Ashford and St. Peter's Hospitals NHS
NHS Foundation Trust

COUNCIL OF GOVERNORS
7th November 2011

TITLE	**Chief Executive's report**
EXECUTIVE SUMMARY	The report gives an overview of issues being addressed by the Trust, together with a perspective on the external environment. Topics include:- ▪ Approval to run AAA screening programme ▪ Implantable cardiovertor Defibrillator ▪ Winter planning ▪ Infection Control ▪ New summary Hospital level Mortality indicator ▪ Car parking ▪ Appointment Reminder service ▪ Epsom and St Helier transaction ▪ Catering ▪ Changes to Medical Director ▪ Health and Social Care Bill ▪ Highlights from the October and November Board .
The Council is asked to:	Discuss the report
Submitted by:	Andrew Liles Chief Executive
Date:	23rd November 2011
Decision:	To note

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Chief Executive's report to the Council of Governors

1 WHAT'S HAPPENING IN THE TRUST?

We continue to develop approaches to improving the care and experience of our patients, a number of which I summarise below;

West Surrey Abdominal Aortic Aneurysm(AAA) Screening Programme

A new AAA screening programme is being rolled out nationally. The aim of the Programme is to reduce deaths from abdominal aortic aneurysms (also called 'AAAs' or 'Triple As') through early detection. The aorta is the main blood vessel that supplies blood to the body. It runs from the heart down through the chest and abdomen.

In some people, as they get older, the wall of the aorta in the abdomen can become weak. It can then start to expand and forms what is called an abdominal aortic aneurysm (AAA). The condition is most common among men aged 65 and above.

Large aneurysms are rare but can be very serious. As the wall of the aorta stretches it becomes weaker and could give way. This is known as aneurysm rupture and is usually fatal. A smaller aneurysm is not dangerous. However, aneurysms can grow and it is therefore important to monitor the size.

The condition is particularly serious because it does not have any symptoms. However, treatment for AAAs detected through screening is highly effective.

Ashford & St Peter's have led the production of the business case for the Surrey vascular group that covers a 1.5m population served by ASPH, Epsom Hospital, Frimley Park Hospital, Royal Surrey County Hospital and Basingstoke & North Hampshire.

The business case has now been approved by the Department of Health, and this approval also secured £300K of funding to be used to implement and run the programme for the first 18 months. From April 1st 2013 funding becomes the responsibility of the Clinical Commissioning Groups.

The target population are 65 year old males, of which there are 5,900 to be screened in the first year. The plan is to identify 25-30 locations across Surrey and Hampshire to run screening sessions to ensure the greatest take up and participation by the local population.

Using statistical analysis gained from similar screening programmes run for many years in other countries, the expectation is for 4% of those screened to have aneurysms. 12% of these (or 23 in actual numbers) will be large enough to require direct referral for surgery. The elective surgery will only be performed at St Peter's Hospital or Frimley Park Hospital.

Undetected large aneurysms are at risk of rupturing, leading to emergency admissions. Not only does this carry a far greater mortality rate but also costs the NHS between £8K to £10K more per case than if the aneurysm was repaired electively.

The proposed timescale is to have all staff recruited and trained by March 2012, with invitations starting to go out the same month and for the first screening sessions to commence in April. The target date for completion of screening for the first cohort of men aged 65 is March 2013.

Implantable Cardiovertor Defibrillator

Our cardiology department were the proud recipients of a Silver Award from the pacemaker manufacturer, Biotroniks, for being the first centre in the UK to register over 100 active users on their home monitoring system for pacemaker and ICD (Implantable Cardiovertor Defibrillator) patients.

The home monitoring device works alongside the pacemakers and defibrillators at the patient's bedside, transmitting readings via a satellite to the Biotronik control centre in Germany, which then gets sent back to a computer here at the Trust. Being able to follow a patient's heart rate remotely helps detection of atrial fibrillation before the patient really notices and also allows any potential problems with the pacemakers to be picked up quickly.

The Board has a regular programme of hearing from patients about their experiences and Directors were delighted to meet the son of a patient who was using this device, and was finding it a real benefit both to himself and also his family as they felt enormously re-assured.

The cardiology department also led a symposium on the subject at the annual Heart Rhythm Conference in Birmingham earlier this month; another opportunity to put Ashford and St Peter's on the map.

