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| **Meeting:** | **Brighton and Sussex University Hospitals NHS Trust**<br>**Board of Directors** |
| **Date:** | **30th November 2015** |
| **Board Sponsor:** | **Sherree Fagge, Chief Nurse** |
| **Paper Author:** | **Elma Still, Associate Director of Quality** |
| **Subject:** | **Care Quality Commission (CQC)** |

**Executive summary**

The purpose of this paper is to update the Board on the progress of the Emergency department (ED) action plan following the publication of the CQC report in October, identify progress against the May 2014 action plan, review the new format of the assurance briefing and provide initial thoughts on the state of readiness plan for the Chief Inspector of Hospitals (CIH) visit in 2016.

The issues identified in the ED report are being taken forward through the Level 5 reconfiguration work, *Right Care, Right Place, Each Time* programme, additional capacity work and the ED safety and quality group.

The Improving Quality and Patient Experience Group continue to meet monthly to discuss and review evidence to support progress against the action plan. In November, each Directorate Management team attended the group amalgamated with the Executive Safety and Quality Committee to review in detail their governance processes, safety and quality issues and delivery of CQC action plan. Whilst all directorates have a safety and quality meeting in place, not all discuss the same items within their agenda. A template will be circulated to ensure consistency across the organisation. All meetings have minutes taken but it was agreed that in future a formal register will be taken to support attendance.

A Board Seminar was held this month to discuss the Emergency department CQC report and the 'must dos' within the report. It was a useful session and the Board accepted that it can and needs to do more to support positive work being completed to improve the situation for patients and staff and agreed for: a review with external support on board governance and effectiveness ; for improvement plans to have clear dates for their delivery to enable the Board to focus by exception on those not being delivered; to review the current Board metrics to facilitate tracking and assurance; and to agree on a way forward with these over the next month. The Non-Executive Directors agreed that it was helpful to have more contact with front line staff in identifying good practice and the challenges they face and there will be an opportunity for them to be involved in the safety and quality walkabout process. They will then be able to share their experiences at a new monthly agenda item for feedback on these at the Board.

The format of the monthly assurance briefing has been revised in the format of a

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| highlight report of the work streams and identifies progress against the action plan, key challenges and risks and cross references with the Board Assurance Framework. This report is circulated to the TDA, CCG and CQC. | |
| **Links to corporate objectives** | The CQC action plan supports the objectives of ***excellent outcomes; great experience; empowered skilled staff***; |
| **Identified risks and risk management actions** | Risk 1. Non Compliance with CQC regulations and the potential adverse impact on Trust ratings.<br>Risk 2. Adverse impact on future Foundation Trust authorisation.<br>**Management actions**.<br>Specific risk management actions will depend on the outcome and teams concerned. |
| **Legal implications** | If the Trust does not comply with the registration requirements, the CQC may issue compliance, warning notice or enforcement actions. |
| **Report history** | A report is submitted bi-monthly to the Quality and Risk Committee and Board |
| **Appendices** | Appendix 1.Ratings for RSCH<br>Appendix 2 Assurance briefing |
| **Action required by Board of Directors**<br>The Board is asked to discuss and note the content of the report and progress with the CQC action plan | |

**Report to the Board of Directors, November 2015**

**Care Quality Commission (CQC) report**

**Purpose**

The purpose of this paper is to update the Board on the progress of the Emergency department action plan following the publication of the CQC report in October, identify progress against the May 2014 action plan, review the new format of the assurance briefing and provide initial thoughts on the state of readiness plan for the Chief Inspector of Hospitals (CIH) visit in 2016.

**CQC report - Emergency Department (ED) June 2015 and action plan**

The CQC ED report was published on 23rd October and focused on the two domains that they reviewed, safe and well led.
(http://www.cqc.org.uk/sites/default/files/new_reports/AAAE3149.pdf )
Their key findings were that they '*observed compassionate and good clinical care provided to patients by staff; the physical capacity and staffing numbers and skill mix did not support the timely assessment of patients arriving at the department; patients were not cared for in the most appropriate environment due to overcrowding in the emergency department and poor patient flow into the main hospital; and there was a lack of management capacity and effective board challenge and support had resulted in a lack of progress in addressing issues over the last 18 months*'. As a result of their findings the CQC has stated that the trust must:

• Reduce the numbers of patients cared for in the cohort area within the emergency department (and the regularity with which congestion occurs in this area) and ensure timely assessment of patients arriving in the department.
• Ensure that appropriate staffing levels and skill mix is in place to meet the needs of the patients within the department and support the process of improvement.
• Enhance board level effectiveness to ensure progress with the emergency department improvement plans.

In response to this report and following on from ongoing work in the Acute Floor Project Board, the acute floor directorate team have identified actions related to their findings. For the most part, the issues with patient flow and staffing are being addressed through the Level 5 reconfiguration (Acute Floor Project) and *Right Care, Right Place, Each Time and additional capacity* programmes. Other issues which include: consistent cleaning between patients, improved record keeping and safeguarding training, have been added to the ED safety and quality meeting so that the actions and improvements can be monitored through their action log.

