Meeting:	**Brighton and Sussex University Hospitals NHS Trust** **Board of Directors**
Date:	**26th January 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. A summary table is attached. The RAG status reflects the evidence to support the delivery of the plan, with good progress overall from the previous report to the Board; but with challenges around the compliance actions concerning unscheduled care and supporting staff.

A monthly assurance briefing is prepared which is sent to the TDA, CCG and CQC. A copy of the January 2015 briefing is attached. This RAG status reflects whether the action plan is running to time and whether there is triangulated evidence of progress.

The new CQC Fundamental Standards of Care were published in November 2014 (Health and Social Care Act 2008 (Regulated Activities) Regulations 2014) and come into force in April 2015. They are designed to set clearly the standards below which care must not fall, and derive from the recommendations of the Francis Inquiry. Monitoring and ensuring compliance with these standards, be the focus of our on-going improving quality visits.

The report also highlights the issues that were identified as a risk within the CQC intelligent monitoring report published in December 2014 and are described in appenxdix 4. The intelligent monitoring report has been discussed with the directorate teams to ensure they are proactively monitoring the indicators in their Quality and Safety meetings.

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 depend on the outcome and teams concerned. Progress with the CQC action plan is detailed in the report
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 January 2015 Appendix 3 Themes from Quality Visits, November 2014 Appendix 4 Risks identified in Intelligent Monitoring report
Action required By the Trust Board The Trust Board is asked to note progress against the action plan and the work that the clinical directorates will undertake to ensure compliance with the Fundamental Standards of Care.	

Report to the Board of Directors, 26th January 2015
Care Quality Commission (CQC) report

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 the introduction of the Fundamental Standards of Care, recently published by the government which come into force in April 2015. Issues identified as a risk or elevated risk in the Trust, were published in December 2014, in the intelligent monitoring report.

2. Progress with action plan

The Chief Nurse and Associate Director are meeting with the CQC to review progress with the action plan on 28th January 2015.

The Improving Quality and Patient Experience Group (IQPE) continue to meet monthly and update the action plan with the operational leads. The group discuss the evidence and compliance and agree subsequent actions and a RAG status.

The Sharepoint site has now been developed and the action plan uploaded. Training for the operational leads and access will be given in the next month to allow for proactive updating of the plan and any associated evidence

Progress is being made with the action plan which is demonstrated by the overall summary attached as Appendix 1. The RAG status reflects the evidence to support the delivery of the plan, with good progress overall from the previous report to the Board; but with challenges around the compliance actions concerning unscheduled care and supporting staff. The unprecedented demand on services within the trust is having a significant impact on the delivery of the overall plan and as such, is a major risk to its realisation.

The Associate Director Quality met with TIAA to discuss the assurance process. They will review an Improving Quality and Patient experience meeting, attend a quality visit and review the evidence being collated against the action plan. The TIAA staff allocated for the review are ex CQC inspectors and will also be able to recommend ways in which the assurance process can be strengthened.

3. Assurance briefing

The assurance briefing is being produced monthly by the executive and operational leads based on progress against the action plan. The briefing is shared with the Trust Development Authority (TDA), local Clinical Commissioning Groups and CQC. The assurance briefing for January 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. Quality visits

The monthly quality visits continue to assess practice and progress within the five domains assessed by the CQC. It is a useful way to monitor progress against the action plan and identify themes of good practice and areas for improvement. The themes from the last visit in November are attached as Appendix 3.

The Quality visits are open to all staff and the Non-Executive Directors have each been assigned an area where they will be able to develop a relationship and understanding of the service and ensure that issues discussed at the Board are reflected within practice. It will also give staff an opportunity to discuss what they are proud of and the challenges within their areas. The next two visit dates are on 21st January and 18th February 2015.

5. Fundamental Standards of Care

The government published the fundamental standards regulations in November 2014. They include two regulations, the duty of candour and the fit and proper persons requirement for directors, which came into force for NHS trusts on 27th November 2014.

The remaining fundamental standards will come into force from April 2015. These regulations replace the previous 16 essential standards of quality and safety. All clinical directorates within the trust will need to ensure that they comply with these standards and the Associate Director, Quality will arrange to meet with directorates as part of the cross directorate meetings. See figure 1. The CQC have strengthened their enforcement guidance such that they may now prosecute without first issuing a warning notice. This is with the intention of them being able to act quickly against organisations who breach the regulations and put patients at risk of harm.

