Agenda Item:.

The Queen Elizabeth Hospital NHS
King's Lynn
NHS Foundation Trust

REPORT TO THE BOARD OF DIRECTORS (IN PUBLIC)

RESPONSIBLE DIRECTOR:	REPORT FOR:		IMPACT ON BUSINESS:		
Dr Mark Blunt, Medical Director, Dr Bev Watson, Deputy Medical Director & Lead for Patient Safety Catherine Morgan, Director of Nursing	Decision	√	High	Med	Low
	Discussion			√	
	Information				
LEAD MANAGER:	**REPORT TYPE:**		**BAF REFERENCES & RAG:**		
	Strategic				
	Operational	√			
	Governance		**RELATED WORK: (PREVIOUS PAPERS TO COMMITTEE)**		
PEER ASSIST:	**PEER REVIEW:**				
CQC Essential Standard Ref:					
NHSLA Standard Ref:					
Media / Communications:					

Meeting Date: 27 May 2014

Report Title: Medical Director and Director of Nursing Report

PURPOSE:

To inform the Board of a number of quality issues.

SUMMARY:

- JAG Accreditation
- Safeguarding (no confidential detail)
- Clinical and Nursing Exclusions (no confidential detail)

FINANCIAL IMPLICATIONS / EFFICIENCY SAVINGS / QUALITY IMPROVEMENT:

RISK ASSESSMENT (CROSS-REFERENCE WITH RISK REGISTER WHERE APPROPRIATE):

Strategic / External	Operational/ Organisational	Financial	Clinical	Legal/ Regulatory	Reputational / Patient Experience
	√	√	√	√	√

RECOMMENDATIONS:

MEDICAL DIRECTOR AND DIRECTOR OF NURSING REPORT

1 JAG ACCREDITATION

The core objectives of The Joint Advisory Group on Gastrointestinal endoscopy (JAG) are:

- To agree and set acceptable standards for competence in endoscopic procedures
- To quality assure endoscopy units
- To quality assure endoscopy training
- To quality assure endoscopy services

The JAG Accreditation scheme is a pathway of quality improvement. Acquiring JAG accreditation is the formal recognition that an endoscopy service has demonstrated that it has the competence to deliver the Global Rating Scale (GRS), provides a safe environment for patients and staff and meets requirements for decontamination.

The Global Rating Scale (GRS) was created in 2004 as a quality improvement and assessment tool for the gastrointestinal endoscopy service.

The GRS assesses 12 key aspects of the experience of patients having an endoscopy. Each aspect (or item) is scored on a scale of D to A where D is a basic level and A is a very high level of achievement. The twelfth item: 'ability to provide feedback to the service' aims to ensure that nothing important is missed by the scale and that a service constantly monitors (and responds to) patient feedback. Endoscopy services are required to complete two online Global Rating Scale census returns, in April and October each year. Services must attain level A for timeliness and no less than level B for all other measures to become eligible for accreditation.

1.1 Decontamination:

Business case now signed off by the board. Estimated date of completion is approximately 6 months. Following this there then needs to be a period of 3-4 months prior to a JAG visit during which time procedures, practices and water quality can be audited.

Estimated time domain will become compliant: Feb 2015

1.2 Clinical Quality:

1.2.1 Consent Process Including Patient Information:

- The unit achieves a level B in practice but requires further evidence from patient survey
- Estimated time for sufficient evidence to be collected: November 2014

1.2.2 Safety:

Presently the unit achieves a level C as the Trust does not presently have a decontamination lead (see measure and evidence required below). In all other aspects the unit achieves a level A here.

> "There is a decontamination lead appointed by the Trust who has overall responsibility for endoscopy decontamination practice. Evidence required: Name of decontamination lead and reporting and accountability structures."

Estimated time domain will become compliant: Reliant on Trust appointing a decontamination lead.

1.2.3 Comfort:

Presently the unit achieves a level A.

1.2.4 Quality of the procedure:

Presently the unit achieves a level D as it only holds one audit meeting per year in November/December time. Plans are in place to hold a second audit day in June/July this year. This will achieve a level A.

