Meeting:	**Brighton and Sussex University Hospitals NHS Trust** **Trust Board**
Date:	**March 2015**
Board Sponsor:	**Sherree Fagge, Chief Nurse**
Paper Author:	**Elma Still, Associate Director of Quality**
Subject:	**Care Quality Commission**

Executive summary

The purpose of this paper is to update the Trust Board on progress against the action plan following the CQC visit in May 2014.

The Improving Quality and Patient Experience Group meets monthly to review evidence to support progress against the action plan. In February, each of the Executive/Operational leads attended to discuss progress and in March, each of the directorates met to discuss progress within their area against issues identified during the visit. A summary table is attached (Appendix 1). The RAG status reflects the evidence to support the delivery of the plan. Whilst some process actions may have been achieved, it is important that practice is embedded across the organisation.

A monthly assurance briefing is prepared which is sent to the TDA, CCG and CQC. A copy of the March 2015 briefing is attached. This RAG status reflects whether the action plan is running to time and whether the evidence is triangulated. (Appendix 2)

The Fundamental Standards of Care will come into force in April 2015. A baseline assessment is being undertaken to ensure that the trust complies with these standards and aims to provide a level of excellence for our patients.

The CQC have produced guidance on publishing the organisations ratings and this comes into force on April 1st, 2015.

The Associate Director of Quality has met with all the directorate teams to discuss the implications of the Fundamental Standards of Care and ways in which they can assure compliance within their teams.

Links to strategic objectives	Best and Safest Care√
Identified risks and risk management actions	Risk 1. Non Compliance with CQC standards and the potential adverse impact on Trust ratings. Risk 2. Adverse impact on future Foundation Trust authorisation. **Management actions**. Specific risk management actions will depend on the outcome and teams concerned.

Resource implications	None
Legal implications	If the Trust does not comply with the registration requirements, the CQC may issue compliance, warning notice or enforcement actions.
Report history	Not applicable
Appendices	Appendix 1. CQC summary table of progress against the action plan Appendix 2 Assurance briefing March 2015
Action required by Trust Board The Trust Board are asked to note the content of the report.	

Care Quality Commission (CQC) report

Trust Board

March 2015

1. Purpose

The purpose of this report is to update the Trust Board on progress with the CQC action plan following the CQC visit in May 2014. It includes the assurance briefing provided to the Trust Development Authority (TDA), Clinical Commissioning Groups (CCG) and the CQC. The report also highlights changes in legislation being introduced by the CQC on 1st April 2015.

2. Progress with action plan

The Improving Quality and Patient Experience Group meets monthly to review evidence to support progress against the action plan. In February, each of the Executive/Operational leads attended the meeting to discuss progress and in March, each of the directorates met to confer progress within their area against issues identified during the visit. A summary table is attached (Appendix 1). The RAG status reflects the evidence to support the delivery of the plan. Whilst some process actions may have been achieved, it is important that practice is embedded across the organisation.

Key risks

The trust has seen a small and sustained improvement in patient flow at the beginning of March. This has coincided with a noted decrease in acuity and a reduction in the age profile of admitted patients. The continuing work around improving patient flow is key to the delivery of the overall plan and agreement has been reached following national guidance with CCGs to roll the winter monies through the Easter period and into May. This will allow continuance of many of the schemes that are supporting flow to continue whilst substantive plans are worked up in this planning round to make them substantive. This still remains a key challenge within the organisation.

Lack of storage for equipment continues to pose difficulties in ensuring that corridors are kept free of beds and equipment to facilitate a safer environment and whilst this may be solved in the longer term with the 3Ts programme, short term it is necessary to continue to use innovative ways in maintaining a safe and clutter free environment (relates to CA 3.1 in Appendix 1).

