Portsmouth Hospitals NHS
NHS Trust

TRUST BOARD PUBLIC – NOVEMBER 2013

Agenda Item Number: 218/13
Enclosure Number: (2)

Subject:	Report from the Chief Executive
Prepared by / Sponsored by / Presented by:	Ursula Ward, Chief Executive
Purpose of paper	To updated the Board on national and local items of interest.
Key points for Trust Board members *Briefly summarise in bullet point format the main points and key issues that the Trust Board members should focus on including conclusions and proposals*	Note contents of the report
Options and decisions required *Clearly identify options that are to be considered and any decisions required*	None required, for information
Next steps / future actions: *Clearly identify what will follow the Trust Board's discussion*	None
Consideration of legal issues (including Equality Impact Assessment)?	Considered, none apparent
Consideration of Public and Patient Involvement and Communications Implications?	None

Links to Portsmouth Hospitals NHS Trust Board Strategic Aims, Assurance Framework/Corporate Risk Register	
Strategic Aim	**Strategic aim 1:** Deliver safe, high quality patient centred care **Strategic aim 2:** Develop a reputation for excellence in innovation, research & development and education in the top 20% of our peers. **Strategic aim 3:** Become the hospital of choice for general, specialist and selected tertiary services. **Strategic aim 4:** Staff would recommend the trust as a place to work and a place to receive treatment **Strategic aim 5:** Develop sufficient financial strengths to adapt

	to change and invest in the future.
BAF/Corporate Risk Register Reference (if applicable)	N/A
Risk Description	N/A
CQC Reference	N/A

Committees/Meetings at which paper has been approved:	**Date**
None	

Report of Chief Executive

Board of Directors – 28 November 2013

1. Strategic and operational planning in the NHS

- NHS England, Monitor, the NHS Trust Development Authority and the Local Government Association have issued some initial guidance and a timetable for the 2014/15 planning round.

- The guidance stresses that the NHS faces an unprecedented level of future pressure and has to change. The covering letter calls for all parties (CCGs, Foundation and non-Foundation Trusts) to play a leading role. There is a need to develop and implement bold and transformative long-term strategies and plans for services, otherwise many will become financially unsustainable and the safety and quality of patient care will decline.

- This long-term transformation will only be achieved through the creation of a fully integrated service between the NHS and local government. NHS England and the Local Government Association have recently written to outline the next steps for implementing the £3.8bn Integration Transformation Fund for 2015/16, which will have significant implications for commissioners and providers alike. However changing services and spending patterns will take time. The plan for 2015/16 needs to start in 2014 and form part of a five-year strategy for health and care. Health and Wellbeing Boards will also play a leading role in this.

- All four bodies (NHS England, NHS Trust Development Authority, Monitor and LGA) consider robust planning to be of paramount importance to both providers and commissioners.

- Given the scale of the challenges there is a move away from incremental one-year planning and instead to plans which cover the next five years, with the first two years mapped out in the form of detailed operating plans.

- The guidance sets out high level assumptions and a timetable for each type of organisation in the NHS. Next steps include:

    - Full guidance in December, including a joint set of assumptions agreed by all parties
    - Align timelines in regards to the planning process
    - Each body (NHS England, Monitor, NHSTDA and LGA) is revisiting their own process to consider how these can be adapted to better facilitate operational and strategic planning
    - Further support will be provided and this will be communicated separately by each body as appropriate

- Key dates in the NHS Trust Development Authority timeline are as follows:

Key dates – NHS TDA

Final Guidance, templates and tools issued	w/c 16 December 2013
Initial, high level plans	13 January 2014
Contracts signed	28 February 2014
Full plan collection	5 March 2014
Dispute resolution for 2014/15 with NHSE	From 5 March 2014
Plans approved by Boards	31 March 2014
Submission of final 2 year plans	4 April 2014
Submission of 5 year LTFMs and IBPs Years 1 & 2 of the 5 year plan will be fixed per the final plan submitted on 4 April 2014	20 June 2014

2. Simon Stevens appointed as new Chief Executive of NHS England

- Simon, who has 26 years' experience in healthcare management at the frontline and national level both in England and internationally, will take over from Sir David Nicholson on 1 April 2014.

3. NHS England launches major exercise to shape the future of specialised services

- Patients, clinicians and other key stakeholders are being encouraged to give their views on the future of specialised health services and how they are to be provided by the NHS over the next five years.
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- A special event will be held in December as part of its wider 'Call to Action' project, which was launched in July, signalling the start of a debate with the public about the future delivery of NHS services.
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- Specialised services are those services which are provided from relatively few specialist centres. Conditions treated range from long-term conditions, such as renal (kidney services), mental health care in secure settings and neonatal services, to rarer conditions such as uncommon cancers, burn care, medical genetics, specialised services for children and cardiac surgery.
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- These services are commissioned nationally through 10 of NHS England's 27 area teams. They account for around £11.8 billion of annual spending, or around 10 per cent of the overall NHS budget.
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- Feedback from the December scoping event will inform the development of a five-year strategy, outlining how specialised services are best provided to improve patient experience and outcomes, against a backdrop of financial challenges and rising demand.