Tea with matrons

One of our Matrons who is on our Good to Great Programme of leadership development has started a project called *Tea With Matron.*

Diane Lashbrook, Matron Outpatients wanted to set up something where patients, ex patients, carers and relatives are able to come and tell us about their experiences whilst in and around our Trust. The aim is for it to be informal, with people feeling comfortable and relaxed and assured that we will listen to their stories, learn from them and most importantly to respond. Her vision is to create a more structured way of working with our local population and so we can make changes to improve patient experience.

The sessions will be advertised widely and start in December 2011 on a pilot basis. All changes from these sessions will be communicated through the press office and having a monthly article in the local newspapers and GP news.

Winter

We know that winter is a challenging time and that

- Emergency admissions are slightly down year on year but peak September to December.
- A&E attendances peak in December and March (up by 5% and 12% respectively last year
- The busiest day in A&E is Wednesday, and attendances peak at 09.00-11.00,

15.00 and 17.00-19.00.

Over the last 6 months we have been making a number of short term improvements to how we run our hospitals to help us be prepared for the challenge that winter brings,. These improvements have included

- Daily 08:00 consultant led board rounds in Medicine and Orthopaedics to ensure that a daily senior review of all patients takes place
- Additional senior physician on site support in the evenings (8pm to midnight)
- Additional on site support senior on Saturdays and Sundays to facilitate discharge
- A senior team to review all outlying patients each day

These changes have put the Trust in a good position in advance of winter, and have led to a reduction in our emergency length of stay of over a day since July. There remains more to do to bed in these changes but early evidence is that they are improving the care to our patients and contributing to our objective of calm, ordered care for all our patients.

At the last Council of Governors meeting I briefed you on our 'Unscheduled care project', which is being led by Valerie Bartlett and our Associate Director for Performance Improvement, Claire Braithwaite. This is a really important piece of work to improve the way our patients flow through our two hospitals and as winter approaches this becomes even more important.

The **Unscheduled Care Project's** overall vision is to:

- have a good winter with calm, ordered care
- prevent (elective) patients having their surgery cancelled on the day
- make sure patients are not in hospital for any longer than necessary
- ensure patients are in the right bed, first time (i.e. no unnecessary moves)

Over the last year Ashford and St Peter's has experienced a number of particularly challenging peaks in demand bringing pressure on the number of available beds for patients who need admitting to hospital. This has had a knock-on effect on our A&E department as well as our performance against national waiting times standards for A& E and ultimately on ambulance turnaround times (the speed at which we can offload patients from emergency ambulances).

The causes of the peaks in demand are multiple. This is partly due to the natural and predictable peaks in demand that are described above. In addition peaks can also be caused by internal issues such as a slowing of discharges, late in the day discharge or poor planning and scheduling of elective work.

However in addition, in common with other Trusts in Surrey, we also face rising demand due to the changing nature of our patients. We have a larger proportion of very elderly patients in Surrey who are often very frail and present to us with complex medical conditions that can take longer to assess and treat. These are also often associated with more complex social conditions and dementia. We also receive more ambulances at St Peter's than other hospitals in the local are and are a particularly busy site for emergencies.

The key aspects of our Unscheduled Care Project which are addressing these issues are as follows:

1. Improving the flow of patients within the A&E department

In response to increasing demand, earlier this year we opened our 'Pit Stop' in A&E, a dedicated ambulance handover area where patients can be rapidly assessed, allowing the crews to get back on the road quickly. This resulted in a dramatic improvement in turnaround times, but as demand continues to increase we are now putting a number of additional measures in place to support continued improvement in the hospital and within our A and E department.

As a next step, on 8th December we will be opening a new Clinical Decision Unit within our A&E department which represents a £250,000 investment on behalf of our patients. The new unit, which is currently being built, will increase our emergency capacity and includes six beds where patients who are unlikely to need admitting to hospital can spend a bit longer being assessed and treated within A&E. Patients will be able to stay in the CDU for longer than 4 hours which will help to avoid unnecessary admissions

We have also improved what is known as our 'escalation policy' – these are the measures we take internally when the number of ambulances arriving starts to put significant pressure on our capacity. Our new policy puts more focus on intervening at an earlier stage to prevent ambulances having to wait, setting out clearer trigger points so staff know when to act to prevent the situation escalating.

2. Improving our management of capacity within the hospital

   We are also introducing a new patient information system, *RealTime*, which captures patient data electronically and is able to track them as they move through our hospitals. This information will help support our ward staff to plan patients' treatment more effectively and will support better bed management and discharge. It will help us get a very accurate and up to date picture of the reasons for any delayed discharge and help us focus our attention on those patients who most need our support.

