

Meeting:	Brighton and Sussex University Hospitals NHS Trust Board of Directors
Date:	25th January 2016
Board Sponsor:	Sherree Fagge, Chief Nurse
Paper Author:	Elma Still, Associate Director of Quality
Subject:	Care Quality Commission (CQC)

Executive summary

The purpose of this paper is to update the Board on the progress of the Emergency department action plan and the May 2014 action plan, provide a summary of the work being undertaken in advance of the Chief Inspector of Hospitals (CIH) visit and identify the key challenges over the next three months.

The issues identified in the ED report are being taken forward through the Level 5 reconfiguration work, Right Care, Right Place, Each Time programme, additional capacity work and the ED safety and quality group.

Progress with the eight compliance actions from the May 2014 CQC report (listed in Appendix 1) continue but there are a number of key risks. These include:

Patient flow through the trust, and performance against the four hour Accident & Emergency standard, which is described in the report on Urgent Care.

A change in the Referral Management System (RMS) has led to issues in receiving referrals from patients GPs which led to a backlog. This is being actively addressed and the backlog is anticipated to be reduced by the end of February. Urgent referrals are being received separately to ensure timely review.

The move of Soft Facilities Management teams in house has led to a shortage in staff due a number of staff leaving. There has been active recruitment and numbers of cleaning staff will be increased.

Storage continues to be an issue across both sites and there is a focus on removing unwanted items on the wards to facilitate improved storage.

There have been overall improvements in the planned maintenance programme but a national shortage of EBME staff has continued to pose a risk as the posts are filled with agency staff.

Staffing has improved through a successful recruitment programme but staff need to ensure that appraisals and statutory and mandatory training are being undertaken and recorded. The new e learning system has been introduced and there is currently a focussed piece of work to input and capture the data centrally.

Emerging Risks

In addition to the risks identified in the 2014 and 2015 action plans, there are a number of additional risks as follows:

- Planned care performance, including waiting times and cancelled operations and its impact on the experience of patients
- Never Events in Theatres
- Uneven performance against the four hour Accident & Emergency standard at PRH
- Compliance with statutory and mandatory training

These risks are discussed at the Board, and plans to address them will be reviewed at the Board Committees in February.

Governance

The Improving Quality and Patient Experience Group will move from a monthly to a weekly meeting. It is chaired by the Chief Nurse and will review progress and delivery of actions from the previous CQC reports and any issues identified through the Quality visit programme. Any slippage will be escalated to the Executive Team which will receive a weekly report on progress.

A Board Seminar was held this month to discuss the Well Led domain.

Quality visits are taking place weekly to review the wards readiness and to identify good practice and any areas where improvements need to be made. Themes will be shared at the Practice Improvement meeting and other appropriate forums.

Links to corporate objectives	The CQC action plan supports the objectives of <i>excellent outcomes; great experience; empowered skilled staff;</i>
Identified risks and risk management actions	Risk 1. Non Compliance with CQC regulations and the potential adverse impact on Trust ratings. Risk 2. Adverse impact on future Foundation Trust authorisation. Key risks are described in the Executive Summary above
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 and Board
Appendices	Appendix 1 Assurance briefing December 2015 Appendix 2. Statement of Purpose

Action required by Board of Directors

The Board is asked to discuss and note the content of the report, progress with the CQC action plan and the risks described in the report

Report to the Board of Directors, 25th January 2016

Care Quality Commission (CQC) report

Purpose

The CQC have informed the Trust that they will visit on 4th -8th April 2016 for a comprehensive announced inspection. The purpose of this paper is to update the Board on the progress of the Emergency department action plan and the May 2014 action plan, provide a summary of the work being undertaken in advance of the Chief Inspector of Hospitals (CIH) visit and identify the key challenges over the next three months.

