### Summary response to Warning Notice

<table>
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<tr>
<th>Key concern</th>
<th>Summary action taken / effect</th>
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| **Failure to ensure systems to assess, monitor and mitigate risks to patients are operating effectively** | • Complete review of corporate governance systems and processes  
  o creation and implementation of Risk Committee  
  o re-drafting / re-scoring of existing risks  
  o thorough revision of risk management strategy (for approval by Board in September)  
  o 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  
  o 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** | • ICT: CIO appointed, three key areas of focus identified  
  o Improvement / extension of electronic patient records  
  o Alignment of IT resource to clinical and organisational priorities  
  o Addressing risks associated with IT infrastructure  
• Performance management: Director of Performance Management appointed  
  o Trust wide and Directorate (inc 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  
  o Ward scorecards produced for use from 19.09.16  
  o Subject specific (including Clinical Governance) scorecards drafted and under consideration  
  o Independent review of 18 week RTT position started 14 Sept  
• Structure: Executive Portfolios redefined; responsibilities re-stated  
  o PMO created and aligned to support of key Recovery Plan priorities |
| **Failure to ensure systems to assess, monitor and improve patient treatment times are met in line with national timescales** |                                                                                                                                                             |
| 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: 
  o June 2016: 15% of all ED patients spent time in corridor, average LoS: 52 mins  
  o July 2016: 14% of all ED patients spent time in corridor, average LoS: 55 mins  
  o 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)  
  o 43 mins in August 2016  
  o 26 mins in September 2016  
• PAT system introduced (although not 24/7) |
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| **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:**                                 | - 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  
  o Two incidents since policy introduced mid-July  
  o 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 | • 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 |
| Lack of respect for patient confidentiality in Sussex Eye Hospital / out-patient department | • 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  
  o Patient Environment Committee agreed for establishment by end of Sept)  
  o Quality checks on housekeeping now unannounced |
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| 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 |
| Hand hygiene audit compliance now at 97% at RSCH site                             | - No MRSA bacteraemia cases since 15.07.15, c. diff at annual trajectory +2 |
| Apparent deterioration in performance at PRH (91% - 77%) under investigation       |         |
| MRSA bacteraemia cases since 15.07.15                                            |         |
| Failure to comply with NHS Protect required standards of security re: prescription pads | - Now compliant  
  o Un-numbered prescription pads removed from use  
  o Warning to all staff issued jointly by Chief Medical Officer and Pharmacy Lead  
  o Numbered prescription pads now kept in safes in OPD when not in use |
| 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 |
| 18 week trajectory developed and in use as indicator of improvements              | - 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 |
<p>| National standard (93%) met since mid-August                                      |         |
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| **Failure to meet cancer 31 day wait standard** (April – Dec 2015 95%) | • National standard (96%) met since mid-August  
  o 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  
  o 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  
  o 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  
  o 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 |