TRUST BOARD IN PUBLIC	**Date: 30th May 2013** **Agenda Item: 2.3**
REPORT TITLE:	**Joint Chief Nurse and Medical Director's Report**
EXECUTIVE SPONSOR:	Sally Brittain, Deputy Chief Nurse Dr. Des Holden, Medical Director
REPORT AUTHOR:	Sally Brittain, Deputy Chief Nurse Dr. Des Holden, Medical Director
REPORT DISCUSSED PREVIOUSLY: (name of sub-committee/group & date)	N/A

Purpose of the Report and Action Required:		**(√)**
An update of ongoing work in relation to safe and quality patient care that sits out with the operational performance reports.	**Approval**	
	Discussion	
	Information/Assurance	**(√)**

Summary: (Key Issues)

There has been much progress over the last few years to take the organisation to where it currently is, however to achieve the overall goal of sustained and assured improvements in the quality of patient care, there is much work to be undertaken both within the organisation and with our health and social care partners externally.

Relationship to Trust Corporate Objectives & Assurance Framework:

Central to the delivery of safe and quality patient care.

Corporate Impact Assessment:

Legal and regulatory implications	NONE identified currently
Financial implications	YES – but have been agreed via the relevant governance channels
Patient Experience/Engagement	YES – key and will require to be robustly demonstrated
Risk & Performance Management	YES – key and will require to be robustly demonstrated
NHS Constitution/Equality & Diversity/Communication	YES – key and will require to be robustly demonstrated

Attachments: Paper

TRUST BOARD REPORT – 30th May 2013
JOINT CHIEF NURSE AND MEDICAL DIRECTOR REPORT

1 BACKGROUND

1.1 Since the last Board presentation there have been well publicised reports on the challenges faced by Emergency Departments nationally and the hospitals behind these public facing front doors. SaSH has seen an increase of 8.4% in ambulance conveyances over the past 6-8 weeks with many days seeing over 100 patients coming to ED by blue light ambulance. This level of increased demand needs to be accommodated while quality and safety of care is maintained. With new commissioning and support structures now in place this paper reviews some of the ongoing changes and resources the trust will work with

2 SAFETY

2.1 Recruitment and Retention:

The recruitment and retention work stream continues and we are pleased to report a very successful recruitment visit to Portugal where 23 nurses were offered posts within SASH.

2.2 Changes to medical staffing:

In response to discussions held with trainee medical staff and influenced by the Deanery we have re-mapped the times of patient arrival, particularly as unscheduled attendance, and restructured junior doctor rotas. These rotas now see doctors working an extra hour on many shifts but having more days off per complete rota. This, changing the start and finish time of some shifts, and in addition employing 8 physicians' assistants has allowed much better matching of capacity with demand. The output has meant that instead of handing over up to 17 patients from day to night shifts, the average now is 1.5 patients. The time to being seen and having management plans made has also reduced significantly as a consequence.

The medical division are in advanced discussion of a plan developed by clinical leads to improve consultant presence, and therefore senior opinion available to emergency admissions, at the weekend. This will enable bespoke review within respiratory medicine and will further expand review for ill patients, while making the workload between specialties more equitable.

2.3 Patient Discharge:

Extensive discussion has taken place with CCGs and with social care. Agreement has been reached within the organisation that our patients will have documented plans written in medical notes and planned dates for discharge set early in patient stays. This will be followed by review and stated MDT fitness to leave acute care beds. These internal mechanisms will facilitate patient discharge and needs based assessment outside of the acute ward environment. The out put of this will be to reduce the need for extra capacity, enable better care to be provided by the medical teams and facilitate patients to be looked after in more appropriate environments.

2.4 CQC Inspection:

On the 24th May the Trust received the formal report following an unannounced inspection which took place on the 26th and 27th February 2013.