4. Transforming urgent and emergency care services in England

- The Urgent and Emergency Care Review led by Professor Sir Bruce Keogh has published his end of Phase 1 report. There are five key elements, summarised below, all of which must be taken forward to ensure success:

    - **Better support for people to self- care.** This is by far the most responsive way of meeting people's urgent but non-life threatening care needs. Millions of people already do this, but millions more could be better supported to take control of their own health. To achieve this, better and more easily accessible information about self-treatment options needs to be made available so that people who prefer to can avoid the need to see a healthcare professional.

    - **People with urgent care needs – to get the right advice in the right place, first time.** To achieve this, the NHS 111 service will be enhanced so that it becomes the smart call to make, creating a 24-hour, personalised priority contact service. This enhanced service will have knowledge about people's medical problems and allow them to speak directly to a nurse, doctor or other healthcare professional if that is the most appropriate way to provide the help and advice they need. It will also be able to directly book a call back from, or an appointment with, a GP or at whichever urgent or emergency care facility can best deal with the problem.

    - **Highly responsive urgent care services must be made easily available outside of hospital so people no longer choose to queue in A&E.** This will mean providing faster and consistent same-day, every-day access to general practitioners, primary care and community services such as local mental health teams and community nurses for patients with urgent care needs. It will also mean harnessing the skills, experience and accessibility of a range of healthcare professionals including community pharmacists and ambulance paramedics.

By extending paramedic training and skills, and supporting them with GPs and specialists, 999 ambulances will become mobile urgent treatment services capable of dealing with more people at scene, and avoiding unnecessary journeys to hospital.

- **People with more serious or life threatening emergency care needs must receive treatment in centres with the right facilities and expertise in order to maximise chances of survival and a good recovery.** Once urgent care services outside hospitals have been enhanced, two levels of hospital emergency departments will be developed, under the current working titles of Emergency Centres and Major Emergency Centres. In time these will replace the inconsistent levels of service provided by A&E Departments. The presence of senior clinicians seven days a week will be important for ensuring the best decisions are taken, reassuring patients and families and making best use of NHS resources. Emergency Centres will be capable of assessing and initiating treatment for all patients and safely transferring them when necessary. Major Emergency Centres will be much larger units, capable of not just assessing and initiating treatment for all patients but providing a range of highly specialist services. These centres will have consistent levels of senior staffing and access to the specialist equipment and expertise needed to deliver the very best outcomes for patients. It is envisaged there being around 40-70 Major Emergency Centres across the country. We expect the overall number of Emergency Centres (including Major Emergency Centres) carrying the red and white sign to be broadly equal to the current number of A&E departments. Decisions on the location of Major Emergency Centres and Emergency Centres will be taken locally.

- **All urgent and emergency care services must be connected together so the overall system becomes more than just the sum of its parts.** Building on the success of major trauma networks, broader emergency care networks will be developed. These networks will dissolve traditional boundaries between hospital and community based services and support the free flow of information and specialist expertise needed to achieve the delivery of patient care in the most appropriate and convenient setting. Major Emergency Centres will have a lead responsibility for the quality of care and operational performance of these networks.

5. Portsmouth Hospital NHS Organ Donation Report

Executive Summary
Actual and Potential Organ Donors
1 April 2013 - 30 September 2013

NHS Blood and Transplant

Portsmouth Hospitals NHS Trust

Donor outcomes

Between 1 April 2013 and 30 September 2013, your Trust had 3 deceased solid organ donors, resulting in 7 patients receiving a transplant. 6 organs were donated and all were transplanted. Further details are provided in the tables below. If you would like further information, please contact your local Specialist Nurse - Organ Donation (SN-OD).

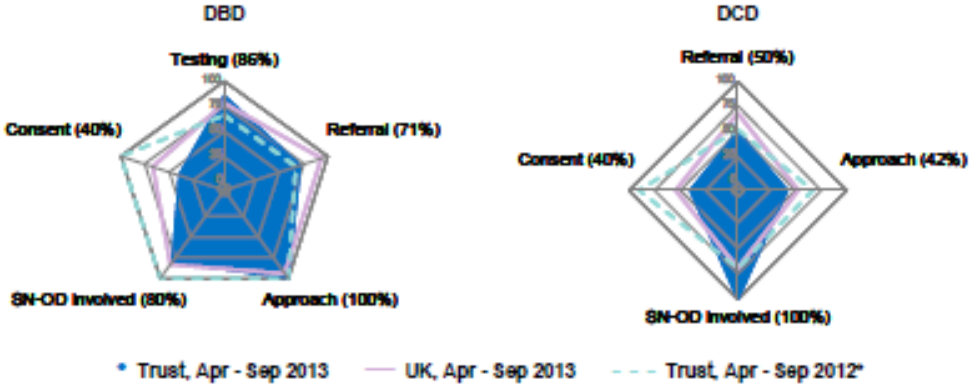
Donors, patients transplanted and organs per donor,
1 April 2013 - 30 September 2013 (1 April 2012 - 30 September 2012 for comparison)

