REPORT TO:	**BOARD OF DIRECTORS**
DATE:	**9 FEBRUARY 2018**
SUBJECT:	**MEDICAL DIRECTOR'S REPORT**
BOARD SPONSOR:	**MEDICAL DIRECTOR**
PAPER AUTHOR:	**MEDICAL DIRECTOR**
PURPOSE:	**DISCUSSION**
APPENDICES:	**NONE**

BACKGROUND AND EXECUTIVE SUMMARY

This report encompasses the following areas:

1. Infection Prevention and Control (IP&C)
   Despite the performance in terms of C.difficile infections versus trajectory (29 cases against an annual objective of 46 cases as of 31 January 2018) IP&C continues to be an area of potential concern. Trust assigned MRSA bacteraemias are currently 5 having had a further positive MRSA contaminant this month. On a positive note Trust clinical staff Influenza vaccination rates have been the highest ever, much needed given the prevalence of Influenza infection this winter.
2. 7 day services
   A full analysis of the September 2017 audit with comparison against National data has yet to be released. The preliminary analysis of our own data showed a worsening position against Standard 2 compared to the March 2017 position, potentially related to the emergency change in service last June, with 66.7% non-elective admissions receiving a documented 1st consultant review within 14 hours of admission to hospital compared to 72.3% previously.
3. Getting It Right First Time (GIRFT)
   There were 2 GIRFT visits in December, Urology on the 7 December and General Surgery on the 18 December. Formal reports from the visits have yet to be received but a short synopsis of key points is detailed in the report below.
4. Health Education Kent Surrey Sussex (HEKSS) and General Medical Council (GMC) training visit December 2017
   A formal visit to assess medical training on the Queen Elizabeth the Queen Mother Hospital (QEQMH) and William Harvey Hospital (WHH) sites and specialties training on the Kent & Canterbury Hospital (K&CH) site following the removal of medical trainees and the move of acute medicine from the K&CH site last June took place on the 11 and 12 December. There were two immediate mandatory requirements, both relating to emergency medicine, one at each acute site. There were no significant concerns with specialty training on the K&CH site. Following the visit the Trust has received a follow up letter from the GMC indicating that the previous enhanced monitoring process in surgery at the WHH site had been removed. However, the GMC have indicated that medicine should be placed into their enhanced monitoring process at both QEQMH and WHH.
5. Venous Thromboprophylaxis (VTE) update
   Although the VTE assessment recording performance slipped slightly to 94% in December 2017 this is significantly better than the national acute Trust

performance for this month. Preliminary analysis suggests that this has recovered to 95% in January 2018.

6. Medication safety thermometer
   The Medication Safety Thermometer is a measurement tool for improvement that focuses on: medication reconciliation, allergy status, medication omission, and identifying harm from high risk medicines. Following the appointment of a medication safety officer the safety thermometer has been re-launched. Since the re-launch the high percentage of missed doses has come down from 36.9% in July 2017 to 20% in December 2017, this is still above the national reported average of 12.2%.

IDENTIFIED RISKS AND MANAGEMENT ACTIONS:	Risks: 1. Patient safety risks from poor safety culture (infection prevention and control and medicines safety) 2. Delivery of inconsistent quality of care through differences in service availability by day of the week 3. Enhanced monitoring raises potential risk to trainees and to training Actions: 1. Re-launch trainee patient safety forum 2. Reinforce implementation of the IP&C action plan 3. Complete current round of job planning and repeat in conjunction with the 7 day working group 4. Director of Medical Education has drafted an action plan in response to the GMC enhanced monitoring status and this is being reviewed with the postgraduate Dean in mid-February 5. Implement the recommendations of the Medication Safety Officer for missed doses; accelerate as far as possible the introduction of electronic prescribing
LINKS TO STRATEGIC OBJECTIVES:	**Patients:** Help all patients take control of their own health. **People:** Identify, recruit, educate and develop talented staff. **Provision:** Provide the services people need and do it well. **Partnership:** Work with other people and other organisations to give patients the best care.
LINKS TO STRATEGIC OR CORPORATE RISK REGISTER	SRR 2 - Failure to maintain the quality and standards of patient care CRR 22 - Failure to record/carry out timely Venous Thromboprophylaxis (VTE) risk assessments CRR 46 - Delays in signing off and implementing Consultant job plans CRR 47 - Inability to prevent deterioration in the number of healthcare associated infection metrics CRR 62 - Failure to comply with standards for medical education and training in particular areas
RESOURCE IMPLICATIONS:	Implementation of 7 day services will have staff resource implications
COMMITTEES WHO HAVE CONSIDERED THIS REPORT	N/A

