners and providers and whilst cancer performance was generally good; performance against the 62 day standard was consistently below the required standard. Delivering the 62 day standard is closely linked with the determinants of good cancer outcomes and positive patient experience. All acute trusts, across the country that provide cancer services have been written to by Monitor, the National Trust Development Authority and NHS England on 14th July 2015 outlining eight key priorities for improving the 62 day cancer performance target. Trusts are expected, as of August, to report on progress against the eight key priorities and provide an action plan with timeframes for when they are likely to be achieved. The key priorities are as follows:

1. The Trust Board must have a named Executive Director responsible for delivering the national cancer waiting time standards.
2. Boards should receive 62 day cancer wait performance reports for each individual cancer tumour pathway, not an all pathway average.

3. Every Trust should have a cancer operational policy in place and approved by the Trust Board. This should include the approach to auditing data quality and accuracy, the Trust approach to ensure MDT coordinators are effectively supported, and have sufficient dedicated capacity to fulfil the function effectively.

4. Every Trust must maintain and publish a timed pathway, agreed with the local commissioners and any other Providers involved in the pathway, taking advice from the Clinical Network for the following cancer sites: lung, colorectal, prostate and breast. These should specify the point within the 62 day pathway by which key activities such as OP assessment, key diagnostics, inter-Provider transfer and TCI dates need to be completed. Assurance will be provided by regional tripartite groups.

5. Each Trust should maintain a valid cancer specific PTL and carry out a weekly review for all cancer tumour pathways to track patients and review data for accuracy and performance. The Trust to identify individual patient deviation from the published pathway standards and agree corrective action.

6. A root cause breach analysis should be carried out for each pathway not meeting current standards, reviewing the last ten patient breaches and near misses (defined as patients who came within 48 hours of breaching). These should be reviewed in the weekly PTL meetings.

7. Alongside the above, a capacity and demand analysis for key elements of the pathway not meeting the standard (1st OP appointment; treatment by modality) should be carried out. There should also be an assessment of sustainable list size at this point.

8. An Improvement Plan should then be prepared for each pathway not meeting the standard, based on breach analysis, and capacity and demand modelling, describing a timetabled recovery trajectory for the relevant pathway to achieve the national standard. This should be agreed by local commissioners and any other providers involved in the pathway, taking advice from the local Cancer Clinical Network. Regional tripartite groups will carry out escalation reviews in the event of non-delivery of an agreed Improvement Plan.

On initial review of the eight key priorities by the cancer leadership team the Trust is currently delivering many of the priorities identified. A GAP analysis took place against all of the 8 priorities and was reviewed by the Executive Management Committee in August 2015. The Trust’s plan to achieve full compliance was submitted by the end of August 2015. For the priorities which are outstanding, the Clinical Lead and Associate Director of Nursing for cancer and clinical support services have developed an action plan to ensure that the priorities are delivered.
3.3 **A&E Improvement Programme**

The Trust has in place a ‘Faster Flow, Safer Care’ Operational Transformation Plan in order to meet the A&E 4 hour performance target, improve patient flow across the whole hospital, and into out of hospital services. This is based on the Trust internal diagnostics and recommendations of the Emergency Care Intensive Support Team (ECIST) review. This intensive programme of work within the organisation will be covered in more detail within the Performance presentation to the Trust Board and actions include:

- Temporary deployment of on call managers present on site during evenings and weekends to provide increased leadership support.
- A 13 week trial of GP's in the department during the evenings and at weekends which commenced on 19\textsuperscript{th} July 2015.
- Daily 8.30am Executive led breach meetings, including specialty level representation to ensure all issues addressed.
- A new nursing establishment for the Emergency Department has been approved by the Executive Management Committee and is being implemented.
- A review of medical workforce is taking place.
- Intensive analysis of performance information to understand changes in admissions and discharge profiles to focus improvement actions.
- Temporary additional inpatient surge capacity available Sunday to Wednesday to address reduced Monday capacity due to reduced weekend discharge levels.
- Changes to the ED whiteboard to identify earlier patients at risk of breaching.
- Intensive support has been provided by the CRS team to ensure improvements in documentation to support the analysis and classification of breaches – this follows the identification of potential inconsistency in the quality of breach data capture.
- The business intelligence team are conducting breach analysis to ensure robustness of data capture going forward.

