REPORT OF: THE JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE (HOSC):

John Radcliffe Hospital CQC Improvement Journey.

REPORT BY: HEALTH SCRUTINY OFFICER, OXFORDSHIRE COUNTY COUNCIL, DR OMID NOURI

INTRODUCTION AND OVERVIEW

1. At its meeting on 08 February 2024, the Oxfordshire Joint Health and Overview Scrutiny Committee (HOSC) received a report providing an update on the John Radcliffe Hospital's Care Quality Commission (CQC) improvement journey.

2. The Committee felt it crucial to receive an update on progress made by the Trust in addressing the concerns highlighted by the CQC around the John Radcliffe and some of the services delivered at the hospital. There have been a few areas of concern that have been identified by the CQC in its most recent inspections of the John Radcliffe, including around the degree to which the hospital's services are "safe", "responsive", and "well led" overall. Other areas of concern revolved around the improvements required in gynaecology, maternity services, surgery, and urgent and emergency services.

3. This item was scrutinised by HOSC given that it has a constitutional remit over all aspects of health as a whole; and this includes the nature of hospital services as well as the initiatives taken by NHS Trusts to address concerns raised by CQC inspections. When commissioning this report on the John Radcliffe CQC improvement journey update, some of the insights that the Committee sought to receive were as follows:

    - The degree to which services at the John Radcliffe are "safe".
    - The extent to which services at the hospital are "responsive".
    - The measures taken by the Trust to address the CQC's concerns around services at the hospital being "well led".
    - The steps taken by the Trust to address the CQC's identification of improvements required in gynaecology, maternity services, surgery, and urgent and emergency services.

SUMMARY

4. The Committee would like to express thanks to Eileen Walsh (Chief Assurance Officer, Oxford University Hospitals NHS Foundation Trust); Andrew Grant (Chief Medical Officer, Oxford University Hospitals NHS Foundation Trust); and Lisa Glynn (Director of Clinical Services, Oxford University Hospitals NHS Foundation Trust) for attending the meeting on 08 February and for answering questions from the Committee.

5. The Chief Assurance Officer informed the Committee that the report provided an insight into how the organisation addressed the specific areas of improvements listed in the CQC report and placed them in the context of the wider strategic and operational developments that had been made.

6. The Committee enquired as to the level of staff and patient involvement in the development of the Trust strategy. The Chief Medical Officer informed the Committee that the strategy was developed with extensive staff and patient engagement. Staff engagement continued beyond the point of publication and adoption of the strategy in the form of regular staff listening events that included members of the leadership team, and were an opportunity to hear staff concerns.

7. Patient engagement had contributed to service development work in the form of patient partners and experts by experience, and individual work streams had involved patient recommendations where possible.

8. The Chief Assurance Officer added that the patient's voice was kept at the heart of the strategy, and that Listening Events were held involving patients and stakeholders that had influenced the development of the strategy, as co-creation was the key platform for developing future strategies.

9. The Chair queried what opportunities there were for the strategic ambition of the Trust to integrate with the wider prevention agenda. The Director of Clinical Services explained that one of the Trust's key priorities was the part that key acute providers could play in prevention. The Trust was heavily involved with early detection of cancer through the Targeted Lung Health Check Programme, that would be initiating in April 2024. The Trust worked closely with the community and partners in relation to Wantage Community hospital, and were looking to expand additional services that would meet the needs of local populations and support the demand seen in local hospitals for acute services. In order to address the demand on urgent care services, the Trust had been involved with the Integrated Neighbourhood Teams as well as the Primary Care Strategy. The Trust had also been looking at admission and attendance avoidance, and the development of same day emergency care services.

10. The BOB ICB Place Director for Oxfordshire explained that the Trust was trying to strike a balance between treatment and prevention. Oxford University Hospitals NHS Foundation Trust (OUH) was involved in many prevention projects, such as co-location of maternity services within 'Flos in the Park', the Early Lives Project, and the Hospital at Home service to support acutely sick

people at home. The BOB ICB Place Director emphasised that the greatest long-term impact on prevention was to focus on children and young people, and the Community Paediatrics service was fundamental to this.