PRIVACY IMPACT ASSESSMENT: *NO*	**EQUALITY IMPACT ASSESSMENT:** *NO*

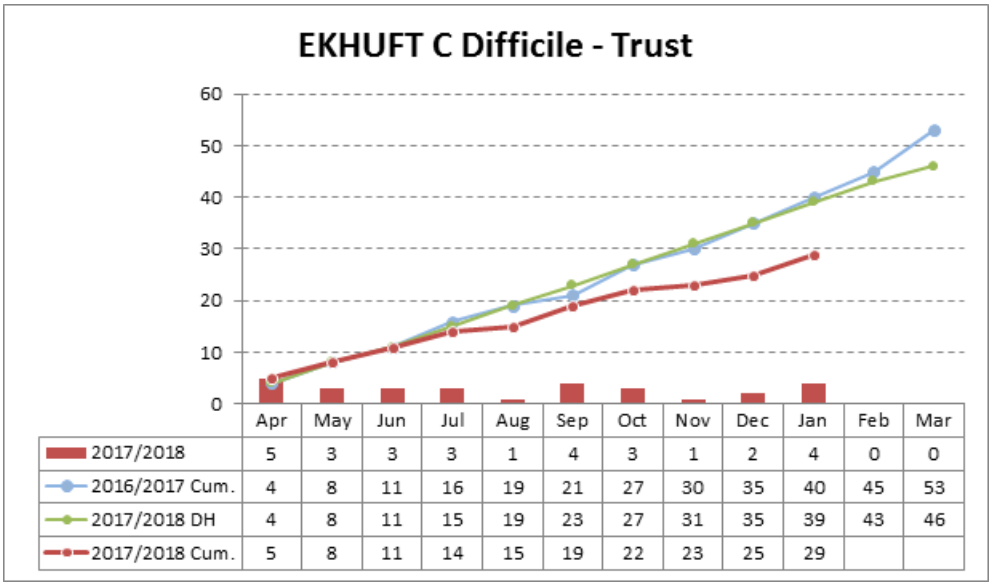
RECOMMENDATIONS AND ACTION REQUIRED:

The Board is asked to note, review and discuss.

1. Infection Prevention and Control (IP&C)

1.1 Clostridium difficile

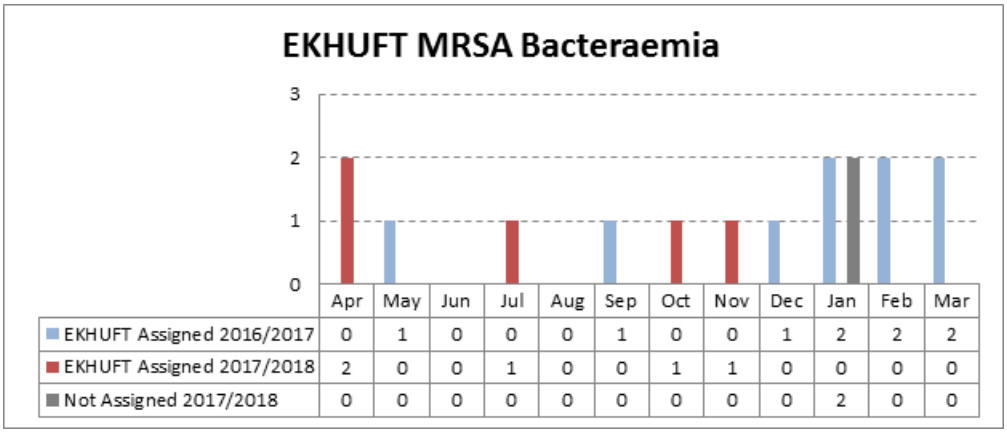
The year-to-date total is 29 cases against an annual objective of 46 cases – please see the graph below (1 case for Specialist Services, 21 cases for Urgent Care & Long Term Condition (UC&LTC) and 7 cases for Surgical Division)



