QAH
QUEEN ALEXANDRA Hospital

Portsmouth Hospitals NHS
NHS Trust

Presentation to Hampshire HASC

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Chief Executive

July 2015

Passion & Pride

Care Quality Commission (CQC) - independent regulator of Health and Social Care in England, wanted to see how good our services are at delivering high quality, safe and effective care.

To do this they undertook a formal inspection of our services from **9th to 13th February 2015.**

CQC Inspections

- Lead to ratings of individual services and of the Trust overall.
- Use Key Lines of Enquires (KLoEs) to assess whether a provider is delivering services that are safe, effective, caring, responsive and well-led.

CQC Inspection team (in excess of 50 members dependent on size of Trust)

- Inspection Chair (a very senior clinician, or manager with knowledge of quality and safety in hospitals).
- CQC Head of Hospital Inspection or team leader.
- Clinical experts.
- Experts by Experience/patient and public representatives.
- CQC managers and inspectors (varying levels of seniority).
- CQC data analysts.
- CQC inspection planner.
- CQC administrative support.

CQC Inspections

Core services (these are CQC groupings not confined to our Trust CSC structure):

- Urgent and Emergency Services.
- Medical Care (including Older People's Care).
- Surgery.
- Critical Care.
- Maternity and Gynaecology.
- Services for Children and Young People.
- End of Life Care.
- Outpatients and Diagnostic Imaging.

CQC Five questions:

Safe	By **safe**, we mean that people are protected from abuse and avoidable harm.
Effective	By **effective**, we mean that people's care and treatment achieves good outcomes, promotes a good quality of life and is evidence-based where possible.
Caring	By **caring**, we mean that staff involve and treat people with compassion, kindness, dignity and respect.
Responsive	By **responsive**, we mean that services are organised so that they meet people's needs.
Well-led	By **well-led**, we mean that the leadership, management and governance of the organisation assures the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent & emergency	Inadequate	Good	Good	Requires improvement	Requires improvement	Requires improvement
Medical care	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement
Surgery	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement	Requires improvement
Critical care	Outstanding	Outstanding	Outstanding	Good	Outstanding	Outstanding
Maternity & gynaecology	Good	Good	Outstanding	Good	Good	Good
Children & young people	Good	Good	Outstanding	Requires improvement	Good	Good
End of life care	Requires improvement	Requires improvement	Good	Good	Good	Requires improvement
Outpatients & diagnostic imaging	Good	Inspected but not rated[1]	Good	Good	Good	Good
Overall	Requires improvement	Good	Outstanding	Requires improvement	Requires improvement	Requires improvement

Next Steps..

- Quality Care Summit held on 2nd July 2015
- Attended by a number of key stakeholders across Health and Social Care
- Quality Improvement Plan is being developed
- Final submission 6th August 2015.

Governance Arrangements..

- The Quality Improvement Plan will be formally monitored by the Trust Development Authority (TDA) monthly
- System wide components will be jointly monitored by the TDA and NHS England
- Progress against the plan will be incorporated into the Trusts reporting framework and will feature on the Board agenda monthly.

Key Themes

- Outstanding care
- Unscheduled Care – need to move at pace
- End of Life Care
- Surgical Ward Leadership
- Medicine
- Variation / Inconsistency
- Governance and Assurance

Other Key Issues

- Equipment – review of all equipment is underway
- Nursing handover – clear standards are being set
- Safe staffing and skill mix – constantly being reviewed
- Organisational learning – not capitalising on good and excellent practice
- Responsiveness
- Electronic Discharge Summaries

Key Theme - Urgent Care – 2 Warning Notices

- Actions taken to ensure compliance related to the care and welfare of patients within the Emergency Department
- We have addressed the medical and nursing staff requirements
- We are compliant with the national triage statement regarding first assessment
- Ambulance delays – w/e 1 March = 129, w/e 14 June = 22
- 1st Assessment – in excess of 90% – ambulance arrivals remain a challenge
- Outliers – w/e 15 Feb = 103, w/e 14 June = 33
- System wide quality review led and monitored by the CCG's monthly
- No SIRIs reported since the end of February
- We await the final report from the unannounced visit on 25 April 2015

The Hospital is a safer place as judged by our staff and commissioners

Key Theme – PHT Urgent Care Improvement Plan

- Phase 1 Plan – delivered a safer and more responsive hospital for patients and staff but delivery of the 4 hour A&E standard not sustainable at times of peak demand
- PHT Phase 2 Plan – 5 High Impact Changes
  - Avoidable breaches
  - Professional standards
  - Frailty and intervention team
  - Medical model
  - Flow
  - Implemented on 18 June, early progress promising with 88% and 91% A&E 4 hour performance
- Improvements are being achieved in patient and staff experience across the urgent care pathway, key focus for Chiefs of Service and executive team on:
  - Consistent delivery of 'SAFER' care bundle standards at ward level
  - Managing the behaviour change needed in some areas to assure consistent delivery of PHTs professional standards

This is a major cultural and re-design programme which is benefiting from clear clinical leadership and Board support

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Safer faster hospital: internal professional standards

in the Emergency Department (ED)

1 All ED referrals to admitting speciality teams will be made to a registrar or higher. This doctor will triage referrals for urgency and clinical need.