Figure 1: Current quality and safety regulations vs new fundamental standards

Current regulations	New regulations
• Care and welfare of service users	• Person-centred care
• Assessing and monitoring the quality of service provision	• Dignity and respect
• Safeguarding service users from abuse	• Need for consent*
• Cleanliness and infection control	• Safe care and treatment*
• Management of medicines	• Safeguarding service users from abuse*
• Meeting nutritional needs	• Meeting nutritional needs*
• Safety and suitability of premises	• Cleanliness, safety and suitability of premises and equipment
• Safety and suitability of equipment	• Receiving and acting on complaints+
• Respecting and involving service users	• Good governance+
• Consent to care and treatment	• Staffing
• Complaints	• Fit and proper persons employed
• Records	and
• Requirements relating to workers	• Fit and proper person requirement for directors
• Staffing	• Duty of candour*
• Supporting workers	* These regulations have prosecutable clauses relating specifically to harm or the risk of harm.
• Cooperating with other providers	+These have clauses requiring information to be provided to CQC on request. Not providing the information could prevent CQC from identifying and responding to harm/risk of harm in a timely and appropriate manner. Breaching these clauses is therefore prosecutable.

6. Intelligent monitoring report

The latest CQC intelligent monitoring report was published in December 2014. The draft report was discussed at the Clinical Management Board and the Trust Board in November 2014 and no new indicators were flagged when the final report was published. See Appendix 4.

The indicators have now been assigned to specific directorates. The Associate Director of Quality will attend the relevant multi-directorate team meetings to discuss the risks and to gain assurance of plans for their mitigation.

7. Summary

Work within the themes identified by the Trust and confirmed through the CQC visit progresses. The unprecedented demand on services has hindered progression on some elements of the plan but the focus on delivery of safe and effective patient care continues and the actions are also focused on improvements to core activities. The clinical directorates continue to progress issues identified within their core services identified within the CQC reports. The directorates will also ensure that they are proactively monitoring the indicators in the intelligent monitoring report and that the Fundamental Standards of Care are being met.

Elma Still
Associate Director of Quality
January 2015

Appendix 1

CQC Action plan – Summary table
December 2014

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	Red	Green
	CA1.5		31/10/2014	Red	Green
	CA2.1		01/11/2014	Amber	Amber
	CA2.2		30/04/2014	Red	Red
	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	Red	Amber
	CA2.7		30/04/2015	Green	Green

			Date for completion	Previous Status	Current status
Facilities & Estates (Compliance Action 3)	CA3.1		30/03/2015	Amber	Green
	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	Green
	CA4.2		30/09/2014	Amber	Green
	CA4.3		30/09/2014	Amber	Green

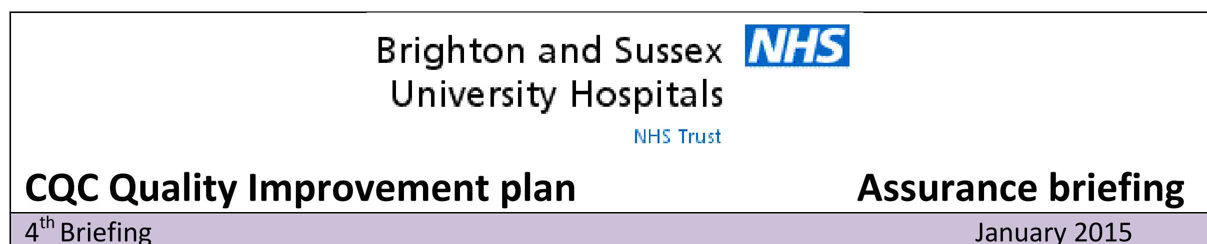
			Date for completion	Previous Status	Current status
Privacy & dignity (Compliance Action 5)	CA5.1		30/11/2014	Amber	Amber
	CA5.2		01/01/2016	Red	Green
	CA5.3		30/09/2014	Green	Green
	CA5.4		30/09/2014	Amber	Green
	CA5.5		01/10/2014	Amber	Amber