The release of staff for training has been difficult due to staffing on the wards. This was identified as an issue in the Emergency Department for PRH. Training days have now been organised for staff to receive paediatric training and this should an improvement in the next report (CA 6.2). The release of staff has been an issue across the trust for statutory and

mandatory training and has also had an impact on staff receiving appraisals. This was compounded by the change in directorate structure and realignment of staff on the computer system to capture the data. (CA7.3, 7.4 and 7.5). The success of the nursing recruitment programme across the trust (over 205 nurses have been offered posts) will begin to be realised over the next 6 months as they begin to work in the trust. Further agreement by the trust to fund maternity leave cover will also help to release staff for training and appraisals.

The staff survey has been received by the trust and will inform the work plan of the People and Well-being Strategy. The Trust performed least favourably with other acute trusts in England for staff receiving well structured appraisals, experiencing physical violence from staff and patients, staff witnessing potentially harmful errors, near misses or incidents and staff suffering work related stress in the last 12 months. These results emphasise the pressurised and stressful environment that staff have been working within and have been exacerbated by the issues with patient flow. The staff survey results are likely to impact on the next intelligent monitoring report which is due to be published in May 2015.

The Associate Director of Quality met the local CQC inspector on 19th March to discuss progress with the plan and to review evidence. These meetings are every 6 weeks and will also cover broader quality and safety issues within the trust.

The Associate Director of Quality also met with the Quality Manager – South, NHS Trust Development Authority on 16th March to discuss the action plan, the associated evidence and the assurance processes in the trust.

3. 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 TDA, local CCGs and CQC. The assurance briefing for March is attached as Appendix 2. The briefing gives a summary which reflects the pathways of work and progress against their delivery.

The RAG status indicates whether the action plan is running to time and if the evidence is triangulated

4. Fundamental Standards of Care

The Fundamental Standards of Care come into force in April 2015. A baseline assessment is being undertaken to ensure that the trust complies with these standards and aims to provide a level of excellence for our patients.

The Associate Director of Quality has met with all the directorate teams to discuss the implications of the Fundamental Standards of Care and ways in which they can assure compliance within their teams. The directorates have safety and quality meetings which will review the fundamental standards as part of their agenda and they will begin to collate evidence on an ongoing basis in the future using the Sharepoint site.

5. Publishing the CQC ratings

The CQC has issued guidance on compliance with the new legislation was published on 12th March and states that organisations must display their performance ratings from 1st April, 2015. The organisation must display its rating at each and every premise where a regulated activity is being delivered and on the trusts website. The guidance is available: http://www.cqc.org.uk/content/display-ratings. The Associate Director of Quality will work with the Communications team to ensure that these are in place by 1st April.

Appendix 1

CQC Action plan – Summary table

March 2015

KEY OF ACTION IDENTIFIED IN THE PLAN AS FOLLOWS:		**PROGRESS KEY**	
MD	Must Do Action	**Finished**	**Complete**
SDD	Should Do Action	**On Target**	**Green**
CD	Could Do Action	**Delayed**	**Amber**
QI	Quality Improve	**Off target**	**Red**

			Date for completion	Previous Status	Current status
Unscheduled care (Compliance Action 1&2)	CA1.1		30/11/2014	Amber	Amber
	CA1.2		30/10/2014	Amber	Amber
	CA1.3		01/01/2015	Red	Red
	CA1.4		30/01/2015	Green	Green
	CA1.5		31/10/2014	Green	Green
	CA2.1		01/11/2014	Amber	Amber
	CA2.2		30/04/2014	Red	Amber
	CA2.3		01/10/2014	Amber	Amber

			Date for completion	Previous Status	Current status
Lessons learned (Compliance action 2)	CA2.4		30/01/2015	Red	Amber
	CA2.5		30/11/2014	Red	Amber
	CA2.6		31/12/2014	Amber	Green
	CA2.7		30/04/2015	Green	Green

			Date for completion	Previous Status	Current status
Facilities & Estates (Compliance Action 3)	CA3.1		30/03/2015	Green	Red
	CA3.2		30/09/2014	Amber	Amber
	CA3.3		30/10/2014	Amber	Amber