3. Improving the pathway for Emergency Medical Admissions

Other measures which will further improve the experience of patients is the redesign of our pathway for emergency medical admissions. We have recently appointed two new acute physicians to work in our Medical Admissions Unit, and are creating better pathways for those patients referred to us by GPs. This includes providing alternatives to hospital which are safe and closer to home, such as direct referrals to the RAC (Rapid Access Centre) at Ashford hospital and where possible to appropriate clinics. In addition, during November we will be establishing a GP unit on our Medical Admissions Unit for patients who are unlikely to be admitted but who need access to urgent medical opinions. And we want to ensure easier access and signposting to alternative services; specialist clinics, community and social services and so on.

4. Ambulatory Care Pathways

We are also introducing a range of ambulatory care pathways, alternative and safe pathways for patients which can involve care outside hospital. All of these are evidence based and signed off by the relevant national Royal Colleges. We have implemented 8 of these pathways to date, and intend to implement a further 7 to10 by the end of March.

5. Improving discharge.

Finally we are also improving our discharge arrangements in the Trust. This includes creating a "hub" on our medical admissions unit for colleagues from social care and the PCT to facilitate good communication and discharge planning with other agencies.

We are confident these measures will help to improve the experience of all our emergency patients, and improve overall turnaround times for ambulance teams. Despite the challenges of the last year, our staff have worked enormously hard to ensure that patients continue to have access to high quality, safe care.

Infection Control

We continue to focus very closely on infection control.

The Trust went over a year without a hospital-acquired MRSA bacteraemia between July 2010 and August 2011.

Unfortunately we then had 2 episodes within a month from the same patient, though neither were thought to be avoidable. The first episode was thought to be secondary to a skin condition that he was admitted with (bruises and blisters) and the second to a chest infection. He responded to treatment on both occasions but died following another chest infection while still on treatment.

We are also doing well in respect of C Difficile where there were 12 hospital-acquired cases in April to September 2011. This is the same as the previous 6 months but half the number in the same period last year (24). Our target for this year is 33, with a maximum target of 15 for the first 6 months so we are within target.

Summary Hospital level Mortality Indicator (SHMI)

The new hospital mortality indicator – published earlier this month by the NHS Information Centre - shows that Ashford and St Peter's continues to be a safe hospital trust, with a lower than expected mortality index. The Trust received a score of 90 (where 100 would be the expected level), which takes into account variables such as age, type of illness, social demography and other factors.

The Summary Hospital-level Mortality Indicator (SHMI) was developed by the NHS Information Centre after recommendations from the Francis Review following events at Mid Staffordshire NHS Foundation Trust. For the first time, the indicator considers all deaths that take place both in hospital and within 30 days of patients being discharged, offering a more comprehensive picture of deaths following hospital care. Whilst the new index is still experimental, the lower than expected mortality data is reassuring.

Car parking update

The recent changes to car parking arrangements, particularly at St Peter's hospital, continue to demonstrate a significant improvement in car parking congestion, with spaces available at all times of the day for patients and visitors. As we had committed to do, we have now reviewed the use of our parking spaces and are able to offer our large volunteer workforce free parking within the patient and visitor areas- the necessary adjustments to our barriers and ticket machines are nearly complete.

An independent audit of car parking for the disabled is underway; this will look at all aspects of car parking for the disabled.

The final stage of the Trust's new car parking policy will be the implementation of staff charges which will be introduced later in the financial year, and are planned to take place in tandem with the creation of new car parking facilities on the site of the demolished sections of The Ramp.

Appointment Reminder Service

In my last report I told you we had just introduced the appointment reminder service. I am delighted to tell you that since its introduction the number of missed appointments in Outpatients has reduced to 7.9%, which is over 30% less than this time last year.

The initiative also aimed to reduce clinic waiting times and improve the experience of patients – which it is so far proving to do well. The Trust has received a vast amount of positive feedback, with patient comments such as: “That's very good that you do remind people and I find that it’s an excellent service", to: “I've never had a phone call to remind me before - that’s a really good idea."

An unexpected benefit has been the avoidance of unnecessary delays to patient care. In one case a patient needed to come back for more tests, but unfortunately had not received their appointment letter due to a change in address. Through the reminder service, the patient’s correct address and telephone number was obtained and they were asked to return to the clinic. If they hadn’t been reminded by telephone, their clinical care would have been delayed.

