Brighton and Sussex NHS University Hospitals NHS Trust

Post – inspection update 03.03.17

Regulation 9 - The care and treatment of service users must be appropriate, meet their needs, and reflect their preferences.							
Requirement		Trust	RSCH	PRH	Must/ should	Progress	
09.01	The trust should ensure all DNACPR, ceilings of care and Mental Capacity assessments are completed and documented appropriately as per guidelines.		X	X	SHOULD	• Audit completed • Documentation to be improved • *Audit recommendations discussed and reviewed at Feb Resus Committee. Policy and training to be revised incorporating recommendations* • *Training reviewed and new programme to be implemented from April 2017. Reviewing areas to accommodate training*	**A**
09.02	Review the provision of the pain service in order to provide a seven day service including the provision of the management of chronic pain services.		X	X	SHOULD	• Comprehensive review meeting booked for end of February • Matter complicated by plans to outsource / re-commission pain service • *Meeting to be held 27.02.17 to discuss the way forward* • *Consultant now has allocated time daily to discuss and review complex acute pain cases*	R
09.03	Review the provision of pharmacy services across the seven day week and improve pharmacy support.			X	SHOULD	• Pharmacy provision reviewed and on call service amalgamated to improve cover • Report of review to be produced to QSIP in March • *PRH outpatient clinics have moved to FP10s to increase pharmacist availability for ward based work* • *NHSI Chief Pharmacist coming to Trust 15 March to support review* • *Item downgraded because of concern that progress not as fast as anticipated – to be reviewed in more detail in March*	~~G~~ A

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Reg 10 - Service users must be treated with dignity and respect							
Requirement		Trust	RSCH	PRH	Must/ should	Progress	
10.01	Ensure that patients' dignity, respect and confidentiality are maintained at all times in all areas and wards.	X	X		MUST	• IG training improved • Records security improved • Clinic room privacy improved • ED Corridor privacy improved • Audits of compliance in hand to ensure embedding • Need to pursue separation of sexes in imaging waiting areas, then whole programme for monitoring to ensure embedding of good practice • *Outpatient privacy and dignity audit performed monthly* • *Review results of annual privacy and dignity audit*	G
10.02	The trust should implement a formal feedback process to capture bereaved relatives' views of delivery of care.		X		SHOULD	• Pilot conducted*, new paper system in use.* • Feedback considered by End of Life Care Committee currently; will feed into Patient Experience Committee • Medical Examiner role to be extended to PRH – phased implementation from 13.03.17	G
Reg 11 - Care and treatment of service users must only be provided with the consent of the relevant person.							
Requirement		Trust	RSCH	PRH	Must/ should	Progress	
11.01	Review the consent policy and process to ensure confirmation of consent is sought and clearly documented.		X	X	SHOULD	• Consent Policy reviewed • Consent Champions appointed • CC Workshop held 24th November • Consent audit to be completed by end of July 2017	G

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Reg 12 - Care and treatment must be provided in a safe way for service users							
Requirement		Trust	RSCH	PRH	Must/ should	Progress	
12.01	The provider should continue to prioritise patient flow through the hospital as this impacted on length of stay, timely discharge and capacity.			X	SHOULD	• Winter Plan prioritises patient flow, including improved discharge processes, step-down facilities and revised pathways (inter-speciality referrals) • More work / progress needed • Programme Manager engaged to collate work form across the Trust into comprehensive strategy • Newhaven Downs open and taking patients from 16 January 2017 • *Hospital @ Home now running and taking up to 16 patients* • *Right Care project re-launching under Clinical Transformation Programme, presentation at SMT 20/02* • *Re-admission audit now being conducted to support improved processes and reduced re-admissions – process for embedding review or results and associated action required*	**A**
12.02	Improve the safety and welfare of patients in the cohort / corridor area of ED		X		WARNING NOTICE	• Comfort rounds in place and well completed • NEWS scoring implemented • No pts in corridor with NEWS >4 • Assessment & treatment cubicles opened • Risk assessments conducted consistently • Mental health risk assessments conducted consistently • Further adaptations to corridor post fire risk assessment completed • *Nursing notes project continues with delays due to staff sickness – this may have given rise to reduced performance in respect of safety etc checks. New nursing notes format withdrawn and previous iteration back in use.*	~~**G**~~ **A**

