Joint Sussex HOSC Working Group: BSUH Quality Improvement

Wednesday 04 October 2017 Meeting Note

HOSC attendees:
Cllr Ken Norman, Chair (BH HOSC); Cllr Colin Belsey (ES HOSC), Cllr Ruth O'Keeffe (ES HOSC); Mrs Anne Jones (WS HASC), Dr James Walsh (WS HASC), Mr Bryan Turner (WS HASC)

BSUH attendees:
Nicola Ranger, Chief Nurse; Pete Landstrom, Chief Delivery & Strategy Officer

1. Apologies

1.1 Apologies were received from Cllrs Kevin Allen, Louisa Greenbaum and Johanna Howell.

2. Notes of the last meeting

2.1 A meeting note from the 30.03.17 meeting was agreed.

Ms Ranger and Mr Landstrom gave three presentations: on the recent CQC inspection (3); on trust quality improvement plans (4); and on specific plans to make improvements in A&E (5).

3. Recent CQC inspection report results and next steps

3.1 Nicola Ranger told the group that the recent CQC inspection report had seen an improved rating for the trust: from *Inadequate* to *Requires Improvement*. The CQC made some positive comments on improvements within the Trust.

3.2 The CQC believes that BSUH is beginning to address its corporate culture issues. It is important to note that the CQC did not inspect against the *Well-led* domain in 2017, as the trust leadership team had only recently been appointed at the time of the inspection. Because of this the BSUH *Well-led* domain still shows as *Inadequate* (the 2016 inspection rating) and the trust remains in *Special Measures*.

3.3 The 2017 inspection has seen significant improvement in the *Caring* domain, with all BSUH services now either good or outstanding in terms of *Caring*.

3.4 Some key services have also seen performance improve substantially – e.g. maternity, urgent care and diagnostic imaging.

3.5 Current areas of concern include the *Safety* domain and the Critical Care service where the CQC picked up on significant culture issues caused by

the move of neurological services from Hurstwood Park to the RSCH site. However, whilst the cultural problems highlighted by the CQC are serious, it is important to recognise that the inadequate score for *Safety* against this service does not mean that Critical Care services at BSUH are unsafe: clinical outcomes (e.g. mortality and morbidity rates) are in fact very good when bench-marked against comparators.

3.6 In answer to a question from Cllr O'Keeffe about the degree of improvement, Mr Landstrom told members that turning around BSUH is a long-term task. Whilst the direction of travel is positive, people need to concentrate as much on the plans for improvement as on what has happened to date.

3.7 In response to a question from Dr Walsh on the Critical Care department, Mr Landstrom told the group that the CQC had identified issues with a very long back-log of incidents and a lack of evidence to demonstrate that the service had learnt from previous incidents. Culture problems connected with the single-siting of trauma were also evident. Ms Ranger added that the CQC had also focused on trust failures in identifying when patients required Critical Care services.

3.8 In answer to a question from Mrs Jones on ambulance performance, Mr Landstrom explained that some aspects of this were covered in the CQC inspection report: for example ambulance to hospital handover times. However, the bulk of ambulance services are inspected separately (i.e. as part of SECAmb's CQC regime).

3.9 In terms of financial pressures, BSUH is currently on track to deliver on its planned year-end financial position (a deficit of £60M). This is good news as it means that the trust does not have to borrow at very high interest rates, as it would be forced to do if it was significantly off-track. It is however recognised that this is a very large deficit.

3.10 The trust has also recently agreed cost improvement plans; established a leadership development programme; had significant Emergency Department (ED) investment approved.

3.11 BSUH has recently introduced a Single Oversight Committee where the trust engages with all its regulators. The aim of this is to reduce the amount of duplication and for the Trust to work to one improvement plan.

4. BSUH Quality Improvement

4.1 Improving staff culture is a key priority for the trust, and the corporate centre can assist by establishing some guiding principles. Cultural change will take time and it is important to maintain focus: having an action plan in place does not mean that culture will improve without consistent reinforcement of messages over time. It also needs to be recognised that this is a long-standing problem and several past attempts to improve organisational culture have failed.

4.2 The trust recognises that patient views are an important driver of improvement and will make efforts to reach out to a wide range of patients. Western has done some excellent work around using some very challenging patient views to improve services, and this will inform the work at BSUH.

4.3 The trust has adopted a new approach to quality improvement planning. Some of its planning will be focused on the CQC's demands for improvement. These can be generally very transactional in nature. Separately, BSUH has identified five 'breakthrough objectives' for change and has developed these into a set of clear and measurable priorities.

4.4 Firstly, there will be more focus on the care of deteriorating patients. The trust does well in terms of most measures of clinical safety: mortality and morbidity rates are relatively low as are statistical measures of avoidable harm suffered by patients whilst in hospital (e.g. pressure sores and falls). However, the trust has studied all Serious Incidents that have taken place over the past 18 months, and has found evidence that BSUH is sometimes challenged in terms of quickly identifying and responding to deterioration. This may partly because staff have become habituated to dealing with increased acuity of patients in recent years and have consequently become slower than they should be in reacting to worsening conditions. The trust also needs to look at the current administrative demands placed on front-line staff. For example, nurses need to fill in more than 40 assessments for every admission. If this can be managed-down into something more reasonable then staff should have more time to interact with patients and be better placed to spot deterioration.

4.5 The second breakthrough objective is to improve staff attitudes to patients. Whilst it is doubtless the case that the great majority of staff consistently display an excellent attitude, some staff attitude is not where we would want it to be. The aim is therefore to reduce complaints about staff.

