Meeting:	**Brighton and Sussex University Hospitals NHS Trust Board of Directors**
Date:	**1st June 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 progress against the action plan following the Chief Inspectors of Hospitals CQC visit in May last year and activities associated with the CQC and the Fundamental Standards of Care.

The Improving Quality and Patient Experience Group meet monthly to discuss and review evidence to support progress against the action plan. In May, each Directorate Management team attended the group to discuss progress against the action plan and compliance with the Fundamental Standards of Care.

A summary table of progress towards the action plan is attached (Appendix 1). The RAG status reflects the evidence to support the delivery of the plan. The key risks relate to actions concerning patient flow and emergency and unscheduled care and their impact on privacy and dignity; storage of equipment; and appraisal rates.

A monthly assurance briefing is prepared which is sent to the TDA, CCG and CQC. A copy of the April 2015 briefing is attached. This RAG status reflects whether the action plan is running to time and whether the evidence is triangulated. (Appendix 2)

The Fundamental Standards of Care came into force in April 2015. A baseline assessment is being undertaken to ensure that the trust complies with these standards and aims to provide a level of excellence for our patients.

The CQC have produced guidance on publishing the organisations ratings from April 1st, 2015 and these are now displayed at all locations where the trust provides services.

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 standards and the potential adverse impact on Trust ratings. Risk 2. Adverse impact on future Foundation Trust authorisation. **Management actions**.

	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. CQC summary table of progress against the action plan Appendix 2 Assurance briefing April 2015
Action required by Quality and Risk Committee 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, 1st June 2015

Care Quality Commission (CQC) report

1. Purpose

The purpose of this report is to update the Board on progress with the CQC action plan following the CQC visit in May 2014. It includes the assurance briefing provided to the Trust Development Authority (TDA), Clinical Commissioning Groups (CCG) and the CQC. This report also includes an update on activities associated with the CQC and compliance with the Fundamental Standards of Care.

2. Progress with action plan

The Improving Quality and Patient Experience Group meets monthly to review evidence to support progress against the action plan. In May, each Directorate Management team attended to discuss progress against the action plan and compliance with the Fundamental Standards of Care.

A summary table of progress against the CQC action plan is attached (Appendix 1). The RAG status reflects the evidence to support the delivery of the plan. Whilst process actions have been achieved, it is important that practice is embedded across the organisation.

The key issues that arose from the directorates include:

Unscheduled care and the patient flow pathway continue to be a challenge for the trust. In respect of the cohort area, whilst there is a focus to move patients into ED in a timely way, patients at times are spending time in the cohort area on a daily basis which has an impact on their privacy and dignity (This relates to CA 2.3. and CA 5.1, Appendix 1) There has been a focused piece of work to improve the use of the discharge lounge to facilitate earlier discharges during the day to improve the flow through the hospital.

The pressures in the system also affect other areas in the hospital, for example, patients are remaining in recovery for longer periods than needed due to the lack of beds in the trust. There have been patients who have left ITU to go to recovery or in another case, discharged directly home as a higher priority case needed to be cared for in ITU (This relates to CA 1.3, Appendix 1). The challenges of patient flow are leading to medical and surgical outliers in the trust where patients are being cared for in areas where the specialist expertise is available by phone rather than on the ward or the necessary specialist equipment is required to be moved to the outlying area. We continue to work internally and externally with our partners to address the issues with patient flow and have agreed a plan with the Trust Development Authority to move to sustainable improvement from October.

All directorates are holding quality and safety meetings monthly. The cross speciality meetings in the directorates are being held at least bi-annually. Risk registers are being updated and will routinely be considered in these meetings.

There are various ways in which directorates are sharing lessons learned within their areas which include daily safety briefings, newsletters, and personal emails to staff on feedback from reported incidents. The directorates were challenged to test this out with junior grades of staff to ensure that these are being cascaded and that staff are able to share instances of learning.

All directorates have been focussing on appraisals where there have been positive improvements. All directorates have local records which support reporting into the OLM system. Some work still needs to be done so that the corporate reports on appraisal rates reflect an accurate position of the directorates. The recruitment of staff is beginning to have an impact on wards and an increase in mandatory and statutory training levels is expected in turn. The red areas in the compliance table (Appendix 1) relate to accuracy of local reporting against the OLM reports and training figures for statutory and mandatory training. (CA 7.3 and 7.4, Appendix 1) The extension of training delivery through face to face, e-learning and workbooks will help support availability.