The Board receives updates with the associated quality improvements on the Level 5 reconfiguration and *Right Care, Right Place, Each Time* programmes via the Finance People and Performance Committee, Quality and Risk Committee and papers on Unscheduled Care and Turnaround to the Board. The Assurance Briefing also identifies key progress and risks in achievement which accompanies the CQC Board papers (Appendix). There has been some positive improvement in length of stay, use of the discharge lounge and discharges before midday with the rollout of *Right Care, Right Place, Each Time* and performance has improved along the 4 hour trajectory. If these improvements continue, it will impact on patient flow and will have benefits to our patients' experience.

The Trust Board held a seminar this month to discuss the ED plan and board assurance on delivery of the ED plan. The Board accepts that it can and needs to do more to support positive work being completed to improve the situation for patients and staff and agreed for: a review with external support on board governance and effectiveness; for improvement plans to have clear dates for their delivery to enable the Board to focus by exception on those not being delivered; to review the current Board metrics to facilitate tracking and assurance which will include time to initial assessment, time to treatment, escalation status and ambulance handover; and to agree on a way forward with these over the next month. The Non-Executive Directors agreed that it was helpful to have more contact with front line staff in identifying good practice and the challenges they face and there will be an opportunity for them to be involved in the safety and quality walkabout process. They will then be able to share their experiences at a new monthly agenda item for feedback on these at the Board.

A follow up risk summit was held in October led by NHS England, with attendance from the Trust Development Authority, the Clinical Commissioning Groups (CCG), the CQC, the General Medical Council, Health Education England, Healthwatch, Brighton and Hove City Council and a further summit is planned for mid-December. Progress was reviewed at the summit and the impact of the Acute Floor Project and *Right Care, Right Place, Each Time* programmes was positively received although it was clear that more work was needed to secure the further necessary improvement.

The Chief Executive, Chair, Chief Nurse and Chief Operating Officer have presented the findings of the ED report and progress to date to Brighton and Hove Overview and Scrutiny Committee in November.

**Progress with May 2014 action plan**

The Improving Quality and Patient Experience (IQPE) Group continue to meet monthly to review evidence to support progress against the work streams from the May 2014 action

plan. The directorates attend the IPQE quarterly and following an Executive Quality and Safety Committee in August, a decision was taken to amalgamate the directorate quality and safety reporting with IPQE so that an in depth review with the Clinical Director, Lead Nurse and Directorate Manager could take place. In November, each Directorate Management team attended to discuss their governance arrangements, safety and quality performance and progress against the CQC action plan. There were a number of issues identified where learning can be shared across directorates such as the use of a common agenda and a formal register will be taken. A summary will be discussed at Clinical Management Board and then shared with NEDs.

All directorates are progressing their work associated with the CQC action plan and fundamental standards of care.

The key issues that arose from the directorates include:

All directorates have regular quality and safety meetings at directorate and specialty level. The content of the meetings vary and an agenda template is being circulated to all directorates to ensure that all aspects of quality and safety are discussed at the meetings and there is consistency across the organisation. It was also agreed that a formal register should be taken on attendance to ensure that the right staff are at the meetings.

Unscheduled care and the patient flow pathway continue to be a challenge for the trust. However, the Level 5 reconfiguration work and *Right Care, Right Place, Each Time* programmes are beginning to have an impact on length of stay, increase use of the discharge lounge and discharges before midday.

Patients are remaining in recovery for longer periods than needed due to the lack of beds in the trust. Whilst acknowledging that this is not ideal, the patients identified to stay in the area are generally post-surgery and will no longer be used for patients coming from ED unless they are critical care patients. If patient flow continues to improve through the hospital then this will ensure that only the appropriate patients are in recovery The Acute Floor change programme seeks to alleviate many of the internal ED and Acute Medicine causes for inefficiency, but will only be successful if ward beds are available to transfer admitted patients to.

Post reconfiguration there will be a review of capacity and finance and this is now being organised

Overall, there is progress against the May 2014 action plan, with the some encouraging signs with improved patient flow following the implementation on the Acute Floor Project and *Right Care, Right Place, Each Time* programmes. Improving patient flow will reduce the use of the cohort area and the issues raised by the CQC around the care of patients in the area and their privacy and dignity.

The approval of the funding for the 3Ts project in October enables the building work programme to move forward and longer term for care to be delivered in modern facilities.

Local, national and international recruitment continues and high intakes of new staff are expected in October and November. The changes to immigration for nurses should enable the recruited Filipino nurses to start in the New Year. However, the new national 4% agency cap which started on 1st October will add an additional challenge to the Nursing and Midwifery workforce. Appraisals and mandatory training figures continue to improve and the launch of the new e learning platform 'Iris' will allow for staff to select the most appropriate form of training to suit their needs. Furthermore, staff on ward visits are reporting a variety of ways that lessons are being shared within their areas.