4.6 The third priority is to improve staff perceptions of the trust. Staff survey results also show that staff are sceptical that patient care is the top priority for BSUH (52% believe it is, compared to a national average of 74% and a score for Western of 86%).

4.7 The fourth priority will be to ensure that there are no Referral To Treatment (RTT) waits over more than 52 weeks. The national RTT target is 18 weeks, but BSUH has no chance of hitting this target in the short term.

4.9 The final priority is to decrease the number of non-admitted A&E patients who are not treated within 4 hours (i.e. patients who will not ultimately require admission as in-patients). The aim is to decrease the number of 4 hour breaches by 75%.

4.10 There are deliberately few breakthrough objectives. This is to allow proper focus on the five targets that have been identified and to ensure that there are in fact delivered.

4.11 As well as the five targets detailed above and the CQC must and should-dos, the trust has a number of strategic priorities. These include continuing to improve quality (with a particular focus on the Emergency Department and on the Intensive Care Unit); refreshing the clinical strategy (lots of successful work has already taken place in terms of developing the Major Trauma Unit); transforming organisational culture; and enhancing leadership (including additional investment in HR capacity and in clinical leadership just below board level).

4.12 The trust will also undertake 'deep-dives' to better understand some key areas of work. These are: fire regulation compliance, patient flow, people & culture, new governance structure, critical care – culture and deteriorating patient, and infection control.

4.13 Workforce remains a major challenge for the trust, as it is for the NHS across the South East of England. BSUH is keen to look at developing nursing apprenticeships so as to provide a route into nursing for people who might otherwise have been discouraged by the abolition of bursaries.

5. A&E Improvement Plan

5.1 BSUH has four distinct A&E access Points: at the RSCH, at Princess Royal (PRH), at the children's hospital (RACH), and at the Sussex Eye Hospital. Performance across all sites varies, but RSCH typically experiences the greatest pressures.

5.2 A&E attendances are actually fairly static, bucking the national trend where they have been rising. This suggests that local diversion measures have been relatively effective.

5.3 While the national target for A&E is that 95% of patients should be seen within four hours, the trust is setting itself an initial target of 90%. This is realistically achievable. Moreover, evidence suggests that an A&E department operating at 90% will generally be functioning well. The target is already being applied.

5.4 In seeking to understand A&E performance, the trust has split attendees into two categories: admitted and non-admitted (i.e. will the patient eventually be admitted to the hospital for treatment or not).

5.5 In terms of non-admitted patients, key to improving performance will be to ensure that the RSCH Urgent Care Centre (UCC) is working effectively, that those patients who will be treated directly by A&E staff are managed efficiently, and that the PRH A&E is re-developed to provide a dedicated area for 'minors' (currently minor and major patients are seen in the same area).

5.6 In terms of admitted patients, the key issue is Delayed Transfers of Care (DTOCs). This has been a long-term problem, particularly at RSCH and is the challenge of the health and care system rather than any single organisation. There are some internal improvements that should help things: for example, improving the number of a.m. discharges. Currently very few patients are

discharged in the morning, even though a.m. discharges have a much more positive impact for flow through the hospital than p.m. ones. This is partly about getting patients and their families used to the idea that they should expect and arrange for a morning discharge. It is partly about the hospital getting its procedures right too: e.g. ensuring that medications are available on discharge and not several hours later.

5.7 Although the 90% target is challenging it is achievable: it amounts to around 10 fewer breaches per day at RSCH.

5.8 Key actions for A&E include:

- Re-design of the UCC and changes to how triage is delivered.
- The RSCH PAT area is very effective, but there is a need to protect staffing as the PAT area is currently suspended when the ED is very busy, which is counterproductive.
- Changes to diagnostics: e.g. blood tests tend currently to be bundled together which means that the results of relatively quick-to-process tests are delayed while other tests are completed. Splitting the tests will mean that some results are available more swiftly.
- Up to 20% of blood tests are cannot be used as the blood has haemolysed by the time the test is taken. This can be avoided by using different procedures.
- The creation of a dedicated treatment area at PRH for minors.
- A dedicated A&E consultant will now be employed at PRH until 10pm.

5.9 There was discussion of what can be done about people presenting inappropriately at A&E. Ms Ranger told members that it was important to address the issue of people who made frequent unnecessary presentations. Mr Landstrom added that RSCH already has excellent links with mental health, rough sleeper and drugs & alcohol services which helps to manage this cohort of attendees. However, the high prevalence of mental health problems in Brighton & Hove means that the issue is persistent.

5.10 In response to a question from Mrs Jones about links with Out Of Hours (OOH) services, Mr Landstrom told the group that GPs are already embedded in RSCH A&E and there are plans to do the same at PRH.

5.11 In answer to a query from Cllr Belsey about the possible introduction of a ‘breakfast room’ for patients being discharged, members were told that this has just been agreed and will be introduced soon along with a revamp of the RSCH discharge lounge.

5.12 There are also significant physical improvements planned to the ED at RSCH. These include adding 30+ new beds, building two new short-term stay wards and reconfiguration of A&E once the extra beds are available.

5.13 The Chair thanked Ms Ranger and Mr Landstrom for their time. Members agreed that they were considerably assured by what they had heard. They particularly welcomed the decision to focus on a few key targets.

7. Date and focus of next meeting

7.1 It was agreed that another meeting should be booked for early 2018. Support officers will liaise with BSUH to identify a date that makes sense in terms of the trust's reporting commitments. The next meeting will provide an update on progress against the targets detailed above as well as information about the deep-dives that will have taken place.