REPORT TO:	**BOARD OF DIRECTORS**
DATE:	**9 SEPTEMBER 2016**
SUBJECT:	**MEDICAL DIRECTOR'S REPORT**
BOARD SPONSOR:	**MEDICAL DIRECTOR**
PAPER AUTHOR:	**MEDICAL DIRECTOR**
PURPOSE:	**Discussion**

BACKGROUND AND EXECUTIVE SUMMARY

The purpose of this report is to update the Board in certain key areas of the Medical Director's work and responsibility. Areas covered by this report include:

1. Junior doctors industrial action
2. The deteriorating patient
3. Kent & Canterbury Emergency Care Centre redesign
4. Mortality steering group
5. Headlines from the Medical engagement Survey

IDENTIFIED RISKS AND MANAGEMENT ACTIONS:	1. Junior doctors industrial action represents a significant patient safety risk and a risk to the Trust's already challenged referral to treatment standards and cancer waits. Contingency planning will mitigate these risks and use of consultant and non-training grade doctors in emergency care should ensure that patient safety risks are minimised but that will be at the expense of elective care. 2. Failure to completely implement systems to support safer care of the deteriorating patient (adults and children) represents a patient safety risk. Mitigating actions are listed in the report. 3. The chief risk to the new model of care in the Kent & Canterbury ECC is staffing of the GP rota and this is outside the Trust's control. Mitigation to date has been through the actions of senior nurses within the ECC. 4. Proposals from the centre for mortality reviews are that each and every death within the Trust are formally reviewed using a standardised tool. Ramifications of this are briefly considered within the report and require a Board view. 5. The Board is asked to note the headline improvement in medical engagement but acknowledge that without further work sustainability will be a risk.
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	CRR 1 - Precipitate loss of acute medicine from the K&C site CRR 3 - Inability to respond in a timely way to changing levels of demand for emergency and elective services CRR 4 - Failure to recognise or treat Patients with sepsis in a timely way CRR 7 - Potential delayed treatment of patients requiring emergency acute general surgery intervention at the Kent and Canterbury Hospital site CRR 18 - Failure to comply with the recommendations in the Mazar's report which include case note review of each and every patient death CRR 19 - Delays in the cancer pathway of over 100 days CRR 25 - Failure to recognise sudden deterioration in critically ill or seemingly well children SRR 8 - Inability to attract, recruit and retain high calibre staff to the Trust
RESOURCE IMPLICATIONS:	Not considered
COMMITTEES WHO HAVE CONSIDERED THIS REPORT	n/a

PRIVACY IMPACT ASSESSMENT: *NO** *** Delete as appropriate***	**EQUALITY IMPACT ASSESSMENT:** *NO** *** Delete as appropriate***

RECOMMENDATIONS AND ACTION REQUIRED:

To note the implications of junior doctors industrial action; to agree in principle further actions to be implemented for care of the deteriorating patients; to note the progress made with the redesign of the K&CH ECC and to send official Board thanks to ECC staff for their hard work and dedication to making this work; to note the implications of implementation of recommendations from the Mazar's report; and to note the positive progress in medical staff engagement.

MEDICAL DIRECTOR'S REPORT

1. Junior doctors industrial action

1.1 Currently it is proposed that junior doctors nationwide will stage a full withdrawal of labour for five days during the following periods:

- 8am–5pm from Monday 12 to Friday 16 September
- 8am–5pm from Wednesday 5 to Friday 7 October, and 8am-5pm on Monday 9 and Tuesday 10 October (industrial action will not take place on the Saturday and Sunday)
- 8am–5pm from Monday 14 to Friday 18 November
- 8am–5pm from Monday 5 to Friday 9 December

1.2 Notice of the September dates has been extremely short. The COO and the Medical Director have started planning contingencies for these strikes in conjunction with the divisional teams, HR and the information team. Self-evidently if these planned strikes go ahead there will be considerable disruption for patients. The contingency plan will involve the support of consultant and non-consultant doctors, together with other health professionals to ensure that the likelihood of major consequences for patient care as a result of industrial action are kept to a bare minimum. As with the previous 48 hour full withdrawal of labour the Trust will be working to ensure there is no significant interruption to critical and/or emergency care by significantly reducing elective care on the days of the strikes. In order to aid our local contingency planning we have asked junior doctors to indicate their intention to take strike action or not, although they are not obliged to inform us and can change their minds at the last minute.