Finally, storage continues to pose a difficulty particularly on the Royal Sussex County hospital site and there are continuing efforts to de-clutter wards and ensure beds are moved from corridors in a timely way. (CA 1.3). A programme of 'Dump the Junk' is being refreshed and a trial of 'placing' mats for equipment is being piloted in theatres initially which may be rolled out to other areas.

The Chief Executive, Chief Nurse and Associate Director of Quality met the Regional Director of the CQC and local CQC inspector on 5th May to discuss unscheduled care. The Trust will receive an announced inspection as part of the follow up with the action plan. This is expected in the autumn but is yet to be confirmed.

3. 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 assurance briefing for April is attached as Appendix 2. The briefing gives a summary which reflects the pathways of work and progress against their delivery.

The RAG status indicates whether the action plan is running to time and if the evidence is triangulated.

4. Fundamental Standards of Care

The Fundamental Standards of Care came into force in April 2015. A baseline assessment is being undertaken to ensure that the trust complies with these standards. All directorates are reviewing these new Standards and are collating evidence to support compliance. The essence of the standards is similar to the previous Essential Standards of Care but they have a stronger focus on patient centred care and dignity and respect.

5. Publishing the CQC ratings

The trust is compliant with the new legislation which states that organisations must display their performance ratings from 1st April, 2015. All locations where the trust provides services have the ratings displayed at the front entrance of the hospital.

6. Intelligent Monitoring

The CQC are due to publish the next Intelligent Monitoring reports on 29th May. The CQC review more than 150 different sets of data on NHS trusts which inform the reports and help them decide when, where and what to inspect. The main risks for the Trust concern performance against the national Accident and Emergency and Referral to Treatment (RTT) standards, and cancellation of operations; and indicators from the national staff survey relating to appraisals and staff engagement.

7. Quality visits

The monthly quality visits continue and the review teams have begun to undertake core service reviews monthly in a similar way to methodology used by the CQC. This month, Women's services were visited. The feedback from the teams was generally very positive. Patients reported that they were happy with the care that they were receiving, felt that they were being involved in the decision making process and informed about their treatment. Staff reported that they were receiving feedback from incidents and received newsletters about learning from incidents. A multidisciplinary forum has been set up weekly in the obstetrics team which discusses recent DATIX incidents. There was positive feedback from staff about leadership and visibility of senior staff in the directorate. Some staff reported difficulties accessing mandatory training but most staff had received an appraisal or a date was set in the near future.

In conclusion, the key risks to delivery of the CQC action plan concern those actions relating to patient flow and unscheduled care (compliance actions 1 and 2) and its impact on privacy and dignity (compliance action 5); storage of equipment (compliance action 3); and further improvements in appraisal rates (compliance action 7).

Elma Still
Associate Director of Quality
May 2015

Appendix 1

CQC Action plan – Summary table

May 2015

KEY OF ACTION IDENTIFIED IN THE PLAN AS FOLLOWS:		**PROGRESS KEY**	
MD	Must Do Action	**Finished**	**Complete**
SDD	Should Do Action	**On Target**	**Green**
CD	Could Do Action	**Delayed**	**Amber**
QI	Quality Improve	**Off target**	**Red**

			Date for completion	Previous Status	Current status
Unscheduled care (Compliance Action 1&2)	CA1.1		30/11/2014	Amber	Amber
	CA1.2		30/10/2014	Amber	Amber
	CA1.3		01/01/2015	Red	Red
	CA1.4		30/01/2015	Green	Green
	CA1.5		31/10/2014	Green	Green
	CA2.1		01/11/2014	Amber	Green
	CA2.2		30/04/2014	Red	Amber
	CA2.3		01/10/2014	Amber	Red

			Date for completion	Previous Status	Current status
Lessons learned (Compliance action 2)	CA2.4		30/01/2015	Red	Amber
	CA2.5		30/11/2014	Red	Amber
	CA2.6		31/12/2014	Amber	Green
	CA2.7		30/04/2015	Green	Green

			Date for completion	Previous Status	Current status
Facilities & Estates (Compliance Action 3)	CA3.1		30/03/2015	Green	Red
	CA3.2		30/09/2014	Amber	Amber
	CA3.3		30/10/2014	Amber	Amber