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017/2018	5	3	3	3	1	4	3	1	2	4	0	0
2016/2017 Cum.	4	8	11	16	19	21	27	30	35	40	45	53
2017/2018 DH	4	8	11	15	19	23	27	31	35	39	43	46
2017/2018 Cum.	5	8	11	14	15	19	22	23	25	29		

1.2 MRSA

MRSA continues to be an area of concern and frustration, although referred to in the Integrated Performance Report (IPR) it is worth repeating here. As of 31 January 2018 there are 5 cases of Trust assigned MRSA bacteraemia this current year and 3 of these are due to contamination. Although this is good for the patient in that it means they do not have MRSA bacteraemia it is representative of continued poor technique.

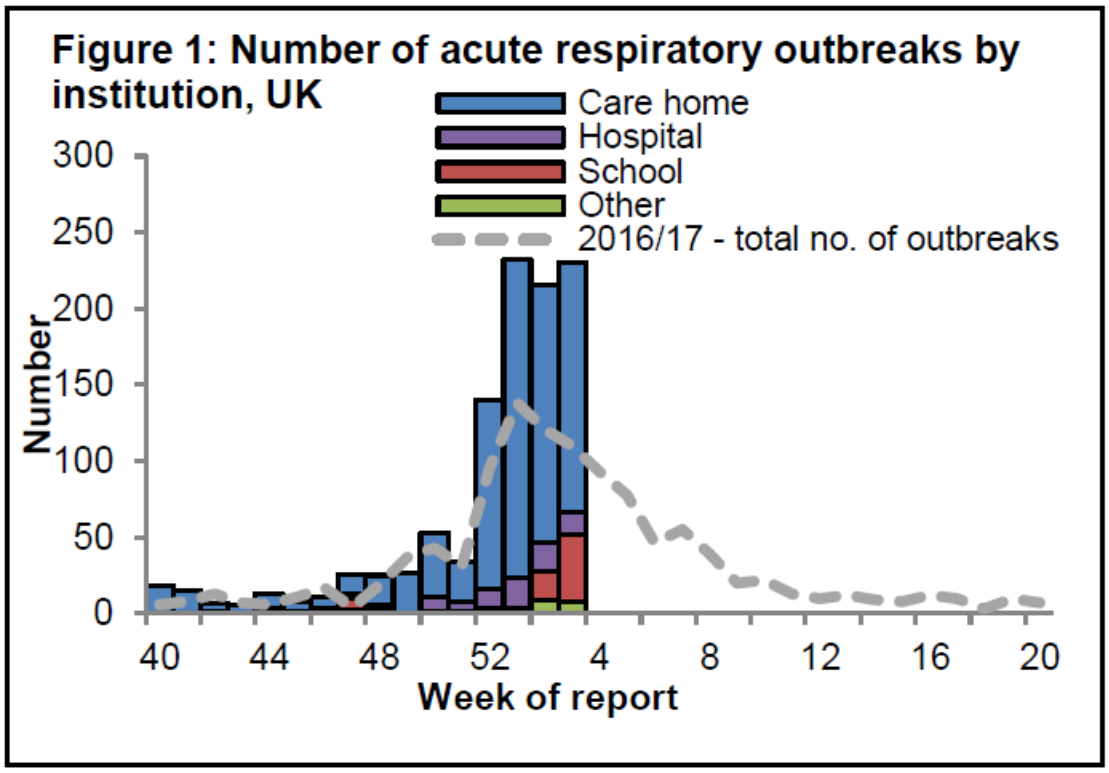


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
EKHUFT Assigned 2016/2017	0	1	0	0	0	1	0	0	1	2	2	2
EKHUFT Assigned 2017/2018	2	0	0	1	0	0	1	1	0	0	0	0
Not Assigned 2017/2018	0	0	0	0	0	0	0	0	0	2	0	0

