Summary response to Warning Notice

Brighton and Sussex University Hospitals NHS Trust

Key concern	Summary action taken / effect

Failure to ensure systems to assess, monitor and mitigate risks to patients are operating effectively	• Complete review of corporate governance systems and processes
	• Complete review of corporate risk management, including
	  ○ creation and implementation of Risk Committee
	  ○ re-drafting / re-scoring of existing risks
	  ○ thorough revision of risk management strategy (for approval by Board in September)
	  ○ presentation of revised risk register to Quality & Performance Committee of Board in July and August
	• Allocation of executive responsibility for risk function to newly created Director of Clinical Governance role
	• All Practice Group Directions (PGD) now reviewed, revised as required and up to date
	  ○ Plan in place to ensure PGDs managed in timely manner in future
	• Plan to ensure fire risk assessments remain up to date now in place

Failure to ensure systems to monitor and improve care, privacy and dignity of patients are operating effectively
 	
Failure to ensure systems to assess, monitor and improve patient treatment times are met in line with national timescales
	• ICT: CIO appointed, three key areas of focus identified
	  ○ Improvement / extension of electronic patient records
	  ○ Alignment of IT resource to clinical and organisational priorities
	  ○ Addressing risks associated with IT infrastructure
	• Performance management: Director of Performance Management appointed
	  ○ Trust wide and Directorate (inc for ED) scorecards in use and under discussion at relevant meetings (eg, SMT, Quality & Performance Committee, Board)
	  ▪ Exception reports / action plans required for red items reported at Board
	  ▪ New format for Directorate Performance Review meetings from 19.09.16
	  ○ Ward scorecards produced for use from 19.09.16
	  ○ Subject specific (including Clinical Governance) scorecards drafted and under consideration
	  ○ Independent review of 18 week RTT position started 14 Sept
	• Structure: Executive Portfolios redefined; responsibilities re-stated
	  ○ PMO created and aligned to support of key Recovery Plan priorities

Clinical governance failures across trust; learning from incidents, complaints etc	• Creation of, and appointment to, Director of Clinical Governance role • Creation of Clinical Governance Directorate in hand, to include introduction of Clinical Governance Partners to ensure rigour and quality of clinical governance activity and sharing of information and lessons • Planned overhaul of clinical governance function to include standardised terms of reference and standing agenda for directorate clinical governance meetings •

Volume of patients in RSCH ED corridor area	• Reduction in use of corridor area:
	  ○ June 2016: 15% of all ED patients spent time in corridor, average LoS: 52 mins
	  ○ July 2016: 14% of all ED patients spent time in corridor, average LoS: 55 mins
	  ○ Aug 2016: 9% of all ED patients spent time in corridor, average LoS: 45 mins
	  ▪ NB: some deterioration in this performance during Sept acknowledged
	• Standard Operating Procedure in place re: escalation if more than 5 patients in the corridor at any given time
	•

Failure to assess and act on risks to safety in RSCH ED corridor	• NEWS score assessments of patients in corridor completed in 100% of audited records since mid-August (although 95% week ending 16.09.16)
	• Patients in corridor limited to those with NEWS score of 4 or more 100% since mid-August)
	• Mental health risk assessments completed in 100% audited records of patient placed in corridor since mid-August
	• All suitably experienced staff now trained in triage
	• Emergency care checklists in place for patients placed in corridor; completed in majority of cases (100% of audited records since 17 August, apart from week ending 2 Sept (97%) and week ending 16 Sept (75%). Dept returning immediately to methods in use during previous weeks)
	• Average time to initial assessment reduced (acknowledged not at required standard)
	  ○ 43 mins in August 2016
	  ○ 26 mins in September 2016
	• PAT system introduced (although not 24/7)

Failure to protect patients' privacy and dignity in RSCH ED corridor	• Four new assessment cubicles opened • Three privacy screens purchased for use in corridor; three more on order • Comfort rounds completed for 100% of audited records of patients placed in corridor since 17 August, apart from week ending 2 Sept (97%) and week ending 16 Sept (65%). Returning immediately to methods in use during previous weeks)
Long waits for mental health patients in ED	• Significant engagement with CCG and Mental Health Trust, but limited impact on experience or outcomes for patients • Royal Coll Emergency Medicine mental health audit completed August/September – improvements in all eight indicators since previous audit • Mental Health assessment of patients allocated to corridor completed in 100% of audited records from mid-August
Failure to comply with RCEM guidelines re: Consultant cover at PRH	• Business case for increased senior presence at PRH agreed • Given national shortage of ED consultants and existing local vacancies, alternative approach to provision of senior cover under development • Additional SHO in place at PRH most evening shifts (currently locum provision, aiming for consistency and all shifts filled)
Failure of 4 hour ED access standard:	• April 2016: 84.2% • May 2016: 86.3% • June 2016: 85.1% • July 2016: 84.1% • Aug 2016: 81.27% (closure balcony beds at RSCH, reduced performance at PRH) • Sept 2016: 82.4% (86% week ending 16.09.16) •

High number of 12 hour breaches:
Oct 2015 – Jan 2016 52 breaches
08.04.16 – 31.05.16 15 breaches
	• 12 hour breaches
	  ○ April 2106: 11
	  ○ May 2106: 4
	  ○ June 2106: 2
	  ○ July 2016: 0
	  ○ August 2016: 1
	  ○ Sept 2016: 0