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

			Date for completion	Previous Status	Current status
Values & behaviours and Supporting staff (Compliance Action 7)	CA7.1		30/04/2015	Amber	Green
	CA7.2			N/A	N/A
	CA7.3		30/03/2015	Amber	Red
	CA7.4		30/03/2015	Red	Red
	CA7.5		30/03/2015	Red	Red
	CA7.6		30/11/2014	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	Amber
	CA8.3		31/12/2014	Amber	Amber
	CA8.4		30/11/2014	Red	Green

Appendix 2



CQC Quality Improvement plan — Assurance briefing

4th Briefing — January 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?	(amber)	Triangulated evidence provided of progress?	(red)

Assurance statement :

Further to the actions already completed, the following additional actions are underway:
1. CIRU, Overton and Plumpton open as extra capacity emergency ward space
2. Progress towards opening Newhaven Downs as a step down facility (30 beds).
3. Transformational work on the frailty pathway, discharge to assess, SAU and surgical pathways, pathway work in ED
4. Additional staffing from overseas (150 nurses) now coming on stream (Dec 14– May 15)
5. Winter enhancements offered to staff to secure extra bank cover.

The overall recovery of the trust over the last two months is now being challenged by the winter pressures noted across the country at present. This has created difficulties for patient flow as we have seen a marked increase in high acuity elderly admissions, particularly with respiratory conditions. This cohort of patients will routinely have longer in-patient stays and a higher proportion of them will require complex discharges. Despite this, the embedding of sustainable change in our emergency care pathway continues to be our highest priority and is a regular focus of both the Trust Board and our daily operational meetings. The system wide work continues and remains our focus along with work within the Trust itself.

Areas of concern for escalation:

Workforce – many of our plans going forward will rely on an expansion over time of our workforce. 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 (150), there still remains a shortfall in many areas including out of hospital which remains a priority and will be addressed.

Performance – the effect of winter pressures have seen a temporary downturn in performance however we are implementing a range of mitigating actions to bring this on track in conjunction with our external partners. Consistency and sustainability around the four hour standard will only come about with genuine system wide buy-in to a new way of working. Therefore our relationships with our partners and their commitment to achieving this as a system rather than as an isolated Trust target remain a risk.
The cohort policy is in place and being implemented. Patients when admitted through majors are assessed and triaged in assessment cubicles. When there are 5 or more patients in the cohort area, a cohort nurse cares for the patients and additional support is drafted in where possible to support the nurse and ensure that patients receive care.

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

Work on the safety and quality strategy is progressing using the framework discussed previously of the 6 key questions that patients may wish to receive during their care. It is still being discussed in a number of forums while the final version is being completed.
Duty of candour systems have been in place since October 1st and feedback is being given to all patients suffering moderate harm. A second senior investigator post has been appointed to help with the additional workload associated.
A faculty of simulation and human factors has been identified and simulation link persons in departments are being created. Simulation training is being delivered currently by the faculty but volume will increase in March -April 15 when new faculty training/ development begins. An external human factors expert has been commissioned and has begun work on specific projects including adding a human factors approach to incident investigation.
Meetings with Directorate Leads to reinforce roles and responsibilities relating to safety and quality and sharing of information are progressing. This initial round of meetings with all Directorates is scheduled to complete by end February 2015.
Terms of Reference of Executive Safety and Quality Committee have been re-written and were approved by the Executive Quality and Safety Committee in January 2015.
The 1st Joint BSMS/BSUH Safety and Quality conference was held on 5th January 2015 and was well received. Internationally renowned speakers presented and there was a showcase of local Safety and Quality initiatives via a poster display. The conference was

attended by a multidisciplinary audience of over 200 people. These included medical students, student nurses, junior and senior doctors and nurses, GPs, the Dean of the Medical School, the Chief Executive, the Chairman and the Brighton and Hove Coroner. The Safety and Quality strategy was presented to the conference. The Safety and Quality team workload is being addressed. Two new posts have been appointed which will increase capacity in incident investigation/feedback and learning and also in co-ordination of clinical audit.
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 and will be an ongoing challenge. The current unprecedented pressure on services in unscheduled care is challenging the quality and safety of the delivery of patient care across the trust. Delivering the cultural change programme while in a period of extreme demand is extremely challenging whilst staff are working to their limits.