1.3 As before the information team are collecting baseline information and will monitor this during the period of industrial action.

2. The deteriorating patient

2.1 Resources to support safer care of the deteriorating patient (adults and children)

a. NEWS (national early warning score) and PEWS (paediatric early warning score) have been implemented across the Trust (maternity has been last area to implement because of the need for a modified version in relation to blood pressure)
b. Use of VitalPac means that in most areas early warning scores are calculated electronically and prompt escalation
c. We are able to easily monitor compliance with VitalPac protocol
d. AKI (acute kidney injury) alerting system has been implemented
e. There are clinical leads for Sepsis (Michelle Webb) and AKI (Ian John)
f. The Sepsis Collaborative led by Michelle Webb has introduced screening tools (consistent with recent NICE guidance) for adult and paediatric inpatients and for the emergency departments. Compliance with these is monitored monthly (CQUIN).
g. Aide memoir cards and other resources have been produced for sepsis (adult and paediatric), AKI and fluid resuscitation.
h. There is active collaboration with the local AHSN (sepsis, AKI, patient safety culture).
i. SBAR has been widely adopted for handover. The Careflow system is being rolled out to improve transfer of information and for alerting.
j. There is access to plenty of data to help drive improvement - data are collected routinely on frequency of observations, time to administration of intravenous antibiotics, AKI stage 2 & 3, DNACPR, cardiac arrests and inpatient escalation to HDU/ITU.

k. There is an improving position with respect to cardiac arrest performance (appendix 1)
l. Sepsis and recognition of the deteriorating patient is covered briefly in annual Resuscitation training.

2.2 Specific recommendations that require implementation

a. We need nursing and medical leads for the deteriorating patient
b. We need an identified Board level champion
c. Mortality from Sepsis and Pneumonia should be included in the monthly quality dashboard
d. All staff should have annual training for sepsis (minimum of 60% of permanent front line staff to be current with training at any one time). To be audited a minimum of biannually.
e. All staff should receive NEWS education (RCP e-learning tool)

2.3 Areas for improvement

a. Escalation, especially out of hours (a challenge for all organisations). A NEWS >5 should trigger an assessment of ceiling of care and consideration of resuscitation status. Medical team response should be within 15 minutes. NEWS 7 or more should trigger assessment by ST3 or above and consideration of transfer to HDU/ITU. Whilst our escalation protocol is in line with this we need to monitor and enforce this and do further work to improve our safety culture such that staff feel comfortable and supported to escalate to the next level when they do not get the desired response.
b. Review by Consultant on call. The consultant on call should review patients admitted during the day within 6-8 hours and overnight within 14 hours. He/she should also be involved in all admissions of patients under their care to critical care areas. Proactive communication at senior (ST3+ or consultant) level between the acute medical and critical care teams is essential. These working practices should be explicit within the job plan and are largely adhered to by physicians but need to be extended to include Surgical and Specialist Consultants.

3. Kent & Canterbury Emergency Care Centre redesign

a. The redesigned Kent & Canterbury emergency care centre (ECC) came into operation at the beginning of July. The key components of the redesign include implementation of revised SECAMB conveyance criteria to ensure that patients with acute abdominal pain, those with severe mental health problems and severely intoxicated patients are not brought by ambulance to the ECC; streaming of patients at the front door to minor injuries, GP led services or the acute medical admissions unit; and withdrawal of the medical trainees from the ECC into the acute medical unit.
b. The implementation is being closely monitored and data is being collected towards a 3 month evaluation. To date the main problems encountered have been gaps on the GP staffing rota (although this is technically the responsibility of Invicta in practice it has been our nursing staff who have taken action to fill these gaps); an occasional slip up by SECAMB in implementation of the revised conveyance criteria; and failure of the agreed criteria for transfer of acute general surgical problems on a couple of occasions. At present the steering committee continues to meet monthly but feedback remains very positive and the ECC at Canterbury has consistently met the ≥95% 4 hour emergency care standard.