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12.03	Establish clear working guidelines and protocols, fully risk assessed, that identify why it is appropriate and safe for general ICU nurses to care for neurosurgery ICU patients. This should include input from neurosurgery specialists.	X	X		MUST	• Review completed • Need for enhanced neuro skills training acknowledged • Bed capacity reduced pending neuro skills increase • In-house training programme implemented • *Neuro Practice Educator has resigned, risk added to programme pack* • *Numbers of neuro-trained nurses decreasing. Associated risks and issues discussed at SMT 06.03.17; further mitigation work in planning phase.*	A
12.04	Implement urgent plans to stop patients, other than by exception being cared for in the cohort area in ED.	X			MUST	• Corridor use reduced, but still happens. • Measures to avoid use in place (Escalation Policy) • Treatment / assessment cubicles in use for delivery of care • *Treatment and assessments conducted in corridor on one occasion in February. Fully risk assessed as least worst option, and reported as incident. No further incidents* • *Result of report from Trust auditors to be reviewed*	B
12.05	Adhere to the 4 hour standard for decision to admit patients from ED, ie patients should not wait longer than 4 hours for a bed	X	X		MUST	• Performance improving, but not at required standard yet • Performance affected by winter pressures • Trust at improved rank amongst other reporting trusts, despite relatively static performance against target • *Improved focus on 4 hour target as a result of reduced incidence of 12 hour breaches* • *Action downgraded as a result of more realistic assessment*	A

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12.06	Stop the transfer of patients into the recovery area from ED /HDU to ensure patients are managed in a safe and effective manner and ensure senior leaders take the responsibility for supporting junior staff in making decisions about admissions, and address the bullying tactics of some senior staff.	X	X		MUST	• Transfer of patients from ED / HDU virtually eliminated *until mid-December, but 4 recent cases* • Recent cases reflect winter pressures but risk assessed on each occasion (1 ED patient, 3 ward patients) • *A few incidents of transfer of patients from wards to ICU upon deterioration continuing through February and March* • *07/03/17 Meeting to be set up with relevant parties to discuss*	~~B~~ A
						• Behaviours training programme drawn up but not yet delivered	A

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12.07	Ensure that resuscitation/emergency equipment is always checked according to the trust policy.			X	MUST	• Resuscitation trolley checks added to safety huddle template • Ward managers conducting monthly audits of daily checks; results reported to Resuscitation Committee • See also 12.15 – checklist to be revised once tamper-evident boxes installed • *Yearly audit by resus team in place but individual ward managers responsible for daily and weekly checks in line with the policy/new trollies. Resus team offer training and advice alongside new trollies.* • *Resus team conducts spot checks when they are in an area for training etc.* • *Annual audit information collated and report taken to Resus Committee and then onto Q&P committee.* • *01/03 72 out of 125 new trollies in place at RSCH.* • *PRH trollies will be rolled out from 20th March.* • *Training on checks process and paperwork to accompany trollies is undertaken by Resus team with ward managers on implementation of new trolley.*	G
12.08	Implement a sepsis audit programme		X	X	SHOULD	• Sepsis Clinical Lead and Nurse in post • Audits complete • Action plans in development • *Data still not being reported through committee structure to Trust Board – added as risk/issue on programme pack* • *Action downgraded as a result of uncertainty re: audit results and their review*	G