1.3 Influenza

In East Kent to date there have been 23 confirmed Influenza A and 52 confirmed Influenza B cases since October 2017 which mirrors national data (1:2 ratio Flu A:Flu B). Most of these have been in January (19 Flu A and 42

Flu B). This year there has been a high uptake of vaccine by clinical staff (74.7%), well above the National uptake of 63.9%. The trivalent vaccine the Trust uses is active against 2 Flu A types (H1N1pdm09-like virus [Michigan strain]; H3N2 [Hong Kong strain] and 1 Flu B [Brisbane strain]), the quadrivalent vaccine is also active against an additional strain of Flu B [Phuket strain]. Public Health data has not indicated which subtype of Flu B is predominant. The chart below details Flu outbreaks by institution and shows the comparison against 2016/17 data.



2. 7 day services

The seven day services programme is designed to ensure patients that are admitted as an emergency receive high quality consistent care, whatever day they enter hospital.

Since 2016 NHS Improvement have required Trusts to undertake 6 monthly audits of their delivery of 7 day services against certain priority standards of the clinical standards supported by the Academy of Royal Colleges. Updated clinical standards were published in September 2017.

There are 4 priority standards:
Standard 2: Time to consultant review (percentage of non-elective admissions receiving 1st consultant review within 14 hours of admission to hospital)
Standard 5: Access to diagnostic tests with a 24-hour turnaround time - for urgent requests, this drops to 12 hours and for critical patients, one hour
Standard 6: Access to specialist, consultant-directed interventions

Standard 8: On-going review by consultant twice daily if high dependency patients, daily for others.

Supported by a further 6 standards:
Standard 1: Patient Experience
Standard 3: Access to multidisciplinary team (MDT) review for complicated patients requiring MDT Review
Standard 4: Robust and safe handover arrangements between shifts
Standard 7: 24/7 access to mental health services
Standard 9: Safe and effective transfer to primary, community & social care
Standard 10: Quality Improvement

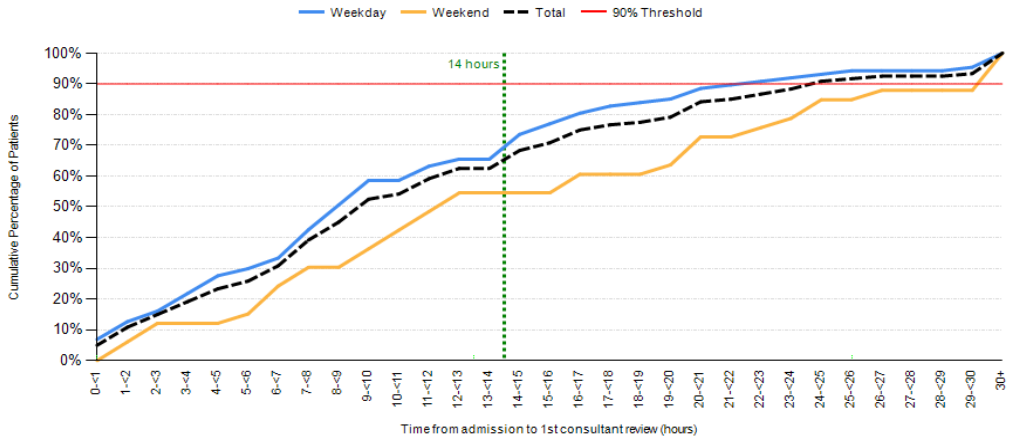
There are three key milestones for the 7 day services programme. 25% of the population were required to be 'covered' by the 4 priority standards by April 2017; 50% by April 2018, and 100% by April 2020. We are working to this common timetable and we will be expected to continue to monitor and report on progress.

