Barking, Havering and Redbridge
University Hospitals
NHS Trust

Unlocking our potential

a summary of our improvement plan for 2014/15

In partnership with

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A brief overview of special measures

- An intervention intended to create focus and support where organisations face significant challenges

- BHRT followed the Chief Inspector of Hospitals findings and in view of the scale of the leadership task given the deteriorating financial position

- Trusts in special measures
  - Have a TDA Improvement Director allocated to oversee and support the Trust's improvement plan
  - Have to produce a plan and deliver improvements over a period of time
  - Receive support to make improvements
  - Have to report progress monthly which is overseen by the TDA
  - Will have a re-inspection from the Chief Inspector of Hospitals

This is one component of our four pronged quality and cost improvement plan for 2014/15 to move us out of special measures and on to a more stable footing

Quality improvement	• **Five key areas of targeted improvement** to address the findings of the Chief Inspector of Hospital's review of the domains of safety, effectiveness, caring, responsiveness and well led in key services
	• **Improvements in national operating standards** in the domains of cancer and referral to treatment
	• **Local quality improvement priorities such as CQUINS and** harm reduction, falls, avoidable mortality, radiology and use of ICT
Cost improvement	• **Delivering a 'stand still' position with a deficit of £38m** through cost reduction of £20m, preparing to reduce the deficit in future years and rebalancing the elective and emergency workload

Our improvement plan has been developed over a period of time

Date	Milestone
18 Dec 2013	Findings of the Chief inspector of hospital's review published
4 Feb 2014	Compliance actions developed and submitted on 4th February 2014
9 Mar 2014	First draft of the improvement plan shared with partners on 9th March 2014 following internal development
17 Mar 2014	Second draft of the improvement plan shared with partners
25 Mar 2014	Endorsed by Quality & Safety Committee
28 Mar 2014	Discussed and endorsed **vision, principles and key intervention** at Urgent Care Board, recognising alignment with the system strategic plan.
31 Mar 2014	Discussed and endorsed **vision, principles and key intervention** with caveats on delivery risk at Integrated Care Coalition, recognising alignment with the system strategic plan.

Our improvement plan contains 5 key themes to address the findings of the Chief Inspector of Hospital's review. Each theme has improvement objectives and supporting improvement actions

1. Workforce
2. The emergency care pathway
3. Clinical Governance
4. Outpatients
5. Leadership & OD

We have identified the priority improvement objectives and actions that will have the biggest impact . There are 26 priority objectives, of which 12 relate to must do actions. The objectives will be delivered by 67 priority improvement actions

Theme	Number of priority objectives	Safe 7	Effective 7	Caring 2	Responsive 10
Workforce	4 (1)	4 (1)			
Emergency Pathway	8 (4)		3 (1)		5 (3)
Quality Governance	8 (5)	3 (3)	3 (2)	2	
Outpatients	6 (2)		1		5 (2)

(Figures in brackets:) Number of objectives relating to 'must do's'

Our 4 priority actions to recruit the best, retain the best, and develop our teams to be the best together

	BHRT actions	'Asks of partners'
1. Improve the senior A&E medical staffing	1.1 Improve the working environment 1.2 Create a parallel training programme for NCCG and improve the training of junior doctors in A&E and Acute Medicine 1.3 Establish an ACCS stem	1.1 Create rotational posts, academic posts and a CEM time limited programme 1.2 Restructure rotations
2. Diversify the workforce	2.1 Train ENP and ANPs	2.1 Develop consolidated training programmes at BHRT (PA and NP)
3. Improve recruitment and attract more people	3.1 Better promote the opportunities in the Trust 3.2 Run targeted campaigns, and recruit for turnover	3.1 Promote the area as a place to live, train and work
4. Retain more people who join BHRT	4.1 Improve our awareness of the reasons that people leave and take actions 4.2 Improve staff engagement	

Patient flow: some context

- Emergency admission rates relative to population around national average
- A&E conversion rate higher than national average
- 40% of patients who spend more than 4 hours in the department are discharged home, and time to see an A&E doctor rises significantly out of hours
- Average medical admissions of 65 at QH per day, of which 50% meet the frailty criteria
- Very high ambulance arrivals, with over one third being for >75 year olds
- Length of stay higher than national average with an opportunity of c140 by moving to peer average in medicine
- Largest bed use appears to be for 65-85 with 1-3 LTCs followed by 86+ with 1-2 LTCs and then 86+ with 3 LTCs
- Wrong beds in the wrong place, and too many beds relative to what **should** be needed, but occupancy at 98%+
- 32% of medical admissions (45% of all) discharged before 2 midnights (against IST recommendation 50-65%)
- Readmissions above national average. 45% readmitted within 7 days, 23% in second week, 33% in week 3 or 4, consuming 204 beds
- 76% of people admitted to hospital who die, die in hospital

The improvement plan aims to align actions with the health economy strategic vision

1. Prevent people having an emergency episode, with home the default place of care
2. Providing alternatives to admission when people do have an urgent need
3. Reducing avoidable **time** in hospital
4. Home being the default place of care on discharge, with people remaining at home 90 days after discharge
5. Supporting more people at the end of their lives to be cared for in their preferred place of care

- Fewer emergency admissions
- Less time in a bed, and acute beds only used for patients with an acute need
- Fewer admissions to nursing and residential care
- Fewer emergency readmissions – more people staying at home
- Fewer patients receiving end of life care in hospital

Home is the default at every stage of the pathway, because we behave as one team, and have the right systems and services in place all the time. This should result in a smaller, higher quality acute hospital base with acute care consolidated on one site.