			Date for completion	Previous Status	Current status
Equipment (Compliance Action 4)	CA4.1		01/04/2015	Green	Amber
	CA4.2		30/09/2014	Amber	Amber
	CA4.3		30/09/2014	Amber	Green

			Date for completion	Previous Status	Current status
Privacy & dignity (Compliance Action 5)	CA5.1		30/11/2014	Amber	Red
	CA5.2		01/01/2016	Amber	Amber
	CA5.3		30/09/2014	Green	Green
	CA5.4		30/09/2014	Green	Green
	CA5.5		01/10/2014	Amber	Green

			Date for completion	Previous Status	Current status
Staffing (Compliance Action 6) and Supporting staff (Compliance Action 7)	CA6.1		30/04/2015	Green	Green
	CA6.2		30/04/2015	Red	Green
	CA6.3		02/05/2015	Green	Green
	CA6.4		30/12/2014	Green	Green
	CA6.5		30/05/2015	Green	Green
	CA7.3		30/03/2015	Red	Red
	CA7.4		30/03/2015	Red	Red
	CA7.5		30/03/2015	Red	Amber
	CA7.6		30/11/2014	Amber	Amber

			Date for completion	Previous Status	Current status
Values & behaviours (Compliance Action 7)	CA7.1		30/04/2015	Green	Green
	CA7.2		30/04/2015	Red	Amber

			Date for completion	Previous Status	Current status
Scheduled care (Compliance Action 8)	CA8.1		31/03/2015	Amber	Amber
	CA8.2		01/11/2014	Amber	Green
	CA8.3		31/12/2014	Amber	Amber
	CA8.4		30/11/2014	Green	Green

Appendix 2

Brighton and Sussex University Hospitals NHS Trust

CQC Quality Improvement plan **Assurance briefing**

7th Briefing
April 2015

About the Briefing

This briefing is produced to provide the stakeholders with an assurance report which will include areas for escalation regarding delivery against the BSUH action plan within BSUH and its external partners.

The briefings will be produced monthly for the Quality Risk Management Meeting chaired by Brighton and Hove CCG, the Integrated Delivery Meeting chaired by the TDA and the Care Quality Commission.

Unscheduled care - (Compliance action 1)

Lead: Director of Operations (Emergency Care)

There are elements of this work stream that relate to all parts of the patients journey; pre-hospital, in-hospital and post-hospital. It is important that all aspects are addressed to improve patient flow through the system.

Action Plan running to time?		**Triangulated evidence provided of progress?**	

Assurance statement :

This month saw the inclusion of the Easter period which is always a challenging time for emergency services. An increased emphasis was placed this year for preparing carefully for the Easter break. Considerable work was done in the week prior to the break itself. This work used many of the recommendations outlined in the DOHs 'Breaking the cycle' guidance. The working week was altered to release clinical staff from non-clinical duties to back to the shop floor. Executive roles were also changed to deliver a daily 08:00 team brief, delivered in each of the Emergency departments by an executive director supported by a clinical director. This was aimed at setting the tenor for the day and also identifying any immediate blocks or challenges that could be resolved with direct management or clinical input.

During the holiday period itself, additional staffing and increased service opening times were delivered to ensure that we operated above and beyond the normal lower delivery profile seen at weekends and holidays. This meant that the Friday and the Monday despite

being bank holidays were actually delivered close to working days for all of our key services.

The approach outlined above led to a much improved performance and patient experience over the Easter period and it is proposed that a system wide learning event is set up to take lessons from this work that could be applied to our normal daily working.

Overall the challenges to the Emergency department continue in the face of a considerably increasing workload. Monday 13th April saw 540 emergency attendances across all sites compared to a daily average of 430. Dealing with these types of surges is extremely difficult and further work is required outside of the trust to support a smoothing out of emergency care flow.

Whilst the winter period has officially ended at the end of March, the Trust continues to see pressure across the emergency care. There were 8 breaches of the 12 hour trolley wait standard across the first couple of days (28/3/15 - 5 patients, 30/3/15 – 2 patients & 31/3/15 – 1 patient), resulting from loss of flow and delays in discharge from the wards.

The ORC Plan was put in place to carry us through the winter. Lessons learned from this indicate that a sustainable system-wide approach is required to support the Trust through the entire year.

This has been captured in the re-design of the whole of the Acute Floor to maximise assessment services, drive down admissions and provide alternatives to ED. This work has completed the design stage and implementation begins now and on into summer and early Autumn to prepare for next winter. It will include Surgical Assessment, Ambulatory Care, an older persons' Frailty Unit and ED short stay.