In addition to giving a reminder, the service also offers patients the chance to re-arrange or cancel their appointment, without the need to make further phone calls to the appointment centre.

3 STRATEGY

Epsom and St Helier transaction

Earlier this month the Board approved our detailed plans to acquire Epsom Hospital which would create a new, three hospital NHS Foundation Trust providing a strong long-term future for local health services. Part of the bid involves partnerships with The Royal Marsden NHS Foundation Trust, the community provider Central Surrey Health and Surrey and Sussex Healthcare NHS Trust, bringing added benefits to Surrey patients and creating an innovative campus approach for Epsom hospital.

Our plans will now be scrutinised by the Epsom and St Helier Transaction Team, which based at NHS London, and assessed against their objectives for Epsom Hospital and the criteria they have developed with staff and local stakeholders before a final recommendation is made early next year. St George’s NHS Healthcare Trust has also submitted their bid for St Helier hospital which will be considered at the same time.

As a successful organisation coming up to our first anniversary as a Foundation Trust, the Board will be careful to ensure that any final agreement remains in the best interests of both organisations and of our patients and staff before proceeding to the next stage.

Catering Services

As the Council knows, the Trust’s catering contract has fallen due for renewal and we are now part-way through the tendering process for appointing a new catering contract to cover all catering throughout our two hospitals, including patient food, all staff and visitor food and retail outlets. Bringing all the Trust’s catering and retail services into one new contract gives us the best opportunity to make significant improvements to the quality of these services, and to patient food in particular.

An initial meeting has been held with the Trust’s Catering Steering Group – which

includes both patient and staff representatives – to consider the detailed service specifications from those organisations who are tendering. A wider stakeholder group met to listen to detailed presentations from those tendering before scoring these against an agreed set of criteria as part of the overall decision making process. This, along with similar representation on the Catering Steering Group - will ensure robust stakeholder engagement at all stages of the process before the final recommendation is made to the Trust Board in December. The new contract would be expected to start on 1st April 2012.

4 OUR WORKFORCE

Medical Director

As Governors will know, Dr Mike Baxter will be retiring from the NHS and his role as Medical Director of the Trust with effect from 31 January 2012. Mike joined Ashford and St Peter's in 1992 as a consultant diabetologist and endocrinologist overseeing the development of the diabetic service and then became Clinical Director for seven years before becoming Medical Director in 2002. Mike has made a significant contribution to the Trust and we wish him well for the future. The good news is that he is going to carry on working with us on some of our big clinical strategic projects including working with Epsom and our partnership with Assura who are taking over the Community Services in Surrey next year.

I am pleased to be able to let you all know that we appointed Dr David Fluck to be our new Medical Director (Acting) from the end of January when Dr Baxter retires. We will advertise the substantive post next year when we are clear about our plans for acquiring Epsom.

Dr Fluck is currently the Deputy Medical Director so is well placed and prepared for this important post. He joined St Peter's as a Consultant Cardiologist in 1996 and since then has introduced many service improvements and developments and held many important posts – including Clinical Director for Medicine and Clinical Lead for the Surrey Cardiac Network.

5 TRUST BOARD MEETINGS

The **October Board** was briefed on progress in Quarter 2 on our **Corporate Business** Plan. All elements were being progressed although some parts are still progressing slower than anticipated. In part this is a reflection of the enormous amount of effort put into reviewing and creating a bid in respect of the Epsom transaction. However, Directors were confident that the speed of delivery on these areas would improve now.

The Board discussed the two objectives identified as red in the Report. The first related to the National Outcomes Framework. The Trust had not been able to progress implementation as the national guidance had not been fully published. It was therefore agreed that the objective should be viewed as 'not applicable' in monitoring the Plan.

The second red rated objective was in respect of the Trust's ambitious target to have had 1200 staff participating in 360^0 appraisals over the year and to have achieved 600 year to date. The Board discussed the possible reasons for the limited take-up, noting that all consultants undertook a formal 360^0 appraisal, either clinical or non-clinical, as part of their formal appraisal process. Staff are actively being encouraged to participate in the process .

(A copy of the Board briefing can be obtained from Jane Gear, Head of Corporate Affairs

or from http://www.ashfordstpeters.nhs.uk/about-us/about-the-trust/meetings-and-minutes.)

The Board also received an informative briefing on the current position on implementing the **Informatics Strategy**. Technology is a key enabler to achieving transformation and it was good to see strong progress against what we set out to achieve in year one.

