Brighton and Sussex University Hospitals NHS Trust

# Integrated Recovery Plan

21 September 2016

# Overview of document

- This document describes the integrated recovery plan for Brighton and Sussex University Hospitals NHS Trust. It is the Trust's response to the CQC report published 17 August 2016.
- This recovery plan addresses issues across the trust related to quality and safety, financial, clinical services, workforce and leadership, governance, communications, performance management, information and technology, and strategy and transformation. This recovery plan outlines the actions required to enable us to deliver safe and effective care for patients in Brighton and Sussex.
- This recovery plan is a live document that will evolve as new initiatives are created, progressed, or completed; it will be updated via the Trust's monthly Quality & Performance Committee.
- The aim is to provide a single view to regulators, staff, and the public of the integrated recovery plan to address the issues BSUH faces.
- An essential prerequisite to delivery of organisational recovery will be the establishment of a stable, committed and substantive board of directors, complemented by strong and effective clinical leadership.

# Summary of BSUH recovery plan 1

- BSUH is a **complex multi-site teaching hospital with significant long standing issues and challenges**. The root causes of these problems include the historical lack of strategy with limited Board level ownership and lack of grip on the basics of delivering high quality care and sound financial planning. This is compounded by a lack of capability and capacity, which has led to a culture of low morale, a lack of accountability and a prevalence of starting but not finishing projects. All of this is within the context of poor estate and capital infrastructure.
- BSUH accepts the CQC findings and **initiated a recovery plan without delay** in April 2016. Further plans will address the root causes of the problems the trust faces and deliver improved quality, safety and compliance with national standards.
- The recovery plan is built upon four transformation programmes and four enabling programmes (supported by a PMO which has full Board approval):
  - Transformation: Quality and Safety, Financial Improvement, Clinical Services Transformation, and Workforce and Leadership
  - Enabling: Governance and Structure, Communications Development, Performance Management and Performance Improvement, Information and Technology, and Strategy, Transformation and BSUH Improvement Academy
- We are currently developing our transformation programmes and have already made **progress in five main areas**:
  1) Introduced new Trust governance and committee structures and processes
  2) Created a strong senior leadership triumvirate of Interim CEO, Interim Chairman, and Board Advisor with a number of changes to executive and non-executive personnel
  3) Reviewed and defined accountability and ensured role clarity for Executive Director roles
  4) Appointed to key recovery roles in line with NHSI special measures requirements
  5) Developed detailed CQC Quality interventions to deliver national standards

# Summary of BSUH recovery plan 2

- This **recovery plan includes clear milestones and measurable KPIs**. Notably, our plans are intended to :
  - Improve performance against all constitutional standards, in particular
    - Improve referral to treatment waiting times from 72.2% to 82.7% by March 2017 and eliminate 52 week waiters by March 2017
    - Improve performance against emergency access target to deliver 89% by March 2017
  - Close the financial deficit for 2016/2017 from potentially worst case scenario of £70m and seek to achieve an agreed revised control total
  - Ameliorate estate and safety issues in the Barry Building by closing beds where necessary on the grounds of safety, conducting a full estates viability assessment and using alternative accommodation where possible and as clinically appropriate
  - Raise our general statutory and mandatory training compliance to 75%, and IG and Fire safety training to 95% by December 2016
- The **recovery that lies ahead is ambitious with significant risks associated with delivery**. The problems the Trust faces have developed over multiple years. Moving to full compliance with NHS standards and meeting public and patient expectations is a journey which requires significant transformation, change management, focus, strong local organisational and clinical leadership, and external support. Investment will also be needed to deliver recovery plans and ensure that care for patients in Brighton and Sussex is delivered in line with national standards.
- **We will also look to our STP Partners** to develop future innovative models of leadership and care delivery across the STP footprint and crystalise BSUH's role within them

**1) Overview of situation and recovery plan**

2) Contents of recovery plan

3) Delivery and risk mitigation

# Issues highlighted by CQC report

Inadequate  Requires improvement

| Area | CQC rating | Examples of findings |
|---|---|---|
| Safety | Inadequate | Urgent and emergency services, medical care, critical care and outpatients are all rated as inadequate for safety |
| | | Staffing levels and skill mix in emergency departments, medical wards, critical care and midwifery are significantly below standards |
| | | The estate is poorly managed leading to utilisation without due consideration for dignity and safety |
| | | Processes for learning and feedback from incidents are largely ineffective and not recognised by staff |
| | | Infection control and other mandatory staff training levels are low |
| Effective-ness | Requires improvement | Some aspects of patient pathway delivery could be improved |
| | | Appraisal compliance (68%) is significantly lower compared to the trust target of 100% |
| | | Some services are not offering a full seven-day service |
| | | Patients in the 'corridor' in ED lacked nursing care rounds resulting in care needs not being met |
| | | Turnaround time for biopsies for suspected cancer of all tumour sites require improvement |
| Caring | Requires improvement | Care in ED corridor area and outpatients lacks privacy and dignity |
| | | Lack of emotional support for staff following episodes of difficult care |
| Responsive-ness | Inadequate | The admitted referral to treatment time (RTT) has been consistently below the national standard of 90% for most specialties |
| | | The percentage of patients whose operations were cancelled and not treated within 28 days consistently is higher than England average |
| | | As a result of patient flow issues critical care patients are not always discharged and cared for in the correct environment |
| | | There is not full adherence to the 4 hour standard for decision to admit patients from ED |
| | | In medical services there is lack of learning from complaints themed analysis and in outpatients complaints do not feature in key meetings |
| Leadership | Inadequate | Leadership is rated as inadequate, especially in emergency care |
| | | Clear disconnect between the Trust Board and staff working in clinical areas and the existing clinical strategy is not well communicated |
| | | Leadership stability and visibility are rated inadequate within the trust |
| | | Culture of bullying and harassment and a lack of equal opportunity |
| | | Executive team is often incapable of providing resources or support to clinical staff in critical care to improve safety and working conditions |



Based on CQC report

# Root causes of persistent problems

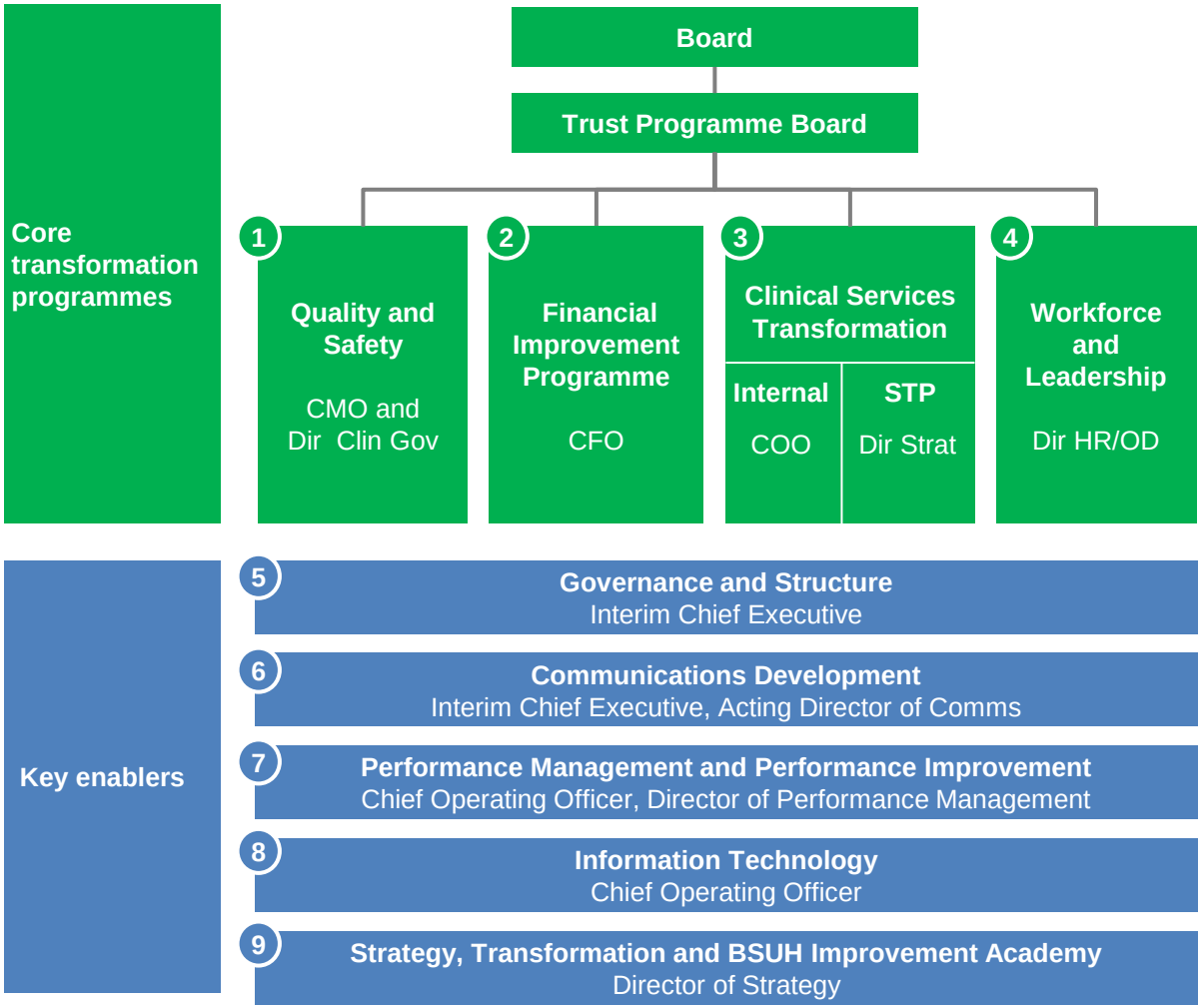
| Persistent problems | Relevant root causes |
|---|---|
| Limited Board ownership | A B |
| Lack of strategic view | C K |
| Capacity / capability | E H L O |
| "Lost a grip of the basics" | H K L |
| "Starters not finishers" | F H |
| "Optionality mindset" | F G H |
| Low staff morale | D I J M |
| Financial shortfall | H K N |
| Estates | M |