CQC report - Emergency Department (ED) June 2015 and action plan

The CQC visited the Emergency department at Royal Sussex County Hospital as part of a responsive visit in June 2015. There were three 'Must Do' actions, two of which related to Emergency care and the associated patient flow in the hospital, namely, '*Reduce the numbers of patients cared for in the cohort area within the emergency department (and the regularity with which congestion occurs in this area) and ensure timely assessment of patients arriving in the department*', and '*Ensure that appropriate staffing levels and skill mix is in place to meet the needs of the patients within the department and support the process of improvement*'. The third 'Must do' related to Board level assurance which stated '*Enhance board level effectiveness to ensure progress with the emergency department improvement plans.*'

The Unscheduled Care Programme Board continues its progress with the inter-related work programmes, namely; the Level 5 reconfiguration (Acute Floor Project) and Right Care, Right Place, Each Time and additional capacity programmes. Other issues which included: consistent cleaning between patients, improved record keeping and safeguarding training, have been added to the ED round (safety and quality) meeting so that the actions and improvements can be monitored through their action log. The Associate Director of Quality has met with the new ED consultant lead to review progress and collate evidence to demonstrate the improvements.

Whilst there had been a positive improvement in the trust overall 4 hour performance against the trajectory up to the end of December, a dip in performance in the New Year is now being recovered. The number of hours in the cohort area has continued to decrease with the improvement in patient flow. This work is being facilitated by the rollout of *Right Care, Right Place, Each Time* across the hospital, which is now in Phase 6 with Renal and Cardiac wards participating in the programme. Discharges before midday have increased to 21% from 13%; the use of the discharge lounge has improved such that 130 patients are now using the facility per week compared with 40-60 per week; and there has been a reduction in the percentage of patients

staying over 10 days from 41.4% to 36.5% (mid-December data). It is imperative for these improvements to continue, to ensure that improvements in patient flow and the benefits to our patients' experience are realised.

The risks in ED include the winter has been relatively mild to date and if this changes significantly it will have an impact on patient numbers, staffing and flow. The full capacity protocol and ambulance handover protocol need to have final sign off and be implemented consistently. There is shortly to be new nursing lead appointment.

The Board metrics have been reviewed to facilitate tracking and assurance and include time to initial assessment, time to treatment, escalation status and ambulance handover.

A follow up risk summit was held in in December led by NHS England, with attendance from the Trust Development Authority, the Clinical Commissioning Groups (CCG), the CQC, the General Medical Council, Health Education England, Healthwatch, Brighton and Hove City Council. They discussed the progress of the plan and the impact of the Acute Floor Project and *Right Care, Right Place, Each Time* programmes. A follow up date in February has been agreed to ensure that if the improvement continues, the process can be signed off.

The Chief Executive, Chief Nurse, Chief Operating Officer and consultant leads for ED and *Right Care, Right Place, Each Time* have met members of Brighton and Hove Overview and Scrutiny Committee, East Sussex and West Sussex Health and Social Care Scrutiny Committees as part of an in depth review of progress against the ED action plan which was well received.

Progress with May 2014 action plan

The Improving Quality and Patient Experience (IQPE) Group continue to meet monthly to review evidence to support progress against the work streams from the May 2014 action plan. In January, the corporate and operational leads presented an update for Unscheduled Care, Booking hub, Facilities and Estates, Equipment and Staffing.

The key challenges that arose from the work-streams included:

Unscheduled care and the patient flow pathway (Compliance action 1) continue to be a challenge for the trust whilst acknowledging that progress is being made against the trajectory as described above. The designs for the new Urgent Care centre are anticipated to be finalised by April 2016 which will improve the environment, clinical facilities and line of sight of patients.

Patients still remain in recovery for longer periods than needed due to the lack of beds in the trust. These patients are generally post-surgery and the work on patient flow needs to continue to improve through the hospital to ensure that only appropriate patients are cared for in recovery.

Booking hub (Compliance action 8) - There has been a change in the Referral Management System (RMS) in the booking hub instigated by the CCG. This led to major issues in receiving referrals from patients GPs which led to a backlog. This is being actively addressed and the backlog is anticipated to be reduced by the end of February. Urgent referrals are being received separately to ensure timely review.

Staffing guidance on changing from agency to substantive posts imposed by the Department of Health, had an impact on increasing sickness levels substantially. This had an effect on service delivery with answering calls and the number of complaints of patients increasing

Facilities and Estates (Compliance Action 3) – the Soft Facilities Management teams have moved in house. There has been a shortage in staff due a number of staff leaving. There has been active recruitment and numbers of cleaning staff will be increased. Environmental audits continue to monitor the cleanliness of areas.