**Ratings**

The ratings following the visit have changed for the Emergency Department at RSCH and both safe and well led domains were rated as inadequate. As such the ratings poster will be changed at the front of the Royal Sussex County Hospital to reflect the outcomes and in order to comply with Regulation 20a, Fundamental Standards of Care, CQC, April 2015. (Appendix 1)

**Assurance briefing**

The assurance briefing is produced monthly by the Executive and Operational leads, based on progress against the action plan. The briefing is shared with the Trust Development Authority, local Clinical Commissioning Groups and CQC. The format of the assurance briefing has been revised in response to feedback from the TDA. It incorporates the 'must do's' and 'should do's' identified from the May 2014 report. The format aims to reflect the key milestones in terms of delivery of the compliance action. In some cases, whilst the milestones are being met the overall improvement outcome is yet to be delivered and the overall RAG status reflects this position. The work streams are cross referenced with the Board assurance Framework. (Appendix 2)

**Intelligent Monitoring**

The CQC have informed trusts that they will no longer publish any further updates of Intelligent Monitoring (IM) for NHS acute and specialist trusts. These reports were first launched in October 2013 and were a key part of the new regulatory approach. IM together with local insight and other factors helped the CQC to decide when, where and what to inspect. They will continue to provide up-to-date intelligence, in the form of data packs, to inform comprehensive inspections to their teams. The information was collated based on data provided by each organisation and a concordat which included national bodies and regulators. The trust dashboard reflects much of the data collated and acts as an early warning if performance drifts.

**Plan for announced CIH visit 2016 – State of readiness**

The Chief Nurse and Associate Director of Quality have met to discuss the plans for the expected announced visit in 2016. The quarterly meetings with the directorates are an important part of this programme with identifying the state of readiness and how the directorates intend to share their good practice with the CQC. It is recognised that that the CQC work is alongside the quality improvement programmes within the trust as they support the quality of care patients receive and their experience. Other work will include: a CQC newspaper for staff , collecting evidence in directorates, staff drop in sessions and quality visits which will be clinically led. A programme will be circulated for staff to sign up to with the purpose of identifying and sharing through peer review areas of good practice and areas for improvement. There will also be Exec and NED walkabouts which will form part of the Board agenda to enable them to share their experiences of staff and patients.

A mock inspection will be held for all core services in two days in March which will include all sites. The inspection will include internal and external colleagues. A more detailed plan will be shared with Clinical management Board in the New Year.

**Building on Strong Foundations**

http://www.cqc.org.uk/sites/default/files/20151030_building_strong_foundations_FINAL.pdf

The CQC recently published Building on Strong Foundations, which forms the basis for developing their new strategy from April 2016. It sets out their current thinking and approach to quality regulation of health and social care services in the future including the development of smarter monitoring and strengthening insight from data.

The new strategy currently being developed by the CQC, Building on Strong Foundations, will be consulted on from January 2016. Part of the CQC inspections from April 2016, will include measures and ratings for the economy and efficiency of service delivery. It will involve how well providers manage their available resources to acquire the appropriate mix of 'inputs' (such as, staff, equipment and medicines) at the lowest cost (economy); and how well they are able to use them and manage their activities to produce the best mix of good quality 'outputs' (efficiency) and will be part of future inspections with our Trust.

**Elma Still**
**Associate Director of Quality**
**November 2015**

Appendix 1

CareQuality Commission

Last rated
23 October 2015

Brighton and Sussex University Hospitals NHS Trust

## Royal Sussex County Hospital

| Overall rating | Inadequate | Requires improvement | Good | Outstanding |
|---|---|---|---|---|
| | | ▼ | | |

| | Safe | Effective | Caring | Responsive | Well led | Overall |
|---|---|---|---|---|---|---|
| Urgent care centre | Requires improvement | Not rated | Good | Inadequate | Requires improvement | Requires improvement |
| Medical care (including older people's care) | Requires improvement | Good | Good | Requires improvement | Good | Requires improvement |
| Urgent and emergency services (A&E) | Inadequate | Not rated | Not rated | Not rated | Inadequate | Inadequate |
| Surgery | Requires improvement | Good | Good | Requires improvement | Good | Requires improvement |
| Intensive/critical care | Good | Good | Good | Requires improvement | Good | Good |
| Maternity and gynaecology | Requires improvement | Requires improvement | Good | Good | Requires improvement | Requires improvement |
| Services for children & young people | Requires improvement | Good | Good | Good | Good | Good |
| End of life care | Good | Good | Good | Good | Good | Good |
| Outpatients | Good | Not rated | Good | Requires improvement | Requires improvement | Requires improvement |

**Compliance Action 1:**
**Unscheduled Care Programme**

# HIGHLIGHT REPORT

**Date of Update:** 20-11-2015

**Completed by:** Mark Smith

**RAG Status:**

| Previous | Current | Forecast |
|---|---|---|
| R | A | A |

**KEY:** High risk | At risk | On track

Brighton and Sussex University Hospitals NHS Trust

## MUST DOs

1.1 Evaluate the effectiveness of the current patient flow and escalation policy and take action to improve the flow of patients within the ED and across the trust. Improvements are needed with discharge planning and arrangements to ensure people are able to leave hospital when they are ready. The trust must continue to engage with partners and stakeholders to achieve sustainable improvement.
1. 3 Ensure that patient flow does not impact on access to services and treatment at PRH
1.5 Ensure that the planning and delivery of care on the obstetrics and gynaecology units meets individual patients' needs