			Date for completion	Previous Status	Current status
Equipment (Compliance Action 4)	CA4.1		01/04/2015	Amber	Amber
	CA4.2		30/09/2014	Amber	Amber
	CA4.3		30/09/2014	Amber	Green

			Date for completion	Previous Status	Current status
Privacy & dignity (Compliance Action 5)	CA5.1		30/11/2014	Amber	Amber
	CA5.2		01/01/2016	Red	Amber
	CA5.3		30/09/2014	Green	Green
	CA5.4		30/09/2014	Green	Green
	CA5.5		01/10/2014	Amber	Amber

			Date for completion	Previous Status	Current status
Staffing (Compliance Action 6) and Supporting staff (Compliance Action 7)	CA6.1		30/04/2015	Amber	Green
	CA6.2		30/04/2015	Red	Red
	CA6.3		02/05/2015	Green	Green
	CA6.4		30/12/2014	Green	Green
	CA6.5		30/05/2015	Green	Green
	CA7.3		30/03/2015	Red	Red
	CA7.4		30/03/2015	Red	Red
	CA7.5		30/03/2015	Red	Red
	CA7.6		30/11/2014	Amber	Amber

			Date for completion	Previous Status	Current status
Values & behaviours (Compliance Action 7)	CA7.1		30/04/2015	Green	Green
	CA7.2		30/04/2015	Red	Amber

			Date for completion	Previous Status	Current status
Scheduled care (Compliance Action 8)	CA8.1		31/03/2015	Amber	Amber
	CA8.2		01/11/2014	Amber	Green
	CA8.3		31/12/2014	Amber	Amber
	CA8.4		30/11/2014	Green	Green

Appendix 2

Brighton and Sussex University Hospitals NHS Trust

CQC Quality Improvement plan — Assurance briefing

6th Briefing — March 2015

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 will be 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.

Unscheduled care - (Compliance action 1)

Lead: Director of Operations (Emergency Care)

There are elements of this work stream that relate to all parts of the patients journey; pre-hospital, in-hospital and post-hospital. It is important that all aspects are addressed to improve patient flow through the system.

Action Plan running to time?		**Triangulated evidence provided of progress?**	

Assurance statement :

The trust has seen a small and sustained improvement in patient flow at the beginning of March. This has coincided with a noted decrease in acuity and a reduction in the age profile of admitted patients. This would seem to suggest that the extraordinary pressures seen through the winter period have begun to show some signs of reducing and that the work initiated in late November (but severely challenged by the winter pressures), is beginning to pay dividends. Agreement has been reached following national guidance with CCGs to roll the winter monies through the Easter period and into May. This will allow continuance of many of the schemes that are supporting flow to continue whilst substantive plans are worked up in this planning round to make them substantive.

The management structure for emergency care was changed in September last year to offer a single clinically led directorate that would encompass all of the elements of the "front door" for unscheduled care including the emergency department, clinical decisions unit, short stay ward, urgent care centre and the medical and surgical assessment units. This has been dubbed "The Acute Floor".

The new acute floor directorate has been working with teams across the organisation to develop a plan to totally re-model the current geography and process models of its units which have grown up ad hoc over a period of time and therefore currently fail to take advantage of changes in care practice, economies of scale and integrated working. The proposed changes are approaching fruition and will be delivered in an integrated plan

across the acute floor from the end of May.

Attention has focussed recently on delays in ambulance handovers and the subsequent cohorting of patients prior to formal admission into an emergency department cubicle. Extensive mitigating work has been taken in this area to ensure patient safety as the first priority and a joint operating policy has been developed with SECAmb to deliver this. In addition constant reviews of working practice and broader flow challenges are aimed at minimising the causes of the issue. A detailed report on this subject was requested by the CQC on 18th February and this was duly submitted on 27th February. A copy of this report is included with this submission.

Areas of concern for escalation:

Workforce – many of our plans going forward will rely on an expansion over time of our work force. Some of this can be mitigated in the short term by the creative use of multidisciplinary roles. However in the long term recruitment and retention of key staff will be important. Whilst the trust has just completed the successful recruitment of international nurses (205), there still remains a shortfall in some areas including out of hospital which remains a priority and will be addressed.