The table below shows a comparison of our performance with national data for the audit from March 2017:

Standard	7 day average		Weekdays		Weekends	
	NHS	EKHUFT	NHS	EKHUFT	NHS	EKHUFT
2	72.3%	78%	73.0%	77%	70.3%	80%
5	95.9%	94%	99.7%	100%	92.1%	87%
6	93.5%	94%	95.2%	100%	91.9%	87%
8	85.2%	(90%)	90.9%	(94%)	69.7%	(79%)

The September 2017 audit considered Standard 2 and results show a fall off in performance which is attributed to the move of acute medicine off the K&CH site onto the QEQMH and WHH sites (7 day average 66.7%, weekdays 65.3% and weekends 70%). This is depicted graphically in the figure below, demonstrating the upward shift required to meet the standard:

Chart 2: Cumulative hours between admission and 1st consultant review



A 7 day working group has been established to work towards full implementation of the priority standards. Successful implementation will be heavily dependent on finalisation of the Trust clinical strategy underpinned by a separation of emergency from elective work supported by a further review of medical job planning.

3. Get It Right First Time (GIRFT)

GIRFT visits centre around a review report generated centrally from historical data and as such represent a guide for comparison to the national picture. The provision of a benchmarking data package, produced by the GIRFT team, is not used to 'performance-manage' the unit but is expected to provide fresh insights into the way the department functions through the use of comparative data. The report provides the basis for discussion during the visit.

3.1 Urology

Key points emerging during the discussion surrounded:

- Staffing establishments, specifically consultants (currently 10, 2 under expected establishment), clinical nurse specialists supporting the cancer pathway (currently 5.6, 3 under expected establishment)
- Comorbidity coding, we consistently code less comorbidity than our demography would predict
- Activity, both outpatient and inpatient activity are high in comparison with other units
- Achievement of national standards all less than desired
- Outcomes, all generally good except for readmissions following radical prostatectomy which reflected the functioning of the ECC at the time of data collection
- Cost of the service, generally low

Prior to the GIRFT meeting the urology cancer pathway had been subject to a 'critical friend' review by NHS Improvement (NHSI) relating to national standards. Pertinent findings were all in expected areas including access to diagnostics (MRI, prostate biopsy and histology reporting) and matching demand to capacity. Work in these areas has already seen the historical position improve with achievement of 2 week wait and 31 day treatment targets, although 62 day treatment targets are still not attained.

3.2 General Surgery

Key points emerging during the discussion surrounded:

- Acute general surgical admissions all generally higher on each day of the week in comparison with nationally, length of stay was the same as the national average

- 18 month stoma rate for colorectal cancer significantly higher than nationally (this has been consistent in national audit data)
- Cholecystectomy within 14 days of admission for acute cholecystitis or biliary pain less than expected, similar finding for within 14 days of admission for acute pancreatitis (WHH site more so than QEQMH)
- Measure relating to implementation of the emergency laparotomy bundle were all good (this has been reflected in the National Emergency Laparotomy Audit reports)

4. HEKSS and GMC training visit December 2017

A formal visit to assess medical training on the QEQMH and WHH sites and specialties training on the K&CH site following the removal of medical trainees and the move of acute medicine from the K&CH site took place on the 11 & 12 December.

Positives included:

- Following a recommendation from HEE the GMC removed enhanced monitoring status in connection with general surgery (foundation, core, higher) at the WHH.
- Initial feedback at QEQMH praised the excellent teaching programme and described the experience in training at QEQMH as excellent.
- At K&CH the specialty trainees were generally happy and felt well supported. No patient safety issues were reported and rota coordination was good. Access to study leave was also good.
- At WHH teaching was again praised and an initiative recently introduced, a trainer "drop in clinic" was also singled out for praise.

Negatives at the initial feedback included:

- The overall workload at both acute sites was too high and rota management was criticised. On both acute sites there were immediate mandatory requirements relating to emergency medicine, 1 at each acute site. At the QEQMH this involved work up of medical referrals by A&E doctors and at the WHH the requirement surrounded the numbers of medical referrals handed over at shift change.
- Trainees were unclear about transfer processes and protocols between sites
- Trainees at all sites requested improved feedback from Datix incidents
- Trainees at both acute sites did not have sufficient access to procedures and to clinics (largely due to emergency work pressures)

Subsequent to the visit the GMC have suggested that the following standards are not being met for medicine across the Trust:

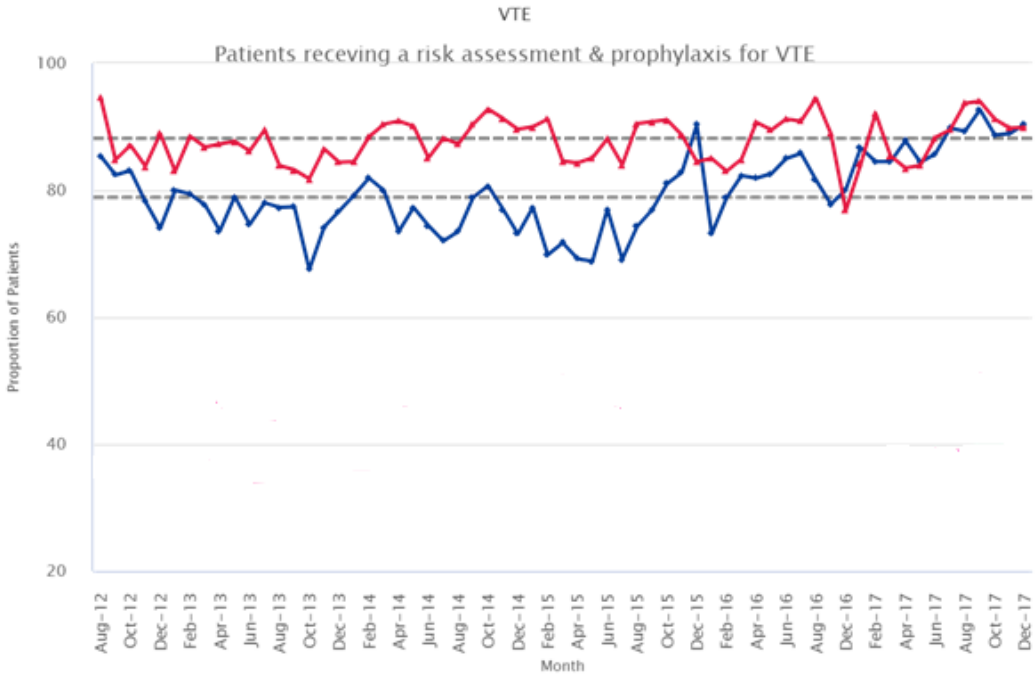
S1.1 The learning environment is safe for patients and supportive for learners and educators. The culture is caring, compassionate and provides a good standard of care and experience for patients, carers and families.
S1.2 The learning environment and organisational culture value and support education and training so that learners are able to demonstrate what is expected in 'Good medical practice' and to achieve the learning outcomes required by their curriculum.

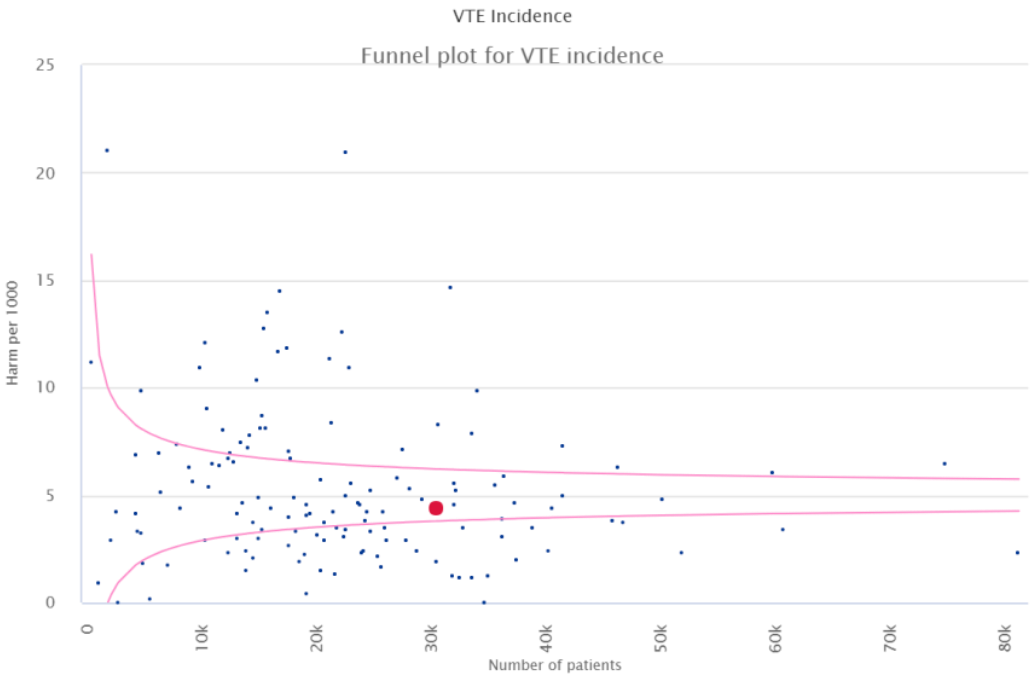
The GMC have therefore concluded that medicine should be placed into their enhanced monitoring process at both QEQMH and WHH (in addition to K&CH) so that they can more actively oversee the situation to make sure the concerns, many of which are trust-wide, are resolved effectively and sustainably.

