REPORT TO:	**BOARD OF DIRECTORS**
DATE:	**7 OCTOBER 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. Kent & Canterbury Emergency Care Centre redesign
3. VTE assessment recording
4. National Joint Registry Report
5. Medical appraisal
6. Medical job planning

IDENTIFIED RISKS AND MANAGEMENT ACTIONS:	1. The risk of Junior doctors industrial action has receded but there remains a risk of alternative action which is apparently under consideration. Implementation of the new contract starts this month with Obstetrics trainees. 2. The chief risk to the new model of care in the Kent & Canterbury ECC remains staffing of the GP rota. This is in the process of transition from Invicta Health to Prime Care. An evaluation report covering the first 3 months of the new model will be presented at the next Trust Board. 3. VTE assessment recording remains below the 95% standard but some improvement in compliance has been noted. 4. QEQMH is an outlier in their hip replacement revision ratio reported in the National Joint Registry report. This is being explored with individual surgeons. 5. Compliance with medical appraisal continues to require further embedding to become business as usual despite December 2016 marking the 4th anniversary of the introduction of revalidation for doctors. 6. Medical job planning is not progressing at the rate required and represents a risk to achieving the 4 priority standards for 7 day working which form part of the new NHS Improvement Single Oversight Framework by which Trusts will be monitored and assessed.
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 21 – Local implementation of the new Junior Doctors contract fails CRR 22- Failure to record/carry out timely Venous Thromboprophylaxis (VTE) risk assessments SRR 14 - Inability to meet performance metrics / trajectories
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 items 1 and 2; to acknowledge some improvement in VTE assessment recording but to note that compliance remains below the required 95% and to note that this carries with it the likelihood of significant fines; to note the further engagement work required to ensure that medical appraisal becomes routine; to note the potential problems arising from medical job planning. It is recommended that items 3, 5 & 6 form part of the proposed consultant accountability framework.

1. Junior doctors industrial action

   The proposed junior doctors industrial action for October, November and December has been cancelled and implementation of the contract will commence this month beginning with Obstetrics trainees.

   The Guardian of Safe Working has been appointed (Dr Neil Goldsack) and will start in his post as soon as negotiations with the UC&LTC division to free up a day of his time for this post are complete.

   A number of junior doctors (through a company called Justice for Health) recently challenged, in judicial review proceedings, the decision by the Secretary of State for Health to introduce the new contract for doctors in training. Their arguments were heard by the court on 19 and 20 September 2016 and the judgment of Mr Justice Green has now been published dismissing the three claims brought by Justice for Health.

   As of Autumn 2017 there will only be one approved national contract: i.e. the 2016 contract whose terms reflect the agreement reached with the BMA leadership earlier this year, overseen by ACAS. NHS Employers have reiterated their wish to commission jointly with the BMA a review of the contract's implementation and efficacy in August 2018.

2. Kent & Canterbury Emergency Care Centre redesign

   The redesigned Kent & Canterbury emergency care centre (ECC) has now been in operation for 3 months and an evaluation is in progress. The key components of the redesign were outlined in last month's report.

   Between 08.00-24.00 the GP service is seeing an average of 28 patients (range 17-44) and between 24.00-08.00 2-5 primary care patients. MIU activity is averaging 72 patients per day and the acute medical unit 47 patients per day. The streaming criteria have required a little bit of tweaking but overall are appearing highly effective.

   The chief concern surrounds the transition from Invicta to Prime Care as providers of the GP service. Prime Care are taking over the 24.00-08.00 service with effect from now, Invicta Health will continue to provide the 08.00-24.00 service until March 2017. Short-term sickness cover can still be an issue for the daytime and weekend rota. There are still some concerns around the ownership of the rota; this is a Primary Care rota not a Trust rota and Invicta Health don't seem as keen as the Trust is to fill any gaps. The CCG believe that this will not be an issue with Prime Care but have agreed to review the contract with Prime Care to negate this issue.

   Estates work is going very well since Jenners have taken over. Handover for Phase 1 will be Friday 7th October with Phase 2 due to be completed on Wednesday 26th October.