Performance – is beginning to improve and the challenge will be turning this into a consistent pattern of delivery and performance. This will continue to require the engagement of all staff internally and our external partners. A local summit is being organised for all acute trusts, the community trust, CCGs and social care colleagues to further discuss these issues as some are consistent across Sussex not least the flow of patients into and away from hospitals.

Learning lessons and feedback from incidents (Compliance action2)

Executive lead: Medical Director

Lead: Deputy Medical Director, Safety & Quality

This work stream focusses on how staff receive feedback from incidents and complaints and then how the learning is shared with individuals, teams and across the organisation.

Action Plan running to time?		**Triangulated evidence provided of progress?**	

Assurance statement

A draft strategy has been circulated to the safety and quality team; comments are being incorporated into the document for further wider circulation. This will be discussed further at the March Executive S&Q committee and will be signed off in April S&Q.

As a result of information rising from serious incidents regulation 28 letters, complaints and whistleblowing, wide ranging improvement programmes are in place in the acute medical unit and abdominal surgery. The action plan for abdominal surgery is reviewed by the clinical oversight group.

Whistleblowing concerns raised about the use of the cohort area in the emergency department BSUH are working with SECAMB to address these concerns both by ensuring

agreed processes are implemented consistently internally and with external partners to improve patient flow and capacity. A formal comprehensive report regarding cohorting in particular has been submitted to the CQC on 27th February.
New safety and quality scorecards have been developed at a directorate level based on the key questions from the safety and quality strategy. This includes data on incident reporting and feedback. These will be used by the Executive Safety and Quality committee to monitor trends in directorate performance. Directorates will be asked to refine this data set so that the data is useful for driving improvement.

As learning from a complaint was protracted, there is a new serious complaints and safeguarding meeting that has been set up between the Chief Nurse, Deputy Chief Nurse and Deputy Medical Director who meet on a monthly basis. This meeting provides oversight on progress on complaints and safeguarding investigations including feedback to departments and directorates. In addition it ensures that, with the most complex complaints, a Director or Deputy can be allocated to act as the liaison person for the patient or their family. This has already ensured that lessons have been fed back locally and Trust-wide, including work on nursing documentation and confidentiality, when discussing diagnoses in clinical areas for medical staff.

Areas of concern for escalation.

With the organisation going through such a large amount of change, ensuring safety and quality remains central to all we do. The current unprecedented pressure on services in unscheduled care and the resultant pressures on maintaining patient flow through the organisation and beyond provides a further risk to the quality and safety of the delivery of patient care across the trust. The most obvious sequelae to these challenges are played out at the “front door” and in the issues surfaced in the acute medical unit and emergency department. These areas in particular reflect the activity and success or otherwise of schemes outside of the hospital aimed at preventing admissions and increasing discharges. Despite significant work from partners including hear and treat and see and treat by the ambulance service to avoid conveyances, the site has seen a 7% increase in attendances overall including a 3% increase in ambulance attendances.

At the height of the winter pressures the Trust opened 30 additional beds on the RSCH site. However, these were not always in optimal locations and could only be very short term to offset any immediate risks. Overall the restoration of flow will depend on fundamentally changing both our internal pathways and more challengingly, influencing our external partners to fundamentally change theirs.

The introduction of RACOP and SAU are examples of admission avoidance. SAU, which started late last year, has seen a downturn in surgical admissions of around 60% thanks to its use. The increase in scope and size of the HRDT coupled with the new RACOP positioned at ED has also seen an increase in patients turned around and safely discharged home rather than admitted.

Expanding the bed base on the RSCH site is challenging due to the well documented space constraints and age of the estate. We are therefore working closely with SCT to secure

beds at Newhaven Downs which could take up to 40 patients out of acute beds. Staffing for this area is challenging but nevertheless there may be the start of a phased opening from May.