Year 1 - Objectives	**Progress**
Complete deployment of wireless	Technical and user acceptance testing is complete. We are ready to switch on 1st November. An Acceptable Use Policy is currently being drafted for approval.
Implement Patient Centre	The roll out of Patient Centre has been put on hold whilst RealTime is urgently deployed to help manage the Trust manage issues of capacity
Upgrading the infrastructure to industry strength	The technical design has commenced. Procurement is scheduled to take place before Christmas. Deployment is expected to be completed March 2012.
Procure and Deploy Single Sign-On	The business case has been developed. The Commercial Group and TEC will consider the business in November. Procurement will be completed by March 2012 with a deployment commencing April 2012 as planned.
Prepare for Electronic Document Management	A service review of Medical Records is, in conjunction with the Chief Nurse and team, scheduled to commence in December. The outcome is expected to directly affect how our records are constructed, handled and stored in future.
Innovate through Pilots	Self Check-In in Outpatients is currently being scoped and developed with the Patient Access Team. Supporting midwives out in the community is currently being explored with a couple of potential solutions emerging.
Commence application integration - CEASR	Our CEASR (**C**linical **E**lectronic **A**shford **S**t Peter's **R**ecord) plan for integrating our clinical applications to achieve a single view of our patients is well developed. A business case is being drafted and it is hoped to commence procurement in January/February 2012.
Initiate change – restructure of Health Informatics Department	A full review of the Health Informatics Service commenced end May and was completed in September. The new staff structure was implemented on 1st October 2011. We are now in the process of recruiting to some key posts in Health Informatics.

The **November Trust Board** will be taking place as this report is produced. This meeting will approve the **Charitable Trust Funds Annual Report and Accounts**. These funds provide invaluable support to our patients and staff and the accounts for 2010/2011 show that the Charity received income of £384,000. The St. Peter's Mother and Children's Fund continues to be an area of significant fundraising, receiving income of £75,000. The Breast Care Fund also received income of

£61,000.

The Charity spent a total of £679,000 in the year of which £574,000 was spent on the purchase of medical and surgical equipment, patient amenities, staff welfare and amenities and research etc., Expenditure during the year to some extent reflects the discussions that the Trustee had in the previous financial year with those responsible for the day to day management of the funds about not accumulating funds unnecessarily.

The Board will also hear from the **Director of Infection Prevention and Control**, Dr Angela Shaw, on the half yearly position on Infection Control.

6 WHAT IS HAPPENING EXTERNALLY

The Health and Social Care Bill Moves Forward

Two high profile motions that would have either halted or seriously delayed the Health and Social Care Bill were defeated when the Bill had its second reading in the House of Lords. The Bill has now moved into committee, where peers will discuss well over 300 amendments. Line by line examination of the Bill took place during the third day of committee stage on 7 November. The Committee stage continued on 9 November when further amendments will be discussed.

It is likely that those parts of the Bill that impact on Foundation Trusts - in particular the new role for Monitor and the specific proposals for foundation trusts - will be debated from late November onwards.

North West Surrey Clinical Commissioning Group (CCG)

The Health and Social Care Bill heralds the introduction of Clinical Commissioning Groups, and the abolition of Primary Care trusts by April 2013. The NHS Commissioning Board has now been set up in shadow form as a special health authority. The Chairman of the Board is Professor Malcolm Grant and the Chief Executive is Sir David Nicholson.

More locally, the North West Surrey CCG is led by Dr Liz Lawn and consists of the three localities (groups) of GPs from:

- SASSE (Stanwell, Ashford, Staines, Shepperton and Egham)
- Thames Medical
- Woking

Management support for the CCG is provided by Jayn Hughes (from Thames Medical) based in Weybridge, with support from a central resource team of PCT staff. NWS CCG has produced a formal Development Plan, to ensure that the three localities are fit for purpose to form a Shadow CCG by April 2012 and to become a Statutory body by April 2013. Key workstreams with specific deliverables are identified in the plan. Workstreams include:

- Organisation Structure and functions
- Performance management processes at practice, locality and CCG levels

- Delivery of NWS QIPP targets – planned and unplanned care, chronic care, mental health, medicines management, safer care
- Leadership and skills development (including Future Leaders programme)
- Engagement with constituent practices
- Engagement with secondary care, non-healthcare providers and patient/public engagement - including a Stakeholder workshop run during October 2011
- Development of robust transitional arrangements with NHS Surrey

Ashford and St Peter's Hospitals Trust continues to work closely with the CCG, in particular through the NW Surrey Transformation Board.