An update on A & E performance will be presented at the meeting.

3.4 **Financial Recovery**

As you will be aware, the NHS is facing an unprecedented financial challenge this year. The current plans nationally project a deficit of £2.1bn this year which is neither affordable nor sustainable. Monitor, the Trust’s economic regulator has been reviewing and challenging our plans along with those of 45 other Foundation Trusts. As part of this process the Trust has been encouraged to do more to reduce our projected deficit and, if possible, avoid the need for interim revenue support in year.
In light of this, and building on the work that was already underway within the organisation, the Trust believes that it can reduce the deficit by approximately £2.7m to £6.1m and avoid the need for cash support during the remainder of this year. This improvement in the position primarily reflects the latest forecast position that has been built up within the organisation, a reassessment of timing of certain items within the capital plan, and an review of certain provisions held within our balance sheet.

As part of the reforecasting exercise it is clear that many areas are performing well, which is fantastic particularly in light of the challenging climate, and have agreed that they can do more to assist with the recovery effort. Other areas that have fallen behind are working to improve their positions.

Although there is good progress made so far there is a need to continue to develop recovery plans for the remainder of the year and to support the longer term sustainability.

An update on this will be presented at the meeting.

3.6 CQC Visit

The Trust will be routinely inspected by the CQC between the 12th and 15th January 2016. All acute Trusts will be inspected by March 2016, and the fact we are at the tail end of all these inspections is a testament to the quality of care provided at the Trust.

This inspection presents a great opportunity for all our staff and services to share with the inspectors what we do well and are proud of, and how it makes a difference to the care we give our patients. In the months leading up to January we will be focusing on this as well as reviewing opportunities to make further improvements for patients, carers, visitors, staff and volunteers.

As we approach the inspection date we will be providing more information to our Governors, patients, visitors and partners that we work with on how they can be involved in the inspection.

Our preparations for the inspection are already well advanced and began last summer with all services completing a self-assessment and peer review process. Services have also already begun to collate the large body of evidence we will provide to give a clear picture of our activities.

An update on preparations for the inspection will be presented at the meeting.

3.5 Senior staff moves

There have been some changes to the Executive team since the last Council of Governors meeting in June 2015.

Ann Radmore has been appointed as interim Chief Executive, and starts full time on September 14th whilst Kate Grimes takes a period of sick leave to manage a long term medical condition.

Eileen Doyle has joined the Trust as Interim Chief Operating Officer.
3.6 Governance – Well Led Review

The ‘well-led framework’ is Monitor’s guidance as to how NHS foundations trusts should structure reviews of their governance. Every 3 years the review must be undertaken by an external independent reviewer and the Board has agreed that an external review should take place during Autumn 2015.

The process to appoint the external reviewers was undertaken in August and September, with the contract advertised and proposals presented as part of an evaluation and interview process based on a combination of proven quality, relevant experience and value for money. The successful candidate will be announced shortly and the final well led review will be presented to the Board in November 2015.

3.7 Estates Update

Esher Wing - Windows Replacement Programme

The programme is progressing well to replace the Esher Wing windows. All of the windows to level 7 have been replaced, 75% of the windows to level 2, and works are now progressing on level 6. We have received positive feedback from both patients and staff about the difference this investment is making. The completion of the windows installation is planned for October 2015 and scaffolding is due to come down in November 2015.

Main Outpatients Phases 1-3

The planned works are now in progress, although completion is estimated to be 8-10 weeks behind schedule due to problems experienced with the construction of the new foundations. This has been due to unexpected obstructions in the ground encountered when undertaking the excavations. The effects on the programme are currently being assessed as well as the actions needed in order to mitigate the delay as much as possible.