There is a focus on removing unwanted items on the wards to facilitate improved storage but this continues to be a risk. It is essential that beds and equipment are removed from corridors in a timely manner and whilst this has improved, this will be audited to ensure that progress continues.

Equipment (Compliance Action 4) – the recent interviews for staff were unfortunately unsuccessful again. There is a national shortage of EBME staff. There have been overall improvements in the planned maintenance programme and stickers have been introduced which state when the equipment needs to be checked, rather than the date checked. This adds clarity to staff when equipment needs its maintenance check.

Staffing (Compliance Action 6) – the recruitment team were diminished in a previous restructure due to financial pressures and led to an increase in time to employ staff. Interim staff have been agreed to help with the delays and the processes are currently being streamlined. A further piece of work will be undertaken to look at improving staff retention. There has been an increase in appraisal levels to 68.3% and directorates are being asked to increase the percentage by 5% each month.

Overall, whilst there has been progress on the CQC action plans, a more focused delivery programme is being implemented with clear escalation processes for any slippage.

Emerging Risks

In addition to the risks identified in the 2014 and 2015 action plans, there are a number of additional risks to achieving a positive outcome for the CQC inspection, as follows:

- Planned care performance (which includes waiting times and cancelled operations) with particular issues in some challenged specialities e.g

digestive diseases and neurosciences. These are reported in detail elsewhere at the Board, with plans to improve performance.

- The Trust has reported seven never events in 2015/16. The actions and learning from these never events will be discussed in detail at the Quality and Risk Committee in February.
- Levels of statutory and mandatory training
- Uneven performance against the 4 hour accident and emergency standard at PRH which is being addressed through the appointment of additional senior leadership on site.

Assurance briefing

The assurance briefing is produced monthly by the Executive and Operational leads, based on progress against the action plan. The briefing is shared with the Trust Development Authority, local Clinical Commissioning Groups and CQC. It incorporates the 'must do's' and 'should do's' identified from CQC reports. The format reflects the key milestones in terms of delivery of the compliance action. The work streams are cross referenced with the Board Assurance Framework.

(Appendix 1)

Plan for announced CIH visit 2016 – State of readiness

The monthly Improving Quality and Patient Experience meetings chaired by the Chief Nurse will become weekly in January and will be attended by the Associate Director of Quality and Improvement Director and items where there is slippage, escalated to the Executive team. All 'must do' and 'should do' items from the May 2014 and June 2015 CQC visits, have been reviewed with a trajectory for delivery agreed with Executive Director Lead.

A data group has been set up to coordinate and review the data required by the CQC. The substantial data set request is likely to come this month and directorates have been informed as there is a short turnaround.

A Board Seminar was held in November to discuss the ED action plan and a further Board Seminar in January was held to discuss the 'Well Led' domain and identify key challenges within the organisation.

Presentations have been given to the senior management and directorate teams and shared with them to discuss with their staff. The Chief Nurse and Associate Director of Quality are also being invited to discuss the visit with individual teams. Drop in sessions for staff have been arranged at both sites in February and March.

A programme of weekly quality visits has begun with clinical and non-clinical staff volunteering as 'inspectors' to visit and peer review ward areas. These are a

valuable way of identifying good practice within the organisation and areas where improvements need to be made. The ward manager and directorate management team receive feedback and their improvement actions which will be monitored through the IQPE Meeting and areas where sufficient progress is not being made will be escalated to the Exec team. Feedback and themes from the visit will be shared with the Practice Improvement meeting and the Nursing and Midwifery Management Board or other appropriate forums. A mock inspection will be held for all core services on the 2nd and 4th March at RSCH and PRH. These inspections will include internal and external colleagues.

Executive and Non-Executive Director (NED) walkabouts began in January and form part of the Board agenda.

The next quarterly meetings with the directorates are being held in February to identify their state of readiness and how the directorates intend to share their good practice with the CQC

A booklet for staff has been produced which is a Self-Assessment and Improvement tool. It aims to help improve the quality of care and experience for our patients and ensure the people we look after are at the centre of everything we do. 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.