## SHOULD DOs

1.2 Make improvements to the efficiency of discharging patients from postoperative wards
1.4 To improve the provision of mental health services for patients at PRH

**ED June 2015 visit – The ED plan is being approved by the ED Q&S group on 1st Dec and will be monitored by Improving Quality and Patient Experience Group**

## KEY MILESTONES

| MILESTONE | DATE | STATUS |
|---|---|---|
| Designation of 2b as medical assessment area | 1-12-15 | |
| Recruitment to any necessary nursing workforce template requirements e.g. SAU | 1 -12-15 On-going | |
| Deliver reductions in ambulance handover times | 31-3-16 | |
| Confirmation of Capital works timeline and works phasing for UCC | 12-11-15 On-going | |
| Agreement on local tariffs for MAU & SAU | 31-12-15 | |
| All inpatients having their discharge plan created and monitored using the eOasis Discharge Planning tool. (Training package rollout in conjunction with Right Care, Right Place, Each Time rollout) | 31-12-2015 | |
| Implementation of Right Care, Right Place, Right Time across all Barry Building wards | 31-10-2015 | |

## KPI UPDATE

Further development of agreed KPIs to ensure new ECIST requested measures are included within data set.
KPIs for wards agreed for Right Care, Right Place, Each Time

## BAF Risk Reference 15/16 & 1

## KEY ACHIEVEMENTS / COMMENTARY

- New front door Clinical Navigation assessment model has been introduced
- Streaming of patients to MAU and SAU has started
- Preparations being made to designate zone 2b as a MAU Ambulance handover trajectory drafted for agreement with SECAmb
- On 19th October, 32 patients were discharged before Midday from RSCH.
- On 26th October, this increased further to 36 patients discharged before Midday from RSCH.
- Our length of stay on Emerald has reduced from 20 to 14 days
- Level 9a has increased their use of the discharge lounge from an average 8 to 18 patients per day.
- Our length of stay on Catherine James & Egremont has reduced from 10 to 7 days
- Use of the discharge lounge has increased from an average 70 to 91 patients since Right Care, Right Place, Each Time commenced rollout
- NEXT STEPS:
- Confirmed funding and recruitment of nursing workforce for 24/7 SAU.
- Process mapping of Acute Floor administrative processes and systems through the patient journey, including ambulance handover and patient transfers, to

## RISKS AND ISSUES (Red risks only)

| RISK / ISSUE DESCRIPTION | SCORE | ACTION PLAN |
|---|---|---|
| Winter pressures stressing a new model | 20 | All models will be assessed under normal and peak demand. Supported by clear comms to all stakeholders full understanding of the new model prior to implementation. |
| Flow out of the Acute Floor | 20 | A programme structure has been established, with a critical path incorporating all relevant projects being developed. |
| Insufficient co-ordination on the Acute Floor | 16 | Review of models of coordinating care across ED and assessment areas adopted by other acute providers. |
| Insufficient Nursing staff to implement cover new model | 16 | Review of nursing templates across the acute floor to confirm nurse to patient ratios and confirm any gap |

## ITEMS FOR ESCALATION

- Funding support for capital works which enable the ED front door model, improving flow into the acute floor, privacy and dignity and ambulance turnaround time.

**Compliance Action 2:**
**Lessons learned**

# HIGHLIGHT REPORT

**Date of Update:** 19-11-2015

**Completed by:** Steve Drage

**RAG Status:**

| Previous | Current | Forecast |
|---|---|---|
| A | G | G |

**KEY:** High risk | At risk | On track

Brighton and Sussex University Hospitals NHS Trust

## MUST DOs

CA 2.4 Ensure that staff reporting incidents receive feedback on the action taken and that the learning from incidents is communicated to staff

## SHOULD DOs

CA 2.5 Learning from complaints to be disseminated among staff to ensure changes to practice are fully embedded.

CA2.6 Ensure that staff at all levels feel confident about reporting incidents so that learning and improvements to practice can take place.

CA2.7 Ensure that staff understand their role in the event of a major incident, as appropriate to their designation.

## KEY ACHIEVEMENTS / COMMENTARY

- Message of the week from the Chief Nurse shared with all nursing teams
- Safety and quality leads attached to each directorate
- Monthly safety, quality and patient experience sent to directorates
- Monthly staff stories
- Monthly patients first distributed to staff

## NEXT STEPS:

- For safety and quality leads to attend the safety and quality meetings to provide support and share learning
- To review with directorates the mechanism of sharing learning with staff and how this is assessed within each directorate

## KEY MILESTONES

| MILESTONE | DATE | STATUS |
|---|---|---|
| CA2.4.1. Upgrade to the latest version of DATIX which has advanced tools to inform the reported when the incident is closed | 10-14 | |
| CA2.4.2 Provide monthly feedback reports for staff in each area | 11-14 | |
| CA2.4.3To use team brief to feedback lessons from serious incidents | 12-14 | |
| CA2.4.4 Develop a network of safety leads across the trust with a focus on sharing and embedding learning from patient feedback | 05-15 | |
| CA2.4.5 Develop a human factors and simulation faculty | 01-15 | |
| CA2.4.6 Developed Safety projects e.g., AKI, deteriorating patient, | 12-14 | |
| CA2.4.7 Implement the safety, quality and patient experience strategy | 12-14 | |
| CA2.5 Directorate s to review complaints and share learning with staff | 12-14 | |
| CA2.6 Emphasize the importance of reporting and ensure learning is shared through central resources and locally | 12-14 | |
| CA2.7 Training for staff and raising awareness of major incident actions. AAR debriefs following major incident | 12-14 | |