More work to influence the practices and provision of services for social and community care will be required in the interim to ensure that the MRD list is brought down and maintained at a manageable level. We have seen improvements in patient experience and flow when the list is in the teens. Deterioration soon occurs and flow slows as soon as it moves into the high 20s and above.

An increased length of stay from an increase in acuity of patients across the Trust also plays into the restriction of flow, with areas such as AMU and ED particularly affected. To help mitigate this risk;

- The Critical Care Outreach Team increased its in reach into AMU, working with the AMU Working Party, and assigning an Outreach Nurse with responsibility for AMU on a daily basis.
- The Critical Care Units have changed their admission and discharge processes to allow easier and more timely access for patients from AMU and vice versa.

Safety and suitability of premises (Compliance action 3)

Executive lead: Chief Financial Officer Lead: Operation Director of Facilities & Estates
This work stream relates to ensuring that the environment and premises are appropriate for the provision of healthcare

Action Plan running to time?		**Triangulated evidence provided of progress?**	

Assurance statement :

The Trust if finalising its Capital investment priorities for 2015/16. These contain a number of areas related to the Trust premises for both upgrading and renewal. The Trust has a major Capital investment project which will be introducing significant changes and will include new buildings as well as enhancements to existing facilities. Funding has been allocated and design work is in progress for a planned start by the end of February 2015.

These projects will initially add additional pressure to space but in the medium to long term will improve current facilities and space.

The Trust continues to develop its operational areas through day to day maintenance programmes and minor works projects.

Patient lead environmental audits (PLACE) are ongoing and the annual inspections are due over the next two months. The Trust is re-establishing operational PLACE inspections and these will be taking place on a monthly basis across the Trust from April 2015. Part of the brief for the PLACE teams will be to monitor as well as ensure action plans are developed

to ensure environmental standards are maintained.

'Dump the junk' programme continues. All Clinical Directorates have been contacted for any redundant or broken equipment that needs to be cleared.
It is anticipated that further campaigns will be needed to keep the focus on removing unwanted equipment and to ensure areas are kept clear.

Areas of concern for escalation.

Lack of overall storage space on the RSCH site for spare beds, trolleys, wheelchairs and other portable medical equipment. This is being mitigated by encouraging all departments to keep their storage areas as tidy as possible and to call the Sodexo helpdesk (Facilities services provider) for assistance in clearing any unwanted or broken items.

Safety, availability and suitability of equipment (Compliance action 4)

Executive lead: Chief Financial Officer
Lead: Operation Director of Facilities & Estates
This work stream relates to ensuring that the equipment provided for patients has regular checks and that staff check routinely according to the schedules.

Action Plan running to time?		**Triangulated evidence provided of progress?**	

Assurance statement :

Initial corrective actions are completed for both sites apart from community placed equipment. Additional short term actions now completed for the PRH special care baby unit.

Short term action to increase bank/agency support in EBME services has been achieved and will be in place until the end of the financial year or successful recruitment to substantive posts has been achieved. Business case approved on the 2nd Jan for an additional Band 6 engineer which will enhance services further.
Interviews carried out on the 12th March with a successful Band 6 outcome pending HR checks. Ward managers and directorate lead nurses have been asked to ensure that equipment checks are being carried out in clinical areas.

Staff participating in the quality visits are asked to review on the wards they visit.

Areas of concern for escalation.

EBME recruitment. This is core to ensure resources are available to sustain the longer term compliance with the action plan. Recent recruitment process to Band 4 and Band 5 posts was unsuccessful. This area remains a risk. Both posts are currently backfilled with Agency engineers. Recruitment process is to go ahead again and there are discussions about using head hunters but is expected to be a challenge and hence the risk element. A full time member of staff has returned from maternity leave on Feb 2nd and will help to alleviate the situation.

Privacy and dignity (Compliance action 5)

Executive lead: Chief Nurse Officer

This work stream relates to ensuring all patients' privacy and dignity needs are being met.

