Meeting:	**Brighton and Sussex University Hospitals NHS Trust** **Board of Directors**
Date:	**29th March 2016**
Board Sponsor:	**Sherree Fagge, Chief Nurse**
Paper Author:	**Wendy Cookson, Director of Improvement** **Elma Still, Associate Director of Quality**
Subject:	**Care Quality Commission (CQC) Improvement Programme**

Executive summary

Ahead of the planned full CQC inspection 5th – 8th April, the report and assurance briefings have been revised from the February report presented at Q&R in February.

Key points:

- Main corporate risks to the organisation for the visit are:
  - Unscheduled care
  - Scheduled care
  - Statutory and mandatory training compliance and Board monitoring
  - Culture

- Programme risk ratings against the compliance actions are:
  Compliance Action 1 – Unscheduled care – RED
  Compliance Action 2 – Lessons Learnt – GREEN
  Compliance Action 3 – Safety and Suitability of Premises – AMBER
  Compliance Action 4 – Equipment – AMBER
  Compliance Action 5 – Privacy and Dignity – RED
  Compliance Action 6 – Staffing – AMBER
  Compliance Action 7 – Culture and Supporting Staff – AMBER/RED
  Compliance Action 8 – Centralised booking - AMBER

- 1250 documents were catalogued and submitted as part of this data request. A further 75 date requests were received 21.3.16
- Lead Inspector spent a day with the CN on the RSCH site 10.3.16 walking the Trust
- Staff meetings with the CQC took place on 15/16.3.16
- There was an unannounced inspection to main recovery in RSCH on

16.3.16.The new Chief Executive Officer, Gillian Fairfield will become the nominated individual for the Trust from 1st April 2016.	
Links to corporate objectives	The CQC action plan supports the objectives of ***excellent outcomes; great experience; empowered skilled staff*.**
Identified risks and risk management actions	**BAF risk reference 3 - Non-Compliance with regulatory standards and statutory duties leading to regulatory or enforcement action.** Multiple actions as Trust-wide and incorporates other BAF risks
Legal implications	If the Trust does not comply with the registration requirements, the CQC may issue compliance, warning notice or enforcement actions.
Report history	A report is submitted bi-monthly to the Quality and Risk Committee. This report has been amended to reflect changes since being presented at the February Quality and Risk Committee
Appendices	Appendix 1 Assurance Brief – March 2016 Appendix 2. Statement of Purpose
Action required by the Trust Board The Committee is asked to discuss the report and to formally approve the appointment of the nominated individual Gillian Fairfield, CEO from 1st April 2016	

Report to the Board of Directors, 29th March 2016

Care Quality Commission (CQC) Improvement Programme

Purpose

The CQC are carrying out a comprehensive announced inspection of the Trust during the 5th -8th April 2016. The purpose of this paper is to update the Committee on the work being undertaken in advance of the visit, give an overview of the data submission to the CQC, review progress of the previous action plans and identify the key risks.

Plan for announced CIH visit 2016 – State of readiness

A weekly CQC Programme Board commenced in February chaired by the Chief Nurse. It is managed by the Improvement Director and attended by the Associate Director of Quality, two Project Managers (for unscheduled care, and facilities and estates/equipment) and the Quality Assistant. Scheduled care is managed by the Deputy Chief Operating Officer (dCOO) for Scheduled Care who reports to the Board every second week. The remaining action plans are shared between the Improvement Director and Associate Director of Quality. The project plan, communication strategy, risks and issues are reviewed. Red risks and slippage are escalated to the Executive team weekly and shared with the Non-Executive Directors (NEDs) every 2 weeks.

The communication strategy was written with the Senior Communications Manager (Internal and Staff Engagement) who is supporting the CQC Programme. The front page of the *infonet* now has a section identified for the CQC. It includes the CQC reports, presentations and various resources available to staff.

Presentations for the preparation for the inspection were delivered to the senior management and directorate teams. They were given a copy of the slides to share with their teams. The Chief Nurse, Associate Director of Quality, Deputy Medical Director and Nurse Consultant for Children's Services (all with experience of being part of an inspection team) attended various sessions and individual team meetings. Drop in sessions for staff were arranged and completed at both sites in February and March. The sessions were attended by a range of staff including clinicians, administration staff and non-clinical staff and were well received.

A Self-Assessment and Improvement tool has also been circulated for staff. Through a series of questions, it allows staff to look in detail at how they work to identify what they do well and how they could improve. It contains information about what to expect during a Care Quality Commission (CQC) inspection and also some contact details for key central services in the Trust. An electronic version is available and has hyperlinks to the various documents.

The programme of weekly quality visits began in January with clinical and non-clinical staff volunteering as ‘inspectors’ to visit and peer review ward areas. Twenty seven wards/areas were visited on both main sites and Preston Park Breast Care centre. These are a valuable way of identifying good practice within the organisation and areas where improvements need to be made. Recurring themes from the visits included:

- Safety of medicines storage;
- Locking of treatment room doors;
- Storage of appropriate items in treatment rooms and sluices;
- Patient feedback on kindness and compassion has been very positive.