Building on Strong Foundations

The new strategy currently being developed by the CQC, Building on Strong Foundations, is due to be consulted on from January 2016. Part of the CQC inspections from April 2016, will include measures and ratings for the economy and efficiency of service delivery. It will involve how well providers manage their available resources to acquire the appropriate mix of 'inputs' (such as, staff, equipment and medicines) at the lowest cost (economy); and how well they are able to use them and manage their activities to produce the best mix of good quality 'outputs' (efficiency) and will be part of future inspections with our Trust. The Trust will incorporate the measures into the plan when the consultation document is released.

Nominated individual and Statement of Purpose

The CQC have been informed of the interim appointment of the Chief executive officer who is the nominated individual for the organisation. The amended Statement of Purpose reflecting this is attached as an appendix. (Appendix 2)

Elma Still
Associate Director of Quality
January 2016

Assurance Brief – December 2015

Quality Improvement Plan

About the Briefing

This briefing is produced to provide the stakeholders with an assurance report which will include areas for escalation regarding delivery against the BSUH action plan within BSUH and its external partners. The briefings are produced monthly for the Quality Risk Management Meeting chaired by Brighton and Hove CCG, the Integrated Delivery Meeting chaired by the TDA and the Care Quality Commission.

The briefing includes the milestones related to the delivery of the 'must do's'. The key achievements/ commentary relate to an update in month. The risk rated issues are based on the 5 x 5 risk rating matrix described in the 'Trust Risk Management Strategy'. The compliance actions have been cross linked to the Board Assurance Framework.

The table below is a status report of all actions related to the plan

Compliance Action	Theme	Finished	On Target	Delayed	Off Target	Total
CA1	Unscheduled care	4	11	5	2	22
CA2	Lessons learned	18	9	2	0	29
CA3	Facilities & Estates	7	2	1	2	12
CA4	Equipment	2	1	2	0	5
CA5	Privacy & Dignity	3	3	1	1	8
CA6	Staffing	3	11	0	0	14
CA7	Culture and Supporting staff	5	11	2	0	18
CA8	Scheduled care	5	13	2	0	20

The eight compliance actions were:

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 Programme	HIGHLIGHT REPORT Date of Update: 11-12-2015 Completed by: Simon Maurice	RAG Status: KEY:	<table border="1"> <tr> <td>Previous</td> <td>Current</td> <td>Forecast</td> </tr> <tr> <td style="background-color: red; color: white;">R</td> <td style="background-color: orange;">A</td> <td style="background-color: yellow;">A</td> </tr> </table> ● High risk ● At risk ● On track	Previous	Current	Forecast	R	A	A	Brighton and Sussex  University Hospitals <small>NHS Trust</small>																																	
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MUST DOs 1.1 Evaluate the effectiveness of the current patient flow and escalation policy and take action to improve the flow of patients within the ED and across the trust. Improvements are needed with discharge planning and arrangements to ensure people are able to leave hospital when they are ready. The trust must continue to engage with partners and stakeholders to achieve sustainable improvement. 1.3 Ensure that patient flow does not impact on access to services and treatment at PRH 1.5 Ensure that the planning and delivery of care on the obstetrics and gynaecology units meets individual patients needs SHOULD DOs 1.2 Make improvements to the efficiency of discharging patients from postoperative wards 1.4 To improve the provision of mental health services for patients at PRH		KEY ACHIEVEMENTS / COMMENTARY <ul style="list-style-type: none"> SAU to function 7/7 in December 2015 New front door Clinical Navigation assessment model has been introduced Ongoing increased use of the Discharge Lounge at RSCH continuing to support improved patient flow. Rollout of RCRPET to PRH wards. Single clerking process in development for implementation at RSCH by December 2015 New ambulance handover SOP implemented 7 December 2015 NEXT STEPS: <ul style="list-style-type: none"> Development of detailed financial plan and timeline for ambulance front door and UCC works to be finalized. RCRPET rolled out on 5 wards at PRH and all demonstrating improvement Process mapping of Acute Floor administrative processes and systems through the patient journey, to identify any current duplications/ inefficiencies that could be removed Closure of staff consultation to support the Barry Building ward reconfiguration and confirmation of ward reconfiguration date. 																																									
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KPI UPDATE Further development of agreed KPIs to ensure new ECIST requested measures are included within data set. KPIs for wards agreed for Right Care, Right Place, Each Time BAF Risk Reference 15/16 & 1		ITEMS FOR ESCALATION <ul style="list-style-type: none"> Funding support for capital works which enable the ED front door model, improving flow into the acute floor and ambulance turnaround time. 																																									