Action Plan running to time?		**Triangulated evidence provided of progress?**	

Assurance statement

Maintaining patients' privacy and dignity is a significant challenge when the organisation is receiving unprecedented levels of demand.
A number of the additional capacity areas that were opened due to the high demand and were a concern around privacy and dignity have been closed.
Privacy and dignity is still a challenge at times in the cohort area in ED. There is a nurse allocated to the cohort area to oversee this group of patients. Whilst it is difficult during periods of high demand, the nurse is conscious of this and communicates with the patient and aims to mitigate the risk and to date there have been no formal complaints related to privacy and dignity raised in the cohort area. Detailed actions with regard to this can be found in the recent detailed response to the CQC regarding the cohort area.

FFT In February the inpatient response rate was 30% and only 2.3% would not recommend the trust. Key issues raised in our Patient voice survey were food with 22% of negative comments relating to this. The Deputy Chief Nurse has re-instated the Nutrition and Hydration Committee to address on-going issues and develop practice across BSUH.
Quotes from Pickford
'The staff whilst not overpowering and sometimes overworked always have time to discuss anything with you or to get anything that you require no matter how trivial, furthermore the staff always have time to talk to you as a person - not as a number'.
Quotes from Twineham
'I have received care from a number of teams over my stay. Every single member of those teams has been outstanding in the care and attention provided. This includes physiotherapy/occupation therapy/ volunteers.'

There have been no reportable mixed sex breaches over the last month.

Areas of concern for escalation.

Privacy and dignity remains a challenge when there is a high demand in service, when ED is overcrowded and the cohort area is in use.

Staffing (Compliance action 6)

Executive lead: Director of Strategy & Change.
Lead: Operational Director of Human Resources

This work stream relates to Staffing and Training.

Action Plan running to time?		**Triangulated evidence provided of progress?**	

Assurance statement :

The plan for the creation and development of the new People and Well-being strategy was agreed at the January Trust Board. Formal consultation with key stakeholders including

managers, staff and Staff Side representatives has now commenced. The final strategy will be drafted in early April for the formal launch of the new strategy at the end of April 2015. The People and Well-being strategy will clearly set out our plans to recruit, retain, motivate, develop, and lead our workforce. The Strategy will be fully implemented by the development of key work streams overseen and performance managed by a new People Board.

To support the new People and Well-being Strategy, a formal external review of the role, function and capacity of the HR Team is currently underway and a proposed new structure will be developed as part of the Strategy and Change Directorate's Business Plan for 2015/16.

Key areas of activity continue including recruitment to all areas of the Trust but specifically targeting nursing vacancies. The Trust continues to recruit locally, nationally and internationally and we are now recruiting more staff per month than leavers.
In consultation with Staff Side, enhanced and overtime rates have continued for bank and substantive nursing staff to better support the shortfall in capacity whilst we fill our vacancies and staff the extra capacity areas.

The first Programme Board for the Race Equality Engagement Strategy was held on 19th February 2015 and the BME engagement event took place on 10th March 2015.

A robust appraisal action plan is in the process of being implemented, and the new appraisal system will be launched in April/May 2015.
Q3 Statutory and mandatory training reports were issued week commencing 16th March to all Directorates. Statutory and mandatory training continues to be delivered face to face 2-3 times per month, in addition to the option of workbooks or the national e-learning content.

Areas of concern for escalation.

Ongoing monitoring of our key HR indicators through a new "HR Dashboard" to the Finance and Workforce Committee including vacancy rates, bank fill rates, sickness absence, staff FFT etc.

Appraisal rates remain a significant concern due to the ongoing pressures on staffing.

A targeted programme of work on appraisals lead by an experienced learning and development professional has commenced. The programme of work includes a detailed action plan; in summary their remit is to work with the relevant managers to address the issues faced by the Teams that have practical problems in completing appraisals as detailed above and to redesign a new appraisal form, guidance notes and training in line with the values and behaviours blueprint by April/May 2015. As part of the new appraisal system a new 360 degree behavioural appraisal assessment is currently being piloted with our senior leaders and if successful it will be rolled out across the organisation by April 2016.