The ward manager receives feedback immediately after the visit. The directorate management team are charged with their improvement actions and they are being monitored by the Chief Nurse through the Directorate Lead Nurses (DLNs). Feedback and themes are also being shared at the weekly Practice Improvement meeting and the Nursing and Midwifery Management Board, the Message of the Week and other appropriate fora.

Staff have given positive feedback on the quality visits, saying that it has given them insight into other areas, understanding issues of the organisation and has given them ideas of best practice to take back to their areas. Executive and NED walkabouts began in January and now form part of the Board agenda.

‘Mock’ CQC inspections were undertaken for ‘core’ services on the 2nd and 4th March at RSCH and PRH. These inspections included internal staff and external stakeholders and colleagues including the TDA and CCG. The quarterly Executive Quality and Safety meetings with the directorates were held in February to identify their state of readiness and how the directorates intend to share their good practice with the CQC.

Data submission

The CQC requested 2 sets of data as part of the preparation for their visit. The data provided helps to inform their Key Lines of Enquiry (KLOE) and will be used to provide a substantial data pack for the inspectors. The initial data set provided in December included information on locations, services provided at each location, bed and staffing numbers. The second data set requested consisted of a significant amount of information from the Trust and each of the core service directorates. Over 1250 documents were catalogued and submitted as part of this data request. The trust has received the final data packs and circulated to the Executives, NEDs and directorate management teams. A further 75 date requests were received 21.3.16.

CQC Staff Fora

The CQC met with various groups of staff on the 15th/16th March. These were an opportunity for staff to share with the CQC their experience of working in the Trust and will also form part of the KLOE. The groups of staff have been specifically asked for and include:

- Consultants, juniors and staff grades;
- Student nurses and qualified nurses of band 5–9;
- Allied Healthcare Professionals;
- Healthcare Assistants;
- Managers and administrative staff;
- Support service staff.
- Black and Minority Ethnic staff

Visits prior to main inspection

The Lead Inspector spent a day with the CN on the RSCH site 10.3.16. The visit was to orientate herself to the site. She met with many of the staff and observed a large number of clinical areas. There was also an unannounced inspection of main recovery at RSCH on 16.3.16. No feedback has been received from either visit.

CQC Programme update - 2014 and 2015 action plans

The March Assurance Briefing is attached in appendix 1. The following are key highlights from the briefing.

Unscheduled care

- There has been deterioration in performance against the 4-hour urgent care standard during March. The performance has decreased through January and February and to-date in March performance is at 80.88%. There have been 6 12-hour breaches in March.

- A draft Escalation Policy (including Full Capacity Protocol) was presented at CMB 17.3.16

- The Surgical Assessment Unit (SAU) is functioning seven days a week but is not yet operational on a 24/7 basis. A revised design for SAU has been developed, however it requires an alternative location for the Rapid Assessment Clinic.

- Work has continued on the re-design of the Urgent Care Centre (UCC); a final 1:200 design and funding for the UCC redevelopment has been agreed and a tender process to appoint a building contractor has commenced

- A re-design of the ambulance entrance at RSCH to establish additional assessment cubicles has been agreed 15th Feb and a programme of works and timetable is to be completed in March.

Scheduled Care - Booking Hub

- Case for Change agreed at CMB and commenced. Trajectories monitored through a comprehensive dashboard daily by team and weekly at PTL meetings

- The impact of financial constraints on call answering has been a significant deterioration. Current service level around 26% answered within 5.5 minutes. Opening hours of the hub have also been reduced from 8-6pm to 8 - 4pm. Work around staffing levels and how to improve these within the financial constraints continue to be raised as a significant risk to the Hub success.

Facilities and Estates

- 6 facet survey improvements continue

- Beds and equipment are attempted to be removed from corridors in a timely manner and whilst this has improved, it remains a fire risk

- The 'Productive Ward' space optimisation and placement of equipment piloted on level 8 has now commenced on level 7

- Outstanding policies were ratified at H&S Committee 16.3.16

Equipment

- Part time agency support continues until end April. No substantive appointments can be found. Backlog of clinical equipment checks is at 45% (1,501 pieces of equipment checked to date). Planned to complete end December 2016.

- Quality visits exposed lack of checking of resuscitation trollies and fridges in PRH ED. Directorate Lead Nurse held accountable to address lapses in practice and report to CN

Staffing

- Currently there are 170 nursing vacancies, of which 130 will be filled by March 2016. Recruitment continues into 2016

- The ED have no current nursing vacancies and all critical care vacancies will be filled by end March 2016;

- The paediatric staff rotation in the Paediatric ED at PRH due to re-commence March 2016.

Culture and supporting staff

- Compliance rates for statutory and mandatory training remain extremely low in some subjects and clinical areas/staff groups. The recovery programme is making slow progress due lack of resource to input data into iris, lack of training capacity for substantive and Bank-only staff and staff requiring to have a Trust email to have their training recorded onto iris

- A presentation compiled by the Operational Director of HR at the Board Seminar 21st March, highlights progress against the E&D/BME agenda

- The network of Values and Behaviour champions, that replace the 'Sounding Board', have been embedded as has a comprehensive programme of team coaching

- Appraisal rates have increased from 42% in December 2014, to 69.4% by 13th March 2016. The project is on target to reach 75% be the end March 2016.