Compliance Action 2: Lessons learned	HIGHLIGHT REPORT Date of Update: 11-12-2015 Completed by: Steve Drage	RAG Status: KEY:	<table border="1"> <tr> <td>Previous</td> <td>Current</td> <td>Forecast</td> </tr> <tr> <td style="background-color: yellow;">A</td> <td style="background-color: green;">G</td> <td style="background-color: green;">G</td> </tr> </table> ● High risk ● At risk ● On track	Previous	Current	Forecast	A	G	G	Brighton and Sussex  University Hospitals <small>NHS Trust</small>																																
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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 ACHIEVEMENTS / COMMENTARY <ul style="list-style-type: none"> • Message of the week from the Chief Nurse shared with all nursing teams • Safety and quality leads attached to each directorate • Monthly safety, quality and patient experience sent to directorates • Monthly staff stories & Monthly patients first distributed to staff • Safety and quality leads attending the safety and quality meetings to provide support and share learning • All directorates met the Medical Director/Chief Nurse to discuss their governance arrangements and how lessons are learned. A variety of ways are being used NEXT STEPS: <ul style="list-style-type: none"> • Safety & quality team meeting on 21st December to review progress with strategy and next steps. • Weekly quality visits from January to identify areas of good practice and areas for improvement through peer review. 																																								
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CA2.7 Training for staff and raising awareness of major incident actions. AAR debriefs following major incident	12-14																																									
RISK / ISSUE DESCRIPTION	SCORE	ACTION PLAN																																								
DATIX system – problems with the server		Requiring support to update the server																																								
KPI UPDATE Staff survey indicators Monthly patients first Every SI to have a podcast on info net S&Q team attendance at directorate meetings		ITEMS FOR ESCALATION Never events: 6 since January 2015. Round table discussion in November with the TDA was very productive. The TDA head of quality attended. The Trust's approach to reporting and investigation was supported and the actions taken going forward were agreed to be appropriate and proportionate by TDA Head of Quality BAF Risk Reference 6																																								

**Compliance Action 3:
Safety & suitability of
premises**

HIGHLIGHT REPORT

Date of Update: 10-12--2015
Completed by: Dale Vaughan

RAG
Status:

KEY:

Previous	Current	Forecast
A	R	A

● High risk ● At risk ● On track

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 (now moved)

KEY MILESTONES

MILESTONE	DATE	STATUS
CA 3.1.1 To receive approval for the FBC and then subsequent building programme	03-15	On track
CA 3.1.2 A Trust-wide 6 facet survey has been commissioned to inform the Estates Strategy refresh.	11-14	On track
CA 3.1.3 & 4 Rolling programme of estates and Health and safety compliance audits.	10-14	On track
CA 3.1.5 Identify & sign designated holding areas for patient moving equipment	10-14	At risk
CA 3.1.6 Rolling 'Dump the Junk' programme	10-14	On track
CA 3.1.7 PLACE assessments to be reviewed and acted upon	10-14	On track
CA 3.1.8 Beds to be removed from corridors in a timely manner	12-15	High risk
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	9-14	On track
CA 3.3 Review the medicines storage for patient by their bedsides	10-14	On track

KPI UPDATE

- Environmental audits
- Patients voice
- Complaints & plaudits

KEY ACHIEVEMENTS / COMMENTARY

- Approval of funding received from the Treasury
- Soft Facilities management has been brought in house
- Building work continues in Sussex Eye Hospital
- Works completed on Levels 8 and 10 of Thomas Kemp Tower.
- Replacement windows on order for areas of Claude Nicole and Lawson unit.
- The full capacity protocol has been revised and beds have been removed but in times of high demand they are part of the escalation plan
- Director of F&E has reviewed options for bar coding beds, information circulated meeting to be arranged to discuss developing this option
- Porters checking corridors regularly