**Root causes identified in reports and senior interviews**

- A Board portfolios were historically unclear
- B High turnover and high proportion of interims in leadership team
- C Strategic view was not communicated from the top
- D Leadership was not visible and leaders were not responsive to incidents
- E Legacy of adding new roles rather than fixing roles and responsibilities
- F Roles, responsibilities, and accountability was not clear and not reinforced
- G Apparent lack of respect for authority – in part caused by high turnover
- H Lack of performance management
- I Culture of acceptance of poor performance
- J Poor labour relations and allegations of bullying
- K Controls and processes were unclear or failing
- L Low morale causes limited pride of ownership
- M Failing facilities and maintenance backlog (e.g., Barry Building)
- N Trust has not maintained a usable risk register
- O Lack of usable, integrated data across the trust

Based on interviews with senior leaders and relevant Board documents

# BSUH recovery programme structure




- **Four programmes** have been established, which will be conducted in a disciplined manner with set meeting schedule and outputs
- A NED will chair the **Trust Programme Board** to hold the senior responsible officer (SRO) to account for each programme

- **PMO support has been approved** and will work across all programmes to ensure weekly action-oriented meetings
- **Regular updates** will be given to the SRO of each programme, and issues will be quickly escalated to the Programme Board as required

- Five key enablers have been set up to **support the core transformation** programmes, each led by Board Directors
- These enablers will be designed to **establish the structures, capabilities, buy in, and vision** necessary to achieve change on a large scale
- The four core transformation programmes are also essentially complemented by and linked to the 3Ts Programme, which reports to the Trust Board via Trust 3Ts Programme Board and to the national 3Ts programme board
- The 3Ts programme outlines and underpins the major capital re-build of a significant proportion of the RSCH estate

# Root causes addressed by recovery plan

| Root causes | Core transformation programmes | | | | Key enablers | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | 1 Quality and Safety | 2 Financial Improve-ment Pro-gramme | 3 Clinical Services Transform-ation | 4 Workforce and Leadership | 5 Governance and Structure | 6 Communi-cations Development | 7 Performance Manage-ment and Performance Improvement | 8 Strategy, Transfor-mation, and BSUH Improvement Academy | 9 Information Technology |
| A Board portfolios were historically unclear | ✓ | | | ✓ | ✓ | | | | |
| B High turnover and high proportion of interims in leadership team | | | | ✓ | ✓ | | | | |
| C Strategic view was not communicated from the top | | ✓ | ✓ | | | ✓ | | ✓ | |
| D Leadership was not visible and leaders were not responsive to incidents | ✓ | | ✓ | | | ✓ | | | |
| E Legacy of adding new roles rather than fixing roles and responsibilities | | | | ✓ | ✓ | | | | |
| F Roles, responsibilities, and accountability was not clear and not reinforced | ✓ | ✓ | | ✓ | | | | ✓ | |
| G Apparent lack of respect for authority – in part caused by high turnover | | | ✓ | | | ✓ | ✓ | | |
| H Lack of performance management | | ✓ | ✓ | | ✓ | | ✓ | | ✓ |
| I Culture of acceptance of poor performance | ✓ | ✓ | | | | | ✓ | | |
| J Poor labour relations and allegations of bullying | | | | ✓ | | ✓ | | | |
| K Controls and processes were unclear or failing | ✓ | ✓ | ✓ | | | | | | ✓ |
| L Low morale causes limited pride of ownership | ✓ | | ✓ | ✓ | | | ✓ | | |
| M Lack of facilities investment and maintenance backlog (e.g., Barry Building) | ✓ | | ✓ | | | | | | |
| N Trust has not maintained a usable risk register | | | | | ✓ | ✓ | | ✓ | ✓ |
| O Lack of usable, integrated data across the Trust | | | | | | | ✓ | | ✓ |

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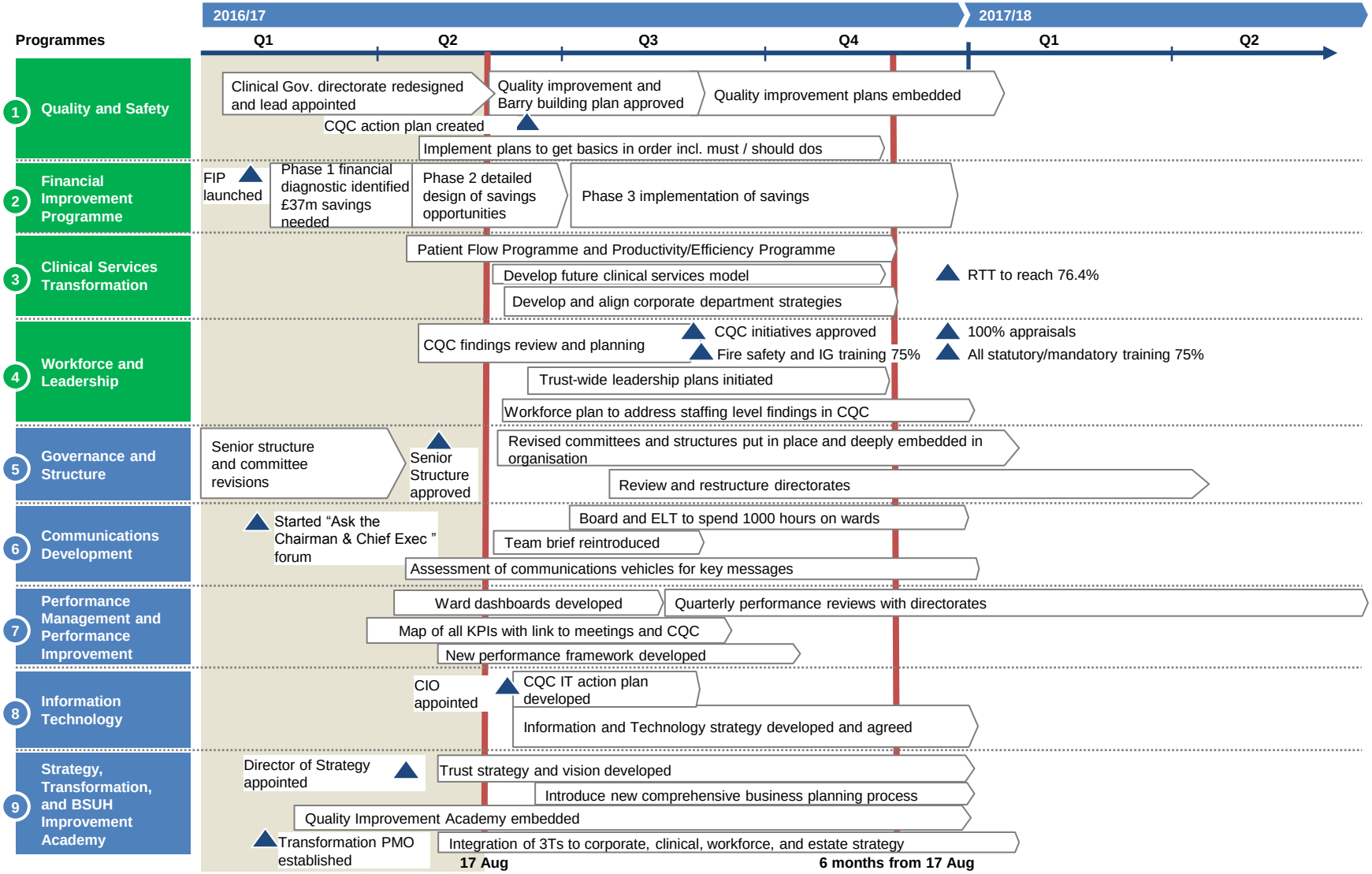
# Recovery plan Gantt for next 12 months