A system wide capacity review is under way to shape all providers in readiness for the year ahead and the winter pressures of 2015/16.

A 10 point plan has been developed for the Trust to lead on that describes the key priorities for change in the coming year with the aim of matching an upward trajectory of performance that delivers 95% consistently by the end of Q2.

Work with SECAmb continues to address cohorting and an audit of patients in this area is underway. A joint trajectory for ambulance handover improvement is being drafted linked to attendances and discharges form the back end of the hospital to encourage system flow.

Improvements in AMU with regard to staffing, training and bed profiling continue and are aimed at delivering a better functioning bespoke assessment service by the end of June.

Areas of concern for escalation:

Workforce – many of our plans going forward will rely on an expansion over time of our work force. Some of this can be mitigated in the short term by the creative use of multidisciplinary roles. However in the long term recruitment and retention of key staff will be important. Whilst the trust has just completed the successful recruitment of international nurses, there still remains a shortfall in some areas including out of hospital which remains a priority and will be addressed.

Staffing for Newhaven Downs remains problematic despite active recruitment. This project remains a high priority one as it delivers additional capacity which is key to delivering flow. There are options around moving whole services from the Trust to Newhaven and this is being explored as an alternative.

Whilst close working with SECAmb continues there remains the clinical concern the Trust has around the issue of the unilateral imposition of the Immediate Handover Policy. This has now been entered onto the Trust risk register.

Learning lessons and feedback from incidents (Compliance action 2)

Executive lead: Medical Director

Lead: Deputy Medical Director, Safety & Quality

This work stream focusses on how staff receive feedback from incidents and complaints and then how the learning is shared with individuals, teams and across the organisation.

Action Plan running to time?		**Triangulated evidence provided of progress?**	

Assurance statement

The Associate Director has met with all the clinical directorates to review how lessons are being shared within their teams. The directorates are sharing lessons in different ways within their teams and examples of good practice have been shared in the Practice Improvement Meeting. This has included newsletters tailored to incidents within the directorates, safety briefings for staff at the beginning of each day, lists of Datix incidents occurring within the month and the outcome of the investigations being shared on the ward staff notice board. These are being used in addition with other central resources which produced by the safety and quality team.

The new safety and quality scorecards have been circulated to directorates on the key questions from the safety and quality strategy and discussed at the Executive Safety and Quality committee. The purpose of these will help to monitor trends in directorate performance.

The quality and safety team are developing new nursing metric reports which will highlight progression/deterioration over time so that teams are able to identify issues and able to act on them in a timely way. These will be available from next month.

Areas of concern for escalation.

There is an increasing back log of open incidents reported on the DATIX database. This was discussed at the Executive Quality and Safety meeting in April and a planned way forward will be agreed by May. A pragmatic review of over 300 open incidents in the Women's Directorate by the newly appointed Governance lead has resulted in the identification of high priority incidents where the likelihood of organisational learning is greatest. These incidents are being thoroughly reviewed and the learning shared. This

methodology will be shared with other Directorates and individualised plans agreed to deal with the backlog whilst maximising learning.

Safety and suitability of premises (Compliance action 3)

Executive lead: Chief Financial Officer Lead: Operation Director of Facilities & Estates

This work stream relates to ensuring that the environment and premises are appropriate for the provision of healthcare

Action Plan running to time?		**Triangulated evidence provided of progress?**	

Assurance statement :

The Trust has finalised its Capital investment priorities for 2015/16. These contain a number of areas related to the Trust premises for both upgrading and renewal. The Trust has a major Capital investment project which will be introducing significant changes and will include new buildings as well as enhancements to existing facilities. Funding has been allocated and design work is in progress for a planned start by the end of February 2015.

These projects will initially add additional pressure to space but in the medium to long term will improve current facilities and space.

The Trust continues to develop its operational areas through day to day maintenance programmes and minor works projects.

Patient lead environmental audits (PLACE) are ongoing and the annual inspections dates have now been confirmed. The Trust is re-establishing operational PLACE inspections and these will be taking place on a monthly basis across the Trust from this month. Part of the brief for the PLACE teams will be to monitor as well as ensure action plans are developed to ensure environmental standards are maintained. The PLACE assessments have started this month and the Royal Alexandra Children's Hospital, The Sussex Orthopaedic Centre and Princess Royal Hospital have been completed. Hurstwood Park and Sussex Eye Hospital are due to be completed in May.