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.
- Tuesday and Thursday walk rounds to indicate any improvements in the areas visited.
- I'll ask Jan to have this element added into them via portering


RISKS AND ISSUES (Red risks only)


RISK / ISSUE DESCRIPTION	SCORE	ACTION PLAN
CA 3.1.8 Beds to be removed from corridors in a timely manner	High risk	This is due to A&E requiring beds/trolleys to remain close to area so removing beds to store will make this an impossible option due to distance..


BAF Risk Reference 2

Compliance Action 4: Equipment	HIGHLIGHT REPORT Date of update: 10.12.2015 Completed by: Brian Jolley	RAG Status: KEY:	<table border="1"> <tr> <th>Previous</th> <th>Current</th> <th>Forecast</th> </tr> <tr> <td style="background-color: yellow;">A</td> <td style="background-color: yellow;">A</td> <td style="background-color: green;">G</td> </tr> </table> ● High risk ● At risk ● On track	Previous	Current	Forecast	A	A	G	Brighton and Sussex  University Hospitals <small>NHS Trust</small>																		
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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 ACHIEVEMENTS / COMMENTARY <ul style="list-style-type: none"> Defibrillator and Resus suction unit planned maintenance: Fully completed Late 2014. Project is underway for 2015 to complete January 2016. Planned maintenance in neonatal area, PRH, completed last year. PM plans for 2015 in progress Physiotherapy planned maintenance for medical devices is under way for 2015. NEXT STEPS: <ul style="list-style-type: none"> Interviews for Band 4&5 EBME unsuccessful, rescheduled for Jan 11th and 15th 2016. Provision of updated "Tested" labelling for all clinical staff to be introduced this year as per the guidelines from the MHRA document, Managing Medical devices 2015 – In place Part time agency support in place and is beginning to have a positive effect mainly on backlog repairs. Costs to be identified for external support on annual device testing - This is designed to mitigate further risks but will have a significant additional costs 																										
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Compliance Action 5: Privacy & Dignity	HIGHLIGHT REPORT Date of Update: 8-12-2015 Completed by: Caroline Davies	RAG Status: KEY:	<table border="1"> <tr> <td>Previous</td> <td>Current</td> <td>Forecast</td> </tr> <tr> <td style="background-color: red; color: white;">R</td> <td style="background-color: red; color: white;">R</td> <td style="background-color: yellow; color: black;">A</td> </tr> </table> ● High risk ● At risk ● On track	Previous	Current	Forecast	R	R	A	Brighton and Sussex  University Hospitals <small>NHS Trust</small>																																	
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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 ACHIEVEMENTS / COMMENTARY <ul style="list-style-type: none"> No patient complaints on P&D in the cohort area There have been no reportable same sex breaches reported Following a visit from the TDA in cardiac, a discussion was held on 9/12/15 at the Nursing and Midwifery Management Board to reiterate the guidance and exemptions and to ensure staff document discussions with patients and the leaflets are being given. The Deputy Chief Nurse and Head of Nursing for Discharge and Partnerships are working with the cardiac and Clinical Site Team. 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 NEXT STEPS: <ul style="list-style-type: none"> All wards will shortly have on display a poster to enable patients and relatives to know how to raise concerns 																																									
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KPI UPDATE Same sex breach reports – no reportable breaches to date Patient Complaints and PALS data Friends and family test / Patient voice – qualitative and quantitative data Cohort data – time spent in the cohort area and number of patients		ITEMS FOR ESCALATION BAF Risk Reference 4																																									

