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 Beverley Watson/Dr Mark Blunt, Joint Medical Directors Valerie Newton, Acting 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: 26 November 2013

Report Title: Medical Director and Director of Nursing Report

PURPOSE:

To inform the Board of a number of quality issues.

SUMMARY:

- Revalidation Update
- Nurse Staffing
- Peer Reviews
- Clinical Governance issues

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:

REVALIDATION UPDATE

The Medical Director is the Trust's Responsible Officer. Dr Sivakumar, Clinical Director for Revalidation leads appraisal and revalidation in the Trust. Both Medical Director and Clinical Director have undergone Responsible Officer training. The Trust has developed a Medical Appraisal Policy to support revalidation and purchased an electronic Revalidation Management System to manage appraisal and revalidation. A full-time Revalidation Support Manager has been appointed from September 2013 to manage appraisal and revalidation.

Currently the Trust has prescribed connection – total 206 doctors. Already 27 doctors have been revalidated. Only one doctor's revalidation was delayed by three months and subsequently the doctor has been revalidated. Current appraisal rate is 85%. It is envisaged the appraisal rate will improve to over 90% by 31st March 2014.

The Trust has provided Revalidation Ready Appraisal Training for 40 Consultant Medical Staff and 31 SAS doctors. Currently the Trust has over 40 appraisers distributed among all Divisions. The Trust has trained one member of the Senior Medical Staff as a Case Manager and one as Case Investigator. Another member will be undergoing Case Investigator Training in the New Year. The Trust has organised an update on appraisal training for appraisers and also a meeting with the GMC's East of England Employment Liaison Advisor in the New Year. The Trust continues to collect feedback from appraisers, appraisees and carry out regular audit of the appraisal process to improve the quality.

Dr Mark Blunt
Joint Medical Director

NURSE STAFFING

1 INTRODUCTION

1.1 In September 2013 the Deputy Director of Nursing and Patient Experience presented a paper to the Board of Directors proposing an aspirational nurse/patient ratio of 1:5 during the day and 1:8 at night (providing an average of 1:6 over a 24 hour period).

1.2 The principles of the paper were accepted as an aspirational target, whilst an understanding that currently the Trust is working at a 1:8 and 1:11 ratio.

1.3 On 25th September 2013 the Trust introduced a zero tolerance that staffing would not fall below 1:8 during the day and 1:11 at night.

1.4 To date the Trust has achieved this target consistently for a 6 week period.

1.5 This paper provides an update of work undertaken to increase staffing levels to meet the minimum (1:8/1:11) staffing levels and plans to recruit to the aspirational target.

2 RECRUITMENT

2.1 Since January 2013 a recruitment steering group has been in place to ensure that all opportunities are explored to ensure that nurse recruitment is prioritised.

2.2 The Trust has recruited overseas in Portugal with 35 nurses commencing in July/August, 19 in October and a further 16 due to arrive in November. The staff coming in November will be working within the clinical areas before Christmas this year.

2.3 Students have been recruited from the local universities (University of East Anglia (UEA) and Anglia Ruskin University (ARU), and plans are in place to recruit students who complete their education in the spring of 2014.

2.4 The Trust has attended a number of job fairs over the past 8 months in Ireland, Scotland, Manchester and London but this has resulted in limited posts being filled, and consideration is being made to what events to attend in 2014.

2.5 The Trust has a long history of the provision of a very successful Return to Practice programme. However, recently, several candidates have completed the programme and then opted to work in other Trusts. Therefore, in the autumn the Deputy Directors of Nursing and Patient Safety organised local press to meet previous candidates who had successfully completed the Return to Practice and who are now in a senior position, to promote the programme. Following this publicity a number of staff have contacted the Trust to commence the programme in February 2014.

2.6 The current vacancy against establishment is 28. This figure takes into account the cohort of Portuguese Registered Nurses (19) and those Registered Nurses (5) who all started on induction at the start of November.

2.7 A further 20-24 Registered Nurses are due to commence employment in the Trust in December. Of these, 16 are from Portugal and a further 4-8 recruited form within the UK.

2.8 Recruitment of a group of Nursing Auxiliaries (37) in October/November has allowed clinical areas to receive increased support to deliver fundamental care.

2.9 The Trust is planning another recruitment event for Nursing Auxiliaries in December 2013/January 2014 to meet existing vacancies and the small attrition from the event held in October.

2.10 Plans are in place to return to Portugal in January 2014 to recruit 25 nurses to commence in March 2013.

3 SKILL MIX/NURSE/PATIENT RATIOS

3.1 Currently there are suggestions form the Government that Trusts publish their staffing levels per ward on a monthly basis and the Acting Director of Nursing is in the process of producing a template to meet this requirement.