Values & Behaviours and supporting staff (Compliance action7)

Executive lead: Deputy CEO / Director of Strategy & Change

The Values & Behaviours (V&Bs) programme focusses on creating an organisational culture/environment where staff and managers are skilled, resilient and feel supported, engaged and empowered to provide high quality, safe care/services.

Action Plan running to time?		**Triangulated evidence provided of progress?**	

Assurance statement:

The programme continues to focus on: (i) developing individuals & teams, (ii) aligning our people processes with V&Bs, (iii) engaging for improvement.

The 2014 NHS Staff Survey results are almost unchanged from 2013; however plans are in place to ensure that improving staff engagement is key to everything that we do in 2015/16. Consultation for the new People and Well-being strategy is well underway and will be launched in April 2015. Our new strategy will clearly set out how we lead, manage and engage our staff. As a direct result of our values and behaviours organisational development work we are in the process of setting out a clear vision as to what it means to be an employee of BSUH and our HR Team will be restructured to ensure we develop and retain talented leaders and motivated staff and equalities will be at the heart of everything that we do.

Areas of concern for escalation.

As previously flagged:

- Staff satisfaction is a function of the 'gap' between expectation and experience. The V&Bs Behavioural Blueprint has increased expectation and it will take some time for day-to-day experience to catch up. In the meantime, the gap has increased – so satisfaction would be expected to fall. This is part of a normal change trajectory.
- The research evidence on Organisational Development is that *'transformational change in a complex system takes time and demands consistency, constancy of purpose and organisational stability.'* Although steady progress is being made, this is not a quick-fix and will take continuing investment of organisational time, energy and resource.

Scheduled care (Compliance action8)

Lead: Director of Scheduled Care and Service Transformation

This compliance action relates to the central Booking Hub ensuring that the Trust is meeting its RTT and measures related to outcomes for patient booking and appointments.

Action Plan running to time?		**Triangulated evidence provided of progress?**	

Assurance statement :

As reported since November we now have 5 high level actions:

1. Ensure that we book all patients within 5 working days
2. Maximise use of clinic capacity with patients assigned to the right clinic first time

through partial booking, triage efficiency and ensuring that the right letter with the right details reaches the patient.

3. An absolute focus on eliminating missed calls with all calls to be answered within one minute in the first instance
4. Fully engage with our clinical directorates to minimise clinics cancelled with less than 6 weeks' notice and ensure a 6 week look ahead for all clinicians so they and the booking team have a shared understanding of the work to be done and can work together to resolve queries as they arise.
5. Introduce a Patient Focussed Booking Programme convenient for all patients. This will follow on once we have made sufficient progress on objectives one to four. Patients need certainty of appointment and communication of the highest standard.

Progress to date is set out below.

1. *Ensure that we book all patients within 5 working days*

For the month of February the booking hub booked on average 1100 patients a day, which was a combination of new and follow up appointments. All patients, on average 580 a day in February are being added to the referral management system within 24 hours of receipt.

We are now working towards clinical triage within 48 hours. The referral team are proactively monitoring the referrals received and highlighting to the directorates any service that exceeds the target of 48 hours. The RMS Team Lead daily checks the in tray's for all services and identifies any waiting longer than 48 hours. The system automatically calculates the hours and these are highlighted in red, making this task easy to identify. Once identified, the directorates are notified for chasing.

An RMS software upgrade will enable a drop down menu making it easier for consultants to use. The trial to be up and running by end of March in a test environment with roll out across the whole system expected by mid - late April.

The date of triage will be added to results reporting, allowing us to identify the time lapse between referral receipt and consultant triage so we can monitor our progress triaging patients within the next 48 hours, a key component of booking appointments within 5 working days. This report has now been requested from CIU and we hope to have it in place by mid-April.

In February we booked 72% of patients 0- 5 days with 90% of patients being appointed in 0 - 10 days. The booking team have requested an altered report to enable specialities to clearly see how many are being booked 0- 5 days and 6- 10 days.