Compliance Action 6: Staffing	HIGHLIGHT REPORT Date of Update: 02/12/2015 Completed by: Helen Weatherill	RAG Status: KEY:	<table border="1"> <tr> <td>Previous</td> <td>Current</td> <td>Forecast</td> </tr> <tr> <td>A</td> <td>A</td> <td>G</td> </tr> </table> ● High risk ● At risk ● On track	Previous	Current	Forecast	A	A	G	Brighton and Sussex  University Hospitals <small>NHS Trust</small>																								
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MUST DOs CA 6.1 Ensure that there are enough suitably qualified, skilled and experienced staff to meet the needs of all patients. CA 6.2 Review the provision and skills mix of staff to ensure they are suitably trained to meet the needs of children who use the service in ED at PRH CA 6.4 Ensure that there are sufficient numbers of staff for critical care and medical wards CA7.1 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. SHOULD DOs CA 6.3 Ensure that cover is in place for specialist services for Obs & Gynae as part of the workforce planning. Ensure that Obs & Gynae consultants are available to support members of the medical team at all times when on call at PRH CA 6.5 Ensure The provider should ensure that there is a review of the nursing establishment for the Children's Community Nursing Team in light of the concerns raised by staff over the caseload.		KEY ACHIEVEMENTS / COMMENTARY <ul style="list-style-type: none"> The Trust continues to recruit locally, nationally, as well as internationally (within and outside the EU). Activity for both Substantive and Bank Recruitment continues to steadily increase compared to last year's data and presently there are 420 candidates being processed by the Substantive Recruitment Team and 343 being processed by Bank Recruitment. In December 2015 the Trust will be preparing to welcome a cohort of 62 Filipino Nurses between January and March 2016, as the CoS have now been awarded. In addition to this a further request for 19 CoS has been submitted, with a hope that these Nurses will commence in role in April 2016. This more recent request is currently subject to Home Office approval. NEXT STEPS: <ul style="list-style-type: none"> To review provision of medical support for children at PRH Medical cover at night at PRH Investigating the introduction of apprenticeship schemes 																																
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KPI UPDATE October Current 12 month Sickness Absence Rate – 4.1% Average rate 3.1% Turnover Rate – 13.1% Vacancy rate – 7.5%. Average rate 6.3%		ITEMS FOR ESCALATION Whilst the current recruitment drives have been successful there are still outstanding vacancies. The cap on agency rates will also present a challenge for staffing levels. BAF Risk Reference 5, 10 & 3																																

Compliance Action 7: Culture & supporting staff	HIGHLIGHT REPORT Date of Update: <u>02/12/2015</u> Completed by: <u>Helen Weatherill</u>	RAG Status: KEY:	<table border="1"> <tr> <th>Previous</th> <th>Current</th> <th>Forecast</th> </tr> <tr> <td>A</td> <td>A</td> <td>A</td> </tr> </table> ● High risk ● At risk ● On track	Previous	Current	Forecast	A	A	A	Brighton and Sussex  University Hospitals <small>NHS Trust</small>																		
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KPI UPDATE <ul style="list-style-type: none"> Staff survey V&B champions Appraisal rates by directorate Statutory & mandatory training reports Attendees on Leading the Way Too Staff Friends and Family test 		ITEMS FOR ESCALATION Appraisal activity continues to show progress and whilst the rates have slowed we are still seeing increases despite winter pressure. The current appraisal rate is 66.3% with 32% of Trust directorates at, or above, 75% compliance target 50% of directorates improved their rates 90% are at or above 60% 41% are above 70% 14% are above 80% Ongoing monthly communication advertising Directorate league tables, Trust-wide training dates and supporting info-net resources continues to generate requests for team-specific briefings and training conducted by our dedicated project resource. Quarter One report shows the average level of compliance across all of the statutory and mandatory subjects as 53%. Further development work is being undertaken to elicit reports from the new iris system. BAF Risk Reference 6																										