Estimated time domain will become compliant: August 2014

1.2.5 Appropriateness:

We presently do not have a formal written policy on vetting or surveillance, although both areas are compliant in practice and the process is documented to some extent in the unit operational policy. A formal stand-alone policy for this would provide more substantial evidence. The process also requires a formal audit providing evidence that practice is compliant with policy.

In addition all guidelines should be reviewed annually. Plans are in place to do this on a rolling basis at the joint GI meeting, thereby providing minuted evidence of compliance with this standard.

With these two small changes in place the unit will achieve a level A.

Estimated time domain will become compliant: December 2014.

1.2.6 Communicating results to the referrer:

Now that histopathology has been taken over by Addenbrooke's hospital it is unclear as to whether we have sufficient evidence to support compliance with this standard. In addition it is clear that there will shortly be capacity issues with processing and reporting of samples on site, this will inevitably increase turnaround time. Thus there is a potential risk of not being able to provide sufficient evidence of compliance for this standard.

1.3 Summary for Clinical Quality Domain

Level for compliance required: B

Current standard: D

Necessary actions to gain compliance:

- The Trust needs to appoint a decontamination lead with reporting and accountability structures
- Patient survey needs to be undertaken twice per year
- Joint GI audit meeting needs to be undertaken biannually
- Vetting and surveillance policies need to be written and both processes audited.
- Minuted evidence of annual review of guidelines required

- Confirmation regarding available evidence of timely pathology reports required.

1.4 Quality of Patient Experience:

1.4.1 Equality and Diversity:

Level A achieved.

1.4.2 Timeliness:

Level C achieved. To Gain accreditation a level A is required in this domain.

1.4.3 Booking and Choice:

At present we achieve level B and with twice yearly patient feedback surveys we will achieve a level A.

1.4.4 Privacy and Dignity:

At present we achieve a level C but with twice yearly patient feedback surveys we will achieve a level A.

We also require a partition erecting in the reception area.

1.4.5 Aftercare:

At present we achieve a level C but with twice yearly patient feedback surveys we will achieve a level B.

1.4.6 Ability to provide feedback to the service:

At present we achieve a level D but with twice yearly patient feedback surveys we will achieve a level B.

1.5 Summary for Quality of Patient Experience Domain

Level for compliance required: A in timeliness, B in the rest
Current standard: D

Necessary actions to gain compliance:

- A robust solution to present capacity problems must be found urgently
- Patient survey needs to be undertaken biannually. Agreement already obtained from audit department.
- Erection of partition in reception area.

Estimated timescale domain will be compliant: Depends on solving capacity problems.

1.6 Workforce

1.6.1 Skill Mix and Recruitment:

At present we achieve a level C. All that is required to achieve a level B is an information pack for potential applicants. This will be available by the end of May.

1.6.2 Orientation and Training:

At present we achieve a level B.

1.6.3 Assessment and Appraisal:

At present we achieve a level A.

1.6.4 Staff are Cared for:

At present we achieve a level C. To achieve a level A we need to formally minute the review of all policies and minute these reviews at the joint GI meeting. Achievement of level A anticipated by end of September.

1.6.5 Staff are Listened to:

At present we achieve a level A.

1.6.6 Summary for Workforce Domain:

Level for compliance required: B

Current standard: C

Necessary actions to gain compliance:

- Minuted evidence that all policies are reviewed annually
- Availability of an information pack for all potential applicants
  Estimated timescale domain will be compliant: December 2014

1.7 Training:

1.7.1 Environment training and Opportunity:

At present we achieve a level A

1.7.2 Endoscopy Trainers:

We achieve a level C.

To achieve a B 50% of trainers need to have completed a TTT course. At present two have and two others are booked onto a course (completion November 2014). In addition all trainers need to undergo an evaluation of their training expertise at least once per year and evidence that recommendations from these assessments are actioned. We also require some training aids e.g. scope guide.

1.7.3 Summary for Training Domain:

Level for compliance required: B

Current standard: C

Necessary actions to gain compliance:

- 50% of all trainers to have completed TTT course
- Program for evaluating trainers competencies annually
- Purchase of scope guide

Estimated timescale domain will be compliant: December 2014

2 SAFEGUARDING ADULTS

An update on key issues relating to adult safeguarding activity for the month of April is provided.