'Dump the junk' programme continues. All Clinical Directorates have been contacted for any redundant or broken equipment that needs to be cleared.

It is anticipated that further campaigns will be needed to keep the focus on removing unwanted equipment and to ensure areas are kept clear.

A Clinical Director for Estates and Facilities has been appointed and stared on 13th April 2015. Her role will be to lead the transfer of the Sodexho contract to in-house provision from 1st August. A project management office is being set up and there is a project team who are meeting regularly in preparation for the transfer date of the 1st August.

Areas of concern for escalation.

Lack of overall storage space on the RSCH site for spare beds, trolleys, wheelchairs and other portable medical equipment. This is being mitigated by encouraging all departments to keep their storage areas as tidy as possible and to call the Sodexo helpdesk (Facilities services provider) for assistance in clearing any unwanted or broken items.

Safety, availability and suitability of equipment (Compliance action 4)

Executive lead: Chief Financial Officer

Lead: Operation Director of Facilities & Estates

This work stream relates to ensuring that the equipment provided for patients has regular checks and that staff check routinely according to the schedules.

Action Plan running to time?		**Triangulated evidence provided of progress?**	

Assurance statement :

Initial corrective actions are completed for both sites apart from community placed equipment. Additional short term actions now completed for the PRH special care baby unit.

The bank/agency support in EBME services will remain in place until the new member of staff starts work following their appointment after the interviews in March and once the existing vacancies have been approved for advert/recruitment

Staff participating in the monthly quality visits are asked to review that equipment checks have been completed and equipment is clean on the wards they visit.

Areas of concern for escalation.

EBME recruitment. This is core to ensure resources are available to sustain the longer term compliance with the action plan. Recent recruitment process to Band 4 and Band 5 posts was unsuccessful. This area remains a risk. Both posts are currently backfilled with Agency engineers. Recruitment process is to go ahead again and there are discussions about using head hunters but is expected to be a challenge and hence the risk element. A full time member of staff has returned from maternity leave and works 3 long days from May 2015 which will help to alleviate the situation. The agency staff will remain until substantive posts are in place.

Privacy and dignity (Compliance action 5)

Executive lead: Chief Nurse Officer

This work stream relates to ensuring all patients' privacy and dignity needs are being met.

Action Plan running to time?		**Triangulated evidence provided of progress?**	

Assurance statement

Maintaining patients' privacy and dignity is a significant challenge when the organisation is receiving unprecedented levels of demand.

A number of the additional capacity areas that were opened due to the high demand and were a concern around privacy and dignity have been closed.

Privacy and dignity is still a challenge at times in the cohort area in ED. There is a nurse allocated to the cohort area to oversee this group of patients. Whilst it is difficult during periods of high demand, the nurse is conscious of this and communicates with the patient and aims to mitigate the risk and to date there have been no formal complaints related to privacy and dignity raised in the cohort area.

A detailed audit is underway to look at patient experience in the cohort area and to match this with our own expectations around the management of care with regard to our policies in place. Feedback from this audit will be used to challenge the effectiveness of the policy and drive improvement changes as required.

FFT In March the inpatient response rate was 32.7% (last month 30%) and only 2.5% (last month 2.3%) would not recommend the trust.

Quotes from Vallence

'Staff very friendly and informative. They take care of patients comfort and protect their privacy. Notice on board always giving information on nurse/HCA on duty.'

Quotes from Lindfield

'I am treated as an individual and with dignity and respect.'

There have been no reportable mixed sex breaches over the last month.

Areas of concern for escalation.

Privacy and dignity remains a challenge when there is a high demand in service, when ED is overcrowded and the cohort area is in use.

Staffing (Compliance action 6)

Executive lead: Director of Strategy & Change.

Lead: Operational Director of Human Resources

This work stream relates to Staffing and Training.

Action Plan running to time?		**Triangulated evidence provided of progress?**	

Assurance statement :

The plan for the creation and development of the new People and Well-being Strategy was agreed at the January Trust Board. Formal consultation with key stakeholders including managers, staff and Staff Side representatives has continued. The final strategy will be presented to the Board at the end of April 2015.

The People and Well-being Strategy will clearly set out our plans to recruit, retain, motivate, develop, and lead our workforce. The Strategy will be fully implemented by the development of key work streams overseen and performance managed by a new People Board.