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12.09	Meet cancer waiting and treatment time targets	X	X		WARNING NOTICE	• 31 day targets met consistently since August • 62 day target met in September; trajectory for consistent compliance from February • *Below trajectory for 62 day compliance in January and February. Recovery plan underway, compliance expected from April 2017.*	~~G~~ A
12.10	Reduce the number of cancelled operations, particularly those for patients whose operations is cancelled without completion of their treatment within 28 days	X	X	X	WARNING NOTICE	• Cancelled ops rate significantly reduced - 134 pts affected in week 18.12.16 • Only 4 pts not treated within 28 days of cancellation since w/e 24.10.16. • December performance reflects NHSE requirement to reduce elective work during December and January • *Apparent issue with MSK, some patients being cancelled 4-5 times (need to review status)- status of action downgraded pending enquiries*	~~B~~ A
12.11	Must ensure that medicines are always supplied, stored and disposed of securely and appropriately. This includes ensuring that medicine cabinets and trollies are kept locked and only used for the purpose of storing medicines and intravenous fluids.	X	X		MUST	• September security audit completed 89% compliant across the trust • Action plans for non-compliant areas developed • December audits not completed because of lack of Pharmacy capacity. Approx 25% completed during January. Feed-back provided to non-compliant areas • *Review of security of all clinical rooms and medicines cupboards underway with a view to improving consistency of approach to locks etc*	A
12.12	Ensure staff are working under appropriately approved Patient Group Directions (PGDs). Ensure PGDs are reviewed regularly and up to date	X	X	X	MUST	• All PGDs reviewed and updated • System for regular review implemented • *PGD spot check undertaken alongside the FP10/outpatient prescription – good compliance with PGDs noted*	B

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12.13	Ensure security of hospital prescription forms is in line with NHS Protect guidance		X		SHOULD	• Process amended but application inconsistent • Further work planned to improve security • Actions for further revision to improve ease of compliance process agreed • *FP10 audit underway, actions to follow out of data analysis. Next meeting w/c 6 March*	A
12.14	Review analgesia authorisation for Band 5 nursing staff (PGD).			X	SHOULD	• Completed	B
12.15	Ensure equipment and medicines required in an emergency are stored in tamper evident containers.			X	SHOULD	• Tamperproof emergency trollies contract awarded and rolled out in January/Feb • First batch of trollies arrived in trust 18 January. 12 more to be delivered each week until programme complete at end of March • Tamperproof medicine stock boxes arrived, to be installed January • Medicine stock boxes on site but installation unlikely to be complete until end of February • *Stock boxes rolled out at RSCH 20/02 and PRH 21/02. Audit procedure and schedule for stock checking implemented alongside trolley roll out*	G
12.16	Must take steps to ensure the 18 week Referral to Treatment Time is addressed so patients are treated in a timely manner and their outcomes are improved.	X	X	X	MUST	• Overall 18 RTT 80.31% (target 92%) but above improvement trajectory	G
12.17	Make adjustments to the rehabilitation pathway to ensure it is fully compliant with NICE CG83.			X	SHOULD	• Nurse assessments underway • Further models for ensuring post-discharge delivery of physiotherapy under exploration • *Steve Drage to update at QSIPB*	R

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Reg 15 - All premises & equipment used by the service provider must be — clean, secure, suitable for the purpose for which they are being used, properly used properly maintained, and appropriately located for the purpose for which they are being used.							
Requirement		Trust	RSCH	PRH	Must/ should	Progress	
15.01	Ensure that there are clear procedures, followed in practice, monitored and reviewed to ensure that all areas where patients receive care and treatment are safe, well-maintained and suitable for the activity being carried out. In particular the risks of caring for patients in the Barry and Jubilee buildings should be closely monitored to ensure patient, staff and visitor safety.	X	X		MUST	• Jubilee building closed • Barry building balcony beds closed • Allocation protocol revised • Audit of transfer documentation taking place monthly • Risk assessment of extra capacity beds in escalation policy completed • Daily ward safety checklist being standardised • *Environmental (H&S) risk assessments required – additional resource has been allocated to ensure completion.*	A
15.02	Ensure there is a robust cleaning schedule and procedure with regular audits for the mortuary as per national specifications for cleanliness and environmental standards.		X		SHOULD	• Schedule in place • Audits revised • Revised cleaning programme starting Jan • *08/03 New cleaning programme now in place signing sheets and QCs checked weekly by duty manager*	G