4. Mortality steering group

a. The recommendations from NHS England as a result of the Mazar's report revolve around the establishment of a mortality steering committee and a

standardised review of deaths in NHS Trusts. A steering committee chaired by the medical director has been established and has both lay and CCG representation. Although the promised standardised mortality review tool has yet to be released by the centre we have been piloting what we think will be the recommended tool to determine exactly how we should implement our mortality reviews locally. The chief concern is the amount of clinical time required to adequately apply the tool in its current form given that there are approximately 2,600 deaths per year within the Trust. Preliminary data from the pilot indicates that a thorough review takes approximately 1 hour to complete. The steering committee considers that to begin with we may need to concentrate on 3 areas: deaths in diagnostic groups where observed mortality is higher than expected, deaths in patients exceeding a threshold early warning score and deaths in patients admitted electively.

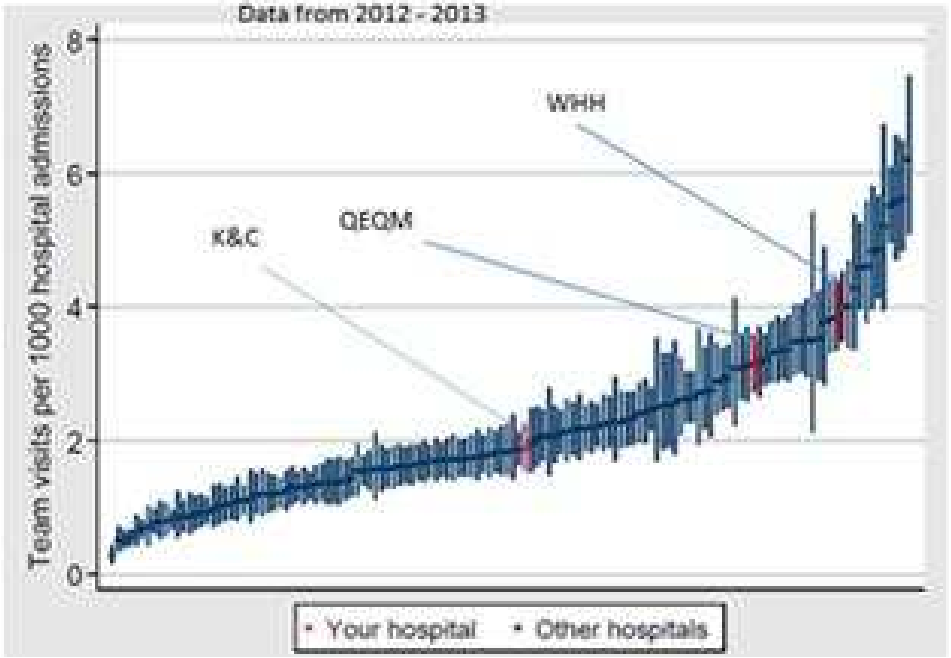
5. Headlines from the Medical engagement Scale Survey