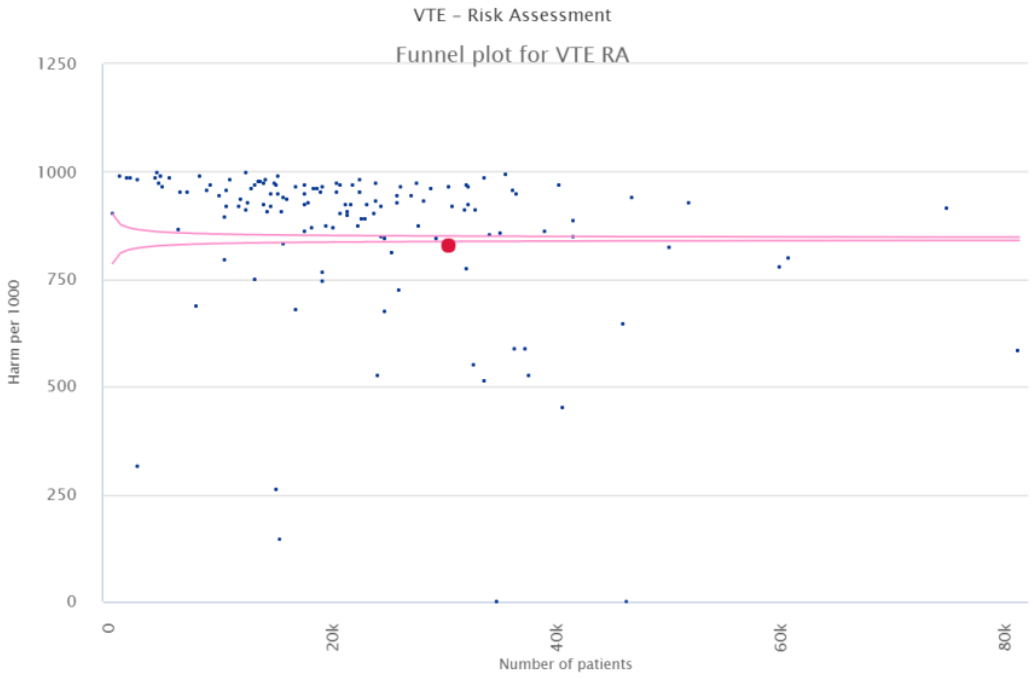
5. VTE update

Although the VTE assessment recording performance slipped slightly to 94% in December 2017 preliminary analysis suggests that this has recovered to 95% in January 2018. Our performance has come back up to, and exceeded, that of national acute Trust performance for the first time this is significantly better than the national acute Trust performance for this month.

The charts below are data published by NHS Improvement and allow a comparison of EKHUFT with national acute trust data. In this data for December the national recorded assessment was 89.9% compared with EKHUFT 90.4% (1st chart). The subsequent 2 funnel plots show firstly rate of harms per 1000 patients versus VTE incidence and secondly the rate of harms per 1000 patients versus VTE risk assessment. Other acute Trusts are depicted by blue dots and EKHUFT by the larger red dot.