This report confirmed that the Trust met all the standards assessed during that two day visit which included;

- Respecting and involving people who use services
- Consent to care and treatment
- Care and welfare of people who use services
- Meeting nutritional needs
- Safeguarding people who use services from abuse
- Cleanliness and infection control
- Management of medicines
- Staffing Met this standard
- Assessing and monitoring the quality of service provision

When a standard is 'being met' it means that the provider was compliant with the regulation. If the CQC find that standards are being met, they take no regulatory action but they may make comments that may be useful to the provider and to the public about minor improvements that could be made.

The assessors looked at the personal care and records of patients, observed how people were being cared for and spoke with service users including patients, carers, family members and staff. They were supported on this inspection by an expert-by-experience. This is someone who has personal experience of using or caring for someone who uses this type of care service.

As part of the inspection the team looked at care in Accident and Emergency (A&E), Neonatal Intensive Care (NICU), the children's ward and three wards dedicated to care of the elderly who required medical and/or surgical treatment.

They observed staff speaking with patients in a polite and respectful manner and noted most of the people that they spoke with told them that they were happy with the care they received and could not criticise the staff or environment in which they were cared for, in any way.

They did however observe that those people experiencing prolonged stays in hospital did not always have a comprehensive plan of care. This is a national issue and the CQC were unable to provide guidance in the way of example templates for which the trust could adopt from other similar organisations.

The full report is available on the CQC website at http://www.cqc.org.uk/

The report will be shared with the Divisions in order that any recommendations to further enhance the service the Trust provides for its patients are put in place.

3 QUALITY

3.1 Kent Surrey and Sussex Academic Health Science Network:

15 AHSNs have now received licenses from NHS England, including the AHSN which covers Kent Surrey and Sussex. Central budget of £2.7M has been allocated and there is an expectation that this will form 80% operational budget with 20% coming through matched funding raised locally. SASH has confirmed its intention to be a member of the AHSN, as have all acute and mental health trusts across the three counties. The license agreement reduces the emphasis on research, and focuses on reducing clinical variation, implementing quality standards (largely as defined by NICE) and promoting the adoption and spread of innovation, and industry products. KPIs to be reviewed on an annual basis have been suggested.

SASH will be a pilot site for a whole health economy approach to improving care for chronic obstructive pulmonary disease (there are pilot of acute provider working with CCG in each of the three counties). This work will be led locally by Dr Ed Cetti, and will be supported by the Enhancing Quality (EQ) programme within the AHSN. The outcome being assessed by the pilot will be reduced need for hospital admission and length of stay in those admitted.

3.2 Strategic Clinical Network Meetings and the KSS Clinical Senate:

On 1st may 2013 the first meeting of strategic clinical networks was held.
The four SCNs are:

- Cancer
- Maternity, children and young people
- Cardiovascular
- Mental health and neurology

The clinical leads of each of the networks presented their vision for the services overseen within their networks to a mixed audience including CCGs, and acute and mental health providers. There was very much a sense of both networks and commissioners finding their way, with broad agreement that the key to success will be alignment rather than duplication, defining quality standards, collecting and publishing data and challenging where services are not meeting expectations

The Chair of the Clinical Senate has been appointed (Dr Lawrence Goldberg, Renal Physician BSUH) and an outline of the composition of the Senate Board has been agreed, drawing from providers, CCGs, social care, public health, clinical networks, AHSN, LETB, area team and patient representatives. The senate is a forum for discussion and does not have a budget to commission (unlike the SCNs), but is statutory and provides an independent multi-professional leadership for commissioners (including Health and wellbeing Boards and specialist commissioning) for service design/ redesign to patient benefit.

A copy of the presentations made on the day can be viewed at http://www.surreyandsussexcsu.nhs.uk/images/ahsn/eqr/2013/20130510/SEC%20SCN_Senate%20Presentations.pdf

Many SASH clinicians attended the event and we will work to help inform these groups as well as to ensure our services are aligned with best practice.