11. The Chief Medical Officer also highlighted the Oxfordshire Rapid Intervention for Palliative and End of Life Care (RIPEL) service for palliative care at home, and that the service had made a fundamental difference to the patients it had served.

12. The Committee queried whether resources would be increased for the Hospital at Home Service to ensure coverage in rural areas, and whether RIPEL would include Primary Care Networks (PCNs). The Director of Clinical Services informed the Committee that OUH were looking at what services were having the most effect to reduce attendance to acute hospitals, including the Hospital at Home service, which was a key programme to manage demand and to support patients to be at home. RIPEL was a service that the Trust was committed to and wanted to evolve further and would build into PCNs and integrated neighbourhood teams. The challenge would lie in the reorganisation of resources and the allocation of funding, and the Trust was assessing this for next year to determine how resources could be used to the best effect.

13. The Committee enquired about how technology was being used to improve patient safety. The Chief Medical Officer informed the Committee that a lot had happened in the last five years to develop the Trust digitally. The Trust invested in the electronic incident reporting service Ulysses that provided a digital architecture for a greatly strengthened patient safety response framework. Electronic patient records provided electronic observations so that teams could view vital signs on patients remotely. Another important change was the introduction of daily Patient Safety Response meetings where senior leaders from across the organisation reviewed every incident from the last 24 hours with moderate harm or above, which allowed close oversight of patient safety in the organisation, and ensured the Trust was responsive to incidents and had the right learning response. The new national framework for responses (PSIRF) focused on changing the culture from one of blame to one of learning and improvement, and offered a range of different incident learning responses such as After-Action Review, Multi-Disciplinary Team Learning Reponses and Patient Safety Incident Responses (PSIIs).The framework introduced thematic responses, so that when incidents occurred, they fed into the broader longer term improvement plan rather than being taken independently. The work was supported by patient safety partners, service users who were part of the safety response framework and contributed to reviews of cases, and some committees that oversee these workstreams. Alongside this, there had been significant safety retraining for all staff, from basic training for all staff to more detailed levels for patient safety experts.

14. The Committee enquired as to who monitored the databases created by the collection of data. The Chief Medical Officer explained that there was a Governance team that overlooked the databases and provided monthly reports with breakdowns of all incidents by harm level and type of incident. For example, there had been an increase in incidents of violence and aggression against staff

over the last year that had been tracked, and which the Trust had provided staff support for. The database allowed the Trust to track specific incidents such as hospital-acquired pressure ulcers and this had been the focus of integrated quality improvement work, the result of which there had been a third reduction in these incidents. The data was important in helping the Trust to understand what the incident risk profile was, and to target learning and improvement responses accordingly.

15. The Committee queried whether the Trust had programmes for staff wellbeing, such as self-harm diversions built into search engines. The Chief Medical Officer informed the Committee that there were numerous internal and external supports for staff clearly signposted on their intranet, and a staff support service had been created, although he was not aware of wellbeing programmes built into the Trust's search engines. The Chief Assurance Officer added that there was an employee assistance programme available 24/7 to provide counselling to staff for both personal and professional issues.

16. The Chair queried whether significant learning was communicated to patients and families affected, and whether they were involved in the learning journey. The Chief Medical Officer informed the Committee that communication with families was essential and would always occur after these incidents under the Trust's duty of candour. Patients were always invited to share their questions after serious incidents, and outcome reports were shared with them. The Trust had sought to triangulate the learning from complaints, so if a complaint had been received it would be examined to see whether an incident needed to be created to learn from it, and a weekly meeting aimed to derive learning from this.

17. The Chief Assurance Officer highlighted that the Trust board and non-executive members took a strong interest in patient safety, and the Chief Executive implemented a direct feedback mechanism with clinical teams who were involved with serious incidents to present their reflections to the executive team. Several key committees had been introduced; including the Risk Committee to discuss proactive risks and thematic risks; the Productivity Committee to focus how to progress performance in the organisation; and the Delivery Committee to ensure large programmes of work had been implemented. The Trust had ensured that patients had been involved in the aftermath of incidents, and had been provided with both clear explanations to understand what went wrong as well as a swift apology when the Trust was at fault.