# Co-ordinated approach to recovery

| Programmes | Apr 16 – Sept 16 (2016/17 Q1 & Q2) | Sept 16 – Apr 17 (2016/17 Q3 & Q4) | Apr 17 – Sept 17 (2017/18 Q1 & Q2) | Sept 17 – Apr 18 (2017/18 Q3 & Q4) |
|---|---|---|---|---|
| 1 Quality and Safety | Develop CQC action plan and begin delivery (incl. Barry Building) | Systematically improve all aspects of quality and safety incl. CQC must and should do's | Continued improvement on all quality and safety metrics, with quality a priority for every staff member | |
| 2 Financial Improvement | Completion of financial review phases 1-2 incl. identifying savings opportunities | Deliver all identified financial improvement opportunities | Continue to identify opportunities and sustain impact of all savings implemented | |
| 3 Clinical Services Transformation | Begin immediate clinical services improvement (e.g., RTT) | Develop future clinical services model for Trust. Link to system plans. | Implement new clinical services model | Embed and sustain new model with continuous improvement |
| 4 Workforce and Leadership | Appoint new Exec Dir. | All staff complete training and undergo appraisals. Begin to develop leadership programme | Begin to deliver workforce leadership programme | Roll-out and embed leadership programme |
| 5 Governance and structure | Implement new governance and Exec. structure changes incl. all key Dir. appointments | Conduct Board capacity and capability review. Review clinical directorate structures. Embed recovery leadership team. | Board leadership development. Begin wider restructuring. Develop leadership transition plan. | Transition to business as usual leadership team post-recovery |
| 6 Communications development | Strengthen regular communications and messages to staff | Crowd-sourcing to engage staff. Enhanced leadership visibility and responsiveness on front-line. | Continue to embed communications with clear, consistent messages to support change. Maintain leadership visibility | |
| 7 Performance Management and Performance Improvement | Introduce new performance management framework (linked to CQC) | Establish regular quality performance reviews with all directorates and hold to account | Embed performance management process | Drive performance improvement across all KPIs. |
| 8 Information and Technology | Understand IT gaps and changes needed to support recovery and performance | Develop Trust-wide IT strategy and determine capital requirements | Begin delivery of IT strategy focused on quick wins | Invest longer term in information and technology as required |
| 9 Strategy, Transformation and BSUH Improvement Academy | Appoint new Exec Dir. | Develop new vision, strategy and business planning process. Set up improvement academy | Roll out and embed quality improvement methodology. Embed new business planning framework | |

# Key initiatives

- In design
- Approved and underway
- Rolled out and being embedded
- Fully complete

Brighton and Sussex University Hospitals NHS Trust

| | Initiative | Status | Start | End | Leadership |
|---|---|---|---|---|---|
| 1 Quality and Safety | Fully develop CQC action plan to address Warning Notice served April 2016 | In design | Apr 2016 | Sep 2016 | **SRO:** CMO + Dir Clin Gov |
| | As part of immediate improvement response, review Barry Building and develop action plan, incl. immediate plans for bed reconfiguration and clear plans for urgent improvement of cleanliness and maintenance | Approved and underway | Apr 2016 | Review Nov 2016 | |
| | Understand baseline data to enable development and implementation of plans to deliver national standards:<br>• Turnaround times, e.g., diagnostics<br>• Patient transfer / DTOC and repatriation<br>• Address wider RTT<br>• Bed and flow modelling | Approved and underway | July 2016 | Nov 2016 | |
| | Quality & Safety Improvement plan will be modified to address all quality and safety issues raised by the CQC full report | Approved and underway | Aug 2016 | Sept 2016 | |
| 2 Financial improvement programme | Participate in national FIP programme and identify in-year savings (phase 1) | Fully complete | May 2016 | June 2016 | **SRO:** CFO |
| | Detailed design (Phase 2) for financial improvement to develop plans to release efficiencies to reduce deficit | Rolled out and being embedded | July 2016 | Aug 2016 | |
| | Implementation (Phase 3) to carry out changes as needed to achieve and sustain savings identified in Phase 2 | In design | Sept 2016 | March 2017 | |
| 3 Clinical Services Transformation | Transform all existing bespoke projects into a coherent Patient Flow Programme and Productivity/Efficiency Programme with detailed plans<br>• Develop flow programme ED, ACU+AMU, core wards, discharge<br>• Review operational model<br>• Immediate review of PRH and RSCH clinical service models<br>• Productivity and efficiency OP, Theatre, diagnostic LOS, RTT<br>• Redesign ED front door and UCC<br>• Remodel ED at both sites | In design | • April 2016 | • March 2017 | **SRO:** COO (internal)<br>Dir Strat (external) |
| | Develop Trust's future clinical services model and link into wider work on the STP and local healthcare economy | In design | April 2016 | Review Feb 2017 | |
| | Work with all corporate departments to draw together their strategies into one comprehensive strategy | In design | Sept 2016 | March 2017 | |

# Key initiatives (continued)

In design
Approved and underway
Rolled out and being embedded
Fully complete

Brighton and Sussex University Hospitals NHS Trust

| | Initiative | Status | Start | End | Leadership |
|---|---|---|---|---|---|
| 4 Workforce and Leadership | Statutory/mandatory training program - at least 75% overall compliance. Achieve 95% target for Fire Safety and Information Governance compliance. Conduct appraisals to reach 100% target for those present | Rolled out and being embedded | April 2016 | March 2017 | **SRO:** Exec Dir. HR & OD |
| | Accelerate People and Wellbeing Strategy | In design | Aug 2016 | March 2017 | |
| | Generate workforce plan to address staffing requirements for future models of care | Approved and underway | July 2016 | March 2017 | |
| | Programme to understand and address CQC findings around culture of acceptance of poor performance, bullying, and equality and diversity | In design | Sept 2016 | March 2017 | |
| | Develop and initiate Trust-wide leadership programme | In design | Sept 2016 | March 2017 | |
| | Work with HEE Education Improvement Director to develop and implement Education Improvement Plan | In design | Nov 2016 | May 2017 | |
| 5 Governance and Structures | Restructure Trust-wide governance committees with stronger control, including revised Terms of Reference | Fully complete | April 2016 | July 2016 | **SRO:** CEO |
| | Executive portfolios reviewed and modified to clarify responsibilities and strengthen governance with new senior management roles:<br>• New appointments incl. Exec. Dir. of Strategy and Commercial Development, Clinical Governance Dir., Improvement Dir., Turnaround Dir., Dir. of Performance Chief Information Officer<br>• Exec. Dir. of Workforce and OD role to be developed and appointed | Rolled out and being embedded | April 2016 | Sept 2016 | |
| | Embed the clinical directorates into the SMT, e.g., "Confirm and Challenge" program set up to allow senior clinical and operational leaders to contribute to the Trust's strategy | Rolled out and being embedded | April 2016 | Sept 2016 | |
| | Board Capacity and Capability review to ensure Board is able to effectively govern the Trust by creating a plan to address any gaps or shortfalls | Rolled out and being embedded | Aug 2016 | March 2017 | |
| 6 Communi-cations Development | Thorough review of Communications Strategy to enable clarity and frequency of key messages | Rolled out and being embedded | April 2016 | Dec 2016 | **SRO:** CEO |
| | Improved leadership visibility through >1,000 hours of visits to services from the Board and SMT annually starting in September | In design | Sept 2016 | March 2017 | |
| | Use core comms to reinforce CQC report response, e.g., Hand Hygiene Week, poster campaigns | In design | Sept 2016 | March 2017 | |

# Key initiatives (continued)

- In design
- Approved and underway
- Rolled out and being embedded
- Fully complete

Brighton and Sussex University Hospitals NHS Trust

| | Initiative | Status | Start | End | Leadership |
|---|---|---|---|---|---|
| 7 Performance Management and Performance Improvement | Development of new performance framework with transparency and clear accountability including new integrated Board reports and weekly KPI reports for SMT | | July 2016 | Dec 2016 | **SRO:** COO |
| | Identify and develop range of KPIs that link to Board to Ward governance structures | | July 2016 | Sept 2016 | |
| | Implement real-time ward level information access to deliver local improvements | | Jul 2016 | Nov 2016 | |
| 8 Information Technology | Appoint CIO and build out IT team to enable the transformation | | Aug 2016 | Nov 2016 | **SRO:** COO |
| | Action plan developed to address CQC findings that require immediate ICT response | | Aug 2016 | Dec 2016 | |
| | Develop comprehensive IT strategy to<br>• support the recovery plan initiatives around e.g., quality and safety, clinical services, performance management<br>• Address long-term strategic initiatives including electronic patient record system, transition to digital informatics | | Sept 2016 | March 2017 | |
| 9 Strategy, Transformation and BSUH Improvement Academy | Development of a sustainable vision and strategy for the Trust, aligned with national policy, regional and STP strategy, and local delivery within the health economy | | Sept 2016 | March 2017 | **SRO:** Dir Strat |
| | Introduce a new comprehensive business planning process, ensuring that all planning is aligned with the 4 core transformation programmes | | Sept 2016 | March 2017 | |
| | Robust project management of the 4 core transformation programmes to track and help deliver action plans | | March 2016 | March 2017 | |
| | Establish BSUH quality improvement academy to embed and support continuous improvement of performance, quality, and process management | | April 2016 | March 2017 | |
| | Integration of 3Ts to become delivery mechanism for trust's long-term clinical strategy, an asset for STP footprint and a model of clinical, service, and capital construction best practice | | Aug 2016 | March 2017 | |