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15.03	Review and improve major incident storage facilities and replenish stock			X	SHOULD	• Complete • Audits planned to ensure practice embedded • *Monthly audits taking place. The HazMat/CBRN check list is part of the annual EPPR assurance process, results reviewed at Resilience Group and the QPC (CBRN stock is discussed specifically if there are any issues raised). Peer review of HazMat/CBRN stock has been undertaken by SECAmb. Result will be sent to the EPRR lead at NHSE South East region and full report to follow in the coming months.*	G
15.04	Review the results of the most recent infection control audit undertaken in outpatients and produce action plans to monitor the improvements required.	X	X		MUST	• Hand hygiene audits continue, with variable results • Human Factors workshop to examine non-compliance issues booked for July (see update below) • Various hand hygiene campaigns in place, including formal warning letters from Chief Nurse / Medical Director • Infection Control issues included in OPD Nursing Checklist • Infection control issues included in safety huddles • *09/03/17 Funding approved for Human factors workshops on hand hygiene, planning in progress with an aim to roll out from 4th April*	G
15.05	Consider improving the environment for children in the Outpatients department as it is not consistently child-friendly.		X		SHOULD	• Child friendly guidance produced • Relevant areas identified • Funding application made	G

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15.06	Review fire plans and risk assessments ensuring that patients, staff and visitors to the hospital can be evacuated safely in the event of a fire. This plan should include the robust management of safety equipment and access such as fire doors, patient evacuation equipment and provide clear escape routes for people with limited mobility.		X		MUST	• All fire plans and risk assessments complete • Work on remedial action completed in some areas, in hand in all others • *A new action plan template is being developed to promote more effective monitoring and reporting of all FRA actions.* •	A
Reg 17 - Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part							
SAFER STAFFING		Trust	RSCH	PRH	Must/ should	Progress	
17.01	Review the actual risk of the Alert computer system.			X	MUST	• Risk assessment completed; replacement agreed, • Replacement completed	B
17.02	Harmonize computerised patient information and management software between trust sites.			X	SHOULD	• Alert to be removed from PRH during January and replaced with Symphony, as at RSCH (main risk) • No other significant differences between sites • *Alert to be removed from Eye Hospital ED and Children's hospital ED during March*	~~B~~ G
17.03	The trust must monitor the turnaround time for biopsies for suspected cancer of all tumour sites.	X			MUST	• Progress hampered by historic inadequate investment in IT • *Investment in staff and IT now agreed* • Other aspects of 2WW timetable compressed to accommodate diagnostic delays	R
17.04	Ensure its governance systems are embedded in practice to provide a robust and systematic approach to improving the quality of services across all directorates. This includes learning from incidents, safeguarding and complaints across the directorates	X	X		MUST	• Review of clinical and quality governance arrangements in all directorates in hand • Monday Message includes patient safety stories • Patient Safety podcasts published	A
17.05	Urgently facilitate and establish a line of communication between the clinical leadership team and the trust executive board.	X	X	X	MUST	• Senior Management Team (SMT) created and meeting weekly	B

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17.06	Continue to ensure lessons learnt and actions taken from never events, incidents are shared across all staff groups			X	MUST	• Monday Message includes patient safety stories • Patient Safety podcasts published • Patient safety newsletters published • Review of trust-wide clinical governance systems planned for early 2017/18	G
17.07	Ensure that there are systems in place to ensure learning from incidents, safeguarding and complaints across the directorates.		X		SHOULD	• Monday Message includes patient safety stories • Patient Safety podcasts published • Patient safety newsletters published • Review of trust-wide clinical governance systems planned for early 2017/18	G
17.08	Ensure all staff are included in communications relating to the outcomes of incident investigations.		X	X	SHOULD	• Monday Message includes patient safety stories • Patient Safety podcasts published • Patient safety newsletters published • Review of trust-wide clinical governance systems planned for early 2017/18	G
17.09	Review aspects of end of life care including, having a non-executive director for the service, a defined regular audit programme, providing a seven day service from the palliative care team as per national guidelines and recording evidence of discussion of patient's spiritual needs.		X	X	SHOULD	• EoL NED appointed • Recording of discussion of spiritual needs agreed • Audit programme defined • EoL committee re-launched • Seven day service to be discussed with commissioner	G
17.10	Improve risk management and reporting from ward to board	X	X	X	WARNING NOTICE	• Risk management strategy and process completely revised • Training programme reviewed and in delivery • Directorate risk reviews commenced • Reporting to Board resumed • *Programme of communication to ward level staff about revised approach required* • *Environmental risk assessment status of some areas currently unknown – status downgraded until position clearer. Additional resource allocated*	R
17.11	Improve processes and systems for ensuring that the Board seeks adequate assurance concerning the quality of care given to pts	X			WARNING NOTICE	• Directorate and trust wide score cards now in regular use, including quality issues	B