Risks

The programme is monitored through the Directorate and Corporate risk registers. Associated red risks (rating 15 and above) are illustrated in the table below:

RISK / ISSUE DESCRIPTION	SCORE	ACTION PLAN
Unscheduled Care		
1483 - Flow out of the Acute Floor /Increased waiting times in Emergency Departments which effects standards of care	**16**	A programme has been established, with a critical path incorporating all relevant projects being developed.
Privacy and Dignity		
1527 - Unsafe area to look after patients Cohort area – includes P&D	**16**	Acute floor action plan being implemented to improve patient flow and reduce time in the cohort area
801 - Delivering same sex accommodation	**12**	Review due 31st March
Staffing		
1480 - PRH ED children's services – public perception full time service (Ref 1480)	16	15/2/2016 Children continue to meet and provide training with ED PRH (Acute Directorate) who have responsibility for this area and risk. Rotation of nurses x3 from PRH to CED for skills acquisition has not occurred lately and issue has been escalated to deputy Chief Nurse. Leaflets given to Midwives and CCG commissioner to distribute to parents and to PRH ED attends re service provided.

Culture and Supporting Staff		
104: Trust staff are not released to attend adequate induction, statutory and mandatory training due to staffing pressures.	**20**	5/2/2016 E-learning modules require rolling out across the organisation. Information Governance complete. Also Managers need to be able to release staff to attend Statutory and Mandatory training. Escalated to Trust board of Directors with attendance rates. Reports to managers re-established in Feb 2016.
Centralised booking service		
1537 Outpatient booking deficits & backlog of referrals for DigestD being booked concern that follow ups are not being uploaded	**16**	Developing robust report for both directorate and bookers to use. New team working to be put in to place

Nominated individual

The new Chief Executive Officer, Gillian Fairfield will become the nominated individual for the Trust from 1st April 2016. The statement of purpose has been amended to reflect these changes and is attached (Appendix 2)

Wendy Cookson, Director of Improvement
Elma Still, Associate Director of Quality
March 2016

Brighton and Sussex University Hospitals NHS Trust

Assurance Brief – March 2016
Quality Improvement Plan

About the Briefing

The Assurance Brief is a highlight report of key achievements, risks and next steps, for any one month against the 8 compliance actions. It includes reports on action updates on all Must and Should actions from the 2014 and 2015 CQC inspections.

The Briefing represents the core reporting document for the Quality and Risk Committee, the Board, other internal stakeholder, and all external stakeholders including the CQC.

The eight compliance actions are:

Compliance Action 1

Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010: Care and welfare of people who use services –Outcome 4

Compliance Action 2

Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010: Assessing and monitoring the quality of service provision – Outcome 16

Compliance Action 3

Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises –Outcome 10

Compliance Action 4

Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2010 Safety, availability and suitability of equipment – Outcome 11

Compliance Action 5

Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010: Respecting and involving people who use services – Outcome 1

Compliance Action 6

Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010: Staffing – Outcome 13

Compliance Action 7

Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010: Supporting workers.- Outcome 14

Compliance Action 8

Regulation 24 HSCA 2008 (Regulated Activities) Regulations 2010 Cooperating with other providers – Outcome 6

Compliance Action 1: Unscheduled Care

HIGHLIGHT REPORT

Date of Update: March 2016

Completed by: Simon Maurice

RAG Status:

Previous	Current	Forecast
R	R	R

KEY: High risk | At risk | On track

Brighton and Sussex University Hospitals NHS Trust

MUST DOs

CA1.1.1 Improve the flow of patients within the ED and across the Trust
CA1.1.2 Improve discharge planning across the organisation
CA1.1.3 Review SECAMB conveyances and conversions
CA1.1.4 Daily support from SECAMB on diverts and use of capacity
CA1.1.7 Implement Surgical Assessment Unit by 1 September 2014
CA1.1.9 Implement early discharges and reduced length of stay
CA2.3 Review cohort protocol
ED008 Improvement in ambulance handover times

SHOULD DOs

CA1.2.2 Make improvements to the efficiency of discharging patients from postoperative wards
Improve the provision of mental health services for patients at PRH
ED033 Improve signage on acute floor

KEY MILESTONES

MILESTONE	STATUS
CA1.1.1 Secure additional capacity	
CA1.1.7 Implement 24/7 Surgical Assessment Unit	
CA1.1.1 Implementation of Right Care, Right Place, Right Time across all Barry Building wards	
CA1.1.1 Implementation of Right Care, Right Place, Right Time Trust wide	
CA1.1.9 Focus on early discharges, reducing Length of Stay	
CA2.3 Implement Escalation Policy & Full Capacity protocol	
CA1.1.9 All inpatients having their discharge plan created and monitored using the eOasis Discharge Planning tool. (Training package rollout in conjunction with Right Care, Right Place, Each Time rollout)	
ED008 Improvement in ambulance handover times	
ED033 Improve signage on acute floor	