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# BSUH principles for delivery

We will ensure:

1. Robust leadership to drive recovery
2. Clear ownership of plan with demonstrable executive accountability
3. Clinical directorate-by-directorate ownership with demonstrable leadership
4. Effective programme and performance management, with weekly delivery pattern
5. Rigorous and systematic follow up on each quality issue identified by CQC
6. Single monitoring and reporting aligned with all regulators to assure progress and address roadblocks
7. Removal of role duplication and reallocation of clinical and corporate staff into programme roles
8. Targeted capital investment deployed efficiently and effectively where needed to enable transformation
9. A single system strategy to which system partners are committed and actively contributing
10. External support where required to address capability and capacity gaps

# New performance dashboard

DRAFT

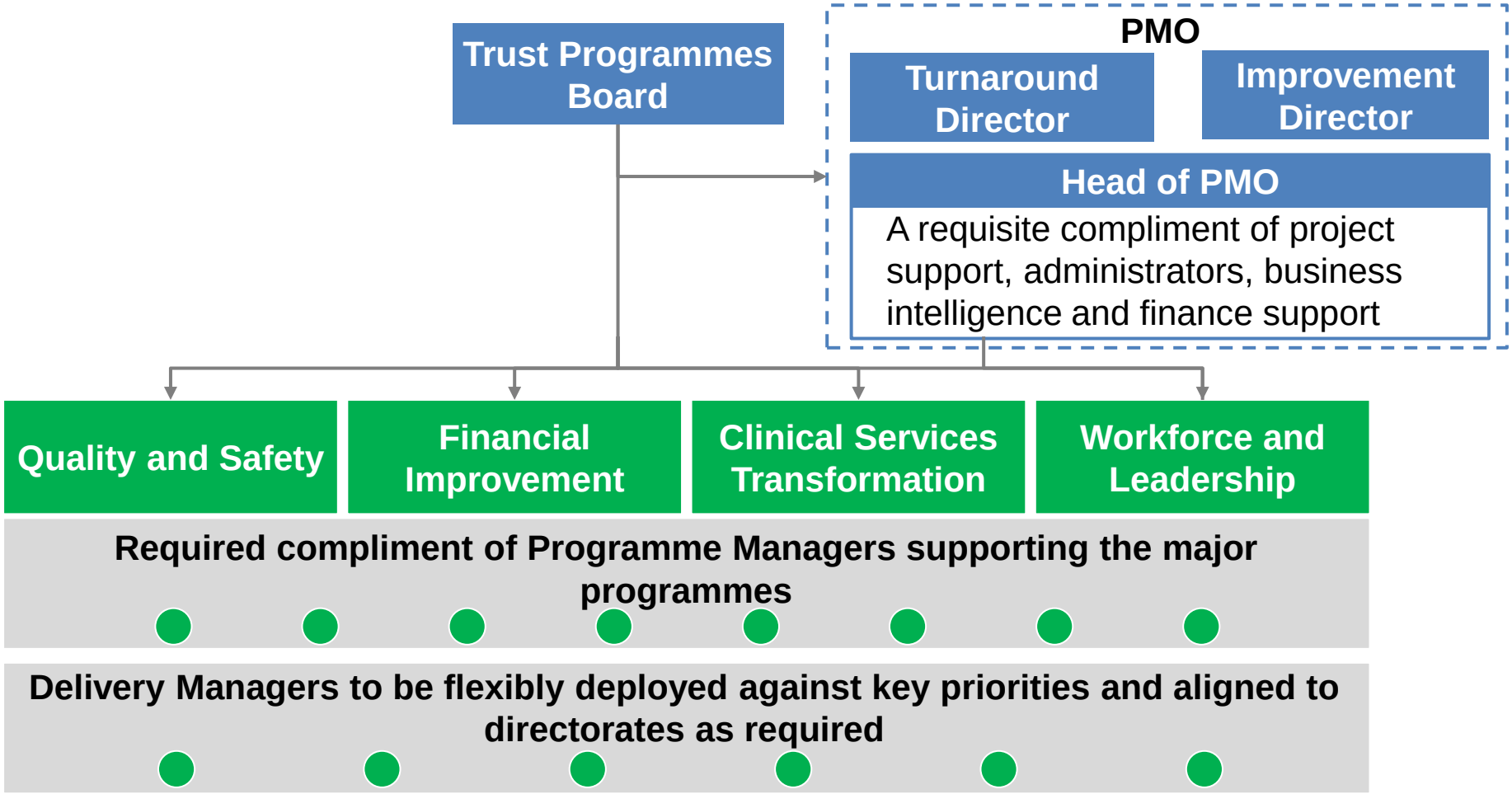
Brighton and Sussex University Hospitals NHS Trust

WEEKLY KPIS

Months complete | Weekly in repoting month

| Metric | Defined by | National Standard | Local agreed trajecory | April | May | June | July | 02/07/2016 | 09/07/2016 | 24/07/2016 | 31/07/2016 | Forecast to year end standard |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Responsive** | | | | | | | | | | | | |
| Referral to Treatment - Incomplete | NHSI | 92% | 82% | 73.50% | 74.80% | 75.20% | | 75.00% | 74.68% | 75.70% | 76.50% | |
| Incompletes 52+ week waiters | NHSI | 0 | | 100 | 87 | 92 | | 140 | 143 | 138 | 117 | |
| Diagnostic Waiting Times | NHSI | 1% | | 6.60% | 2.60% | 1.65% | | 2.32% | 2.10% | 2.40% | 1.60% | |
| A&E: 4 hour waits (all types) | NHSI | 95% | 89% | 84.20% | 86.30% | 85.10% | | 86.15% | 84.23% | 83.00% | 82.80% | |
| A&E: Total 12 hour waits from arrival regardless of DTA | L | 0 | | | | | | | | 81 | 73 | |
| A&E: 12 hour trolley waits | NHSI | 0 | | 11 | 4 | 2 | | 0 | 0 | 0 | 0 | |
| A&E ambulance hand over delays > 60 | L | 0 | | 51 | 77 | 56 | | 14 | 15 | 48 | 34 | |
| Number of hours patients in corridor | L | reduce | | | | | | | | 321 | 273 | |
| Mean wait of patients in corridor mins | L | < 15 mins | | | | | | | | 56 | 51 | |
| Max wait of pt in corridor mins | L | < 15 mins | | | | | | | | 395 | 323 | |
| Cancer Two Week Wait Standard | NHSI | 93% | | 88.60% | 93.80% | 95.11% | | not weeklly see month end for position | | | | |
| Breast Symptom Two Week Wait | NHSI | 93% | | 97.80% | 94.80% | 98.70% | | not weeklly see month end for position | | | | |
| 31 Day Standard diagnosis to treatment | NHSI | 96% | | 100.00% | 97.30% | 99.10% | | not weeklly see month end for position | | | | |
| 62 Day Standard urgent GP referral to | NHSI | 85% | | 78.10% | 77.20% | 81.10% | | not weeklly see month end for position | | | | |
| 62 day screening standard | NHSI | 90% | | 75.00% | 66.00% | 62% | | not weeklly see month end for position | | | | |
| Cancer 104 day waits | NHSI | 0 | | 8.5 | 7 | 5.5 | | not weeklly see month end for position | | | | |
| Delayed Transfers of Care | NHSI | <3% | | 5.90% | 6.70% | 6.90% | | | | | | |
| **Safe** | | | | | | | | | | | | |
| Histology report Turnaround Time ( % within 7 | Nat | 80% | | 30.00% | 26.00% | 19.00% | | Urgent need for weekly tracking | | | | |
| Histology report Turnaround Time ( % within 10 | Nat | 90% | | 59.00% | 51.00% | 51.00% | | Urgent need for weekly tracking | | | | |
| C Difficile - number of cases | NHSI | 46 | | 4 | 2 | 2 | | 0 | 1 | 3 | 3 | |
| MRSA Bacteraemia - | NHSI | 0 | | 0 | 0 | 0 | | 0 | 0 | 0 | 0 | |
| Never Events - number of | NHSI | 0 | | 0 | 0 | 0 | | 0 | 0 | 0 | 0 | |
| Serious Incidents - number declared | L | min | | 8 | 3 | 4 | | 5 | 0 | 0 | 0 | |
| Avoidable Pressure Ulcers ( category 3 & 4) | NHSI | 0 | | 3 | 4 | 0 | | 0 | 0 | 0 | TBC | |
| Hand Hygiene compliance | CQC | 98% | | | | | | | | | 60% | |
| Fire Risk assessments completed | CQC | 100% | | | | | | | | 73% | TBC | |
| **Effective** | | | | | | | | | | | | |
| Crude morality ( non elective pts) | NHSI | <2.5% | | 3.32% | 3.37% | 2.81% | | 2.76% | 3.31% | 3.10% | 2.20% | |
| VTE | NHSI | 95% | | | | 88.00% | | not weeklly see month end for position | | | | |
| **Caring** | | | | | | | | | | | | |
| Complaints responded to < 40 days | NHSI | 85% | | 62.00% | NYA | NYA | | *monthly with time lag* | | | | |
| Outstanding complaints over 6 months | L | <1% | | | | 11.98% | | *monthly with time lag* | | | | |
| Re-opened complaints | L | <10% | | 10.30% | 15.89% | 9.82% | | *monthly with time lag* | | | | |
| FFT - Inpatient - % positive | NHSI | 95% | | 95.9% | 97.6% | 94.80% | | *monthly with time lag* | | | | |
| FFT - A&E/WiC/MIIU - % positive | NHSI | 95% | | 87.7% | 87.0% | 89.90% | | *monthly with time lag* | | | | |
| FFT - Maternity - % positive | NHSI | 95% | | 90.6% | 94.9% | 94.70% | | *monthly with time lag* | | | | |
| **Well Led** | | | | | | | | | | | | |
| Staff sickness | NHSI | <3% | | 4.27% | 4.50% | 4% | | *monthly only at moment* | | | | |
| Staff turnover | NHSI | <12% | | 12.81% | 12.81% | 13.17% | | *monthly only at moment* | | | | |
| % of STAM training | NHSI | >75% | | | 49% | 55% | | *needs to move to weekly* | | | | |
| % of IG training | NHSI | >95% | | | | 50% | | *needs to move to weekly* | | | | |
| Safe staffing fill | NHSI | >95% | | 96.8% | 98.3% | 98.23% | | *needs to move to weekly* | | | | |
| % Appraisals completed | L | 100% | | | | 70.20% | | *needs to move to weekly* | | | | |