Compliance Action 8: Centralised booking service	HIGHLIGHT REPORT Date of Update: 20/12/2015 Completed by Liz Pickering Sally Howard	RAG Status: KEY:	<table border="1"> <tr> <td>Previous</td> <td>Current</td> <td>Forecast</td> </tr> <tr> <td>A</td> <td>A</td> <td>G</td> </tr> </table> ● High risk ● At risk ● On track	Previous	Current	Forecast	A	A	G	Brighton and Sussex  University Hospitals <small>NHS Trust</small>																					
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MUST DOs CA8.1 Ensure that there are effective systems in place so that patients needing urgent referrals for assessment or treatment are dealt with 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 review the lessons learned from the experience within the booking hub and share lessons across the local health economy 4 Key Objectives established 1. Book patients within 5 days 2. <u>Maximise</u> clinic capacity with effective triage and data quality 3. <u>Eliminate</u> missed calls and answer within 1 minute 4. <u>Minimise</u> cancelled clinics with < 6 weeks notice Also realign service to stay within budget.		Key Achievements / Commentary <ul style="list-style-type: none"> RTT pathway training plan is near completion for the Admin team leaders. Production of SOPs is ongoing. Recruitment of band 3's has been completed with delays in HR in post by Jan 16.. Backlog within RMS continues to grow. Recovery plan is in place, awaiting financial decisions. Outsourcing process and procedures have been developed with use of alternative provider starting January 16 for Dental Reduction in the telephone service continues with opening now 8am – 4pm.. Built the capacity and demand model for the booking hub and monitoring against this continues. NEXT STEPS: Two waytexting and Webpages update will be completed by Jan 16. RMS Oasis project is due to be implemented in January, which will allow priority of referrals to be available on patient tracking list.																													
KEY MILESTONES <table border="1"> <thead> <tr> <th>Milestone</th> <th>Date</th> <th>Status</th> </tr> </thead> <tbody> <tr> <td>CA 8.1 Ensure that there are effective systems in place so that patients needing urgent referrals for assessment or treatment are dealt with promptly. .</td> <td>01/03/2016</td> <td>On target</td> </tr> <tr> <td>CA 8.2 Continue the work to ensure that the Hub is providing an effective service to patients and staff.</td> <td>01/03/2016</td> <td>On target</td> </tr> <tr> <td>CA8.3 To review the lessons learned from the experience within the booking hub and share lessons across the local health economy</td> <td>01/03/2016</td> <td>On target</td> </tr> </tbody> </table>		Milestone	Date	Status	CA 8.1 Ensure that there are effective systems in place so that patients needing urgent referrals for assessment or treatment are dealt with promptly. .	01/03/2016	On target	CA 8.2 Continue the work to ensure that the Hub is providing an effective service to patients and staff.	01/03/2016	On target	CA8.3 To review the lessons learned from the experience within the booking hub and share lessons across the local health economy	01/03/2016	On target	RISKS AND ISSUES <table border="1"> <thead> <tr> <th>RISK / ISSUE DESCRIPTION</th> <th>SCORE</th> <th>ACTION PLAN</th> </tr> </thead> <tbody> <tr> <td>Financial reduction = 5 wte agency staff let go + bank overtime to bring within the financial envelope</td> <td>16</td> <td>Tailor services within booking centre without compromising services</td> </tr> <tr> <td>Eliminate missed calls and answer within 1 minute but within reduced financial envelope</td> <td>16</td> <td>Training for new staff, plus condense telephone opening hours</td> </tr> <tr> <td>Increasing backlog with RMS</td> <td>15</td> <td>Asked for financial help with overtime to bring back into service, otherwise delays are inevitable</td> </tr> <tr> <td>MSK Referrals with incorrect clock start dates (IPT forms incomplete or incorrect)</td> <td>12</td> <td>Work with MSK to ensure a robust process</td> </tr> </tbody> </table>			RISK / ISSUE DESCRIPTION	SCORE	ACTION PLAN	Financial reduction = 5 wte agency staff let go + bank overtime to bring within the financial envelope	16	Tailor services within booking centre without compromising services	Eliminate missed calls and answer within 1 minute but within reduced financial envelope	16	Training for new staff, plus condense telephone opening hours	Increasing backlog with RMS	15	Asked for financial help with overtime to bring back into service, otherwise delays are inevitable	MSK Referrals with incorrect clock start dates (IPT forms incomplete or incorrect)	12	Work with MSK to ensure a robust process
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Appendix 2

Statement of Purpose

Brighton and Sussex University Hospitals NHS Trust (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

Amanda Fadero
 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:

	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 January 2016