Kingston Hospital NHS
NHS Foundation Trust

CHIEF EXECUTIVE'S REPORT

Name of meeting: Trust Board	**Item: 7**
Date of meeting: 25th January 2017	**Enclosure: C**
Purpose of the Report / Paper: To provide the Board with information on strategic and operational issues.	
For: Information ☒ Assurance ☐ Discussion and input ☒ Decision/approval ☐	
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Risk Implications - Link to Assurance Framework or Corporate Risk Register:	The issues outlined in this report touch on many of the Trusts objectives and risks
Link to Relevant Corporate Objective:	The issues outlined in this report touch on many of the Trusts objectives and risks
Document Previously Considered By:	
Recommendations: The Trust Board is asked to **note** and discuss the content of this report.	

Chief Executive's Report

January 2017

1. Introduction

This paper provides the Board with an overview of matters to bring to the Board's attention which are not covered elsewhere on the agenda for this meeting. The Board is asked to note the content of this report.

2. Current developments not elsewhere on the agenda

2.1 Safe, Sustainable and Productive Staffing Improvement Resources

NHS Improvement has launched draft improvement resources for setting staffing in learning disability services and acute adult inpatient services. These have been launched for comment and align with the National Quality Board's (NQB) improvement resource, *Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time - safe, sustainable and productive staffing*, published in July 2016. The consultation on these closes on 3rd February 2017. The draft adult in patient resource can be accessed via the following link: https://improvement.nhs.uk/resources/safe-staffing-improvement-resources-adult-inpatient-acute-care/ along with the opportunity to give feedback via an online survey.

The development of further setting-specific safe, sustainable and productive staffing improvement resources to help providers of NHS services implement NQB's expectations, are being led nationally by NHS Improvement and will cover:

- Mental health services
- Maternity services
- Children's services
- Urgent and emergency care
- Community nursing

The Board will receive further updates on progress with relevant resources in the next six monthly Nursing & Midwifery Safe Staffing paper.

2.2 Challenge & Opportunity Matrix

As reported previously to Finance and Investment committee,in order to support the Trust in achieve financial sustainability and improve operational performance, the Executive team has taken a range of actions to augment existing arrangements. This has included regularly reviewing all items included within a framework recommended by Monitor. The Executive Management Committee has overseen the review programme, described internally as the 'Challenge & Opportunity Matrix', and has convened regular additional meetings for dedicated steering group activity, as well as following up on actions through its scheduled meetings. The matrix has enabled the EMC to review and challenge or extend control across 149 lines of activity in 13 key areas:

- Cash, cash flow and debtors
- Income
- Cost and Expenditure:
  - Finance
  - Procurement
  - Contracting
  - Estates
- Programme Management and Cost Improvement Programmes
- Forecasts, reporting and turnaround plans
- Business cases / Capital expenditure
- Governance
- Management and Executive Board
- Culture and Communications with internal and external stakeholders
- Performance Management
- Workforce Planning
- Inventory
- Operational grip

The majority of short-term actions arising from the matrix review have now been completed. Some actions have been taken into ongoing as business as usual and the remainder, such as reviewing the Estates strategy, have been incorporated into in the longer term work plan.

2.3 Progress on delivering CQC action plans

Detailed action plans have been developed with clinical teams and departmental heads in relation to the must do and should do actions identified by the CQC following its inspection in 2016.

Good progress has been made in delivering the 7 must do actions and, as previously agreed , a report on progress was given to the CQC in January 2017. This is provided at Appendix 1. Work is ongoing to embed the actions taken and this will be tested through audits, walkabouts and an internal self-assessment in Q4 2016/17, prior to submission of a further progress report to the CQC at the beginning of April 2017.

Good progress has also been made in delivering the should do actions. Of the 42 must do actions, 33 have either been completed or are planned to be completed in 2016/17, 5 have plans which are due for completion in 2017/18 and 4 have funding implications which require further discussion. The most significant funding implications relate to recommendations to review maternity capacity A and E capacity and to improve the environment in ICU. Further discussion of the should do action plans and progress is scheduled for the next CQC liaison meeting in February 2017.

2.4 Learning, candour and accountability – A review of the way NHS Trusts review and investigate the deaths of patients in England – CQC December 2016

This review, published by the CQC, has been carried out in response to the very low number of deaths that were investigated in Southern Health's learning disability and mental health for older people's services, the most high profile of which was the death of 18 year old Conor Sparrowhawk.

The review reports on the processes and systems NHS trusts need to have in place to learn from problems in care before the death of a patient. Information was gathered from data supplied by NHS Trusts and from visits to a sample of Trusts including 4 acute trusts. The Trust was not one of those visited by the CQC for this report. Information was also gained from surveys of families and carers and listening events.

Overall the report describes inconsistencies in the way the health system identifies, investigates and learns from deaths in healthcare. It is particularly critical of the lack of importance given to the views and concerns of families and carers of those who have died.

The seven key recommendations from the report are:-

Recommendation 1 – Learning from deaths needs much greater priority across the health and social care system.