a. The results from the recent repeat of the medical engagement scale survey have been released and a full report will be presented to the Strategic Workforce committee.
b. Medical engagement is defined as "The active and positive contribution of doctors within their normal working roles to maintaining and enhancing the performance of the organisation which itself recognises this commitment in supporting and encouraging high quality care."
c. The medical engagement scale survey tests medical engagement in a variety of ways under 3 main headings - Working in a collaborative culture, Having purpose and direction, and Feeling valued and empowered. In total there are 10 scales. Poor medical engagement predicts poor organisational performance.
d. In the 1st survey at the beginning of 2015, 148 members of medical staff at EKHUFT completed the survey. The Trust was in the bottom quintile of 9/10 measures and just above the bottom quintile in the other measure. On this occasion 234 members of medical staff completed the survey. There has been a significant improvement. Seven of the ten MES scales were rated in line with the medium relative engagement band, two of the remaining three MES scales (Meta-Scale 1: Working in a Collaborative Culture, and Sub-Scale 5: Development Orientation) were rated within the low relative engagement band and one scale (Sub-Scale 2: Good Interpersonal Relationships) was rated within the lowest relative engagement band compared to the external norms. Overall this represents improved medical engagement for nine of the ten MES scales.
e. There is still a lot of work to be done to further improve medical engagement and there is specific work to be done with certain medical staff groups and in all medical staff groups with interpersonal relationships. This will be elaborated on in the Strategic Workforce committee report but the Board is asked to note the encouraging progress to date.

Appendix 1.

EKHUFT NCAA Reports 2011-2016

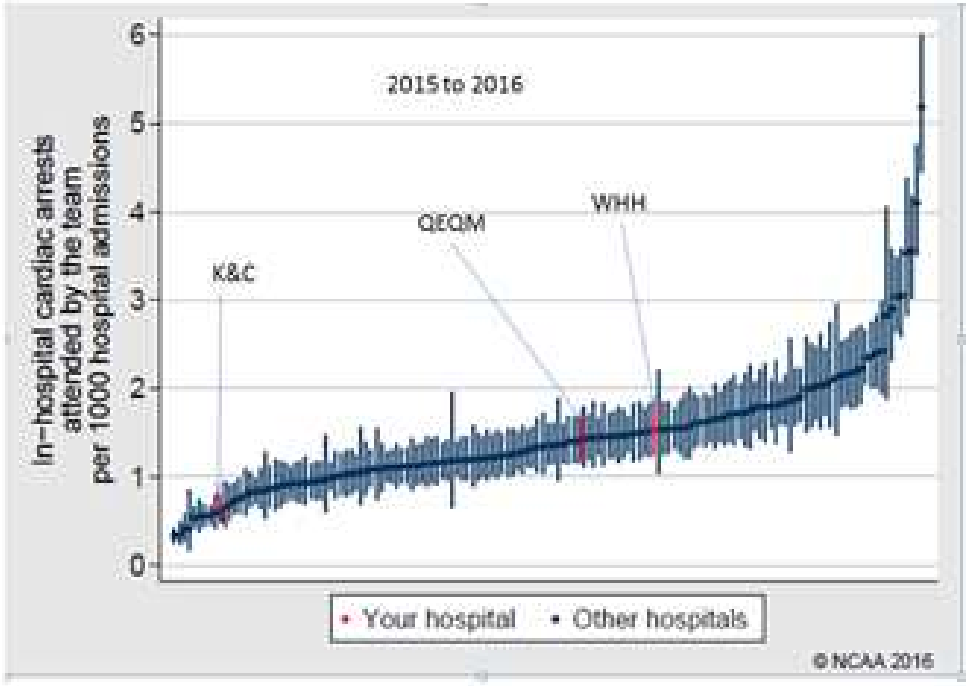
The number of cardiac arrests has remained stable over this period at K&C and QEQM. However whilst from 2011 -2015 at WHH the numbers were very stable (164, 160, 160, 156) we have seen a 37% drop in arrests (101) in the year 2015-16, which is likely to be significant. Further analysis of quarterly results is to be undertaken. Whilst the failure to see any fall in arrests at other two sites may seem disappointing it is interesting to note that our performance at all 3 sites has improved with respect to national picture. We know that in patient acuity and complexity has increased and so a stable baseline may actually reflect improved performance with regards to deteriorating patient.



April 1st 2012 to 31st March 2013

In hospital cardiac arrests per 1000 admissions.

Cardiac arrests rates at our sites are in red. All other hospitals are in blue.



April 1st 2015 to March 31st 2016

All 3 sites have moved down the curve.

Survival to discharge was 20.97%