## RISKS AND ISSUES (Red risks only)

| RISK / ISSUE DESCRIPTION | SCORE | ACTION PLAN |
|---|---|---|
| DATIX system – problems with the server | | Requiring support to update the server |

## KPI UPDATE

Staff survey indicators

Monthly patients first  Every SI to have a podcast on info net

S&Q team attendance at directorate meetings

## ITEMS FOR ESCALATION

Never events: 6 since January 2015. Round table discussion in November with the TDA was very productive. The TDA head of quality attended. The Trust's approach to reporting and investigation was supported and the actions taken going forward were agreed to be appropriate and proportionate by TDA Head of Quality

**BAF Risk Reference 6**

**Compliance Action 3:**
**Safety & suitability of premises**

# HIGHLIGHT REPORT

**Date of Update:** 19-11-2015

**Completed by:** Dale Vaughan

**RAG Status:**

| Previous | Current | Forecast |
|---|---|---|
| A | R | A |

**KEY:** High risk | At risk | On track

Brighton and Sussex University Hospitals NHS Trust

## MUST DOs

CA 3.1 Ensure that the environment is suitable for patient investigations, treatment and care and that hazards related to the storage of equipment, which may impact on staff, are minimised. It was noted that equipment was being stored on corridors

CA 3.2 Ensure the appropriate use of beds spaces which are suitable by their position, design and layout within wards including the Stroke Unit, Grant ward and Baily Ward.

## SHOULD DOs

CA 3.3 Ensure the secure storage of medicines in neurology ITU at PRH (now moved)

## KEY ACHIEVEMENTS / COMMENTARY

- Approval of funding received from the Treasury
- Soft Facilities management has been brought in house
- Building work continues in Sussex Eye Hospital
- The full capacity protocol has been revised and beds have been removed but in times of high demand they are part of the escalation plan
- (CA3.1.5) New wheelchairs have been purchased, which are coloured coded and labelled per building, this will make sure these are returned and placed in the correct areas in a timely manner. Wheelchair policy being finished and designated areas to keep wheelchairs is being identified around the site.

**NEXT STEPS:**

- (CA3.1.5) Need to identify designated storage areas for areas of concern. The Chief Nurse and Clinical lead for F&E raised issue with the Finance & Workforce Committee and H&S Committee.

## KEY MILESTONES

| MILESTONE | DATE | STATUS |
|---|---|---|
| CA 3.1.1 To receive approval for the FBC and then subsequent building programme | 03-15 | |
| CA 3.1.2 A Trust-wide 6 facet survey has been commissioned to inform the Estates Strategy refresh. | 11-14 | |
| CA 3.1.3 &4 Rolling programme of estates and Health and safety compliance audits. | 10-14 | |
| CA 3.1.5 Identify & sign designated holding areas for patient moving equipment | 10-14 | |
| CA 3.1.6 Rolling 'Dump the Junk' programme | 10-14 | |
| CA 3.1.7 PLACE assessments to be reviewed and acted upon | 10-14 | |
| CA 3.1.8 Beds to be removed from corridors in a timely manner | 11-14 | |
| CA 3.2To review the bed space on the Stroke Unit, Grant ward and Baily. The beds to be removed from the escalation policy | 9-14 | |
| CA 3.3 Review the medicines storage for patient by their bedsides | 10-14 | |

## KPI UPDATE

- Environmental audits
- Patients voice
- Complaints & plaudits

## RISKS AND ISSUES (Red risks only)

| RISK / ISSUE DESCRIPTION | SCORE | ACTION PLAN |
|---|---|---|
| CA 3.1.8 Beds to be removed from corridors in a timely manner | | Corridors will be checked on a regular basis to make sure any beds are removed and placed in the designated storage areas. Portering will carry out regular routine checks of all areas. Winter pressures, however, will make it problematic to remove beds. This is due to A&E requiring beds/trolleys to remain close to area so removing beds to store will make this an impossible option due to distance. The Director of F&E is looking to implement bar coding and location monitoring for beds, so that we know where each bed is at any time, this would assist in removing beds form corridors etc. at the earliest possible opportunity. |

**BAF Risk Reference 2**

**Compliance Action 4:**
**Equipment**

# HIGHLIGHT REPORT

**Date of update:** 17.11.2015

**Completed by:** Brian Jolley

**RAG Status:**

| Previous | Current | Forecast |
|---|---|---|
| A | A | G |

**KEY:** High risk | At risk | On track

Brighton and Sussex University Hospitals NHS Trust

## MUST DOs

CA 4.1 Ensure that all equipment used directly for patient treatment or care is suitably checked and serviced to ensure that it is safe and fit for use.
CA 4.2 Ensure that equipment allocated to manage sick children or newborn babies is routinely checked to ensure it is safe for use. (In ED dept at PRH)

## SHOULD DOs

CA 4.3 Ensure equipment in all of the departments is checked, as required, and the outcomes recorded.