3.2 The Trust has a system in place to review staffing per ward each shift and this is published after each bed meeting. Over the past 3 months this system has developed to establish the requirements per ward per shift in relation to Registered and Non-Registered Nurses. The responsibility for staffing levels remains with the Director of Nursing who reviews these levels 3 times again with the support of the senior nursing team.

3.3 A review of the current staffing levels has been agreed by the incoming Interim Director of Nursing and the Associate Chief Nurses for Women and Children, Elective Care and Emergency Services will all revise the nursing ratios following the recent reduction of bed bases from 24 to 32 (with the exception of Terrington Short Stay).

3.4 PWC had been requested to undertake a skill mix review of all specialist areas. Although some work was commenced, PWC are not able to release work undertaken to date. Therefore, the Acting Director of Nursing will be requesting the Associate Chief Nurse in each area to undertake a specialist review of staffing to be completed before the end of December 2013.

3.5 Currently 50% of ward sisters/charge nurses are working in a supervisory capacity with a trajectory to increase to 80-90% by January 2014 and 100% by February 2014.

4 ACUITY

4.1 A 20 day review of patient acuity using the Shelford Tool was undertaken in September/October 2013 and once analysed will be presented at the next Board of Directors meeting.

4.2 The Care Quality Commission in their visits in May and August of this year were critical that the Trust has not staffed clinical areas in accordance with acuity.

4.3 The Acting Director of Nursing has spoken with the incoming Interim Director of Nursing regarding options available, as currently there is not one specific acuity tool being recommended that reviews acuity per shift per patient, as requested by the Chief Nurse for the East of England, Ruth May.

4.4 The Interim Director of Nursing and Deputy Director of Nursing are due to visit Guy's and St Thomas' NHS Foundation Trust in early December, and will review the acuity tools in use within the Trust to consider its use within The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust.

4.5 Once reviewed, the Interim Director of Nursing will recommend to the Board of Directors which acuity tool should be used to assess patient dependency; this will be undertaken at the Board of Directors in January 2014.

5 CONCLUSION

5.1 Following work undertaken over recent months, a revision of nursing/patient ratios will be undertaken for inpatient areas and specialist areas together with an implementation plan for further recruitment to the agreed skill mix. Nurse/patient ratios will be published at the Board on a monthly basis from January 2014. An acuity tool will be chosen by the Interim Director of Nursing and presented to the Board of Directors at the January meeting.

Valerie Newton
Acting Director of Nursing and Patient Experience

19th November 2013

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

WARD DASHBOARD - OCTOBER 2013

	Measure	A & E	CCU	Castleacre	Day Surgery	Delivery Suite	Denver	Elm	Feltwell/Leverington	Gayton	Leverington	MAU	Necton	NICU	Oxborough	Pentney	Rudham	SAU/Leverington	Shouldham	Stanhoe	Terrington	Theatre	Tilney	W Raynham
CQC 1 Respect & Inv	comp v non																							
CQC 2 Consent	comp v non																							
CQC 4 Care & Welfare	comp v non																							
CQC 5 Nutrition	comp v non																							
CQC 6 Co other providers	comp v non																							
CQC 7 Safeguarding	comp v non																							
CQC 8 Inf Control	comp v non																							
CQC 9 Medication	comp v non																							
CQC 10/11 Safety Premises/Equip.	comp v non																							
CQC 12 Requirements relating to w orkers	comp v non																							
CQC 13 Staffing	comp v non																							
CQC 14 Supporting Workers	comp v non																							
CQC 16/17 Quality Service/Complaints	comp v non																							
CQC 21 Records	comp v non																							
CQC Mock Visit - Overall Rating	comp v non																							
Safety Thermometer - harm Free	95% Target		⇔	⇔			⇧	⇔	⇔	⇧		⇔	⇧	⇔	⇔	⇧	⇔	⇔	⇧	⇩	⇔		⇔	⇔
Patient Obs (orange = no fluid Rcvd)	%	N/A	N/A	⇩	N/A	N/A	⇧	⇩	⇧	⇧		⇧	⇧	⇧	⇩	⇧	⇔	⇧	⇧	⇧	⇧	N/A	⇩	⇧
High Impact Interventions	%		⇧	⇔		⇔	⇔	⇧	⇧	⇧		⇔	⇧	⇧	⇩	⇔	⇔	⇔	⇩	⇩	⇩	⇧	⇧	⇔
Complaints - Nursing Care	0	⇧						⇧	⇩			⇩	⇧		⇧						⇧			⇩
Never Events	0																							
Falls	0						⇩		⇩	⇧		⇧	⇧		⇧	⇧	⇩			⇩	⇧		⇩	⇩
Falls + SI (# of serious harm)	0																							
C Diff Positive >2 days post admission	0																							
MRSA Bacteraemias >2 days post adm.	0																							
Norovirus	0																							
Press Ulc 3/4 avoidable	0																							
Press Ulc 3/4 unavoidable	0																							
Vacancy Ward Sister - Band 7	0																							
Sickness Reg	<3.5%	⇧	⇧	⇧	⇧	N/A	⇩	⇩	⇩	⇩	N/A	⇧	⇧	⇩	⇧	⇧	⇩	⇧	⇩	⇧	⇧	⇧	⇧	⇧
Sickness Unreg	<3.5%	⇩	⇩	⇧	⇧	N/A	⇧	⇩	⇩	⇩	N/A	⇧	⇩	⇩	⇔	⇧	⇩	⇔	⇧	⇧	⇔	⇩	⇧	⇩