18. The Committee queried how the values of kindness and caring were taught in the organisation and how this was evaluated. The Chief Medical Officer responded that the organisation prioritised kindness, and kindness interaction training was provided to all senior leaders. The success of this was measured by examining metrics produced from staff surveys and by looking at sickness and turnover rates.

19. The Committee asked if data could be provided to show how improvements had been made. The Chief Assurance Officer informed the Committee that the Trust could provide metrics that demonstrated the improvement trajectory over the

last few years. This data could be supplemented by staff and patient surveys that provided anecdotal and human experiences. The Chief Medical Officer added that the board adopted a nationally recommended approach of presenting data, using Statistical Process Control (SPC) charts that helped focused discussions and identified improvement areas.

20. The Committee enquired as to how strong the internal audit function was and how the sharing of patient stories was imbedded in the organisation. The Chief Medical Officer explained that not all incidents generated patient stories that go to the board, but the patient experience team supported stories that generated different learning to help the board gain insight into the range of issues faced by the organisation.

21. The Chief Assurance Officer added that although patient stories were not heard at every committee, stories were sometimes made into videos that could be shown before conferences. The Trust had a very strong internal audit function that developed a comprehensive audit plan every year, which was formed with cooperation from all the executive directors and the areas of examination were stress-tested. The audit committee, chaired by non-executives, received this plan, and examined it with auditors to determine key risk and concerns.

KEY POINTS OF OBSERVATION & RECOMMENDATIONS

22. Below are some key points of observation that the Committee has in relation to the John Radcliffe Hospital's CQC improvement journey. These key points of observation relate to some of the themes of discussion during the meeting on 08 February, and have also been used to shape the recommendations made by the Committee. Beneath each observation point is a specific recommendation being made by the Committee.

Improving Patient Safety: The committee is pleased to see the Trust's commitments to improve patient safety at the John Radcliffe, and hopes that further measures are taken to address the concerns raised by the CQC around patient safety at the hospital. Patient safety should be at the heart of how the Trust operates, including in relation to how acute hospitals are managed throughout the entire management structure. Patients should also feel safe and reassured that their safety is of utmost concern, and that there are clear protocols and procedures in place that are followed through by all staff that patients get into contact with.

Therefore, the committee strongly believes in the importance of appropriate and adequate training for staff at the John Radcliffe so as to improve staff awareness and understanding of processes and procedures to enhance patient safety. There may also be a point about not merely adhering to statutory obligations around patient safety, but also about exploring ways in which the Trust can enhance its own internal processes to improve the safety of patients.

Given that many residents or patients would attend and utilise the services provided at the John Radcliffe, it is vital that their views,

thoughts, and experiences are also taken into account when thinking about how to improve patient safety. The Committee recommends that there is some measure of patient and stakeholder engagement so as to enable the Trust to understand how patients who receive services from the hospital feel about their safety and overall wellbeing in that context.

Additionally, technology should be maximised for the purposes of improving patient safety, and strong considerations should be given to how to avert the prospects of IT outages or IT system failures. The safety and reliability of the storage of medical records of patients is also crucial in this regard, as clinical staff depend significantly on such records (as well as technology more broadly) for the purposes of treating both in-patients as well as outpatients.

Furthermore, the importance of ensuring patient safety and getting this right is also reflected in the fact that many of the patients who may attend the hospital are vulnerable individuals who may exhibit physical and mental vulnerabilities. It is also the case that the families of such vulnerable patients would want to be reassured that their safety is of paramount concern to the hospital and its staff.

Recommendation 1: *For the Trust to continue to take improved measures to improve patient safety at the John Radcliffe. It is recommended that staff are sufficiently supported and trained in being able to maximise patient safety.*

Importance of stakeholder engagement: The Committee is pleased to see that there has been some level of staff and patient engagement in the development of the OUH Trust strategy, which should ideally have a knock-on effect on the improvement of services at the John Radcliffe. Nonetheless, the Committee strongly believes that given that several services and overall areas of concern have been raised by the CQC, it is crucial for there to be further stakeholder engagement (including although not limited to patients and staff) around the hospital's improvement journey. Staff listening events are a useful avenue for the Trust to directly engage with staff in a manner that could allow them to express their views and experiences. In the context of the hospital's improvement journey specifically, listening events can allow staff to reflect on how they feel about the services they provide to patients, and could therefore generate additional insights and further inform the hospital and wider Trust's management around the ways in which services could be improved. There are indeed significant benefits to having extensive engagements with staff, as this could help bolster the morale of hospital staff in a manner that could have a positive impact on how services are delivered to patients at the John Radcliffe.