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17.12	Ensure safe and secure storage of medical records.			X	MUST	• IG training levels improved • Lockable storage facilities provided • Audits of compliance taking place in key areas • Need to extend audit to all areas • *IG training currently 87% Trust wide (Target 95%)* • *Downgraded due to mock inspection results and observations of current practice.*	A
17.13	Review funding for multidisciplinary specialties and ensure business cases submitted by specialists are considered appropriately. This specifically refers to pharmacy, occupational therapy and dietetics.			X	MUST	• Corporate Governance Review included establishment of Business Appraisals Committee (reports to FBI) • BAC met September and December but slightly stalled; will resume January 2017 • BAC now meeting fortnightly • External review of Pharmacy planned for Q4 • Guidance for Operational Planning to be revised to ensure adequate focus on support and multi-disciplinary services	A
17.14	The provider should ensure there is a cohesive vision and strategic plan for the directorates which engages staff and provides an effective guide in the development of services.			X	SHOULD	• Trust has re-set priorities for 2017/18 and approach for Trust Operational Plan • Clinical Directors heavily involved in development of TOP • Position impacted by lack of clarity re: future arrangements with Western • Clinical strategy reviewed at SMT	R

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Reg 18 - Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this Part							
Requirement		Trust	RSCH	PRH	Must/ should		
18.01	The provider should ensure that there are sufficient staff available to offer a full seven-day service across all directorates and support services.			X	SHOULD	• Clinical transformation programme includes progress towards seven –day services in relevant areas, but current focus is Winter Plan • Clinical transformation Programme Manager in post; drawing together comprehensive plan	A
18.02	Ensure that there are sufficient numbers of staff with the right competencies, knowledge, qualifications, skills and experience to meet the needs of patients using the service at all times.	X	X	X	MUST	• NHSI supported review of nurse staffing levels complete, going to January Board • Ward / dept benchmark of educational / skills need underway, due 31.03.17 • Workforce modernization programmes in hand • *Significant number of gaps in staff establishment across the Trust.*	R
18.03	Ensure that newly appointed overseas staff have the support and training to ensure their basic competencies before they care for and treat patients.	X	X	X	MUST	• Induction programme completely reviewed and updated since last in use • Plan for 2017 cohort reflects feedback and learning from previous attendees	G

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18.04	Implement an action plan to reduce further nurse sickness absence and attrition through a transparent, sustainable programme of engagement that must include a significant and urgent improvement in staff training			X	MUST	• Workforce modernization programmes support improved attendance / retention • Retention Lead Nurse in post and focused on newly qualified / appointed staff • Foundations of Care programme supports enhanced engagement, training, development, retention • Consciously Competent programme in place to improve training and development • Wellbeing sessions being run by Chaplaincy Team • *Advance Care Practice (ACP) project phase 1 part of the Workforce Transformation programme is due to complete end of March and proposal for extension has been drafted.* • *Nurse turnover and sickness absence figures April 16 – Feb 17 to be included in next month's report*	G
18.05	Adhere to RCN guidelines that the nurse coordinator remains supernumerary at all times.			X	MUST	• All nurse staffing templates show nurse coordinator as supernumerary • Review of equity of role underway	G
18.06	Review the nurse staffing levels to ensure all areas are adequately staffed.			X	SHOULD	• NHSI supported review of nurse staffing levels complete, going to January Board • Ward / dept benchmark of educational / skills need underway, due 31.03.17 • Workforce modernization programmes in hand	G
18.07	Review consultant cover in the ED at PRH, per Royal College of Emergency Medicine guidance			X	WARNING NOTICE	• Consultant increase business case approved but recruitment not successful • Clinical Fellow programme implemented to help mitigate risks	G