NB.

No mock CQC inspections were carried out during October. There was no Hospital Acquired MRSA during October, no wards were closed due to Norovirus, there were no cases of hospital acquired C.dif. There were no never events, there were 7 Grade 3 PUs, 2 attributable to Gayton 2 to Necton and 3 to Stanhoe. During October no falls resulted in serious harm, falls targets are based on a previous years performance, where the ward total is lower than their average monthly total for that year they score green, if greater they score red.

Key: Compliant | Minor Non Compliance | Non compliant | Not audited | Some results (fluids) not received

Patient Observations	>95%	Between 85 & 94%	Below 85%
Harm Free Care	>95%	Between 90 & 94%	Below 90%
High Impact Interventions	At or above 95%	Between 85 & 94%	At or below 84%

PEER REVIEW

Three cancer peer reviews took place on 10th and 11th September 2013: Skin, Colorectal and Upper GI. Final reports are not yet available; however, draft reports were received on 11th October 2013. They reported as follows:

Skin

81.3% compliant

Concern was raised that there is no named pathologist in the core team for the local MDT. Two Histopathologists currently work part-time to cover the service.

Action taken:

- 10% of all histopathology specimens are submitted to double reporting outside the Trust to provide external assurance and the discrepancy rate is within expected limits.
- EPA (Eastern Pathology Alliance) will result in all our histopathology going off site from April 2014. This will result in specialist input into every MDT via video conferencing.

Lower GI

92.3% compliant

There were no major concerns raised.

Upper GI

71.9% compliant

Considerable concerns were raised relating to the organisation of the local MDT and communication with patients.

Action taken:

- Action Plan being developed
- Increased availability and identification of attendance of core members at the local MDT
- Information folder produced for patients with cancer
- From early December the Upper GI outpatient clinics will move from Thursday to Monday weekly. As the SMDT meeting occurs on a Friday, this will mean that the patients' clinic appointment will occur immediately after the SMDT so that the decisions made at that meeting can be reported to the patient face-to-face at their clinic appointment.

Dr Mark Blunt
Joint Medical Director

CLINICAL GOVERNANCE ISSUES

Clinical Governance:

Obstetrics and Gynaecology

For information: A special internal clinical governance review took place on 28th October, chaired by the Medical Director (Quality). A panel, including the interim CEO and Quality Committee Chair, received written and verbal evidence against a number of pre-agreed criteria from 5 of the department's 7 full time consultants and the CD for the Women and Children's Service Line. The final report has been agreed and will be presented at the Clinical Governance Committee. It will also be tabled at the next Quality Committee, together with the O & G Department's response and action plan.

The CCG commissioned external review (which took place last month) into the May 2013 neonatal death SI has now been shared with the Trust. The recommendations will also be incorporated into an Action Plan, currently in development, and its delivery will also be monitored through the Quality Committee.

Pharmacy

There are continuing concerns about the capacity of the pharmacy to drive quality improvement measures.

Following the pharmacy review and development of an action plan to address a number of areas, there have been some improvements. However, 2 key posts remain unfilled – Risk and Governance Pharmacist (locum currently in post), and Deputy Chief Pharmacist – and the Board should be aware that this will continue to limit our ability to manage discharges efficiently, optimise ward rounds and reduce prescribing errors.

Clinical Audit:

National Audit and Cancer Databases

The QEH cancer services upload patient data to the National Somerset database, from where information is obtained to create published national audit reports eg the national lung cancer audit report, benchmarking the QEH performance and outcomes. Performance data is prioritised for uploading and this is done by a number of different administrative and clinical staff in different areas of the Trust. Clinical data uploaded is often incomplete. As a result, the national audit reports do not always provide a true reflection of the work carried out at QEH.

The Clinical Audit department recommends that administrative staff use standard operating procedures for all such data entry, and that this is overseen and validated in a consistent way across all cancer specialties.

The Board is asked to support this approach to ensure that the data submission process is robust across the Trust.

Dr Beverley Watson
Joint Medical Director