The Secretary of State is urged to make the findings of the report a national priority and to publish a full response to the report by April 2017.

Action:- DoH, CQC, NHSE, NHSI, Royal Colleges

Recommendation 2 – Healthcare providers should have a consistent approach to identifying and reporting, investigating and learning from the deaths of people using their services, and when appropriate, sharing this information with other services involved in a patient's care before their death.

A single framework with oversight by NHS improvement, NHS England and the CQC, and working with families should be developed to learn from deaths. Cross system approaches between providers must be considered along with the role of commissioning in coordination. Additional scrutiny to be placed on deaths of individuals with learning disabilities or mental illness. Guidance to be developed for Boards to support improvements.

Action:- NHSI, NHSE, CQC

Recommendation 3 – Bereaved relatives and carers must be treated as equal partners and receive honest and caring responses from health and social care providers with full explanation of processes of investigation, and accurate explanation of the reasons the person died and response to all the concerns they have raised.

Guidance will be produced by NHSI, NHSE and the CQC to inform the process to determine when an investigation should be carried out and how families and carers should be involved.

Action:- NHSI, NHSE, CQC

Recommendation 4 - the deaths of people with a learning disability or severe mental illness should receive the appropriate attention at a local and national level.

NHSE and NHSI with Royal Colleges should aim to improve consistency, definitions and practices that support the reduction of the increased risk of premature death in these groups of patients.

Action:- NHSE, NHSI

Recommendation 5 – Systems and processes should be developed and implemented to ensure that all providers are aware when a patient dies and that information from reviews and investigations is collected in a standardised way.

A standard dataset of information should be collected on all patients who have died which includes information regarding disability and mental illness and any concerns raised from family and staff. NHS digital and NHSI should determine how they can facilitate this process.

Action:- NHS Digital and NHSI

Recommendation 6 – Investigation should focus on system analysis rather than individual errors and should be undertaken by staff who have had specialist training to do so and

time protected in order that the investigations identify missed opportunities to improve care.

Health Education England (HEE) and the Healthcare Safety Investigation Branch (HSIB) should work together to develop approaches to ensure staff have the capability and capacity to carry out good investigations, write good reports and focus on improvement. An accredited training programme for people undertaking hospital-led investigations should be considered.

Action:- HEE

Recommendation 7 - To ensure that learning from deaths is given sufficient priority at a local level, provider boards and clinical commissioning groups must take action without delay on this report and implement national guidance when this becomes available.

Provider Boards should ensure that patients who have died under their care are properly identified, that cases are screened to identify concerns and possible improvements, that families are proactively supported and involved in the investigations as they wish. Staff should be trained and investigations carried out in a timely manner. There should be a low threshold to investigate and learning should be disseminated across other organisations where appropriate.

Information on deaths investigations and learning should be regularly reviewed at Board level and reported in Quality Accounts and that particular attention is paid to patients with a learning disability or mental health condition.

Action:- Boards in NHS trusts and other healthcare organisations

The Board will note that it is that last recommendation that has immediate relevance. All deaths in the Trust are currently identified at a service line level and subject to clinical review. All unexpected deaths are discussed at Mortality review meetings and full investigations undertaken where concerns are raised or when a death is referred to the Coroner. The Trust has introduced templates and reporting tools to guide these discussions though further work is required to embed this and also to take into account the recommendations of this report. Further consideration does need to be given to most appropriate way to involve families. The Trust has good experience of doing this with serious incidents but will need to consider lower threshold investigation. It is consistent with the work being undertaken to embed the Duty of Candour.

The Trust already has a Trust wide Mortality review group chaired by the Medical Director and a Clinical Trust Lead for Mortality. The report makes a recommendation that Boards should consider nominating a non-executive director to lead on mortality and learning from deaths.

The Board receives information regarding mortality in the integrated performance report and details of avoidable deaths all of which are investigated as serious incidents. Further consideration should be given to greater visibility of unexpected deaths where learning has been

identified and to reporting of numbers. It is suggested that the Mortality Group are tasked with identifying the format of this information.

Staff training is already in place to undertake investigations, this will continue to be rolled out and training will be reviewed in light of any further recommendations that follow on from this report.

The role of a Medical Examiner, similar to that associated with the Coroner's Office, is in discussion and is expected to be introduced nationally from April 2018. Once this role is in place it is envisaged that all deaths (except those investigated by a coroner) will be reviewed before the death can be registered. The Medical Examiners will be senior doctors who report to local authorities.

2.5 Brexit and KHFTs EU Staff

The Trust is undertaking a number of measures to support its EU workforce who are concerned about the potential impact of Brexit on their status in the UK:

- A Support group with staff lead Pascale Varley
- A visit by NHS Employers Chief Executive Danny Mortimer who met with Executive Team and Board Members on 23rd January 2017
- A meeting with local MPs who have agreed to meet staff directly to discuss their concerns, planned for early March 2017

2.6 Campaign for Better Hospital Food

The Trust responded to a survey by the Campaign for Better Hospital in 2016. The findings from the survey are due to be published in a report in early 2017, with the target audience government and hospitals in England. The report will be divided into 9 different sections including hospital food for patients, hospital food for staff and visitors, food environment, food experience for patients. Following our response to the survey, which included the work undertaken on improving food for patients, the Trust was asked and has agreed to be featured as a case study in the section on hospital food for patients.