2.1 Completed safeguarding adults investigations:

A patient fell from an A&E trolley whilst in the CT scan department in April. The Community Social Worker made a safeguarding referral which alleged neglect by the QEH. A comprehensive report on the incident was completed and submitted by the QEH Safeguarding Lead. The safeguarding referral was then withdrawn following review of the investigation findings. The patient did not suffer any serious injury from the fall.

2.2 Training:

Volunteer's attendance at safeguarding adults training sessions is increasing, having previously been poor. New volunteers also attend the Trust Induction which includes a safeguarding adult's session.

2.3 Review of Norfolk Safeguarding Adults Service:

- Peer Review - there was a week-long review of Norfolk Safeguarding Adults Services from April 28th 2014. Two members of the review team attended the QEH Safeguarding Adults Committee on April 29th

- The Peer Review Team saw over 200 people and held over 40 meetings which will enable a very thorough analysis of the service in Norfolk. The full report should be available over the next month and a detailed action plan will be drawn up. Headline feedback included:

    - There is a swift response to safeguarding alerts
    - The MASH adds value and has built a very good working relationship between the police and social services
    - Adult Safeguarding has a sound foundation with no major issues
    - Adult Safeguarding has been largely protected from the Council cuts, but future resources need to be carefully managed to mitigate against a demonstrable impact on safeguarding
    - Adult Safeguarding needs bringing out of the shadow of Children's Services
    - The Safeguarding Adults Board is ripe for a major revamp
    - Practice and culture need a step change from a process driven to a user focussed service

2.4 Change in Referral Practice

Pressure ulcers – from April 1st 2014 it is mandatory that grade 3 or 4 pressure ulcers that are deemed avoidable, following a root cause analysis, are referred to the MASH (Multi-

Agency Safeguarding Hub) in Norwich for further consideration. Three have been submitted by the QEH since April 1st 2014.

2.5 Referrals in April 2014

- Financial abuse x 3 patients
- Pressure ulcers present on admission to QEH x 1
- Nursing home patient assaulted by other resident – arm broken
- Neglect at care home x 2 patients
- Sexual assault led to hospital visit for emergency contraception – declined police action.
- Discharge from QEH to Care home- alleged grade 3 pressure ulcer developed at QEH – unfounded on report.

2.6 Safeguarding Champions

There are now 30 safeguarding champions in the Trust. Clinical supervision sessions are available for them to attend throughout the year, to share experiences, get support and develop in the role.

3 SAFEGUARDING CHILDREN REPORT

3.1 An update on key issues relating to children's safeguarding activity for the month of April is provided.

3.2 Photography of Non-accidental Injury (NAI) in Children: Issue challenges in ability to provide this service at the QEH was discussed at the Safeguarding Children Committee Meeting in April and then taken to the clinical network meeting for named nurses. Findings form this meeting were that both the JPH and N&NUH have medical photography/illustration departments and photography of NAI is managed by these departments and the policy is owned by information governance. There are issues around the management of digital images, staff training, quality of images (if they are to be used as legal evidence) and also chain of evidence issues. The Deputy Designated nurse for Norfolk will raise this issue on behalf of the QEH. Current practice is that in hours the safeguarding team take photographs, out of hours some paediatric trained staff are able to undertake this. There remain gaps in service for A&E and limited resource in terms of trained staff as well as the other issues identified above.

3.3 CQC Planning for looked after children (LAC) and Safeguarding Children Inspection: Key documents and work plan preparation work continues; for the case tracking element 4 cases have been identified to date with 2 further cases required.

3.4 Guidelines for reporting cases of Female genital Mutilation (FGM) are on track to be completed by the end of June in line with new guidance from the Department of Health.

4 CLINICAL AND NURSING EXCLUSIONS

4.1 Nursing

There is currently one band 5 nurse suspended for inappropriate patient care. An investigation has been undertaken and is complete; a hearing has been scheduled and will take place in June 2014.

A registered nurse was suspended from duty in April as a result of unprofessional behaviour. An investigation was carried out and following completion the suspension was lifted and the individual has returned to work.

4.2 Medical

A verbal update on medical exclusions will be provided at the Board meeting.

Catherine Morgan, Director of Nursing
Dr Mark Blunt, Medical Director
Dr Beverley Watson, Deputy Medical Director
May 2014