2 A decision-making doctor should see new patients in the ED so that a management plan is documented within 60 minutes of referral by the ED team

3 Tests requested in ED on new patients will be completed and the results available within one hour for critical tests.

4 If another speciality would provide more appropriate care, it is the responsibility of the first speciality, not the ED, to make the second referral and arrange transfer of care.

5 Patient care and admission will not be delayed by inter-speciality dispute over clinical ownership or placement. ED consultants have the authority to allocate immediate clinical ownership to ensure timely care and admission.

6 The Trust does not admit patients who are likely to be able to go home from the ED to avoid a breach of the emergency care 4 hour wait standard.

7 Patients will not be transferred from Outpatient areas to the ED unless they require immediate emergency medical care not available elsewhere in the hospital.

8 Patients discussed by a GP with a speciality team will be seen and assessed by that team and not directed to ED for streaming. Exceptions to this are patients for which there is an agreed pathway utilising the ED.

9 Accepting referrals from primary care means that specialities take responsibiity for evaluating the patient in the ED or elsewhere, or for directing the patient to an agreed alternative pathway for the condition.

Medical Illustration ref: 15/2461

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Safer faster hospital: internal professional standards

in the Emergency Department (ED) and Acute Medical Unit (AMU)

1 Specialities must have a decision-maker to assess emergency or accepted patients referred from primary care within 60 minutes of arrival in ED. Breaches will be escalated to the appropriate consultant and Clinical Director by the ED senior clinical decision-maker.

2 No team providing an acute take function can refuse a request to assess a patient in ED or AMU. Seeing the referred patient is not dependant on diagnostic results being available.

3 If admission or transfer is obvious, specialities must not insist on tests or the availability of results, that do not contribute to the decison to admit or transfer, or to the immediate management of the patient. Once a decision to admit or transfer is made, stable patients will not be kept in ED or AMU for further review or assessment.

4 Patients requiring admission from outpatients should be admitted directly to the appropriate specialty bed base. Outpatients should only be referred to ED/ AMU for admission if clinically unstable and should be referred by a consultant or registrar to the on-call registrar who will triage the patient to the appropriate location.

Medical Illustration ref: 15/2461

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Safer faster hospital: internal professional standards

in the Acute Medical Unit (AMU)

1. All new medical admission with a predicted LoS <48 hours or who are significantly unwell will be admitted to the AMU where capacity allows

2. Patients will have a Consultant review within 12 hours of admission. Expected date of discharge and location of discharge/transfer will be agreed within 48 hours

3. AMU staff will compile a daily list at 08:00 of those patient requiring specialty in reach review. Reviews should occur by 11:00 the same day to maximise discharge planning at the Consultant led board round

4. At daily patient reviews in AMU, a decision will be made about whether the patient is likely to stay for more than 48 hours, if so they will be escalated to the appropriate specialty flow co-ordinator or DHM within 60 mins for timely bed allocation

5. Patient who remain on AMU overnight due to high acuity will be reviewed by the specialty Consultant by 09:00 and transferred off AMU by 11:00

6. If the patient stays on AMU after being accepted by the specialty team they will be cared for by the specialty as an outlier

Medical Illustration ref: 15/2461

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Safer faster hospital: internal professional standards

in all wards

8am

1 Board rounds will commence at 08:00 Monday to Friday, led by the Consultant or SpR. Expected discharge dates and diagnostics required before discharge will be identified as will referrals to therapists/social services

10am

2 TTOs will be written and submitted the day before discharge and flagged during the board rounds. Predicted discharges should be made before 10:00 via the Discharge Lounge

3 Delays will be escalated to the Consultant and CSC silver command where appropriate for action. Deteriorating patients should be identified for Consultant review directly after the board round followed by patients ready for home today

24 hrs

4 All patients to have a documented predicted date of discharge (PDD) set by a senior clinical decision maker within 24 hours of admission and reviewed daily. If this standard is breached the ward manager should escalate to the CSC Board. A multi professional assessment for complex needs will be performed within 14 hours of admission

5 Patients on acute medical &and surgical units should be seen and reviewed by a Consultant or SpR during twice daily ward/board rounds. Aiming for continuity of care from the same senior clinician.