In addition, avenues for patients to formally share their recommendations as to how services at the hospital could be improved are also crucial. Any workstream that is relevant to addressing the CQC's concerns. For instance, the insights from maternity patients who had recently given birth could help determine crucial ways in which both inpatient as well as

outpatient maternity services could be enhanced in ways that improve the birthing experience as well as the safety and wellbeing of mothers and newborn babies.

Furthermore, there is also a point about engaging with patients and families who may have had poor experiences with the services they have received at the hospital. In such instances, such engagements should form part of a wider co-production exercise to determine and identify patterns of where improvements are required in the hospital's services.

Recommendation 2: *For ongoing stakeholder engagement and coproduction to be at the heart of the John Radcliffe Hospital's efforts to address the concerns identified by the CQC, and for there to be clear transparency and further evidence of this to be provided.*

Importance of Transparency and key indicators: Related to the point above around the importance of public/stakeholder engagement, the Committee feels that general transparency around the hospital's improvement journey should be a key commitment for the Trust. Transparency is important in this regard for two reasons:

1. It helps to create an environment where patients, staff, the wider public, as well as other system partners feel a sense of reassurance that the Trust is immensely committed to improving services at the John Radcliffe in a manner that addresses the CQC's identified areas of improvement.

2. Transparency would help improve the level of accountability around the improvement journey. This could help to determine and provide clarity around which bodies/individuals are responsible for driving improvement not only in the overall sense, but also in each of the four service areas of genecology, maternity, surgery, and urgent and emergency care.

Related to the point about transparency is the importance of developing clear key performance indicators that could help to determine the extent to which the Trust is producing outcomes that indicate improvements at the John Radcliffe. Each of the aforementioned four service areas should have clearly identifiable leads as well as indicators that could measure, with realistic timescales, the improvements being made. In this respect, such indicators could be utilised for the purposes of achieving any of the improvements recommended by the CQC, as well as any further improvements to the hospital and its services that the Trust sees fit.

Recommendation 3: *For clear transparency around the Trust's efforts to address the CQCs concerns around the John Radcliffe. It is recommended that there are clear indicators that could help determine how improvements in the John Radcliffe are being driven overall as well as in the specific service areas of Gynaecology, Maternity, Surgery, and Urgent & Emergency Care.*

Resourcing Hospital at Home: The Committee is supportive of the use of Hospital at Home services, as this could potentially allow patients to receive the care that they require within their own homes in a convenient and safe manner. This way, patients do not always necessarily have to make hospital trips or be admitted into hospital. However, it is important that the service operates in as safe and effective a manner as possible, particularly given the likely risks involved. Getting the hospital at home service right is a process that would involve the need for adequate levels of resources to make it work.

Indeed, with the increasing resort to providing support to people in their own homes as opposed to in hospital wards, it is crucial that there are adequate levels of staff members to support this. This may require the Trust to train existing staff to provide this service, coupled with securing external staff who may already have experience and expertise in providing hospital at home.

Recommendation 4: *For sufficient resources to be secured for the purposes of delivering and potentially expanding the Hospital at Home Service.*

Recommendation 5: *For a site visit to be orchestrated for the purposes of providing the Committee with insights into the measures taken by the Trust to improve patient safety at the John Radcliffe.*

Legal Implications

23. Health Scrutiny powers set out in the Health and Social Care Act 2012 and the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 provide:
  - Power to scrutinise health bodies and authorities in the local area
  - Power to require members or officers of local health bodies to provide information and to attend health scrutiny meetings to answer questions
  - Duty of NHS to consult scrutiny on major service changes and provide feedback on consultations.

24. Under s. 22 (1) Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 'A local authority may make reports and recommendations to a responsible person on any matter it has reviewed or scrutinised'.

25. The Health and Social Care Act 2012 and the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 provide that the committee may require a response from the responsible person to whom it has made the report or recommendation and that person must respond in writing within 28 days of the request.

Annex 1 – Scrutiny Response Pro Forma

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