# Proposed PMO structure and internal resources



# Key risks and mitigation

| Key risks | Mitigation plans |
|---|---|
| **Leadership capability and capacity**: Significant number of initiatives across several areas leading to potentially insufficient resource to execute programmes | • Plans to deliver in phases and ensure realistic timeframes<br>• Transformation workload shared across organisation, with robust PMO to provide support and monitoring |
| **Reputational impact**: CQC report has detrimental impact on BSUH reputation, which may impact staff retention and recruitment, patients, and community support | • Focused communications and messaging<br>• Visible and active leadership<br>• Staff actively involved in plans via crowdsourcing |
| **Clinical ownership**: Not all clinical staff see the recovery as relevant to the entire trust, which may limit needed ownership mindset and broad support for successful recovery | • Increased engagement between Board, Executive, and clinical leadership, including “Confirm and Challenge” Board meetings |
| **Leadership and stability**: Transitioning from interim turnaround leadership to substantive leadership risks losing momentum and slowing recovery | • Robust interim leadership for recovery in place<br>• Transition plans for sustainability under development |
| **Momentum and resilience**: There is initial motivation for change but may be difficult to sustain new ways of working and pace in the long term | • Focus on quick wins to show early success and build morale to sustain through the program<br>• Hold individuals to account with tracked KPIs and milestones |
| **System response**: Relationships and alignment with system partners including CCG and STP need to improve, as recovery will require active response from the whole health economy | • Wider stakeholder engagement key priority for Board |
| **Integrated performance reporting and management:** Systems and culture are underdeveloped, leading to mistrust of data and limited use and buy in. | • Clear and agreed performance management established, including dashboards for all key meetings<br>• Effective communication and alignment on expectations |
| **Weak capital programme:** Lack of investment over long period time leaves estates, clinical equipment, and IT vulnerable to sudden failures that could impact quality and patient safety or prevent delivery of programmes | • Clearly defined and fully costed capital plan to improve and maintain infrastructure<br>• Clarity on approval processes and decision-making responsibilities |
| **PMO capacity:** The lack of a coordinated programme management function has necessitated the creation of a new PMO resulting in its growth whilst programmes have commenced | • Utilisation of current project management capability whilst recruiting temporary and substantive staff<br>• Prioritisation of key programmes where required |

# APPENDIX 1:
# Sources

# Sources

| Programme | Key leaders who have provided input | Source documents underlying plans |
|---|---|---|
| **Quality and Safety** | Improvement Director, Chief Medical Officer, Director of Clinical Governance, Interim Chief Nurse, Director of Estates and Facilities | Quality and Safety Improvement Plan, CQC Inspection and Quality and Safety Improvement Plan |
| **Financial Improvement Programme** | Chief Finance Officer, Turnaround Director | BSUH Financial Improvement Programme: Phase 1 Report (Draft) |
| **Clinical Services Transformation** | Chief Operating Officer, Director of Strategy | Performance Dashboard Month (June), Quality and Safety Improvement Plan |
| **Workforce and Leadership** | Exec Director of HR & OD | Quality and Safety Improvement Plan |
| **Governance and Structures** | Interim Chief Executive, Interim Chairman, Board Advisor | Future governance arrangements, Executive Portfolios and high level Structure |
| **Communications Development** | Chief Operating Officer, Acting Director of Comms, Director of Corporate Affairs | M1 Communications Strategy |
| **Performance Management and Performance Improvement** | Director of Performance Management | Quality and Safety Improvement Plan |
| **Information Technology** | Chief Operating Officer, Head of Health Informatics | n/a |
| **Strategy and Transformation** | Director of Strategy, 3Ts Programme Director | Sustainability and Transformation Plan, PMO and programme approach |

# APPENDIX 2:
# Further detail on programme plans

1a

# Quality and Safety

**Objective**

Establish holistic quality and safety programme to address underlying issues and systematically improve care

**Overall accountability**

Chief Medical Officer, Medical Director Improvement Director, Improvement Director

**Key interventions**

| | Description | Start date | Design/pilot | Fully embedded | Owner |
|---|---|---|---|---|---|
| 1 | Fully develop CQC action plan to address Warning Notice served April 2016 | April 2016 | Aug 2016 | Sept 2016 (CQC assessment of progress) | Director of Clinical Governance |
| 1a | As part of immediate improvement response, review Barry Building and develop action plan, including:<br>• immediate bed reconfiguration to align with regulations and based on detailed bed modelling<br>• Clear plan for urgent improvement of cleanliness and maintenance | April 2016 | Aug 2016 | Aug 2016 (CQC assessment of progress) | Chief Operating Officer / Chief Finance Officer / Interim Chief Nurse / Director of Estates and Facilities / |
| 1b | Develop and implement plans to deliver national standards:<br>• Turnaround times, e.g., diagnostics<br>• Patient transfer / DTOC and repatriation<br>• Address wider RTT<br>• Bed and flow modelling | July 2016 | Aug 2016 | Nov 2016 | Chief Operating Officer / Director of Performance Management |
| 2 | Quality Improvement plan will be modified to address all quality and safety issues raised by the CQC full report, including:<br>• Full health and safety across both sites<br>• Statutory and mandatory training<br>• Staffing against patient acuity<br>• Record management and information governance<br>• Medicine management<br>• Sample highlight report included at Appendix 10 | August 2016 | August 2016 | September 2016 | Director of Clinical Governance |

1b

# Quality and Safety

**Key milestones**

| | Description | Timeline |
|---|---|---|
| 1 | Engagement meetings with all clinical directorates to develop scenarios for immediate capacity solutions to resolve congestion-related patient safety issues | Completed |
| 2 | Quality Summit to engage all system partners to develop unified plans | Completed |
| 3 | Demonstrable continued progress on CQC Warning Notices including:<br>• Bed modelling and development of a solution for Barry Building to meet necessary quality and safety levels (e.g., fire code, decongestion whilst maintaining RTT levels)<br>• Improvement to turnaround times (e.g., diagnostics), repatriation and DTOC patients | Completed |
| 4 | Delivery of CQC 'Must-do' actions Compliance Actions including staffing to match patient acuity, statutory and mandatory training, performance target improvement, medicines management and IG | Various dates |
| 5 | Delivery of CQC 'Should-do' actions and Compliance notices including IPC and cleaning, sepsis audit implementation, DNACPR and MCA assessments are completed and improvements in EofL care | Various dates |

| Key risks | Mitigation plans |
|---|---|
| • System-wide response needed to effectively address the issues raised by the CQC report | • Active engagement with NHSI, CCG, and other stakeholders through e.g., Quality Summit |
| • Ability of leadership to carry out large programmes with limited resource | • Governance reviews to clarify responsibilities and strengthen roles; filling all key roles and supporting programmes with robust PMO |
| • Organisational buy-in needed to sustain success over time | • Early involvement of employees to generate solutions, and extensive communication and leadership engagement |

# 2a Financial Improvement Programme

| Objective | Overall accountability |
|---|---|
| Support Trust in reaching financial sustainability by achieving £15.6m deficit control total in year as agreed with NHSI | Chief Finance Officer, CFO |