The booking hub is still experiencing issues with capacity in certain specialities and is working closely with the PAMS to identify appropriate slots.

2. *Maximise use of clinic capacity with patients assigned to the right clinic first time through partial booking, triage efficiency and ensuring that the right letter with the right details reaches the patient*

The RMS upgrade already referenced will help us allocate patients to the 'right clinic first time' as it will automatically populate new RMS patient records and include an automatic data quality check including address. We are also trialling software to enable us to track when a letter has been generated, printed, folded and collected. This will show us exceptions which will give further assurances that the right letter reaches the right patient.

We are continuing to telephone any patient to be booked with <7 working days notice to ensure they are able to make the date and have it noted in their diary.
Text reminders continue (where patients have given their mobile number). We continue to explore a two way messaging so patients can cancel by text if they are unable to attend. The current service provider will stay in place until further options have been evaluated. We are working with IT to move this forward and put in place a timescale plan for implementation.
The Booking Centre are working with the Trust CIU (Central Information Unit) team to obtain compile and validate a DNA report that will include where letters have not been sent (taking into account appointments made under 7 working days where contact will have been made via phone) and also where no text reminder has been generated. Once we have analysed the report we can publicise the DNA figures more widely and work with directorates and patient groups to understand what else we can do to bring about a reduction in these numbers.

3. *An absolute focus on eliminating missed calls with all calls to be answered within one minute in the first instance*

In February the booking team received an average of 1036 calls (range 835-1564) a day with 94% being answered within an average pick up time of 30 Seconds.
A missed / dropped call report is run daily and if a telephone number is logged as having waited over 45 seconds we will contact the caller to ensure that there query is resolved. Detailed logging practice continues.

4. *Fully engage with our clinical directorates to minimise clinics cancelled with less than 6 weeks' notice and ensure a 6 week look ahead for all clinicians so they and the booking team have a shared understanding of the work to be done and can work together to resolve queries as they arise.*

A 'look forward' report is sent weekly to directorates to review their clinic schedule. Current performance in February saw 976 clinics cancelled with 135 with less than 6 weeks' notice impacting on 907 patients.
We continue to work on the cancellation process including authorization and reasons for cancellation and we expect that this electronic clinic management form will be implemented by Mid to late April.
We continue to work on the improving the booking efficiency to ensure first time accuracy in all points of the system to ensure we reduce ineffective working processes.
In February we received 3 datix which were actioned within 3 days of receipt. These issues led to audits on accuracy within the RMS team and further training for staff on processes.
Training programmes have been identified for staff centring on RTT pathways and customer services. The booking hub management are working with Education and Training to identify appropriate courses.
A Job description for the new Transformation Lead has been agreed and will be going through to the Vacancy Control group and then to advert as soon as possible.
The booking hub management team continue to work with our change consultant to ensure that the improvement programme is kept on track and that we continue to meet our goals and objectives and that we have clear processes for dealing with immediate issues as they arise.
The booking hub has received 2 letters of praise from a consultant and patient saying the

service they have received has been exceptional. The booking hub manager has also received numerous telephone calls from internal and external users saying how happy they are with the service and they recognise the change of ongoing improvements made by the service.
Areas of concern for escalation.
There continues to be a mismatch between demand and capacity in a number of specialities and this will continue into the first quarter of 15/16. The Trust is working to reduce wait times through its work on the delivery of the Referral to Treatment waiting standard. There are also significant data quality issues. The new Patient Access Policy will help as will the competency based training programme to be developed and rolled out by the new Transformation Lead. Until we can reduce the number of cancelled clinics and long waits for patients we will continue with a level of inefficiency, both in terms of re-work and dealing with important queries from patients.

KEY
Significant Assurance
Limited Assurance
Significant Risk

IMPORTANT NOTE:

Read receipts are activated on the email containing this briefing and these will be used as evidence of receipt.

Please submit comments and actions required to Elma Still, Associate Director of Quality - elma.still@bsuh.nhs.uk