3.3 Nursing and Midwifery Strategy:

As outlined in our last report, the Nursing and Midwifery Strategy was completed and was successfully launched on 10th May. This was one of the pieces of work presented to the TDA when they visited on 23rd May. The Chief Nurse and Divisional Chief Nurses handed out copies of the strategy throughout the hospital prior to an afternoon tea with staff to promote the launch of the strategy.

'Your Care First: our commitment to safety, quality and compassion'

The nursing and midwifery strategy called '*Your Care First: our commitment to safety, quality and compassion'* sets out how our nurses and midwives will take their practice to the next level and demonstrate the huge positive difference we can make to patient outcomes, care and experience.

Subsequent to the launch the Divisions are now allocating matron leads for each of the respective objectives and will report to the Patient Experience Delivery Group with their implementation plans.

3.4 Patient Led Assessment of the Care Environment Assessment (PLACE):

On the 15th May 2013 the Trust underwent its PLACE inspection (formally known as PEAT). Although those who were familiar with the PEAT process will see many similarities with the revised process, there are also a number of key changes.

Key Changes

- Patient/Public Involvement:

In accordance with the Prime Minister's commitment to give patients a real voice in assessing the quality of healthcare, including the environment for care, at least

50% of those involved in undertaking assessments must meet the definition of 'patient':-

'anyone whose relationship with the hospital is as a user rather than a provider of services'

which definition allows for anyone to act as a 'patient' representative except:-

- Current employees of the organisation;

- Former employees of the organisation who have left employment within the preceding 2 years;
- Anyone with a professional relationship with the organisation – e.g. as a facilities service provider.

Members of Trust Board of Governors or members of Trusts are eligible to act as 'patient representatives' within their own Trust since their primary role is to represent the interests of patients/the public. However, it is good practice that patient assessors are not drawn solely from this group.

Responsibility for providing training for Patient Assessors will rest with individual organisations.

Trusts should endeavour to assess either **25% of their site and a minimum of 10 or 25% of wards whichever is the greater**. Organisations with**10 or fewer inpatient wards should assess all of them**.

- Local publication of results and action plans

Each PLACE visit will generate a score in the four separate domains of cleanliness, food, privacy and dignity, and general maintenance/décor. The results must be published locally, with an accompanying action plan that sets out how the organisation expects to improve their services before the next assessment.

- Information Governance

All PLACE data will be published as Official Statistics and in particular will be shared with the following organisations:

  - Care Quality Commission
  - Department of Health
  - NHS Commissioning Board
  - Clinical Commissioning Groups (when requested)
  - National Audit Office (when requested)
  - The Health and Social Care Information Centre (Clinical Quality Indicators)

Informal feedback following the assessment was that the process had gone well with the team being impressed with the standards they observed.

The 6 teams conducting the assessments were fully supported by matrons, nurse specialists, the Volunteer Services Manager, external validator colleagues from Queen Victoria Hospital and the E&F management team. The feedback from the teams was that the ward staff and ED staff were very welcoming and helpful.

We will circulate the formal report once it is received.

3.5 Trust Development Authority (TDA) Visit:

On 23rd May a team from the TDA visited the hospital to review compliance with the 13/14 Operating Plan Checklist for Quality, Innovation and Workforce and to tour the hospital. They met a range of clinical staff and also reviewed evidence for compliance in infection control standards.

Initial feedback at the end of the afternoon was positive and we await the formal report.

4 SUMMARY

4.1 The difficulties faced by acute hospital providers emerging from winter has recently received national media and political attention. SASH continues to approach the delivery of patient care from a quality and safety focus and continues to seek feedback from its users on the experience they have had. We continue to review all internal processes for their efficiency and effectiveness, and continue to make changes (for instance to admission and discharge protocols and staffing templates to align capacity with need) our interactions with local and regional networks will also play an increasing part in the driving up standards of patient care.

Des Holden
Medical Director
May 2013

Sally Brittan
Deputy Chief Nurse