## KEY ACHIEVEMENTS / COMMENTARY

- Defibrillator and Resus suction unit planned maintenance: Fully completed Late 2014. Project is underway for 2015 to complete January 2016.
- Planned maintenance in neonatal area, PRH, completed last year. PM plans for 2015 in progress
- Physiotherapy planned maintenance for medical devices is under way for 2015.

**NEXT STEPS:**

- Interviews for Band 4&5 EBME unsuccessful. rescheduled for Jan 11th and 15th 2016.
- Provision of updated "Tested"" labelling for all clinical staff to be introduced this year as per the guidelines from the MHRA document, Managing Medical devices 2015 – In place
- Part time agency support in place and is beginning to have a positive effect mainly on backlog repairs.
- Costs to be identified for external support on annual device testing - This is designed to mitigate further risks but will have a significant additional costs

## KEY MILESTONES

| MILESTONE | DATE | STATUS |
|---|---|---|
| CA 4.1.1 Carry out urgent specific Planned Maintenance (PM) checks (using existing PM procedures) on identified devices that have missed or delayed Planned maintenance activity | 01-15 | |
| CA 4.1.2 Urgently continue recruitment process to cover current Band 4 and Band 5 EBME posts. | 04-15 | |
| CA 4.1.3Instigate additional external temporary resources to assist with back log. | 10-14 | |
| CA 4.2Daily documented checks of all paediatric equipment in ED at PRH and cleaned as appropriate | 10-14 | |
| CA 4.3 Nursing staff on all wards to complete the daily checks and document on the recording sheet | 10-14 | |

## RISKS AND ISSUES (Red risks only)

| RISK / ISSUE DESCRIPTION | SCORE | ACTION PLAN |
|---|---|---|
| Recruitment process un successful Re aligned further recruitment process for January 2016 | 9 | Initial agency support (part time) to try and mitigate the risk and to cover the recruitment process. |

## KPI UPDATE

Planned maintenance dashboard 15_16

- Portable suction 50% complete Nov 2015
- Defibrillators 50% completed Nov 2015
- Anaesthetics Underway December 2015
- Physiotherapy 90% complete Nov 2015

## ITEMS FOR ESCALATION

Risks: Staff resources as difficult to recruit staff in EBME (national issue), may lead to a backlog of repair works (Risk assessments to be created to identify equipment that has a higher priority for testing), additional costs through use of external contractors

**BAF Risk Reference 8**

**Compliance Action 5:**
**Privacy & Dignity**

# HIGHLIGHT REPORT

**Date of Update:** 17-11-2015
**Completed by:** Caroline Davies

**RAG Status:**

| Previous | Current | Forecast |
|---|---|---|
| R | R | A |

**KEY:** High risk | At risk | On track

Brighton and Sussex University Hospitals NHS Trust

## MUST DOs

CA 5.1 Ensure that the privacy of dignity of patients is maintained within the ED, including the current cohort area
CA 5.2 Ensure that women using the day assessment unit have their privacy and confidentiality maintained

## SHOULD DOs

CA 5.3 Ensure same sex breaches are being managed in acute areas such as AMU
CA 5.4 Maintain the privacy and dignity of patients on the neurological unit at PRH
CA 5.5 Ensure that information on how to complain is available in languages other than English.

## KEY ACHIEVEMENTS / COMMENTARY

- Full capacity protocol has been revised and approved
- No patient complaints on P&D in the cohort area
- There have been no reportable same sex breaches reported
- The complaints leaflets have been revised and on the back contain information on how to complain in the top 10 languages

**NEXT STEPS:**

- To assess whether the staff rooms in corridor can be converted to 6 patient cubicles

## KEY MILESTONES

| MILESTONE | DATE | STATUS |
|---|---|---|
| CA 5.1.1 Full capacity policy to be updated which when implemented will work to reduce the consequences of over-crowding in the cohort area. | 11-14 | |
| CA 5.1.2Nurse to be allocated to cohort area to care for and assess the patients, as part of cohort policy | 11-14 | |
| CA 5.1.3P&D to be maintained when patients in cohort area | 11-14 | |
| CA 5.2The day unit will move as part of the Birth Centre business case and all clinical assessment areas are individual rooms with doors. As an interim arrangement, curtains will be used. | 2016 | |
| CA 5.3To ensure that that mixed sex breaches are eliminated or kept to a minimum. Screens to placed between patients if required | 09-14 | |
| CA 5.4 To change access arrangements in neuro ITU. Service will move | 09-14 | |
| CA 5.5 Provide information in different languages on complaints leaflet | 10-14 | |

## RISKS AND ISSUES (Red risks only)

| RISK / ISSUE DESCRIPTION | SCORE | ACTION PLAN |
|---|---|---|
| Unsafe area to look after patients Cohort area ( Ref 1527) – includes P&D | 16 | Acute floor action plan being implemented to improve patient flow and reduce time in the cohort area |
| Delivering same sex accommodation (Ref 801) | 12 | Screens are used |
| | | |
| | | |