KPI UPDATE

4 hour performance - 83.34% YTD
12 hour trolley breaches - YTD 111 (6 in March) – National outlier
Ambulance handovers - >60 mins breached (Jan and Feb)
KPIs for for Right Care, Right Place, Each Time

KEY ACHIEVEMENTS / COMMENTARY

- CA1.1.7 SAU operational 7/7 from 1 December 2015 and plans to be operational 24/7 by April 2016.
- Single clerking process implemented at RSCH from 3 February 2016 with early senior input
- CA1.1.1 New Acute Floor Transformational Team appointed and commenced w/c 7.3.16
- CA 1.1.2 Implementation of whiteboard system across the organisation from 1st March
- CA 2.3 New Escalation Policy approved by Clinical Management Board 17.3.16.

NEXT STEPS:

- CA 1.1.1 Rollout of RCRPET to RSCH and PRH wards to be completed by 31 March 2016
- CA1.1.1 Redevelopment of Urgent Care Centre and additional patient assessment spaces; timeline for works in development but expected to start in early April 2016
- CA1.1.9 New ambulatory care pathways to be developed by 30 April 2016
- CA 1.1.2 and 9 New discharge lounge at PRH to be implemented on Balcombe Ward

RISKS AND ISSUES

RISK / ISSUE DESCRIPTION	SCORE	ACTION PLAN
1483 - Flow out of the Acute Floor /Increased waiting times in Emergency Departments which effects standards of care	16	A programme has been established, with a critical path incorporating all relevant projects being developed.

BAF Risk Reference 15/16 & 1

ITEMS FOR ESCALATION

CA 2.3 The escalation policy will incorporate the cohort protcol for RSCH ED remains in development and will be completed by 31 March

Compliance Action 2: Lessons learned

HIGHLIGHT REPORT

Date of Update: March 2016

Completed by: Steve Drage

RAG Status:

Previous	Current	Forecast
A	G	G

KEY: High risk | At risk | On track

Brighton and Sussex University Hospitals NHS Trust

MUST DOs

CA 2.4 Ensure that staff reporting incidents receive feedback on the action taken and that the learning from incidents is communicated to staff

SHOULD DOs

CA 2.5 Learning from complaints to be disseminated among staff to ensure changes to practice are fully embedded.
CA2.6 Ensure that staff at all levels feel confident about reporting incidents so that learning and improvements to practice can take place.
CA2.7 Ensure that staff understand their role in the event of a major incident, as appropriate to their designation.

KEY MILESTONES

MILESTONE	STATUS
CA2.4.1. Upgrade to the latest version of DATIX which has advanced tools to inform the reported when the incident is closed	
CA2.4.2 Provide monthly feedback reports for staff in each area	
CA2.4.3To use team brief to feedback lessons from serious incidents	
CA2.4.4 Develop a network of safety leads across the trust with a focus on sharing and embedding learning from patient feedback	
CA2.4.5 Develop a human factors and simulation faculty	
CA2.4.6 Developed Safety projects e.g., AKI, deteriorating patient,	
CA2.4.7 Implement the safety, quality and patient experience strategy	
CA2.5 Directorate to review complaints and share learning with staff	
CA2.6 Emphasize the importance of reporting and ensure learning is shared through central resources and locally	
CA2.7 Training for staff and raising awareness of major incident actions. AAR debriefs following major incident	

KPI UPDATE

Incident reporting - over 12 months the numbers have risen by 0.5% - 8693 to 8739.
Never Events March – 0 (cumulative 8)
WHO compliance sign-in 97.9%; sign out 94.1%

KEY ACHIEVEMENTS / COMMENTARY

- CA2.4 Quality visits and Mocks have found staff well versed in lessons learnt
- CA2.5 Safety Ombudsman post remains vacant. Requirements of the service to be reviewed in March to agree remit of new role.
- CA2.7 PRH ED staff training programme for MI planned to commence May 2016. Exercises have been well managed by staff despite formal training gap.
- CA2.4.2 The Observational Study of WHO Safety Checklist and Stop Before You Block has evidenced good compliance with three steps of WHO and briefing. Debriefing is being reinforced as the weaker compliance rates.
- CA2.4.4 Trust Mortality Review group meets monthly. Expanding to review data collected by medical examiners to identify S&Q themes. Learning expected to identify wider Trust themes.
- CA 2.4.7 Quality Accounts 16/17 and business planning 16/17quality priorities aligned around Trust's biggest challenges and in line with SQPE strategy gap analysis. On going discussions between DMD S&Q and Dir. of Change to develop organisational approach to quality improvement.