**Key interventions**

| | Description | Start date | Design/pilot | Fully embedded | Owner |
|---|---|---|---|---|---|
| | Financial Improvement program designed over 3 phases to get the Trust to a state of financial sustainability by March 2017 | | | | |
| 1 | Participate in national Financial Improvement Programme (FIP) and identify in-year savings | May 2016 | n/a | June 2016 | Turnaround Director |
| 2 | Detailed Design (Phase 2) for financial improvement to develop plans to release efficiencies to reduce deficit | July 2016 | n/a | Aug 2016 | Turnaround Director |
| 3 | Implementation (Phase 3) to carry out changes as needed to achieve and sustain savings identified in Phase 2 | Sept 2016 | n/a | March 2017 | Turnaround Director |

# 2b Financial Improvement Programme

**Key milestones**

| | Description | Timeline |
|---|---|---|
| 1 | £20m in plans at L3 (agreed to implement with detailed financial milestones and in quality impact assurance pipeline) | July 2016 |
| 2 | £17m gap being addressed to reduce as much as possible | March 2017 |

| Key risks | Mitigation plans |
|---|---|
| • Falling behind targets early could lead to low morale and commitment | • Highly focused on tangible early successes |
| • Energy for change leads to spending to look for savings | • Mandate to find savings without additional spending; need clear and robust business case for spending approval |
| • Organisational capacity and capability to implement | • Populate the PMO rapidly and source a partner for Implementation Phase 3 |
| • CQC report will rightly be first priority but may divert attention or resource | • Fully functioning PMO can continue right level of focus |

# 3a Clinical Services Transformation

**Objective**

Ensure efficient care and treatment of our patients and identify the most appropriate operating model for Trust going forward

**Overall accountability**

Chief Operating Officer, COO Director of Strategy, Executive Director of Strategy and Commercial Development

**Key interventions**

| Description | Start date | Design/pilot | Fully embedded | Owner |
|---|---|---|---|---|
| 1 Internal: Transform existing bespoke projects into a Patient Flow Programme and Productivity/Efficiency Programme | | | | |
| • Develop flow programme ED, ACU + AMU, core wards, discharge | Aug 2016 | Sept 2016 | Sept/Oct 2016 | COO |
| • Review operational model | Sept 2016 | Oct 2016 | Oct/Nov 2016 | COO |
| • Immediate review of PRH and RSCH clinical service models | Aug 2016 | Sept 2016 | Oct/Nov 2016 | COO / CDS |
| • Productivity and efficiency OP, Theatre, diagnostic LOS, RTT | Aug 2016 | Sept 2016 | Oct/Nov 2016 | COO / CDS |
| • Redesign ED front door and UCC | Jan 2016 | March 2016 | Oct/Nov 2016 | n/a |
| • Rebuild ED | July 2016 | Aug/Sept 2016 | n/a | n/a |
| 2 Internal: Develop and deliver site clinical reconfiguration projects based on CQC findings | Aug 2016 | Nov 2016 | March 2017 | COO |
| 3 Develop and implement appropriate operating model for the Trust | Oct 2016 | March 2017 | Dec 2017 | COO |
| 4 STP: Develop Trust's future clinical services model and link into wider work on the STP and local healthcare economy | Aug 2016 | Oct 2016 | Feb 2017 | Director of Strategy |
| 5 STP: Work with all corporate departments to draw together their strategies into one comprehensive strategy | Sept 2016 | Dec 2016 | March 2017 | Director of Strategy |

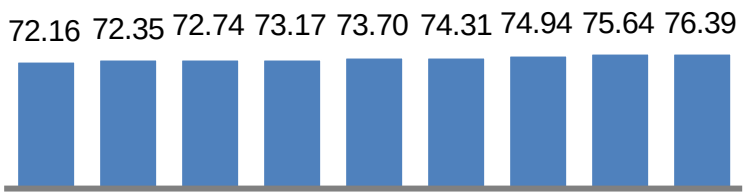
# 3b Clinical Services Transformation

**Key milestones**

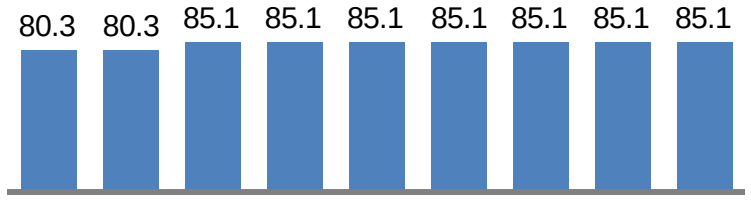
| | Description | Timeline |
|---|---|---|
| 1 | STP: Sustainability of Major Trauma Centre specialised services review | September 2016 |
| 2 | Internal: Existing projects incorporated into Patient Flow Programme | November 2016 |
| 3 | Internal: Site clinical reconfiguration projects based on CQC findings delivered | Barry beds: Aug<br>Other: ASAP |

**Key KPIs – how to measure success**

**BSUH projected RTT trajectory**




**62-day cancer waiting times trajectory**




**Key risks**

- Limited ownership mindset might make it difficult to get needed buy in and action from entire staff
- Lack of investment over long period time leaves estates, clinical equipment, and IT vulnerable to sudden failures that could impact quality and patient safety or prevent delivery of programmes

**Mitigation plans**

- Increased engagement with between Board, executive, and clinical leadership, including “Confirm and Challenge”
- Clearly defined and fully costed capital plan to improve and maintain infrastructure; clarity on approval processes and decision-making responsibilities

# 4a Workforce and Leadership

**Objective**

Ensure competent, skilled, healthy and appropriately resourced workforce while improving the working environment for staff including addressing bullying and equality issues within the Trust.

**Overall accountability**

Executive Director of Workforce and OD

**Key interventions**

| | Description | Start date | Design/pilot | Fully embedded | Owner |
|---|---|---|---|---|---|
| 1 | Statutory/mandatory training program set up to ensure at least 75% overall compliance and 95% for Fire Safety and Information Governance. Appraisals to reach 100% for those present | April 2016 | August 2016 | March 2017 | Exec Director of HR & OD |
| 2 | Acceleration of People and Wellbeing Strategy | August 2016 | October 2016 | March 2017 | Exec Director of HR & OD |
| 3 | Generate workforce plan to address staffing requirements for future models of care, to include recruitment and retention plan to address staffing levels concerns raised by CQC | July 2016 | October 2016 | March 2017 | Exec Director of HR & OD |
| 4 | With the support of an external expert, address the bullying, harassment, tolerance of poor performance and equality issues highlighted in the CQC report | Sept 2016 | Dec 2016 | March 2017 | Exec Director of HR & OD |
| 5 | Implement actions from June 2016 Review of HR, including consolidation of HR structure to include education and workforce modernisation | June 2016 | Aug 2016 | March 2017 | Exec Director of HR & OD |
| 6 | Develop and initiate Trust-wide leadership programme | Sept 2016 | Dec 2016 | March 2017 | Exec Director of HR & OD |
| 7 | Work with HEE Education Improvement Director to develop and implement an Education Improvement Plan | Nov 2016 | Jan 2017 | June 2017 | Director of Medical Education |

# 4b Workforce and Leadership

## Key milestones

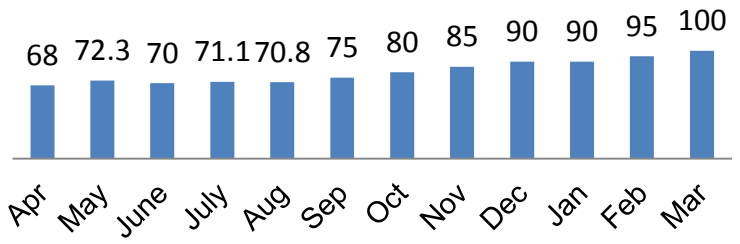
| Description | Timeline |
|---|---|
| 1 Full review of all HR policies | Dec 2016 |
| 2 Staffing level review completed and plan approved with staffing targets | Dec 2016 |
| 3 Consolidation of HR, education, and workforce modernisation completed | March 2017 |

## Key KPIs – how to measure success

### Statutory and mandatory training trajectory

| Subjects | Aug'16 | Oct '16 | Dec '16 | March '17 |
|---|---|---|---|---|
| IG | 95% | 95% | 95% | 95% |
| Fire training | 62% | 85% | 95% | 95% |
| All other | 60% | 65% | 70% | 75% |

### Staff appraisals trajectory, %




## Key risks

- Line management capabilities
- Low morale, and potential for further decrease in morale as a result of the CQC report
- High volume of work to be done in short time

## Mitigation plans

- Ongoing leadership development strategy
- Increased leadership visibility, crowdsourcing approaches to increase ownership, focus on quick wins to boost morale
- Fully staffed PMO to support and enable progress

# 5a Governance and Structure

**Objective**

Ensure that the governance structure is in place to enable transformation of care at BSUH