## KPI UPDATE

Same sex breach reports – no reportable breaches to date
Patient Complaints and PALs data
Friends and family test / Patient voice– qualitative and quantitative data
Cohort data – time spent in the cohort area and number of patients

## ITEMS FOR ESCALATION

**BAF Risk Reference 4**

**Compliance Action 6:**
**Staffing**

# HIGHLIGHT REPORT

**Date of Update:** 17/11/2015

**Completed by:** Helen Weatherill

**RAG Status:**

| Previous | Current | Forecast |
|---|---|---|
| A | A | G |

**KEY:** High risk | At risk | On track

Brighton and Sussex University Hospitals NHS Trust

## MUST DOs

CA 6.1 Ensure that there are enough suitably qualified, skilled and experienced staff to meet the needs of all patients.
CA 6.2 Review the provision and skills mix of staff to ensure they are suitably trained to meet the needs of children who use the service in ED at PRH
CA 6.4Ensure that there are sufficient numbers of staff for critical care and medical wards
CA7.1 Ensure that the values, principles and overall culture in the organisation supports staff to work in an environment where the risk of harassment and bullying is assessed and minimised and where the staff feel supported when it comes to raising their concerns without any fear of recrimination.

## SHOULD DOs

CA 6.3 Ensure that cover is in place for specialist services for Obs & Gynae as part of the workforce planning. Ensure that Obs & Gynae consultants are available to support members of the medical team at all times when on call at PRH
CA 6.5 Ensure The provider should ensure that there is a review of the nursing establishment for the Children's Community Nursing Team in light of the concerns raised by staff over the caseload.

## KEY ACHIEVEMENTS / COMMENTARY

- As part of the People Strategy 10 key programmes of work have been identified and work will be under way this month to progress these.
- The Trust continues to recruit locally, nationally, as well as internationally (within and outside the European Union (EU). Recruitment activity has increased dramatically compared to last year's activity. Presently there are 404 candidates being processed by the Substantive Recruitment Team and 366 being processed by Bank Recruitment. In November 2015 the Trust will be on-boarding and welcoming to the Trust a further cohort of 20+ overseas nurses.

**NEXT STEPS:**

- To review provision of medical support for children at PRH
- Medical cover at night at PRH
- Care Certificate to be introduced from November 2015 for all HCA's new to the trust. Existing HCA's that are interested in further development will also be encouraged to do the certificate.
- Investigating the introduction of apprenticeship schemes

## KEY MILESTONES

| MILESTONE | DATE | STATUS |
|---|---|---|
| CA 6.1Design and implement recruitment and retention strategy | 04-15 | |
| CA 6.2 Rotate nursing staff through the RACH ED department. To include staff training for nursing and medical staff | 04-15 | |
| CA 6.3Meet the Royal College standards for consultant presence | 10-14 | |
| CA 6.4 Recruitment plan for staff, to include medical cover at night at PRH | 10-14 | |
| CA 6.5 Reviewed the current caseload and met with commissioners. KSS wide review of community nursing will help inform ongoing provision | 05-15 | |
| CA7.1 Race Equality Workforce Engagement Strategy Programme | | |

## RISKS AND ISSUES (Red risks only)

| RISK / ISSUE DESCRIPTION | SCORE | ACTION PLAN |
|---|---|---|
| Nursing staff shortages are more evident due to less agency use(Ref 1460) | 12 | |
| PRH ED childrens services – public perception full time service (Ref 1480) | 16 | |

## KPI UPDATE

**October**

Current 12 month Sickness Absence Rate – 4.1%
Turnover Rate – 13.1%
Vacancy rate – 7.5%. Average rate 6.3%

## ITEMS FOR ESCALATION

Whilst the current recruitment drives have been successful there are still outstanding vacancies. The cap on agency rates will also present a challenge for staffing levels.

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## BAF Risk Reference 5, 10 & 3

**Compliance Action 7:**
**Culture & supporting staff**

# HIGHLIGHT REPORT

**Date of Update:** 17-11-2015

**Completed by:** Helen Weatherill

**RAG Status:**

| Previous | Current | Forecast |
|---|---|---|
| A | A | A |

**KEY:** High risk | At risk | On track

Brighton and Sussex University Hospitals NHS Trust

## MUST DOs

CA 7.1 Ensure that the values, principles and overall culture in the organisation supports staff to work in an environment where the risk of harassment and bullying is assessed and minimised and where the staff feel supported when it comes to raising their concerns without any fear of recrimination.
CA7.2 Ensure that relationships and behaviours between staff groups, irrespective of race and ethnicity, is addressed to promote safety, prevent potential harm to patients and promote a positive working environment.
CA7.3 & 7.4 Ensure that staff are supported to receive mandatory training in line with trust policy. (centrally & at directorate level)
CA7.5 Ensure that staff receive an annual appraisal.

## SHOULD DOs

CA7.6 Ensure parity across wards/units regarding access to training, education and study leave.