NEXT STEPS:

- CA2.4.1 and 2 Review staff feedback at quality visits on receiving datix responses, and lessons-learnt from complaints etc. and share good practice across all areas
- CA2.4.3 The latest initiative is a database looking to pull SI' Action Plans, safety Alerts, NICE guidance, CQUIN initiatives, national and local audits into a unified forward audit plan for specialities, more info in this initiative can be found in the paper "Towards an Organisation with a Database linking Quality and Safety".
- CA2.4.5 Boston Children's Hospital experts in Human Factors coming to work with staff in September '16 to further embed and expand the work of the faculty
- CA2.6 The next round of Directorate Governance Reviews have commenced Feb 2016

RISKS (Red risks only) No current red risks

BAF Risk Reference 6

ITEMS FOR ESCALATION

CA2.4.2 Debriefing is being reinforced as compliance rates are 94.1%
CA2.7 Executive addressing lapse in MI training with leadership of PRH ED. Training programme to commence in May

Compliance Action 3: Safety & suitability of premises

HIGHLIGHT REPORT

Date of Update: March 2016
Completed by: Dale Vaughan

RAG Status:

Previous	Current	Forecast
A	A	A

KEY: High risk | At risk | On track

Brighton and Sussex University Hospitals NHS Trust

MUST DOs

CA 3.1 Ensure that the environment is suitable for patient investigations, treatment and care and that hazards related to the storage of equipment, which may impact on staff, are minimised. It was noted that equipment was being stored on corridors

CA 3.2 Ensure the appropriate use of beds spaces which are suitable by their position, design and layout within wards including the Stroke Unit, Grant ward and Baily Ward.

SHOULD DOs

CA 3.3 Ensure the secure storage of medicines in neurology ITU at PRH (*service moved sites in August 2015 into a space with better medicine security facilities*).

KEY MILESTONES

MILESTONE	STATUS
CA 3.1.1 To receive approval for the FBC and then subsequent building programme	
CA 3.1.2 A Trust-wide 6 facet survey has been commissioned to inform the Estates Strategy refresh.	
CA 3.1.3 &4 Rolling programme of estates and Health and safety compliance audits.	
CA 3.1.5 Identify & sign designated holding areas for patient moving equipment	
CA 3.1.6 Rolling 'Dump the Junk' programme	
CA 3.1.7 PLACE assessments to be reviewed and acted upon	
CA 3.1.8 Beds to be removed from corridors in a timely manner	
CA 3.2To review the bed space on the Stroke Unit, Grant ward and Baily. The beds to be removed from the escalation policy	
CA 3.3 Review the medicines storage for patient by their bedsides	

KPI UPDATE

- Environmental audits/6 Facet survey action plan
- Patients Voice
- Complaints & plaudits

KEY ACHIEVEMENTS / COMMENTARY

- CA 3.1.2 Whilst the 6 facet survey was undertaken a review in November 2015, further detail added on work completed ,works added and outstanding works as part of back log planning.
- CA 3.1.3 and 4 As above. A large number of improvements identified and action plan now in place. '
- CA3.1.5 Pilot successful on level 8 (as part of Productive Ward) and Cardiac. Roll-out to other wards predicated on costs being approved. Principles being adapted to Level 7 through March 16
- CA3.1.7 Rolling programme of work to correct PLACE findings. February progress - 553 completed and 54 remain open.
- CA 3.1.8 Porters undertake regular sweeps of the corridors in addition to departments asking for them to be removed via the helpdesk. Director of F&E has reviewed options for bar coding beds, however funding unavailable 2015/16. The risk to fire evacuation on corporate risk register.
- CA3.2 stroke patients bed incorporated into the establishment and remaining 3 beds removed from escalation policy/use in escalation from 17.3.16

NEXT STEPS:

- CA3.1.5 Need to identify designated storage areas for areas of concern. The Chief Nurse and Clinical lead for F&E raised issue with the Finance & Workforce Committee and H&S Committee.

RISKS AND ISSUES (Red risks only) no current red risks

BAF Risk Reference 1, 2 and 4.

ITEMS FOR ESCALATION

CA 3.1.8. Director of F&E has reviewed options for bar coding beds, however funding unavailable 2015/16. The risk to fire evacuation on corporate risk register. CA 3.1.3 and 4 As above. A large number of improvements identified and action plan now in place.

Compliance Action 4: Equipment

HIGHLIGHT REPORT

Date of update: March 2016

Completed by: Brian Jolley

RAG Status:

Previous	Current	Forecast
A	A	A

KEY: High risk | At risk | On track

Brighton and Sussex University Hospitals NHS Trust

MUST DOs

CA 4.1 Ensure that all equipment used directly for patient treatment or care is suitably checked and serviced to ensure that it is safe and fit for use.
CA 4.2 Ensure that equipment allocated to manage sick children or newborn babies is routinely checked to ensure it is safe for use. (In ED dept at PRH)

SHOULD DOs

CA 4.3 Ensure equipment in all of the departments is checked, as required, and the outcomes recorded.