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 :			
Initial corrective actions within the detailed plan are complete. Trust-wide 6 facet survey is complete. A prioritised and risk assessed Estates rolling capital investment programme is based on the outcome of the survey. This will form the basis of Estates capital investment priorities for 2015/16. Actions arising from 2014 PLACE audits are complete except for major refurbishment of SEH (2 year programme), but funding has been allocated and design work is in progress for a planned start on site in February 2015. 'Dump the junk' programme is underway. The main storage area (Level 10 plant room) for spare patient moving equipment (beds, trollies and wheelchairs) has now been cleared of redundant and broken items that are beyond economical repair. All Clinical Directorates have been contacted for any redundant or broken equipment that needs to be cleared from their areas. A programme is being prepared, supported by Sodexo, starting with Anaesthetics in the week commencing 12 January 2015.			
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.

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.

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. The next quality visit is on 21st January.

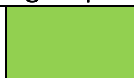
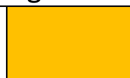
Areas of concern for escalation.

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 is returning to work 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. During the Christmas and New year period capacity needed to be opened which was supported by additional staff. The additional capacity was opened in a planned way.

Privacy and dignity was raised by the CQC within the ITU neurology ward in Hurstwood Park (HWP)and the cohort area in ED. The access arrangements have now been addressed in the ITU at HWP.

In ED at RSCH, patients are assessed in the assessment cubicles within the cohort area to be examined and then moved back to the cohort area until a bed is found. Screens are used to help maintain patients in P&D in the cohort area in the interim. The implementation of the cohort policy and work to improve patient flow, as described under Compliance action 1, will reduce the use of the cohort area.

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 :			
A new People Strategy is being developed and will be launched at the end of April 2015. It will include how we recruit, engage, motivate, develop, lead, reward , 'look after' and manage our people and how we embed the values and behaviours blueprint and equalities work, in all that we do. We have a robust recruitment strategy for nursing and have been involved in international recruitment and have recruited 150 international nurses. The first 15 nurses have commenced in employment with the remaining nurses due to start in cohorts of up to 40 over the next three months. An additional 60 nurses have been recruited from within the UK and will start over the next two months. To improve our ability to cover temporary shortfalls in staffing whilst we wait for our new recruits to commence in post, we have worked in partnership with Trust Council to review how we pay our staff who work additional hours in their own Department and have agreed to pay overtime rates for the next four months. The booking of medical locums is currently being reviewed in terms of spend and ensuring that the trust has the right cover and quality of locums working within the organisation. In addition we are offering bonus payments to part-time and bank staff for working extra capacity shifts. We have invested in a new comprehensive Virtual Learning Environment platform and e-learning developers to improve the quality and accessibility to statutory and mandatory training. Implementation has now started and modules will "go live" from 1st April 2015. Staff will still be able to access face to face training. The Race Equality Workforce Engagement Strategy (REWES) was launched at the joint BME Network and BSUH conference in October 2014. A programme board has been established and the first meeting will take place in February 2015 and is co-chaired by the CEO and Associate Director of Transformation. The purpose of the board will be to provide oversight, performance management and governance of the race equality action plans developed by the various Engagement Groups.			
Areas of concern for escalation.			
Ongoing monitoring of our key HR indicators through a new "HR Dashboard" to the Finance and People Committee including vacancy rates, bank fill rates, sickness absence, staff FFT etc. Uptake of statutory and mandatory training will continue to be a challenge over the next couple of months until we fill our vacancies but this will improve from April once the new staff are in post and with the introduction of the new e-learning packages. 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 in an action plan; however 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 and launch a new appraisal system in line with the values and behaviours blueprint by 1st April 2015. As part of the new appraisal system a new 360' 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 and behaviours and Supporting staff (Compliance action 7) **Executive lead: Director of Strategy & Change.** The work stream focusses on the culture within the organisation and ensuring that staff are supported by their managers			
Action Plan running to time?		**Triangulated evidence provided of progress?**	
Assurance statement :			
The Values & Behaviours Programme is progressing, supported by a Trust Working Group, Sounding Board/wider staff engagement processes, and reporting to the Values & Behaviours Programme Board (Chaired by the Director of Strategy & Change/Deputy CEO). The overall strategic objectives and a detailed programme of work for the next six months have been agreed, closely aligning external consultancy input (which focuses on the 'Leading the Way' leadership development programme for c. 70 of the Trust's most senior leaders, and supporting a Process Redesign project) with Trust-side actions			
Areas of concern for escalation.			
All the literature/research evidence on Organisational Development (OD) (most recently, for example, the December 2014 evaluation from the North East Transformation System – weblink below) is that 'transformational change in a complex system takes time and demands consistency, constancy of purpose and organisational stability.' Although we're making good, steady progress with the Values & Behaviours Programme, this is not a quick-fix and will take investment of organisational time/energy/resources. http://kingsfund.blogs.com/health_management/2014/12/a-mixed-methods-evaluation-of-transformational-change-in-nhs-north-east.html Staff satisfaction is a measure of the gap between staff expectations and their day to day experiences. We have articulated bold expectations through the Behavioural Blueprint but it will inevitably take time for staff experience to catch up – so we should expect (in anticipation of the 2014 National Staff Survey Results, to be published in Spring 2015) that satisfaction will dip in the meantime. This is part of the normal trajectory.			