**Overall accountability**

Interim Chief Executive , CEO

**Key interventions**

| | Description | Start date | Design/pilot | Fully embedded | Owner |
|---|---|---|---|---|---|
| 1 | Restructure Trust-wide governance committees with stronger control, including revised Terms of Reference; Strengthened committees are given clearer authority to act on spend, hiring, and contracting decisions | April 2016 | June 2016 | July 2016 | Interim Chief Executive |
| 2 | Executive portfolios reviewed and modified to clarify responsibilities and strengthen governance; positions rapidly being filled by the CEO (40% of board positions are interims or vacancies) | April 2016 | June 2016 | Sept 2016 | Interim Chief Executive |
| 3 | Appointment of Clinical Governance Director to revise Safety, Quality, and Patient Experience Strategy by October 2016, incorporating CQC findings | April 2016 | Oct 2016 | March 2017 | Interim Chief Executive |
| 4 | Embed the clinical directorates into the SMT, e.g., “Confirm and Challenge” program set up to allow senior clinical and operational leaders to contribute to the Trust’s strategy | July 2016 | Aug 2016 | Dec 2016 | Interim Chief Executive |
| 5 | Board Capacity and Capability review to ensure Board is able to effectively govern the Trust by creating a plan to address any gaps or shortfalls | Aug 2016 | Oct 2016 | March 2017 | Board Advisor |
| 6 | Restructure and simplify directorates in long term | Sept 2016 | March 2016 | Sept 2017 | Interim Chief Executive |

# 5a Governance and Structure

**Key milestones**

| Description | Timeline |
|---|---|
| 1 Revised Trust-wide governance committees approved | June 2016 |
| 2 Executive portfolios clarified and approved by Board | June 2016 |
| 3 Board capacity review completed | Oct 2016 |

**Key risks**

- Insufficient communication and messaging could lead to continued uncertainty on escalation and decision processes

**Mitigation plans**

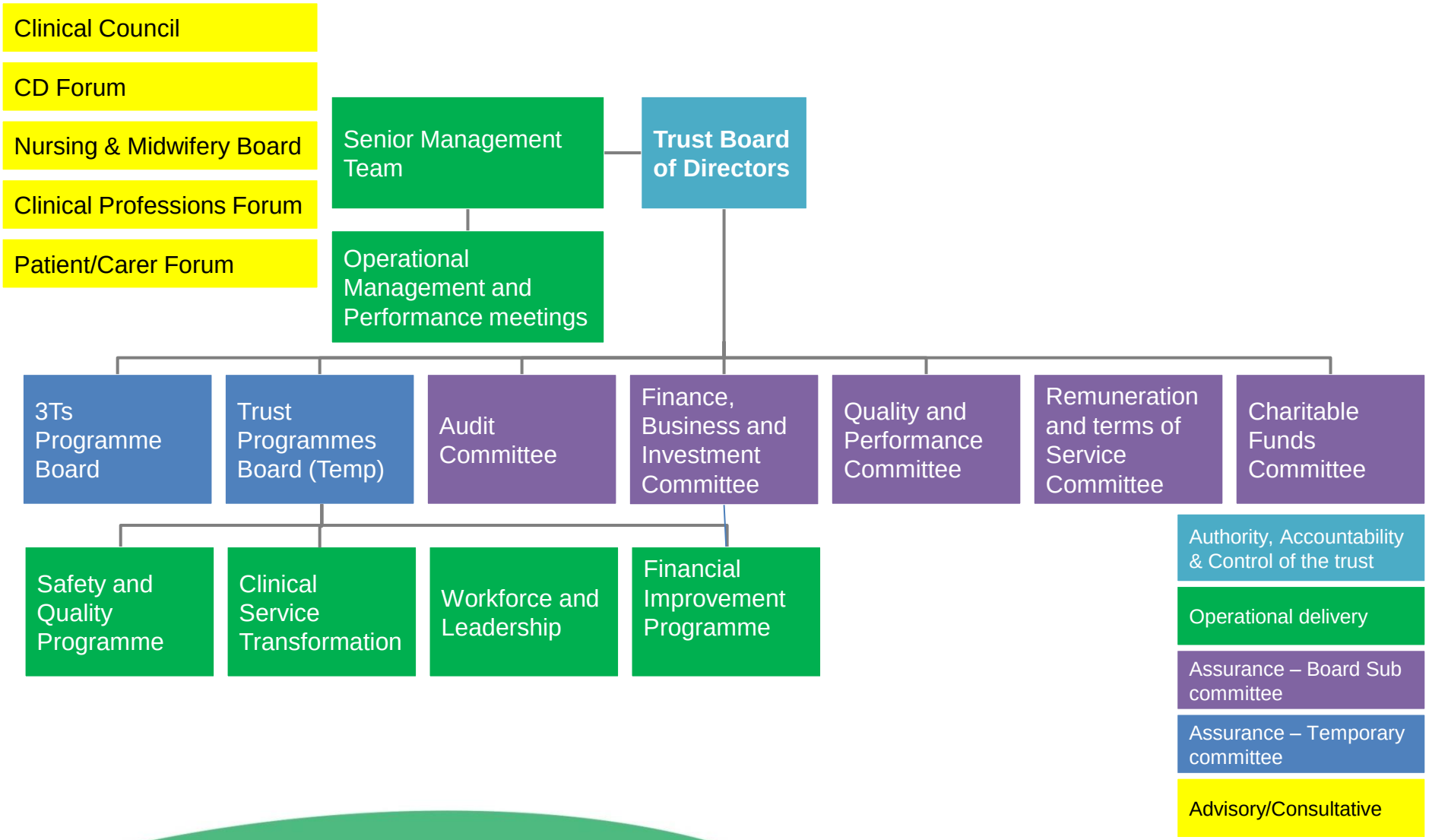
- Extensive communication effort around the governance and process reforms

5c

# Governance transformation

| | From | To |
|---|---|---|
| **Structure** | • Vacancy and interim appointments make up 40% of the Board | • CEO continues to clarify structure and fill vacant/interim roles |
| | • New top team meetings in place | • Ensuring disciplined meeting schedule becomes embedded |
| | • Board governance and programme structure recently defined | • Programme structure being implemented with appropriate approvals scheduled |
| | • Lack of accountability in driving change | • CEO continues to move quickly to assign clear portfolio responsibilities for top team |
| | • Limited visibility / understanding of root causes of performance and financial challenge | • Instituting meaningful performance reporting supported by action-focused discussions |
| **Culture** | • Team absorbed in 'fire fighting,' with limited capacity to manage change | • Empower staff by providing capacity focused on change rather than immediate operational issues |
| | • Challenges with prioritisation given scale and complexity of issues | • Ensure PMO operates across all programmes to drive informed prioritisation |
| | • Limited 'implementation culture', with history of failed turnaround efforts | • Focus on early visible wins to help drive performance culture |
| **Processes and controls** | • Decision making processes are unclear, with limited 'rules' in place and timelines typically lengthy | • CEO has introduced weekly PMO and SMT cycle to help expedite decisions against clear rationale |
| | • Some controls are in place but success and adherence is uneven | • Introduce more robust controls including:<br>– Decision making and escalation process<br>– Spend hiring and contracting controls |

# 5d Agreed future governance structure



# 5e New roles within Director portfolios

1. **Interim Chairman and Interim Chief Executive Office**: The Interim Chairman and Interim Chief Executive's office is key to supporting new ways of working as a Board and Senior Management Team (SMT). In addition the Trust must continue to develop both its internal governance and external stakeholder relationships and governance arrangements. The Interim Chairman and Interim Chief Executive's Office continues to be focused around the complementary roles of Board Secretary and Director of Corporate Governance. This post, reporting to the Interim Chairman and Interim Chief Executive focuses on Board support, governance, Board sub committees, Board cycle and compliance. The current post-holder also supports the CEO in all aspects of business in particular those relating to high level partnerships. The postholder also holds the operational management of the communication function working closely with the CEO.
2. **Director of Performance:** Performance reporting and management is an identified gap in current arrangements. A new post of Director of Performance has been established to address this gap and reports directly to the Chief Operating Officer. This post will ensure a robust performance reporting function is established.
3. **Chief Information Officer:** A Chief Information Officer has been recruited to replace the Director of Health Informatics and will report to the Chief Operating Officer.
4. **Executive Director of Strategy and Commercial Development**: Has been recruited on an interim basis and will play a crucial role in coordinating our complex partnership arrangements, and in supporting all members of the SMT in partnership working across all areas we serve. This role will map all stakeholder relationships and hold the ring on the stakeholder plan and relationship management. It will continue to forge a vital link in developing good relationships.
5. **Executive Director of Workforce and Organisational Development:** A new workforce and OD post is being created and will report to the Interim Chief Executive . The remit of this role includes organisational development, workplace health and well-being, HR management, employment services and learning and development. This role will be advertised imminently
6. **Turnaround and Improvement Directors**: The Turnaround Director reports to the Interim Chief Executive and has established a PMO to oversee and lead a suite of coordinated and linked programmes to transform the Trust. This is now led by the Director of Strategy and Commercial Development who will continue to work closely with the Turnaround and Improvement Director. An Improvement Director will be appointed by NHSI to support the Board in delivery of required transformation.