KEY MILESTONES

MILESTONE	STATUS
CA 4.1.1 Carry out urgent specific Planned Maintenance (PM) checks (using existing PM procedures) on identified devices that have missed or delayed planned maintenance activity	
CA 4.1.2 Urgently continue recruitment process to cover current Band 4 and Band 5 EBME posts.	
CA 4.1.3Instigate additional external temporary resources to assist with back log.	
CA 4.2Daily documented checks of all paediatric equipment in ED at PRH and cleaned as appropriate	
CA 4.3 Nursing staff on all wards to complete the daily checks and document on the recording sheet	

KPI UPDATE

Planned maintenance dashboard 15/16
6 Facet action plan

KEY ACHIEVEMENTS / COMMENTARY

- CA 4.1.1 Provision of updated "Tested"" labeling for all clinical equipment to be introduced by end 2016 as per the guidelines from the MHRA document. Risk assessments created to identify equipment that has a higher priority for testing. This will be in line with similar Trusts in the south east facing the same challenges.
- CA 4.1.2 Clinical equipment checking 55% complete (1501 items of equipment). Trajectory is to complete by end December 2016
- CA 4.1.3 Part time agency support in place until 23rd April 2016 as substantive appointment has failed despite 2 interview rounds (National shortage of suitably qualified EBME staff)

NEXT STEPS

- CA 4.1.2. Apprenticeship role for band 4&5 EBME to be explored as recruitment unsuccessful.
- CA 4.2 Quality visits exposed lack of checking in PRH ED. Directorate Lead Nurse held accountable to address lapses in practice and report to CN
- CA 4.3 Quality visits have identified variation in practice. CN action as 4.2

RISKS AND ISSUES (Red risks only) No current red risks

BAF Risk Reference 8

ITEMS FOR ESCALATION

CA 4.1.2 Staff resources as difficult to recruit staff in EBME (national issue), may lead to delay in managing existing backlog of repairs
CA 4.1.2 Clinical equipment checking 45% to be complete by end December 2016
CA 4.2 Quality visits exposed lack of checking in PRH ED. Directorate Lead Nurse held accountable to address lapses in practice and report to CN

Compliance Action 5: Privacy & Dignity

HIGHLIGHT REPORT

Date of Update: March 2016

Completed by: Caroline Davies

RAG Status:

Previous	Current	Forecast
R	R	R

KEY: High risk | At risk | On track

Brighton and Sussex University Hospitals NHS Trust

MUST DOs

CA 5.1 Ensure that the privacy of dignity of patients is maintained within the ED, including the current cohort area

CA 5.2 Ensure that women using the day assessment unit have their privacy and confidentiality maintained

SHOULD DOs

CA 5.3 Ensure same sex breaches are being managed in acute areas such as AMU

CA 5.4 Maintain the privacy and dignity of patients on the neurological unit at PRH

CA 5.5 Ensure that information on how to complain is available in languages other than English.

KEY MILESTONES

MILESTONE	STATUS
CA 5.1.1 Full capacity policy to be updated which when implemented will work to reduce the consequences of over-crowding in the cohort area.	
CA 5.1.2 Nurse to be allocated to cohort area to care for and assess the patients, as part of cohort policy	
CA 5.1.3 P&D to be maintained when patients in cohort area	
CA 5.2 The day unit will move as part of the Birth Centre business case and all clinical assessment areas are individual rooms with doors. As an interim arrangement, curtains will be used.	
CA 5.3 To ensure that that same sex breaches are eliminated or kept to a minimum. Screens to placed between patients if required	
CA 5.4 To change access arrangements in neuro ITU. Service will move	
CA 5.5 Provide information in different languages on complaints leaflet	

KPI UPDATE

Same sex breaches

Patient Complaints and PALs data

Friends and family test / Patient voice– qualitative and quantitative data

Cohort data –average patient - wait 74 mins (w/e 6.3.16)

KEY ACHIEVEMENTS / COMMENTARY

- CA 5.1.1 The cohort area continues to take multiple patients for long periods of time. Draft Escalation policy presented at CMB 17.3.16.
- CA5.2 CQC Lead inspector shown day unit patient waiting area, and mitigations for private conversations explained by lead nurse 10.3.16
- CA 5.3 (cohort area)There have been no patient complaints however screens are not in use due to inability to see patients.
- CA 5.3 (rest of Trust) TDA meeting 17.2.16. Director of Nursing from Dartford and Gravesham is doing a site visit at the end of March re. how they manage P&D
- CA5.5 There is a nominated lead for each directorate who will meet with complaints monthly to ensure timely response of the complaints process within the directorate and oversight of learning. All wards have a poster displayed to enable patients and relatives with details on how to raise concerns

NEXT STEPS:

RISKS AND ISSUES (Red risks only)

RISK / ISSUE DESCRIPTION	SCORE	ACTION PLAN
1527 - Unsafe area to look after patients Cohort area – includes P&D	16	Acute floor action plan being implemented to improve patient flow and reduce time in the cohort area
801 - Delivering same sex accommodation	(12)	March 31st review date for risk

ITEMS FOR ESCALATION

BAF Risk Reference 4

CA 5.1.3 Cohort area remains in use at times of high demand. Patients are assessed in co-located cubicles but wait in an open area. No solution to managing P&D in this area has been found that allows nursing visibility of patients

Compliance Action 7: Culture & supporting staff

HIGHLIGHT REPORT

Date of Update: March 2016

Completed by: Helen Weatherill

RAG Status:

Previous	Current	Forecast
A	A	A

KEY: High risk | At risk | On track

Brighton and Sussex University Hospitals NHS Trust

MUST DOs

CA 7.1 Ensure that the values, principles and overall culture in the organisation supports staff to work in an environment where the risk of harassment and bullying is assessed and minimised and where the staff feel supported when it comes to raising their concerns without any fear of recrimination.
CA7.2 Ensure that relationships and behaviours between staff groups, irrespective of race and ethnicity, is addressed to promote safety, prevent potential harm to patients and promote a positive working environment.
CA7.3 & 7.4 Ensure that staff are supported to receive mandatory training in line with trust policy.(centrally & at directorate level)
CA7.5 Ensure that staff receive an annual appraisal.