3. VTE Assessment recording

   The CCGS and the Trust agreed an action plan to improve compliance with VTE assessment recording in January 2016. Actions to improve compliance have been reported previously and compliance has been monitored through the contract meeting process. The Board will be aware that compliance has still not improved sufficiently and the reported position remains below the standard of 95%. There has been a further Quality visit in September 2016 to review progress with the action plan and to understand the challenges for clinicians to undertake and document VTE assessments and why there is a climate of slow and poor progress. Actions have included attempting to mandate VTE assessment recording in theatres and on the clinical decision units, but these have not met with sufficient success.

Nevertheless the % of adult patients who have been risk assessed has improved from 83.4% in April 2016 to 89.6% in September 2016. The % of those assessed within 24hr of admission is 80.5% (improved from 74.7%).

The Patient Safety Board have undertaken a further audit for the months of August and September 2016 to inform compliance with the policy "The Policy for Risk Assessment, Prevention and Management of Venous Thrombosis" version 1.2.1 and in accordance with NICE guidance for Venous thromboembolism (CG92). This will be reported and discussed at the next Patient Safety Board (Monday 10th October).

4. National Joint Registry Report

The latest report from the National Joint Registry (NJR) encompassing data from 1 April 2003 - 31 July 2015 indicates that QEQMH are an outlier for hip revision rates, with an observed versus expected revision ratio of 1.57 compared with a ratio of 1.0 at the WHH and 1.0 Nationally. There were no other outliers in the reports which encompass hip, knee, ankle, shoulder and elbow joint replacement.

More in depth analysis indicates that 4 of the surgeons performing hip replacement surgery at QEQMH have revision ratios significantly >1.0 and this will be addressed individually with each surgeon to understand the reasons and whether or not any actions are required.

5. Medical Appraisal

Despite completion of annual appraisal being a condition of a doctor's license to practice medicine the Appraisal and Revalidation team continue to have to strongly challenge those not yet completing their appraisal. The Board will be aware that since revalidation came into force (December 2012) I have incrementally increased the rigour applied to late appraisal. Currently any doctor whose appraisal is 3 months or more overdue without good reason receives a personal letter outlining the consequences of failure to complete the process within 6 weeks of receipt of the letter. This includes notice of non-engagement to the GMC. The usual GMC action after notification of non-engagement is to issue the doctor with a further deadline after which their license will be withdrawn unless appraisal is completed. To date no EKHUFT doctor has had their licence withdrawn.

6. Medical Job Planning

Job planning guidance was updated and agreed with the Local Negotiating Committee in November 2015 but subsequent progress within the divisions has been slow. Consultant job planning is also captured in the recently published NHS Improvement's Single Oversight Framework as part of delivering the four priority standards for 7-day hospital services.

The actual process of job planning in EKHUFT involves 1st sign off with the clinical lead in each area, 2nd sign off with the division led by the divisional medical directors and then 3rd sign off by the Trust Medical Director. To date, other than in the support services division, few job plans have been submitted to me for 3rd sign off from the inpatient bed holding divisions. Of those that have been presented I have chiefly 2 concerns. Firstly formal inclusion of Saturday and Sunday predictable time in weekend on call and secondly the variability in supporting professional activities (SPAs) between job plans submitted.

Within the Trust objectives (which are part of the job plan) I have recently included those objectives required for the four priority standards for 7-day hospital services to bring the process in line with NHSI's oversight framework. One of those objectives is consultant review of non-elective admissions within 14 hours of admission. To deliver this objective requires a physical presence when on call for every day of the week.

There is no standard amount of time to apportion to this because it very much depends on the specialty, for example the number of non-elective admissions in medicine and elderly care is far greater than in all other specialties and much more easily predictable. This is complicated further by the distinction between normal time and premium time, any activity timetabled outside the hours of 07.00-19.00 Monday to Friday is premium time. Three hours of work in premium time constitutes 1 PA compared with 4 hours of standard time.

EKHUFTs job planning principles allow up to 2 SPAs for a 'standard' 10 PA/week consultant job plan, half of that SPA time is for contracted activities including appraisal, audit and continuing professional development. The remainder should be linked to organisational objectives such as research, clinical management or medical education roles. SPA time over and above 2 PAs requires additional justification.

This whole process is confounded by the current consultant contract negotiation about which nothing has been heard from NHS Employers since they published a briefing for Medical directors in January 2015.