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
The new Chief Executive Officer, Gillian Fairfield will become the nominated individual for the Trust from 1st April 2016.

<table>
<thead>
<tr>
<th>Links to corporate objectives</th>
<th>The CQC action plan supports the objectives of <strong>excellent outcomes; great experience; empowered skilled staff.</strong></th>
</tr>
</thead>
</table>
| 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:

<table>
<thead>
<tr>
<th>RISK / ISSUE DESCRIPTION</th>
<th>SCORE</th>
<th>ACTION PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unscheduled Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1483 - Flow out of the Acute Floor /Increased waiting times in Emergency Departments which effects standards of care</td>
<td>16</td>
<td>A programme has been established, with a critical path incorporating all relevant projects being developed.</td>
</tr>
<tr>
<td>Privacy and Dignity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1527 - Unsafe area to look after patients Cohort area – includes P&amp;D</td>
<td>16</td>
<td>Acute floor action plan being implemented to improve patient flow and reduce time in the cohort area</td>
</tr>
<tr>
<td>801 - Delivering same sex accommodation</td>
<td>12</td>
<td>Review due 31st March</td>
</tr>
<tr>
<td>Staffing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1480 - PRH ED children’s services – public perception full time service (Ref 1480)</td>
<td>16</td>
<td>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.</td>
</tr>
</tbody>
</table>
## 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)

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**Wendy Cookson, Director of Improvement**  
**Elma Still, Associate Director of Quality**  
**March 2016**
Appendix 1  Assurance Brief March 2016

Assurance Brief – March 2016
Quality Improvement Plan

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

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.
**Compliance Action 1:**

**Unscheduled Care**

**Date of Update:** March 2016

**Completed by:** Simon Maurice

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### 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 divers 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

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### KEY MILESTONES

<table>
<thead>
<tr>
<th>MILESTONE</th>
<th>STATUS</th>
</tr>
</thead>
<tbody>
<tr>
<td>CA1.1.1</td>
<td>Secure additional capacity</td>
</tr>
<tr>
<td>CA1.1.7</td>
<td>Implement 24/7 Surgical Assessment Unit</td>
</tr>
<tr>
<td>CA1.1.8</td>
<td>Implementation of Right Care, Right Place, Right Time across all Barry Building wards</td>
</tr>
<tr>
<td>CA1.1.10</td>
<td>Implementation of Right Care, Right Place, Right Time Trustwide</td>
</tr>
<tr>
<td>CA1.1.9</td>
<td>Focus on early discharges, reducing Length of Stay</td>
</tr>
<tr>
<td>CA2.3</td>
<td>Implement Escalation Policy &amp; Full Capacity protocol</td>
</tr>
<tr>
<td>CA1.1.8</td>
<td>All patients having their discharge plan created and monitored using the eQOld Discharge Planning tool. (Training package rollout in conjunction with Right Care, Right Place, Each Time rollout)</td>
</tr>
<tr>
<td>ED008</td>
<td>Improvement in ambulance handover times</td>
</tr>
<tr>
<td>ED033</td>
<td>Improve signage on acute floor</td>
</tr>
</tbody>
</table>

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### 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.
- CA1.1.2 Implementation of whiteboard system across the organisation from 1st March 2016.
- CA2.3 New Escalation Policy approved by Clinical Management Board 17.3.16.

### NEXT STEPS:
- CA1.1.1 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
- CA1.1.2 and 9 New discharge lounge at PRH to be implemented on Balcombe Ward

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### RISKS AND ISSUES

<table>
<thead>
<tr>
<th>RISK / ISSUE DESCRIPTION</th>
<th>SCORE</th>
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</tr>
</thead>
<tbody>
<tr>
<td>1483 - Flow out of the Acute Floor; Increased waiting times in Emergency Departments which effects standards of care</td>
<td>6</td>
<td>A programme has been established with a critical path incorporating all relevant projects being developed.</td>
</tr>
</tbody>
</table>

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### BAF Risk Reference 15/16 & 1

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### ITEMS FOR ESCALATION
- CA2.3 The escalation policy will incorporate the cohort protocol 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: G

Brighton and Sussex University Hospitals

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.
CA 2.6 Ensure that staff at all levels feel confident about reporting incidents so that learning and improvements to practice can take place.
CA 2.7 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 whether the incident is closed | Green
CA2.4.2 Provide monthly feedback reports for staff in each area | Green
CA2.4.3 To use team briefs to feedback lessons from serious incidents | Green
CA2.4.4 Develop a network of safety leads across the trust with a focus on sharing and embedding learning from patient feedback | Green
CA2.4.5 Develop a human factors and simulation faculty | Green
CA2.4.6 Develop Safety projects e.g., AKI, deteriorating patients | Green
CA2.4.7 Implement the safety, quality and patient experience strategy | Green
CA2.5 Directorate to review complaints and share learning with staff | Green
CA2.6 Emphasize the importance of reporting and ensure learning is shared through central resources and locally | Green
CA2.7 Training for staff and raising awareness of major incident actions, AAR districts following major incident | Green

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 2010. 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.
- CA2.4.7 Quality Accounts 16/17 and business planning 16/17 quality 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 specialties, 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 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

**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 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.

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

**KPI UPDATE**
- Environmental audits/6 Facet survey action plan
- Patients Voice
- Complaints & plaudits
Compliance Action 4: Equipment