8

6 Cross cover for Consultant absence will be transparent and all planned leave will be arranged with 8 weeks prior to absence

7 Referrals for specialist opinion will be seen by specialties within 24 hours. Specialties cannot refuse to see a patient based on incomplete diagnostics

8 Documentation will be made according to current standards, in particular date, time, name, grade and contact details for medical staff in capitals

9 All patients must have a clear management plan documented in the health records. If this is not present, the ward manager should escalate to the SpR or Consultant

LOS

10 All patients with a length of stay over seven days should have their clinical plan reviewed weekly by the Consultant and ward manager, informing the relevant CSC Board

11 Senior decision making & leadership should be available on medical / surgical units 7 days per week. Consultants leading high volume specialty takes should be freed of routine daily clinical duties on these days. Consultants on call should ensure their service and the Trust is in a safe position before leaving the hospital by contacting their specialty teams and the DHM. If the hospital is on Black escalation, consultants on call should not leave the hospital until the on-call director has agreed that it is safe to do so

Unscheduled Care – support needed from system partners

- Key issues
  - Bed occupancy and increased demand
  - Attendance rates for frail elderly patients are 4% higher than the national average
  - Ambulance conveyance rates are 5% higher than the national average
  - Over 120 medically fit patients who are not in the right place for their care needs, including patients at the end of their life
  - Significant number of mental health and detox patients using A&E services
  - Imbalance between admission and discharge, particularly at the weekend

Support needed	KPI	By When	Lead
PSEHF&G System Urgent Care Improvement Plan to sustainably deliver NHS Constitution Standard, including partner response times	4 hour A&E standard 95%	9 July 2015 (plan)	CCGs
Frail elderly commissioning strategy and plan	4% reduction attendances	31 Aug 2015	CCGs
Plan to deliver reduced conveyance rates and 'batching'	5% reduction	31 Aug 2015	CCGs/ SCAS
Reduction in medically fit patients to better meet their needs, including first home to assess model of care	< 64	31 July 2015	CCGs/ Partners
Increase in psychiatric and detox services in the community to release observation ward beds	6 beds released	30 Sep 2015	CCGs
Plan for Hampshire to match Portsmouth's daily responsiveness	20 complex discharges	31 July 2015	HCC/ Southern

- Step change for winter is going to be community capacity and pace

Accountability Framework

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Key Theme – End of Life Care

- End of Life Care:
  - We have re-launched our Trust-wide strategy
  - We have established an integrated team
  - Training of staff on-going
  - We have formed pro-active links with all Wessex acute providers and our local hospice

- Support needed from system partners
  - Commissioning strategy and plan by 31 August 2015 from Clinical Commissioning Groups
  - Increased care capacity in the community to respect the wish of every patient who wants to die at home in place by 30 September 2015

Key Theme – Surgical Ward leadership

- Surgical Ward Leadership:
  - New Head of Nursing
  - We have retrained surgical nurses with regards to End of Life care
  - Ward E3 has achieved silver accreditation
  - 15-step challenge – unannounced CCG visit – positive outcome

- Medicine
  - Reduction in outliers
  - Reduction in non clinical moves
  - Improved staffing
  - More responsive, for example direct admission to the ward

Key Theme – Variation / Inconsistency

- Professional Standards
  - Specific to patient pathways – example unscheduled care
  - Safer discharge bundle
  - Tissue viability care / Trust wide formulae – trained additional staff
  - Daily monitoring of pressure relieving devices
- Transformation Programme:
  - Re-launch with a particular focus on clinical ownership
  - Research and Innovation
  - Benchmarking and adopting best practice

Key Theme – Governance and Assurance

- Board review of overarching strategy moving forward
  - 5-year forward view
  - Commissioners intentions
- Review of the Monitor Quality Governance Framework
  - Incident reporting / Datix
  - Review Clinical Service Centre - Leadership, Capability and Capacity
  - Revalidation – Managers and Leaders
  - Review organisation approach to risk
- Organisational Development – Ernst & Young cultural assessment of the organisation underway
- Review of Board operation and performance
- Establish a Board development programme

Strengthening our governance is key to reducing variation and delivery of good quality care for every patient every time

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Conclusion

- Thank you
- Some surprises – Paediatrics
- Great spring board for moving forward
- Support moving forward
  - Continued engagement from the system for unscheduled care
  - The need to redesign the Emergency department – resource requirement
- Support from the TDA to maintain and grow our capability