# 6a Communications Development

**Objective**

To ensure trust's vision, values and future plans are communicated clearly to everyone, and promote morale, commitment and a sense of team

**Overall accountability**

Interim Chief Executive, CEO
Acting Director of Communications

**Key interventions**

| | Description | Start date | Design/pilot | Fully embedded | Owner |
|---|---|---|---|---|---|
| 1 | Thorough assessment of management comms leading to specific actions to improve clarity and frequency of comms, e.g., weekly CEO messages, Ask the Chairman & CEO Forum, reintroduce team briefs, open staff forums | April 2016 | Sept 2016 | Dec 2016 | Interim Chief Executive |
| 2 | Improve leadership visibility by >1,000 hours of visits to services from the Board and SMT | Sept 2016 | Sept 2016 | March 2017 | Interim Chief Executive |
| 4 | Raise awareness of and promote Values and Behaviours programme to empower staff<br>• Open forums with executives<br>• V&B champions<br>• Employee of the Month | 2015 | 2015 | March 2017 | Acting Director of Comms |
| 6 | Leverage communications to encourage and support effective CQC response, e.g., Hand Hygiene week in Oct, poster campaigns | Sept 2016 | Oct 2016 | March 2017 | Acting Director of Comms |

# 6b Communications Development

**Key milestones**

| | Description | Timeline |
|---|---|---|
| 1 | New website completed to improve patient and community communications, ease of service | October 2016 |
| 2 | Business case for new BSUH intranet completed and approved by Board | March 2017 |

| Key risks | Mitigation plans |
|---|---|
| • Public confidence and being labelled as an inadequate trust | • Proactive media management |
| • Initial motivation for change but may be difficult to sustain new ways of working | • Communications and messages empower and motivate staff and thus build support for enabling change |

# 7a Performance Management and Performance Improvement

**Objective**

Ensure robust performance management to improve accountability and overall care of the Trust

**Overall accountability**

Chief Operating Officer, COO

**Key interventions**

| | Description | Start date | Design/pilot | Fully embedded | Owner |
|---|---|---|---|---|---|
| 1 | Development of new performance framework with transparency and clear accountability including new integrated Board reports and weekly KPI reports for SMT | August 2016 | ongoing | Dec 2016 | Director of Performance Management |
| 2 | Map out all KPIs into a master list of KPIs and link to meetings and CQC plan and agree month-by-month trajectory on major measures | July 2016 | ongoing | Sept 2016 | Director of Performance Management |
| 3 | Engage with corporate areas collecting data and work alongside so data collection centrally can be done and reported easily, i.e., integrated reporting | July 2016 | ongoing | Sept 2016 | Director of Performance Management |
| 4 | Capacity, demand and bed modelling - linking to performance trajectories recovery , including scenarios of corridor space | 14 Aug 2016 | n/a | Oct 2016 | Director of Performance Management |
| 6 | Development of new ward dashboards (current ones under review) and ensure flow of ward to board reporting | Aug 2016 | n/a | Oct 2016 | Director of Performance Management |
| 7 | Development of new weekly A&E KPIs to support improvement plans | Aug 2016 | n/a | Sept 2016 | Director of Performance Management |

# 7b Performance Management and Performance Improvement

**Key milestones**

| | Description | Timeline |
|---|---|---|
| 1 | Launch of new performance framework | Aug 2016 |
| 2 | All management dashboards in place and in use | Dec 2016 |
| 3 | Completion of bed modelling linking to performance trajectories recovery, including scenarios of corridor space | Oct 2016 |

**Key risks**

- Performance reporting and management systems and culture are underdeveloped, leading to mistrust of data and limited use and buy in

**Mitigation plans**

- Establishment of clear and agreed performance management, including dashboards for all key meetings; effective communication and alignment on expectations

Brighton and Sussex University Hospitals NHS Trust

# 8a Information Technology

| Objective | Overall accountability |
|---|---|
| Deploy technology appropriately to support and improve quality of care, efficiency, and financial performance | Chief Operating Officer, COO |

**Key interventions**

| | Description | Start date | Design/pilot | Fully embedded | Owner |
|---|---|---|---|---|---|
| 1 | Appoint new CIO and build out IT team to enable the transformation | Aug 2016 | n/a | Nov 2016 | Chief Operating Officer |
| 2 | Action plan developed to address CQC findings that require immediate response | Aug 2016 | Sept 2016 | Dec 2016 | Chief Operating Officer |
| 3 | Develop comprehensive IT strategy to<br>• support the recovery plan initiatives around e.g., quality and safety, clinical services, performance management<br>• Address long-term strategic initiatives including electronic patient record system, transition to digital informatics | Sept 2016 | Nov 2016 | March 2017 | Chief Operating Officer |
| 4 | Complete key ongoing initiatives, including upgrade of wireless infrastructure, upgrade of patient administration system, and digital dictation system | ongoing | ongoing | March 2017 | Chief Operating Officer |
| 5 | Internal portal system being piloted and ready to be rolled out selectively to Renal and A&E ahead of full rollout in 2017/2018 | ongoing | ongoing | Nov 2016 | Chief Operating Officer |

# 8b Information Technology

**Key milestones**

| | Description | Timeline |
|---|---|---|
| 1 | New CIO and IT team in post | Oct 2016 |
| 2 | Comprehensive IT strategy developed | Dec 2016 |
| 3 | Wireless infrastructure upgraded | March 2017 |

| Key risks | Mitigation plans |
|---|---|
| • Information technology could become a roadblock for CQC response in other areas, e.g., quality and safety, performance management, workforce and leadership | • Appointment of CIO and other IT leaders as soon as possible; required investment approved quickly as needed |
| • Lack of investment over long period time leaves estates, clinical equipment and IT vulnerable to sudden failures that could prevent delivery of programmes | • Clarity on approval processes and decision-making responsibilities; clear plans in development to improve infrastructure |

# 9a Strategy, Transformation, and BSUH Improvement Academy

| Objective | Overall accountability |
|---|---|
| Guide and optimise BSUH corporate and individual directorate vision and strategy to best improve quality of care, efficiency, and financial performance | Director of Strategy, Executive Director of Strategy and Commercial Development |

**Key interventions**

| | Description | Start date | Design/pilot | Fully embedded | Owner |
|---|---|---|---|---|---|
| 1 | Development of a sustainable vision and strategy for the Trust, aligned with national policy, regional and STP strategy, and local delivery within the health economy | Sept 2016 | Jan 2017 | March 2017 | Director of Strategy |
| 2 | Introduce a new comprehensive business planning process, ensuring that all planning is aligned with the 4 core transformation programmes | Sept 2016 | Jan 2017 | March 2017 | Director of Strategy |
| 3 | Robust project management of the 4 core transformation programmes to track and help deliver action plans | March 2016 | Sept 2016 | March 2017 | Programme Director |
| 4 | Establish BSUH quality improvement academy to embed and support continuous improvement of performance, quality, and process management | April 2016 | May 2016 | March 2017 | Director of Service Transformation / Deputy Medical Director |
| 5 | Integration of 3Ts to become delivery mechanism for trust's long-term clinical strategy, an asset for STP footprint and a model of clinical, service, and capital construction best practice | Aug 2016 | Oct 2016 | March 2017 | 3Ts Programme Director |
| 6 | Crowd-sourcing initiative to increase staff engagement in solution and strategy development | Sept 2016 | Oct 2016 | March 2017 | Interim Chief Executive |

# 9b Strategy, Transformation, and BSUH Improvement Academy

**Key milestones**

| | Description | Timeline |
|---|---|---|
| 1 | PMO fully staffed with structures, decision making processes, and regular meetings operational | Oct 2016 |
| 2 | Over 30 staff trained in LEAN service improvement methodology based on the work of Virginia Mason. A Minimum of 7 Rapid Process Improvement Workshops, linked to the quality improvement plan, completed. | Jan 2017 |
| 3 | Completion of compliance review of Major Trauma and co-dependent services, cross checked with the 3Ts capital and clinical plans and the East Surrey and Sussex STP | Dec 2016 |

| Key risks | Mitigation plans |
|---|---|
| • Recruitment of PMO staff with requisite competencies and availability | • Testing the interim and agency market, sourcing secondments from other NHS organisations and sectors with experience in management of complex public sector programmes |
| • Inability to release Trust staff to participate in the appropriate training and RPIW meetings due to demand and capacity constraints | • Working with all leaders to ensure plans in place to support staff development in service improvement and ensure a robust selection process for RPIW events that are appropriate, relevant and associated with CQC Improvement Plan priorities |
| • The compliance review is jointly delivered with NHSE and is dependent on NHSE providing requisite resource | • BSUH seeking to support the work by reassigning members of the existing 3Ts programme to support the NHSE Compliance Review |