Date of update: March 2016
Completed by: Brian Jolley

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

<table>
<thead>
<tr>
<th>MILESTONE</th>
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</tr>
</thead>
<tbody>
<tr>
<td>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</td>
<td>Green</td>
</tr>
<tr>
<td>CA 4.1.2 Urgently continue recruitment process to cover current Band 4 and Band 5 EBME posts.</td>
<td>Green</td>
</tr>
<tr>
<td>CA 4.1.3 Instigate additional external temporary resources to assist with backlog.</td>
<td>Green</td>
</tr>
<tr>
<td>CA 4.2 Daily documented checks of all paediatric equipment in ED at PRH and cleaned as appropriate</td>
<td>Green</td>
</tr>
<tr>
<td>CA 4.3 Nursing staff on all wards to complete the daily checks and document on the recording sheet</td>
<td>Green</td>
</tr>
</tbody>
</table>

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
Date of Update: March 2016
Completed by: Caroline Davies

**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**

<table>
<thead>
<tr>
<th>MILESTONE</th>
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</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
<td>Red</td>
</tr>
<tr>
<td>CA 5.1.2 Nurse to be allocated to cohort area to care for and assess the patients, as part of cohort policy</td>
<td>Green</td>
</tr>
<tr>
<td>CA 5.1.3 P&amp;D to be maintained when patients in cohort area</td>
<td>Green</td>
</tr>
<tr>
<td>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.</td>
<td>Green</td>
</tr>
<tr>
<td>CA 5.3 To ensure that same sex breaches are eliminated or kept to a minimum; Screens to be placed between patients if required</td>
<td>Yellow</td>
</tr>
<tr>
<td>CA 5.4 To change access arrangements in neuro ITU. Service will move</td>
<td>Green</td>
</tr>
<tr>
<td>CA 5.5 Provide information in different languages on complaints leaflet</td>
<td>Green</td>
</tr>
</tbody>
</table>

**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.
- CA 5.2 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
- CA 5.5 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)**

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

**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: A
- Current: A
- Forecast: A

**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)**

<table>
<thead>
<tr>
<th>Risk / Issue Description</th>
<th>Score</th>
<th>Action Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>104: Trust staff are not released to attend adequate induction, statutory and mandatory training due to staffing pressures.</td>
<td>20</td>
<td>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.</td>
</tr>
</tbody>
</table>

**KPI Update**
- Staff survey
- Staff Friends and Family test
- Appraisal rates
- Statutory & mandatory training compliance
- Attendees on ‘Leading the Way Too’

**BAF Risk Reference 6**

**Items for Escalation**
- CA7.1.2 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
Date of Update: March 2016
Completed by Liz Pickering

RAG Status: A A AVG

KEY MILESTONES

<table>
<thead>
<tr>
<th>MILESTONE</th>
<th>STATUS</th>
</tr>
</thead>
<tbody>
<tr>
<td>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</td>
<td>Green</td>
</tr>
<tr>
<td>CA 8.1.2 Each specialty to agree milestones for urgent and routine referrals</td>
<td>Green</td>
</tr>
<tr>
<td>CA 8.1.3 Migrate all specialties onto e-RMS</td>
<td>Yellow</td>
</tr>
<tr>
<td>CA 8.1.4 Services to review templates and demand, identify specific clinics/slots to be ring-fenced for urgent and routine referrals</td>
<td>Red</td>
</tr>
<tr>
<td>CA 8.1.5 Complete clean-up of e-RMS, review of all the queues on the system</td>
<td>Red</td>
</tr>
<tr>
<td>CA 8.1.6 All follow-up spots to be booked by reception staff with patient</td>
<td>Green</td>
</tr>
<tr>
<td>CA 8.1.7 Services to review capacity and clinic templates to ensure adequate capacity</td>
<td>Green</td>
</tr>
<tr>
<td>CA 8.1.8 Implement partial booking invites for all routine new referrals</td>
<td>Red</td>
</tr>
<tr>
<td>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</td>
<td>Green</td>
</tr>
<tr>
<td>CA 8.1.10 Clinic staff to be trained in 18 week pathway rules</td>
<td>Green</td>
</tr>
<tr>
<td>CA 8.2 Numerous actions - all completed and BAU</td>
<td>Green</td>
</tr>
<tr>
<td>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</td>
<td>Green</td>
</tr>
<tr>
<td>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</td>
<td>Green</td>
</tr>
</tbody>
</table>

KEY ACHIEVEMENTS/COMMENTARY
- CA 8.1.4 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-site of the BSUH network at Goodwood, court has been installed (community base).

NEXT STEPS:
- CA 8.1 An explicit 4 week action plan to address the backlog of referrals and associated risk (1584) Commenced 16.3.16.

RISKS AND ISSUES (red risks only)

<table>
<thead>
<tr>
<th>RISK / ISSUE DESCRIPTION</th>
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<th>ACTION PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>1337 Outpatient booking deficits &amp; backlog of referrals for DigestD being booked concern that follow ups are not being uploaded</td>
<td>16</td>
<td>Developing robust report for both directorate and bookers to use. New team working to be put in to place uploaded</td>
</tr>
</tbody>
</table>

KPI UPDATE: Central book hub dashboard

ITEMS FOR ESCALATION - as on the Risk register
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
Brighton and Sussex University Hospital
Trust Headquarters,
St Marys Hall
Eastern Road
Brighton
BN2 5JF
01273-696955
The regulated activities that are provided by BSUH at these sites are:

<table>
<thead>
<tr>
<th></th>
<th>RSCH</th>
<th>PRH</th>
<th>Bexhill</th>
<th>HPC</th>
<th>LVH</th>
<th>Park Centre</th>
<th>BGH</th>
<th>WDU</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment of disease, disorder or injury</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Assessment of medical treatment for persons detained under the Mental Health Act 1983</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Surgical procedures</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Diagnostic and screening procedures</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Maternity and midwifery services</td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td>Termination of pregnancies</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
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Revised April 2016