SHOULD DOs

CA7.6 Ensure parity across wards/units regarding access to training, education and study leave.

KEY MILESTONES

MILESTONE	STATUS
CA 7.1 & 7.2 Values and behaviours (V&B) programme	
CA 7.3 Mandatory training of staff to be supported and part of the directorate performance reviews	
CA 7.4 Launch of the VLE platform and new e learning	
CA 7.5 Staff to receive annual appraisals	
CA 7.6 Study leave policy updated and circulated and parity of access to training.	

KPI UPDATE

- Staff survey
- Staff Friends and Family test
- Appraisal rates
- Statutory & mandatory training compliance
- Attendees on 'Leading the Way, Too'

KEY ACHIEVEMENTS / COMMENTARY

- CA7.1 and 2 Staff survey results are poorer than expected. Presented at FPP Committee 29th February. Staff FFT launched on-line 14.3.16. To date, the *Leading the Way Too* programme uptake is high and new cohort dates released until Dec 2016. *Well-Being* MOT demand continues to grow and new weight management courses commence late March.
- CA 7.3 and 4 The Trust STAM compliance rates as of 7.3.16 are at 48% (mean, all subjects). Working group is addressing validation of data, reducing the backlog, increasing training opportunities and the release of staff for essential training. Bank only staff training a significant issue. Plan to address extends into April as accurate staff numbers and additional training opportunities need to be created.
- CA 7.5 Trust wide appraisal rates continue to increase and are on trajectory to reach 75% by 31st March 2016. As of 14th March, 69.4%

NEXT STEPS

- CA7.1 and 2 Picker attending the Trust 23.3.16 to work with the Trust on an action plan
- CA 7.3 and 4 STAM report mid-march expected to show improvement. Management of Trust Bank and STAM to be managed by HR Department from April

RISKS AND ISSUES (Red risks only)

RISK / ISSUE DESCRIPTION	SCORE	ACTION PLAN
104: Trust staff are not released to attend adequate induction, statutory and mandatory training due to staffing pressures.	20	5/2/2016 E-learning modules require rolling out across the organisation. Information Governance complete. Also Managers need to be able to release staff to attend Statutory and Mandatory training. Escalated to Trust board of Directors with attendance rates. Reports to managers re-established in Feb 2016.

BAF Risk Reference 6

ITEMS FOR ESCALATION

CA 7.1.2 Staff survey results are poorer than expected.
CA7.3 STAM compliance rates 48% 7.3.16 (mean, all subjects)

Compliance Action 8: Centralised booking service

HIGHLIGHT REPORT

Date of Update: March 2016
Completed by Liz Pickering

RAG Status:

Previous	Current	Forecast
A	A	A/G

KEY: High risk | At risk | On track

Brighton and Sussex University Hospitals NHS Trust

MUST DOs

CA 8.1 Ensure that there are effective systems in place so that all patients referrals for assessment or treatment are dealt with accordingly and promptly.
CA 8.2 Continue the work to ensure that the Hub is providing an effective service to patients and staff.
CA 8.3 To share information and lessons learned from implementation of new processes and technologies and to share this knowledge internally and externally across the local health economy.
CA 8.4 Ensure IT connectivity across all clinical bases is at a level where all community midwives can review essential information.

KEY MILESTONES

MILESTONE	STATUS
CA 8.1.1 Booking staff to use Referral Management System (RMS) triaging information to ensure that patients who are coded as urgent are booked within the agreed specialty timeframes	
CA 8.1.2 Each specialty to agree milestones for urgent and routine referrals	
CA 8.1.3 Migrate all specialities onto e-RMS	
CA 8.1.4 Services to review templates and demand. Identify specific clinics/slots to be ring-fenced for 2ww and urgent referrals	
CA 8.1.5 Complete clean up of e-RMS, review of all the queues on the system	
CA 8.1.6 All follow up appts to be booked by reception staff with patient	
CA 8.1.7 Services to review capacity and clinic templates to ensure adequate capacity	
CA 8.1.8 Implement partial booking invites for all routine new referrals	
CA 8.1.9 Staffing profile to be completed on phone call demand. Use phone reports to establish number of repeat callers in a day	
CA 8.10 Clinic staff to be trained in 18 week pathway rules	
CA 8.2 Numerous actions – all completed and BAU	
CA 8.3 To hold a lessons learned exercise or debrief following the review and improvements within the booking hub and to share with our partners.	
CA 8.4 The Trust has worked through the requirements of ensuring connectivity for midwives in the community and submitted a bid through the Nursing technology Fund	

