F1 Post – inspection update 24.01.17

Brighton and Sussex NHS University Hospitals NHS Trust

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 • *Documentation update due end January*	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 ~~January~~ *February* • *Matter complicated by plans to outsource / re-commission pain service*	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 to be amalgamated to improve cover • *Report of review to be produced to QSIP inMarch*	G
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*	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 - *date unclear*	G

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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
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*	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*	G
12.03	Establish clear working guidelines and protocols, fully risk	X	X		MUST	• Review completed	B

	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.					• Need for enhanced neuro skills training acknowledged • Bed capacity reduced pending neuro skills increase • In-house training programme implemented	
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	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*	G
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 • *Recent cases reflect winter pressures but risk assessed on each occasion (1 ED patient, 3 ward patients)* • Behaviours training programme drawn up but not yet delivered	B A
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*	G
12.08	Implement a sepsis audit programme		X	X	SHOULD	• Sepsis Clinical Lead and Nurse in post • Audits complete	B

						• Action plans in development	
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	G
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*	B
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*	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	B
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*	G
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	G

						be installed January • *Medicine stock boxes on site but installation unlikely to be complete until end of February*	
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	R

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	G
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	G
15.03	Review and improve major incident storage facilities and replenish stock			X	SHOULD	• Complete • *Audits planned to ensure practice embedded*	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* • *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*	G
15.05	Consider improving the environment for children in the Outpatients department as it is not consistently child-friendly.		X		SHOULD	• Child friendly template produced • Relevant areas identified • Funding application made	G
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	B
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	B
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 • 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 • Clinical Governance Business Partners planned for early 2017/18 • 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 • Board Confirm & Challenge sessions being held quarterly	B
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	B

						• Training programme reviewed and in delivery • Directorate risk reviews commenced • Reporting to Board resumed	
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
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	G
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
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			X	SHOULD	• Clinical transformation programme includes progress towards seven –day services in relevant	A

	and support services.					areas, but current focus is Winter Plan • Clinical transformation programme Manager in post; drawing together comprehensive plan	
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	G
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
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*	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	G

						• Clinical Fellow programme implemented to help mitigate risks	
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	A
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	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	R
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	R
18.15	The provider should ensure there is documentary evidence			X	SHOULD	• IRIS system extended to include all aspects of	B

	available to support recording that staff mandatory training is in line with trust targets.					STAM	
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	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	A