Portsmouth Hospitals NHS
NHS Trust

Hampshire County Council
Health and Adult Social Care Select Committee
May 2018

Portsmouth Hospitals NHS Trust update

Quality Improvement Plan

On 31 October 2017 the Trust published our Quality Improvement Plan which was described in detail at our last appearance before the Committee in November. Since then we have formalised the actions required for improvement into an action plan which maps progress against each area. A full copy of the action plan has been included at Appendix 1.

The Quality Improvement Plan is organised into five key aims:

- Valuing the basics
- Supporting vulnerable patients
- Moving beyond safe
- Organisation that learns
- Good governance

Each aim has its own workstream, overseen by an Executive lead to ensure delivery of the actions required in each area and progress is overseen by a Quality Improvement Assurance Group which meets monthly.

The action plan includes a total of 272 actions, the majority of which are either complete or on track. A Key Performance Indicator dashboard has been created to track delivery and measure the impact of the actions across each of the five key areas. Where actions are at risk or overdue delivery the action plan includes a clear reason for this as well as detailing the steps being taken to bring it back on track.

Some of the key improvements delivered to date include:

- Protected mealtime initiative re-invigorated in Autumn 2017 and monthly audits now in place
- Head of Safeguarding appointed January 2018 and now in post
- External review of adult safeguarding processes completed by Portsmouth City Council and action plan in place
- Patient engagement strategy (2017-20) ratified and being implemented
- Learning from Deaths policy implemented and embedded in practice
- Urgent care transformation plan ratified and being implemented
- Calendar of regular staff engagement events in place
- First junior doctor and junior nurse forum held in March 2018
- Training plan commenced for staff to increase knowledge and awareness of domestic violence in high risk areas
- Training implemented on bruising / birth marks for staff in paediatrics and the Emergency Department as well as raising awareness of the importance of Trust bruising protocol.
- NHS Improvement led Trust wide Quality Review was held on 16 March
- Mental Health lead appointed for Emergency Medicine and AMU and mental health awareness training offered to all staff in ED

Radiology

On 19 July 2017 the CQC undertook an unannounced inspection of the diagnostics imaging department at the Queen Alexandra Hospital. During the inspection the CQC looked in particular at the reporting of chest x-rays and the processes in place to ensure that any backlog in reporting was managed. The inspection report was published on 1 December 2017.

The investigation highlighted delays in reporting some chest x-rays and as a result CQC took enforcement action against the Trust which required us to take immediate action to address the concerns raised. As soon as the concerns were raised with us following the CQC's inspection in the summer of 2017 we immediately put in place a range of improvements. All chest x-rays from the Emergency Department (ED) are now formally reported by a trained specialist in addition to being interpreted by the requesting ED clinician..

There have been staffing capacity issues within the radiology department and we know that this is a challenge that is reflected nationally. To help alleviate this we are training dedicated reporting radiographers, with further training also being offered to clinical staff.

At the end of February we delivered on our commitment to complete a review of the backlog of chest x-rays. This has shown that the vast majority of chest x-rays were interpreted sufficiently well by clinicians to ensure that patients received the appropriate treatment. From a total of over 30,000 chest x-rays reviewed, four patients have so far been found to have suffered significant harm as a result of their x-ray not having been interpreted by a trained specialist. It should be emphasised that even one instance of serious harm to a patient is too many, but the numbers have been lower than had been first feared. Those who suffered significant harm represents only around one in ten thousand of all those who did not have their x-ray reported. Each of these instances is being managed through our SIRI process and we are in contact with those patients and their families directly to explain the action we are taking.

To provide additional assurance we also commenced an independent investigation into the backlog to determine the root cause and the findings from this independent investigation were reported to our Board on 3 May 2018. This has clearly identified that there were problems in the past with the Trust's governance processes, however the action we have taken in response to the CQC's concerns, and the processes now in place are considered to be exemplary. The update paper provided to the Trust Board is attached to this report as an appendix.