Donor type	Number of donors		Number of patients transplanted		Average number of organs donated per donor: Trust		UK	
DBD	2	(1)	5	(1)	2.0	(3.0)	4.0	(4.0)
DCD	1	(2)	2	(5)	2.0	(2.5)	2.5	(2.6)
DBD and DCD	3	(3)	7	(6)	2.0	(2.7)	3.4	(3.4)

Organs transplanted by type,
1 April 2013 - 30 September 2013 (1 April 2012 - 30 September 2012 for comparison)

Donor type	Number of organs transplanted by type: Kidney		Pancreas		Liver		Heart		Lung	
DBD	2	(0)	0	(0)	2	(1)	0	(0)	0	(0)
DCD	2	(4)	0	(0)	0	(1)			0	(0)
DBD and DCD	4	(4)	0	(0)	2	(2)	0	(0)	0	(0)

Radar charts of key rates, 1 April 2013 to 30 September 2013



The blue shaded area represents your Trust's rates for the first six months of 2013/14. The latest UK rates and your Trust's rates for the equivalent period in the previous year are superimposed for comparison. The fuller the blue shaded area the better. Additionally, the funnel plots in the detailed report can be used to identify the maximum rates currently being achieved by Trusts with similar donor potential.

* The PDA data collection changed on 1 April 2013. Therefore comparisons made between time periods should be interpreted with caution.

Key numbers and rates

There are nine measures (as indicated by the cells highlighted as red, amber or green below) on the Potential Donor Audit (PDA) which are most likely to affect the conversion of potential donors into actual donors. Between 1 April 2013 and 30 September 2013, your Trust met the national target in 4 of these measures. Of the 7 potential DBD donors with suspected neurological death, 2 proceeded to donation and 5 did not proceed. Of the 12 eligible DCD donors, 1 proceeded to donation and 11 did not proceed. Further details are provided below. Caution should be applied when interpreting percentages based on small numbers.

	DBD				DCD			
	Apr - Sep 2013		Apr - Sep 2012[3]		Apr - Sep 2013		Apr - Sep 2012[3]	
	Trust	UK	Trust	UK	Trust	UK	Trust	UK
Patients meeting organ donation referral criteria[1]	7	916	3	764	34	3,731	25	3,416
Referred to SN-OD	5	851	2	696	17	2,553	13	2,115
Referral rate %	R *71%*	*93%*	*67%*	*91%*	R *50%*	*68%*	*52%*	*62%*
Neurological death tested	6	717	2	580				
Testing rate %	G *86%*	*78%*	*67%*	*76%*				
Eligible donors[2]	5	674	1	544	12	1,861	15	1,522
Family approached	5	635	1	503	5	975	10	867
Approach rate %	G *100%*	*94%*	*100%*	*92%*	R *42%*	*52%*	*67%*	*57%*
Family approached and SN-OD involved	4	528	1	378	5	681	7	580
% of approaches where SN-OD involved	G *80%*	*83%*	*100%*	*75%*	G *100%*	*70%*	*70%*	*67%*
Consent given	2	425	1	348	2	533	9	455
Consent rate %	R *40%*	*67%*	*100%*	*69%*	R *40%*	*55%*	*90%*	*52%*
Expected consents based on ethnic mix	4		1		3		5	
Expected consent rate based on ethnic mix %	*72%*		*73%*		*54%*		*55%*	
Actual donors from each pathway	2	389	1	310	1	270	2	223
% of consented donors that became actual donors	*100%*	*92%*	*100%*	*89%*	*50%*	*51%*	*22%*	*49%*
Colour key - comparison with national targets	R *Red*		A *Amber*		G *Green*			

[1] DBD - A patient with suspected neurological death
DCD - A patient in whom imminent death is anticipated, ie a patient receiving assisted ventilation, a clinical decision to withdraw treatment has been made and death is anticipated within 4 hours

[2] DBD - Death confirmed by neurological tests and no absolute contraindications to solid organ donation
DCD - Imminent death anticipated and treatment withdrawn with no absolute contraindications to solid organ donation

[3] The PDA data collection changed on 1 April 2013. Therefore comparisons made between time periods should be interpreted with caution.

Further Information

- A detailed report for your Trust accompanies this Executive Summary, which also contains definitions of terms, abbreviations, table and figure descriptions, targets and tolerances, and details of the main changes made to the PDA on 1 April 2013.
- The latest Activity Report is available at http://www.organdonation.nhs.uk/ukt/statistics/transplant_activity_report/
- The latest PDA Annual Report is available at http://www.organdonation.nhs.uk/ukt/statistics/potential_donor_audit/
- Please refer any queries or requests for further information to your local Specialist Nurse - Organ Donation (SN-OD).

Source

NHS Blood and Transplant: UK Transplant Registry (UKTR), Potential Donor Audit (PDA) and Referral Record. Issued November 2013 based on data reported at 07 November 2013.