2.7 Nursing & Midwifery Conference

The Trust has confirmed two keynote speakers for its annual Nursing & Midwifery Conference which this year takes place on Friday 12th May 2017, and is also International Nurses day. The conference is held every year to celebrate the work of our nurses, midwives, and nursing & midwifery assistants. The two speakers are Professor Oliver Shanley OBE, the new Regional Chief Nurse (London Region) for NHS England & NHS Improvement; and Professor Cathy Warwick, CBE, Chief Executive of the Royal College of Midwives.

2.8 Coffee and Conversations

The new initiative to improve engagement between Board members and staff commenced this month with the first meeting held on 26th January. The Chairman and Director of Workforce met with a group of staff to discuss a range of issues affecting them and the Trust. The feedback from these meetings (held monthly) will be fed back to the Board under the Staff Story heading starting at the next Board meeting

2.9 Staff Survey 2016

I'm very pleased to report that the Trust achieved a 51.1% return for the staff survey, compared to 46% in 2015-an increase of over 300 staff returns .The best performing Acute Trust in the country was 52.2% demonstrating how positive this response rate was for the Trust. The first analysis of results has been received with the full set due in February. As the results are embargoed until next month the Director of Workforce will circulate a summary to Board members as soon as this is lifted and will bring a full report with the Trusts response to the findings to the March Board Meeting.

2.11 Freedom to Speak Up Guardians

As reported in December, an internal recruitment campaign was carried out to select the Trust's first Freedom to Speak Up Guardian. The requirement for Trusts to establish this post was a recommendation from the report by Sir Robert Francis on the culture of the NHS. The successful candidate was subsequently offered another post within the Trust and has therefore decided not to take up the FTSUG role. After re-evaluation it was decided to offer the role externally and interviews are due to take place in the week beginning 23rd January 2017.

2.12 Changes to CCGs- Appointment of Accountable Officer

We are pleased to announce that Sarah Blow has been appointed as the new Accountable Officer for Kingston, Richmond, Merton & Wandsworth CCGs from 2017/18, and Sutton CCG from April 2018.

Sarah is currently the Chief Officer of Bexley CCG in south east London, a role she has held since 2012.

A local resident in south west London, Sarah has previously worked for the former Sutton and Merton PCT and has a good knowledge of the opportunities and challenges we face in this part of London.

We look forward to Sarah joining and have written to her to invite her on visit.

3. Governance

3.1 Board Assurance/Corporate Risk Assessment

The Board Assurance Framework (BAF) is the means by which the Board monitors progress towards achievement of the annual corporate objectives and identifies sources of assurance that the risks to achieving these objectives are being managed.

The Board is asked to note the content of Appendix B, which shows the BAF 2016/17 for month 9 and the top risks facing the Trust.

4. Things to celebrate

4.1 Funding Bid to the Burdett Trust for Nursing – Nurse Retention Programme

In December 2016, The Trust received confirmation from the Burdett Trust for Nursing (a national charity that supports the development of nurses and nursing), that it will receive a funding grant of £112,752. This grant will allow the Trust to undertake a research programme over two years which is specifically focused on reducing nursing turnover through the deployment of interventions that will build resilience in the nursing workforce. The programme will be focused in the Acute Assessment Unit, and will evaluate a model that could be provided in other settings. This also fits with the Trusts desire to reduce sickness through workplace stress. The Trust will work in partnership with a designated provider over the two years, with research evaluation by Kingston University.

4.2 Student Nurses

The Trust has a very proud history of helping to train nurses and earlier this month welcomed 80 student nurses from Kingston University who are starting placements throughout the hospital. The Trust's Practice Development team ran a very comprehensive induction programme and that attracted a great deal of positive feedback and the Trust is looking forward to continuing to support the students on their journeys to becoming fully qualified nurses.

4.3 Volunteering Programme

The Trust's volunteering programme has been shortlisted for the 2017 HSJ Value in Healthcare Awards. The programme has been shortlisted for the Improving the value of NHS support services category and the winner will be announced on the 24 May 2017. The High Impact Volunteering programme aimed to strengthen relationships between Kingston Hospital NHS Foundation Trust and the local communities by establishing a high impact volunteering model

and thriving volunteer function. The Trust utilised core funds and an award from the Cabinet Office to establish a suite of over 10 roles accommodating more than 800 volunteers at its peak. The programme demonstrated three statistically significant patient improvements, including an 18% improvement in mood for patients with dementia and a 28% reduction in patient reported anxiety when they were due to be discharged. The programme also demonstrated a link between volunteering support for patients and improvements in overall patient experience, accessing community and voluntary services and satisfaction with food and mealtimes.