There are 8 priority actions to improve flow, which have been grouped into 5 pathway improvements

	BHRT actions	'Asks of partners'
1. Improved A&E assessment	1.1 Create an ED observation unit 1.2 Develop a standalone UCC service 1.3 Improve paediatric ED 1.4 Improve diagnostic access	
2. Improved Frailty Pathway	2.1 Create a frailty unit 2.2 Daily ambulatory clinics 2.3 Pre-hospital interventions 2.4 Implement LACE scoring	2.1 Trusted assessor model 2.2 Discharge to assess 2.3 Restarts and simple care packages 2.4 Implement 7 evidence based interventions 2.5 IRS to support acute elderly beds 2.6 CTT model to extend to ERU and MRU
3. Improved Acute assessment	3.1 Create MRU 3.2 Extend AAU consultant presence to 10pm 3.3 Daily ambulatory clinics 3.4 Eliminate delays for in-patient diagnostics	
4. Improved in-patient model	4.1 'On-off' model and roll out productive ward 4.2 Improve capacity planning using level of care audits	
5. Improved end of life care	5.1 Implement liaison palliative care into MAU and acute wards 5.2 Provide SPC as part of complex care hubs	5.1 Streamline paperwork and implement brokerage at weekends 5.2 Implement structured ACP

This will need to be supported by a significant programme of development, and an aligned 'focus' to deliver

The urgent care board and integrated care coalition have endorsed the approach and the 'interventions' and have raised the need to:

1. Implement clinical leadership across organisations
2. Align our collective efforts on frailty with support from UCLP
3. Ensure the governance arrangements between organisation support a 'many organisations one team' approach
4. Implement a programme of training and development to support front line staff move to this way of working

There are 8 priority objectives to improve our quality governance arrangements

	BHRT actions
1. Improve awareness of sepsis	1.1 Delivery mandatory training
2. Increase the number of patients receiving evidence based care	2.1 Implement sepsis six care bundle 2.2 Regular audit of compliance
3. Improve documentation of care	3.1 Communicate and reinforce required standards 3.2 Regularly audit notes 3.3 Review and streamline documentation
4. Improve systems for monitoring effectiveness of care	4.1 Implement standardised clinical governance framework 4.2 Strengthen the clinical governance department 4.3 Expand the range of quality metrics 4.4 Implement peer review of services 4.5 Review compliance against NICE standards
5. Improve risk management systemts	5.1 Put in place risk manager and review all risk registers 5.2 Implement regular review of risk registers 5.3 Audit completed actions 5.4 Strengthen QIA process
6. Improve learning	6.1 Audit all action plans for severe or moderate harm 6.2 Communicate the top 3 lessons in targeted campaigns
7. Improve satisfaction by responding to feedback	7.1 Increase range and frequency of FFT 7.2 NED visits to departments 7.3 Patient stories on Board agenda 7.4 Learn from other Trusts
8. Positively promote the Trust's services to enhance reputation	8.1 'You said we did' campaign 8.2 Understand the views of key opinion formers

There are 6 priority objectives to improve our outpatient and day case surgery services

	BHRT actions
1. Restructure our outpatient clinics	1.1 Reprofile all clinics 1.2 Rebuild DOS 1.3 Implement firebreak clinics 1.4 Ensure clinicians attend on time
2. Improve our oversight of outpatients	2.1 Weekly monitoring of % patients seen in 15minutes of appointment time 2.2 Implement FFT by consultant 2.3 Improve senior management engagement in OPD
3. Improve our admin and customer service	3.1 Review letter and printing content and workflow 3.2 Improve call handling 3.3 Implement the Medway PAS improvement plan
4. Improve the recovery environment	4.1 Create toilet and shower facilities at QH 4.2 Create a dedicated elective centre at KGH
5. Reduce cancelled operations	5.1 Additional flexible lists to reduce short notice cancellations
6. Improve our aftercare	6.1 provide a dedicated point of contact

We have identified 3 key risks to the delivery of our improvement objectives, and these are consistent with the views of our partners

1. What is different this time? - our capacity, capability and focus to deliver

2. The support we need from others being implemented

3. Implementing significant change whilst we are still running in the old model, with no headroom and a lack of transitional support

Support from partners

Frailty / Care of the elderly	
IRS to support acute elderly beds	
CTT model to extend to ERU and MRU	
Implement 7 evidence based interventions	

End of Life care services	
Streamline paperwork and implement brokerage at weekends	
Implement structured ACP	

Discharge arrangements	
Trusted assessor model	
Discharge to assess	
Restarts and simple care packages	

‘One team’ governance and behaviours. Consistent translation of intent to operational practice at the patient interface

Next steps and questions