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18.08	Review staffing and skills mix on ICU and cardiac ICU		X		WARNING NOTICE	• Sickness absence issues present during inspection period largely addressed but turnover and vacancy rates remain higher than desirable – further plans required • Nursing skill mix assessment completed; gaps identified. Business case in development	A
18.09	Must undertake an urgent review of staff skill mix in the mixed/neuro ICU unit and this must include an analysis of competencies against patient acuity.	X	X	X	MUST	• Skill mix reviewed • Bed capacity reduced to match neuro-trained staff resource • Staff development programme underway	B
18.10	Review and improve medical and nursing cover to meet relevant CEM and RCPCH standards and reflect/review activity rates relating to paediatric for the unit.			X	MUST	• Review of paediatric attendance / need at PRH in hand • *07/03/17 Report submitted to informal exce meeting, urgent review underway by COO*	R
18.11	Review the workload of the nurse practice educators and assess the impact on their availability for bedside learning and teaching.			X	SHOULD	• Gap analysis of clinical educators and directorates/ wards underway	A
18.12	Ensure that all staff have attended mandatory training (including conflict resolution training and appropriate levels of safeguarding training)	X	X	X	MUST	• STAM levels improving but below trajectory • *Trust wide Feb 17 71% (target 75% by end of March)*	R
18.13	Review clinical training records for medical and nursing staff and rectify gaps in role specific resuscitation training such as ALS and PILS.			X	MUST	• Discrepancy between data on IRIS and previous records makes position unclear • Data quality issue being addressed • Capacity to provide and undertake specialist training limited by demands on clinical time due to winter pressures etc but delivery being pursued • *Additional trainers being recruited to improve provision of training* • *07/03/17 Review completed and gaps identified in A&R specifically, report to follow*	A

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18.14	Provide mandatory training for portering staff for the transfer of the deceased to the mortuary as per national guidelines.		X		SHOULD	• Training programme under development • *Training now in progress and compliance is 75%*	G
18.15	The provider should ensure there is documentary evidence available to support recording that staff mandatory training is in line with trust targets.			X	SHOULD	• IRIS system extended to include all aspects of STAM	B
18.16	The provider should review the HR policies and ensure they are fit for purpose.			X	SHOULD	• All HR policies now reviewed by external legal advisors • Necessary changes made and under discussion with staff side • Training programme planned ready for implementation	G
18.17	The provider should ensure that effective HR resources are available that support staff. In particular the provider should continue to address the culture of bullying and intimidation found in some areas of the service.			X	SHOULD	• Diagnostic programme currently under procurement • Funding for support secured • Working Effectively Together campaign commenced November 2016	G
18.18	Undertake a review of the HR functions in the organisation, including but not exclusively recruitment processes and grievance management.	X	X		MUST	• HR function review complete • Recommended changes agreed by Board, but implementation delayed	A
18.19	Ensure all staff have an annual appraisal.	X	X	X	MUST	• Appraisal levels below trajectory • *07/03/17 81.3% (Target 85% by end of March)*	R
18.20	Develop and implement a people strategy that leads to cultural change. This must address the current persistence of bullying and harassment, inequality of opportunity afforded all staff, but notably those who have protected characteristics, and the acceptance of poor behaviour whilst also providing the board clear oversight of delivery.	X	X		MUST	• Diagnostic work to be commissioned during January • *LGBT newsletter published regularly* • *"People Together" working in the trust currently to support development of strategy. Staff-side, BME Network, LGBT+ Forum all engaged in process.*	A