Scheduled care (Compliance action 8) **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 previously, 5 high level actions have been identified:			

1.Ensure that we book all patients within 5 working days.
2.Introduce a Patient Focussed Booking Programme convenient for all patients.
3.Ensure 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.
4.An absolute focus on eliminating missed calls with all calls to be answered within one minute in the first instance
5.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.

We are focussing on (1), (4) and (5) at present:
1.Ensure that we book all patients within 5 working days.
Data on current performance has been prepared and analysed. We have seen an overall increase in the volume of new patient referrals booked within 5 days from 53% to 76% overall but we remain with long waits in a number of specialities and will not see a significant improvement in service until waiting times in longer waiting specialities, notably Digestive Diseases (surgical) are resolved
4.An absolute focus on eliminating missed calls with all calls to be answered within one minute in the first instance
Figures from December show:
•Number of incoming calls : 17559
•Calls answered: 16550 (94.3%)
•Average pick up time : 28 seconds
This is a much improved position from July when performance of calls answered was 60.9% with an average pick up time of just under 2 minutes. Performance has been improved by flexing staff onto the telephone team during periods of high demand thereby significantly reducing repeat calls.
5.Minimise clinics cancelled with less than 6 weeks' notice and ensure a 6 week look ahead for all clinicians
This was one of the processes we identified as being cumbersome and frustrating for all parties as part of our work on Values and Behaviours across the Trust and we have developed a simpler process and one that will ensure last minute cancellations are kept to a minimum. After some further refinement the new process will be launched at the end of January.
A simpler 'look forward' has been developed so it is easier for clinical teams to check what is actually booked on the system. It was introduced 9 January and feedback is awaited at the time of writing.
In terms of the current level, figures from December show cancellations:
•2-6 weeks: 123 clinics affecting 623 patients
•<2 weeks: 63 clinics affecting 468 patients
•Same day: 10 clinics affecting 84 patients
In terms of wider engagement :
•The Clinical Lead has met with Clinical Leads and Directorate Managers to understand their specific requirements from the Hub and to identify problems and workable solutions;
•The Director of Scheduled Care and Service Transformation presented work to date and work to follow as part of her update to the Local Health Economy Scheduled Care Board

on 6 January; •The Patient Access Policy is also being re-drafted to ensure the requirements are crystal clear together with a summary for patients in plain English that will be posted on the Trust web site. This is currently work in progress. We have identified a clear improvement programme and have put robust measures in place to ensure that the Booking Hub delivers a gold standard service along with processes and regular audits of performance to ensure that small problems never again develop into massive threats to the delivery of best and safest care.
Areas of concern for escalation.
As noted previously, the performance of the booking hub is heavily influenced by the availability of slots into which we can book patients and a number of our specialities have a mismatch between the referrals that they receive and the capacity to treat these patients. The Trust has re-engaged the Intensive Support team (Elective care) to work with specialities with the greatest challenge as part of the programme of work underway to reduce waiting times to an acceptable level.

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

Appendix 3

Themes for Quality visit in November 2014

Nine ward areas were visited across the Trust this month and the themes have been grouped under areas of good practice and areas for improvement. There is a table attached for the areas of improvement to ensure that systems are in place in your wards and that practice is embedded.