KPI UPDATE Central book hub dashboard

KEY ACHIEVEMENTS / COMMENTARY

- CA8.1.4 Dashboard in place. 2 systems also in place - 'ALLOCATE' , a consultant rostering tool and 'OASIS' in theatres.
- CA 8.1.5 90% complete . Reviewed at weekly PTL meeting
- CA 8.1.6 creating a 'to be checked' tab on PTL to validate outstanding F/U patients and book where necessary.
- CA 8.1.7 Addressed at each PTL
- CA 8.1.8 commenced 2-way texting reminders to patients. DNA report run monthly to track rates
- CA 8.1.9 call response rates is currently 26% and complaints have doubled. Case for Change agreed 3/3/16 and commenced.
- CA 8.4 All community midwives had smart-phones and an off-shoot of the BSUH network at Goodwood court has been installed (community base).

NEXT STEPS:

- CA8.1 An explicit 4week action plan to address the backlog of referrals and associated risk (1584) Commenced 16.3.16.

RISKS AND ISSUES (red risks only)

RISK / ISSUE DESCRIPTION	SCORE	ACTION PLAN
1537 Outpatient booking deficits & backlog of referrals for DigestD being booked concern that follow ups are not being uploaded	16	Developing robust report for both directorate and bookers to use. New team working to be put in to place

ITEMS FOR ESCALATION – as on the Risk register

Brighton and Sussex University Hospitals NHS Trust

Appendix 2

Statement of Purpose

BSUH is the regional teaching hospital working across two sites: the Royal Sussex County Hospital in Brighton and the Princess Royal Hospital in Haywards Heath. The Brighton campus includes the Royal Alexandra Children's Hospital and the Sussex Eye Hospital.

We provide District General Hospital services to our local populations in and around the City of Brighton and Hove, Mid Sussex and the western part of East Sussex. We also provide more specialised and tertiary services for patients across Sussex and the south east of England.

Both hospitals provide many of the same acute services for their local populations. In addition, the Princess Royal Hospital is our centre for elective surgery and the Royal Sussex County Hospital is our centre for emergency and tertiary care. Our specialised and tertiary services include neurosciences, neonatal, paediatrics, cardiac, cancer, renal, infectious diseases and HIV medicine. We are also the major trauma centre for the region.

We treat over three quarter of a million patients each year. Working as one hospital across two sites, and playing to the strengths of both, gives us the flexibility to develop services which meet the needs of our patients at different stages of their treatment and care.

Central to our ambition is our role as a developing academic centre, a provider of high quality teaching, and a host hospital for cutting edge research and innovation; and on this we work with our partners, Brighton and Sussex Medical School (BSMS) and the Kent, Surrey and Sussex Postgraduate Deanery, as well as with our local universities.

We also work in close partnership with our local GPs to ensure that we are especially attentive to the quality of our District General Hospital services, especially how well we look after our most elderly patients, and that these services are provided and improved in ways which best meet the needs of those patients and their families.

More information on BSUH's work, ambitions and objectives can be found on its website: www.bsuh.nhs.uk.

The services provided at the Royal Sussex County Hospital include:

- Medicine includes elderly, dermatology, respiratory
- Clinical infection service
- Haematology/oncology
- Trauma
- Surgery including vascular, upper GI, complex urology, Gynae oncology, head and neck cancer
- Renal services including dialysis
- Cardiac services including cardiac surgery

- Breast care services
- Accident and emergency
- Elective ophthalmology services
- Maternity
- Paediatrics and neonates including day case
- HIV
- Oncology, including haematology–oncology
- Intensive care
- Orthopaedics
- Neurosciences including neurosurgery and neuro- intensive care

The services provided at the Princess Royal Hospital include:

- Medicine includes elderly, dermatology, respiratory
- General elective surgery
- Accident and Emergency
- Intensive care
- Orthopaedics
- Maternity
- Rehabilitation

The services provided at Brighton General Hospital include:

- Physiotherapy
- Dermatology
- Outpatients

We are registered with the CQC to provide services from:

- Royal Sussex County Hospital (RSCH)
- Princess Royal Hospital (PRH)
- Lewes Victoria Hospital (LVH)
- The Park Centre for Breast Care
- Hove Polyclinic (HPC)
- Bexhill Haemodialysis Satellite Unit
- Brighton General Hospital (BGH)
- Worthing Dialysis Satellite Unit (WDU)

Nominated Individual for the organisation

Gillian Fairfield
Chief Executive
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Trust Headquarters,
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The regulated activities that are provided by BSUH at these sites are:

	RSCH	PRH	Bexhill	HPC	LVH	Park Centre	BGH	WDU
Treatment of disease, disorder or injury	Yes	Yes	Yes	Yes		Yes	Yes	Yes
Assessment of medical treatment for persons detained under the Mental Health Act 1983	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Surgical procedures	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
Diagnostic and screening procedures	Yes	Yes	Yes	Yes		Yes	Yes	Yes
Maternity and midwifery services	Yes	Yes						
Termination of pregnancies	Yes	Yes						

Revised April 2016