## KEY ACHIEVEMENTS / COMMENTARY

- Leading the Way 1 – Action Learning Sets underway. Plan to communicate themes arising from this and their value Trust wide in December
- Leading the Way Too continues with new weekly cohorts until Christmas. Dates for January onwards to be released shortly.
- SHINE – Feedback collated which were overall positive.
- Team Coaching Sessions continue
- Team Coaches: Original coaches recruited: 15, Number currently active: 7 (others withdrew due to workload/leaving Trust)
- V&B Champions: Aim: 5% of workforce, circa 350 staff, 220 to date. V&B event planned for new Year with existing champions.
- Staff survey launched on 5 October and closes on 30 November. Current response rate is 34.2%. A number of updates have been sent to staff to encourage completion as well as an incentive being offered.

## KEY MILESTONES

| MILESTONE | DATE | STATUS |
|---|---|---|
| CA 7.1 & 7.2 Values and behaviours (V&B) programme | 10-14 | |
| CA 7.3 Mandatory training of staff to be supported and part of the directorate performance reviews | 09-14 | |
| CA 7.4 Launch of the VLE platform and new e learning | 03-15 | |
| CA 7.5 Staff to receive annual appraisals | 03-15 | |
| CA 7.6 Study leave policy updated and circulated and parity of access to training. | 11-14 | |

## RISKS AND ISSUES (Red risks only)

| RISK / ISSUE DESCRIPTION | SCORE | ACTION PLAN |
|---|---|---|
| Lead for V&B leaving | | Lead for V&B is is discussion with Operational director of HR on who will lead going forward |

## KPI UPDATE

- Staff survey
- V&B champions
- Appraisal rates by directorate
- Statutory & mandatory training reports
- Attendees on Leading the Way Too
- Staff Friends and Family test

## ITEMS FOR ESCALATION

Appraisal rate is 65.9%. The aim is to reach 75% by the end of the year with focused efforts on areas with outstanding appraisals.
Quarter One report shows the average level of compliance across all of the statutory and mandatory subjects as 53%. When compared to previous quarters the figure remains fairly static. The Virtual Learning Environment launched in the Trust on the 26th October. There are several new mandatory modules available for staff to help with achieving compliance. More modules will become available over the forthcoming weeks. This product will provide greater accessibility for completing essential training and drive up the Trust's compliance rates across many of the subject areas.

**BAF Risk Reference 6**

**Compliance Action 8:**
**Centralised booking service**

# HIGHLIGHT REPORT

**Date of Update:** 19/11/2015
**Completed by** Liz Pickering
Sally Howard

**RAG Status:**

| Previous | Current | Forecast |
|---|---|---|
| A | A | G |

**KEY:** High risk | At risk | On track

Brighton and Sussex University Hospitals NHS Trust

## MUST DOs

CA8.1 Ensure that there are effective systems in place so that patients needing urgent referrals for assessment or treatment are dealt with promptly.
CA 8.2 Continue the work to ensure that the Hub is providing an effective service to patients and staff.
CA 8.3To review the lessons learned from the experience within the booking hub and share lessons across the local health economy
4 Key Objectives established

1. Book patients within 5 days
2. Maximise clinic capacity with effective triage and data quality
3. Eliminate missed calls and answer within 1 minute
4. Minimise cancelled clinics with < 6 weeks' notice

Also realign service to stay within budget.

## Key Achievements / Commentary

- Training Workshop for team leaders items taken from the feedback sessions from 'Providing Choice and Certainty for Patients' workshop.
- SLA's for Clinical Administration have been written and in the process of the Ops Managers sign off. They will be sent for Directorate review by end Nov 15.
- Recruitment of band 3's has been completed and all starters will be in post by Dec 15.
- Speciality meetings have started to hear from consultants about working closely together.
- Two way texting and improved internet webpage continues.
- RMS update for better triaging being tested and rollout to Digestive Diseases expected by end Nov 15.

**NEXT STEPS:**
Evaluate processes and procedures and ensure robust communication with directorates during financial constraints.
Focus on slot utilization, DNA rates and best use of templates.

## KEY MILESTONES

| Milestone | Date | Status |
|---|---|---|
| CA 8.1 Ensure that there are effective systems in place so that patients needing urgent referrals for assessment or treatment are dealt with promptly. . | 01/03/2016 | On target |
| CA 8.2 Continue the work to ensure that the Hub is providing an effective service to patients and staff. | 01/03/2016 | On target |
| CA8.3 To review the lessons learned from the experience within the booking hub and share lessons across the local health economy | 01/03/2016 | On target |

## RISKS AND ISSUES

| RISK / ISSUE DESCRIPTION | SCORE | ACTION PLAN |
|---|---|---|
| Financial reduction = 5 wte agency staff let go + bank overtime to bring within the financial envelope | 16 | Tailor services within booking centre without compromising services |
| Eliminate missed calls and answer within 1 minute but within reduced financial envelope | 16 | Training for new staff, plus condense telephone opening hours |
| Affordability of Advice and Guidance service which is part of the SDIP, a key part of the contract between BSUH and commissioners | 12 | Alternative arrangements put in place to ensure service can continue. |
| MSK Referrals with incorrect clock start dates (IPT forms incomplete or incorrect) | 12 | Work with MSK Sussex Partnership to ensure a robust process. |

## KPI UPDATE

Central book hub dashboard

## ITEMS FOR ESCALATION – those on the Risk register