Themes

Positive themes	**Areas for improvement**
Patients generally very positive about the care that they were receiving Team working observed and reported by staff Team meetings/handovers are used to discuss learning from incidents Up-to-date Patient Safety Boards Cleaning boards up to date DNAR forms appropriately completed Call bells within reach Confidentiality of notes – notes stored appropriately Documentation generally well completed Some good examples of 'You said, we did' boards Toilets labelled appropriately Staff reported approachable by patients Nurse to Patient Ratio boards up to date	Staffing – bank and agency, availability & being aware of trust policies Extra capacity areas – P&D, availability of food , not adequate stock Patient Safety folders – not being updated and used by wards Sharing lessons learned from incidents and complaints on the ward Storage and clutter Arrest trolleys not always checked Drug trolley left open Drug keys going home with a member of agency staff Noise at night Call bells being in reach Shower leaks Staff board not up to date Low level dusting

Appendix 4: Intelligent monitoring December 2014 – Risk identified

Risk	Comments	Action being taken
Whistleblowing alerts (18/07/13 to 29/09/14)	This is indicator is flagged if the trusts has more than one alert	Patient Safety Ombudsman Advisory Panel established and meeting monthly, and provides framework for review of concerns raised with PSO.
Never Event incidence (01/09/13-31/08/14)	There have been 5 never events reported over this time period. All are investigated and learning is shared with individuals, the team and the organisation.	An Independent Review of Theatre Practice & Culture was carried out in July 2014. Recommendations were made and an action plan has been developed in response & in relation to each of the recommendations. The External Report & resulting action plan has been discussed at Executive Safety & Quality Committee (September) and Risk & Quality Committee (September). The Report's author is attending the Risk & Quality Committee in November along with the Perioperative Directorate Leads who will be sharing the Action Plan and progress to date.
Composite of hip related PROMS indicators (01/04/13-31/03/14) & Composite of knee related PROMS indicators (01/04/13 to 31/03/14)	The trust has been receiving a very low percentage of returns from PROMS patients. This was under 20% but is now closer to 50%. There will be a greater statistical variance from this low compliance. The trust has a case mix with known poor outcome-e.g. the trust take the morbidly obese from other hospitals in the locality and complex cases	The clinical lead for PROMS is changing the order for pre-op PROMs A business case for taking the PROMs data programme back in house – whilst an additional cost will have better control of our data. This will also be used to increase the PROMOs from 6 months to 2 years - to help identify patient problems early PROMS – Patient Reported Outcome Measures
Composite indicator: A&E waiting times more than 4 hours (01/07/14 -30/09/14)	There are a number of programmes of work reflected in the Operational Resilience and Capacity Plan which involve pre hospital, in-hospital and post hospital initiatives	10 High Impact Interventions Initiative Re-designation of AMU to medical assessment Conversion of CIRU to Urgent ambulatory and assessment clinical areas
The number of patients not treated within the 28 days of last minute cancellation	LMC i.e. – current performance not acceptable and requires immediate action to minimise occurrence	Aligning scheduled and unscheduled requirements through Operational resilience planning - there is a significant programme of work on unscheduled care

(LMC) due to non-clinical reason (01/04/14-30/06/14)		which will reduce overall occupancy levels at both our RSCH and PRH and enable improved patient flow and make LMC an exception - as part of its response to ensure that we reduce the overall size of our waiting lists, all directorate teams have been asked to complete a capacity and demand analysis to ensure that we have sufficient slots to treat our patients within the 18wk operating standard and meet their unscheduled care commitments. BSUH is working with IMAS to progress this work An absolute focus on cancellation on day of surgery to ensure we can accommodate patients soonest
Inpatients response percentage rate from NHS England Friends and Family Test (01/08/13-31/07/14)	This financial year the run rate is 23%. The CQC figure requires the trust to be at least 32.9%	The introduction of detailed in month monitoring and feedback to the wards has resulted in a steady and sustained increase in the inpatient response rate which is currently 31% (October).
TDA - Escalation score (01-Jun-14 to 30-Jun-14)		
NHS Staff Survey - KF7. The proportion of staff who were appraised in last 12 months (01/09/13-31/12/13)	The staff survey for 2014 is currently open and will be reported in Spring 2015	An action plan will be developed following receipt of the outcome of the 2014 staff survey. A report on work to improve the appraisal rate was discussed at the Finance and Workforce Committee in November 2104
NHS Staff Survey - KF21. The proportion of staff reporting good communication between senior management and staff (01-Sep-13 to 31-Dec-13)	The staff survey for 2014 is currently open and will be reported in Spring 2015	An action plan will be developed following receipt of the outcome of the 2014 staff survey

Key – items in red were assigned an elevated risk by the CQC.