Inappropriate use of recovery area at RSCH	• ICU Escalation Policy in force
	• Inappropriate use of recovery area almost eliminated
	  ○ Two incidents since policy introduced mid-July
	  ○ Each incidence of inappropriate use reported as an incident on Datix and discussed at SMT

Failure to maintain full range of fire risk assessments	• 100% of fire risk assessments now complete • Programme for maintaining compliance in place • Action planning for identified issues underway • Remediation of highest risk items underway, and complete in many areas
Failure to maintain required standards of fire safety practice	• Highest risk beds in Barry Building ("balcony beds") closed • Ski-sheets purchased and fitted to all beds • Checking of fire exits part of all ward visits by SMT, Execs etc
Failure to maintain patients' privacy and dignity in Sussex Eye Hospital / out-patient department **Lack of respect for patient confidentiality in Sussex Eye Hospital / out-patient department**	• Snellen charts removed from corridors and provided in appropriate manner in clinic rooms • Building temperature reduced to obviate need for doors to be propped open in hot weather • "Knock and wait" signs applied to clinic doors • IG training amongst OPD staff increased from 63% in June to 83% (acknowledged still below required 95%, trajectory for full compliance in place) • Lockable storage room provided to improve security of records
Failure to act on risk assessments prior to allocating patients to Barry Building	• Highest risk beds ("balcony beds") closed • Risk assessment process reviewed and revised • Escalation Policy revised • Full review of incidents associated with allocation to Barry wards – no harm identified • Monthly review of all apparent incident of inappropriate allocation started 09.09.16

Poor patient environment in Barry Building	• Highest risk beds ("balcony beds") closed
	• Works commenced on key wards to ameliorate layout etc
	• Revisions to housekeeping and estates practice and governance completed
	  ○ Patient Environment Committee agreed for establishment by end of Sept)
	  ○ Quality checks on housekeeping now unannounced

	• Approach to calculating and publishing performance against national environment standard introduced • Revised checklist for ward managers introduced • Programme of 1000 hours of SMT visits to all areas per annum commenced – areas of focus to include patient environment
Failure to comply with hand hygiene standards	• Hand hygiene audit compliance now at 97% at RSCH site • Apparent deterioration in performance at PRH (91% - 77%) under investigation • No MRSA bacteraemia cases since 15.07.15, c. diff at annual trajectory +2

Failure to comply with NHS Protect required standards of security re: prescription pads	• Now compliant
	  ○ Un-numbered prescription pads removed from use
	  ○ Warning to all staff issued jointly by Chief Medical Officer and Pharmacy Lead
	  ○ Numbered prescription pads now kept in safes in OPD when not in use

Failure to maintain safe levels of neuro-trained staffing in Neuro-ICU	• Safe level of service provision calculated in line with availability of neuro-trained, experienced staff
	  ○ service temporarily reduced to seven beds to match staffing
	  ○ capacity to increase only in line with increases in numbers of specialist trained staff (resumption of previous level expected around end of November)
	• Neuro-surgery / ICU education strategy developed and out for consultation
	• In-house training programme developed and in use

Failure to meet 18 week RTT 95% standard	• 18 week trajectory developed and in use as indicator of improvements
	  ○ 16.09.16: performance 75.12% against trajectory of 72.35%
	• Reduction in backlog of patients waiting more than 52 weeks
	  ○ 16.09.16: 7063 patients who have waited more than 52 weeks against plan of 9363

Failure to meet cancer 2ww standard (April 2016: 92%)	• National standard (93%) met since mid-August ○ 16.09.16: 94.06%
Failure to meet breast cancer 2ww standard	• National standard (93%) met since mid-August ○ 16.09.16: 98.57%
Failure to meet lower GI cancer 2ww standard (April 2016 67%)	• National standard (93%) met since mid-August ○ 16.09.16: 95.94%

Failure to meet cancer 31 day wait standard (April – Dec 2015 95%)	• National standard (96%) met since mid-August ○ 16.09.16: 98.4%
Failure to meet cancer 62 day wait standard (April – Dec 2015 82%)	• Trajectory to deliver national standard (85%) in place • Current deviation from trajectory (70.54% performance vs. 80.3% plan) to enable focus on longest waiters.

High numbers of cancelled appointments
82,873 appts cancelled 2015/16
	• Reduction in number of cancellations, although still below trust target of no cancellations within six weeks
	
	  ○ Week ending 02.09.16 – 536 appointments cancelled
	  ▪ < 2 weeks' notice: 24 clinics, 106 patients affected
	  ▪ 2-6 weeks' notice: 52 clinics, 162 patients affected
	  ▪ 6 weeks+ notice: 76 clinics, 268 patients affected
	
	  ○ Week ending 09.09.16 – 296 appointments cancelled
	  ▪ < 2 weeks' notice: 16 clinics, 109 patients affected
	  ▪ 2-6 weeks' notice: 8 clinics, 39 patients affected
	  ▪ 6 weeks+ notice: 24 clinics, 148 patients affected
	
	  ○ Week ending 16.09.16 – 218 appointments cancelled
	  ▪ < 2 weeks' notice: 10 clinics, 59 patients affected
	  ▪ 2-6 weeks' notice: 13 clinics, 50 patients affected
	  ▪ 6 weeks+ notice: 23 clinics, 109 patients affected
	
	• Annual performance based on 19.09.16 data: 11,336 appointments cancelled

Poor performance in respect of cancelled operations not completed within 28 days • national average 5% • last data at time of inspection: 15%	• August performance: 1 cancelled operation not completed within 28 days • Sept performance: 0 cancelled operations not completed within 28 days