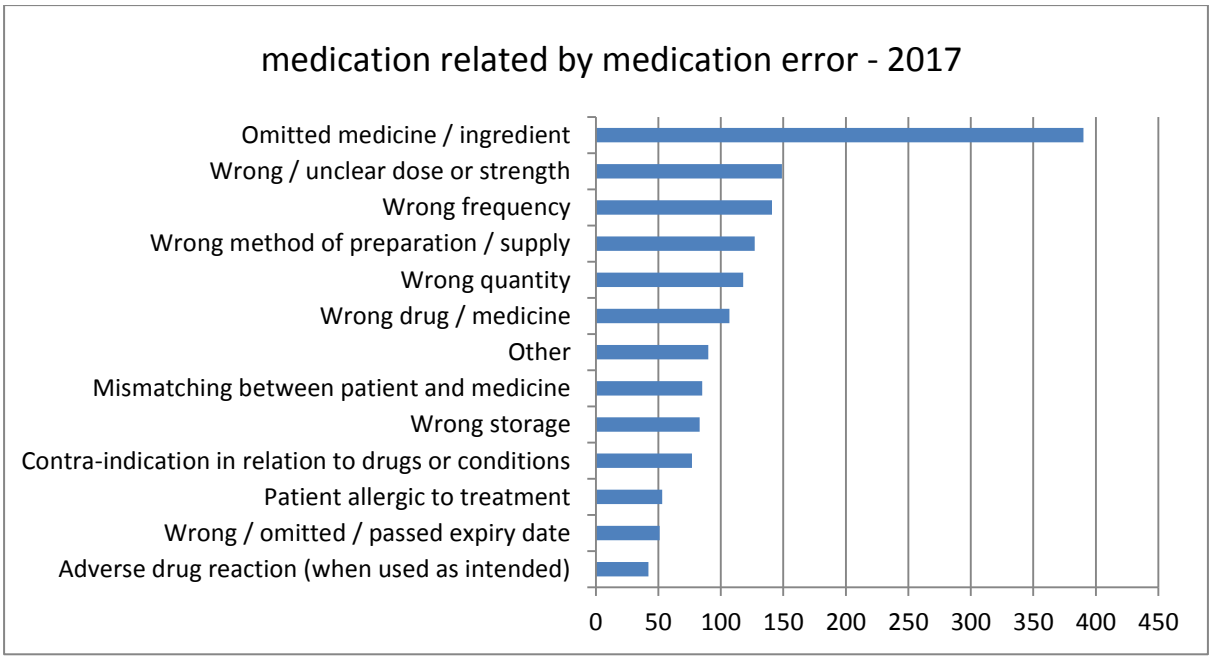
6. Medication safety thermometer

Omitted doses of medicines are a significant risk to patient safety. As part of the national patient safety thermometer a medication safety thermometer was developed in 2013/14 (https://www.safetythermometer.nhs.uk/index.php/medication-safety-thermometer). In our Trust it was undertaken on selected wards and became sporadic due to lack of pharmacy resource to support its effective use. As the clinical pharmacy service was re-established and with the appointment of a nurse as our medication safety officer (MSO) the tool was re-introduced and

rolled out across the whole organisation to give the Trust a much clearer picture of medication safety issues. The medicine safety officer has continued the cross sectional audits of missed doses and although the position is one of sustained improvement the overall percentage of missed doses remains above the national acute trust position as detailed below.

% patients with omission of medicine	April 17	May 17	June 17	July 17	Aug 17	Sept 17	Oct 17	Nov 17	Dec 17
Trust	35.7	41	28.7	36.9	23.7	36.7	25.6	27.4	20
All	10.8	11.5	11.1	11.1	12.3	11.3	11.1	13.2	12.2

This picture triangulates with reported medication safety incidents



Key actions to address the issue of missed doses include:

- Increased awareness of missed doses amongst all nursing staff.
- Increased awareness of missed doses amongst all medical staff.
- A structured approach to understand the multifactorial issues surrounding missed doses and the formulation of collaborative action plans involving medical, nursing and pharmacy staff.
- To protect the drug round times and ensure distraction is minimal when nurses are administering medicines.
- Maintain operational and strategic awareness of the missed doses data from the MST and key themes.