To support the new People and Well-being Strategy, a formal external review of the role, function and capacity of the HR Team has been conducted. A proposed new structure will be developed as part of the Strategy and Change Directorate's Business Plan for 2015/16.

Key areas of activity continue including recruitment to all areas of the Trust but specifically targeting nursing vacancies. The position with nursing recruitment at 31/3/2015 showed the vacancy gap for nursing was 2%, a drop of 7% points compared to the same time in 2014 and compared with a 4.5% gap of vacancies across the Trust at 31/3/2015. The Trust continues to recruit locally, nationally and internationally and we continue to recruit more staff per month than leavers.

We continue to use bank and substantive nursing staff to better support any shortfall in capacity whilst we fill our vacancies and staff the extra capacity areas. We are refreshing our bank staff groups regularly to meet any short-term demands for people with the right skills and qualifications. We are succeeding in our domestic recruitment exercises to recruit specific nursing grades. In numbers, where in the 15 months to 31/3/15 we successfully recruited 1253 nursing staff, 85% of the target of 1467 request to recruit. And since April 2014, we have improved our speed to appoint. We have brought 79% of new nursing recruits into the Trust within 8 weeks.

The first Programme Board for the Race Equality Engagement Strategy was held on 19th February 2015 and the BME engagement event took place on 10th March 2015. A more detailed update will be provided next month.

A robust appraisal action plan is underway and the new appraisal system will be launched in May 2015.

An Apprenticeship Strategy has been developed and discussed with various stakeholders. A proposal will go to the Finance and People Committee by the end of May 2015. In the meantime steps are underway to prepare on approval of the proposal.

Q3 Statutory and mandatory training reports were issued week commencing 16th March to

all Directorates. Statutory and mandatory training continues to be delivered face to face 2-3 times per month, in addition to the option of workbooks or the national e-learning content.

Areas of concern for escalation.

Ongoing monitoring of our key HR indicators through the "HR Dashboard" to the Finance and People Committee includes vacancy rates, sickness absence, staff FFT etc.

Appraisal rates continue to concern us, due to the ongoing pressures on staffing. However our completion rates have shown notable improvement from 42% in December 2014 to 51% at 31s March 2015. Figures are taken from central appraisal records for all non-medical staff rather than staff survey. This is because staff survey scores are based on a percentage of respondents from 850 staff surveyed. For example: 2013 staff survey showed 67% appraisal rate from 55.1% respondents and in 2014 a 73% based on only 34.5% of respondents.

The targeted programme of work on appraisals lead by an experienced learning and development professional has borne fruit. The programme includes a remit to work with the relevant managers to increase the rates of completion and to address the issues faced by their teams who have practical problems in completing appraisals. Outcomes are the redesign of our appraisal form, related guidance notes and training in line with the values and behaviours blueprint. The new appraisal system will be rolled out across the organisation by April 2016.

Values & Behaviours and supporting staff (Compliance action7)

Executive lead: Deputy CEO / Director of Strategy & Change

The Values & Behaviours (V&Bs) programme focusses on creating an organisational culture/environment where staff and managers are skilled, resilient and feel supported, engaged and empowered to provide high quality, safe care/services.

Action Plan running to time?		**Triangulated evidence provided of progress?**	

Assurance statement:

The programme's focus is: (i) developing individuals & teams, (ii) aligning our people processes with V&Bs, (iii) engaging for improvement.

The programme continues but we are also preparing for the next phase, pending approval of the 2015/16 budget/work programme as part of the Trust Business Plan 2015/16 and aligned to the new People & Wellbeing/OD Strategy – both due for consideration by the Trust Board on 27th April 2015.

Of particular note since the last briefing:-

- The 'Leading the Way' development programme for 67 Directors/direct reports, and associated Action Learning Sets, is drawing to a close and will be complete by the end of

April 2015.

- 14+ internal part-time team coaches have been recruited and are working with an external Team Coach to hone/pilot a V&Bs-based 'improving how we work as a team' development intervention with early adopter teams – for wider rollout from late Summer 2015.

- 160+ staff have signed up as 'V&Bs Champions' and the number continues to grow. An active engagement programme is underway to support the Champions in promoting the Behavioural Blueprint and V&Bs programme in their teams.

- Work is continuing (detailed elsewhere, and subject to separate governance processes) to refresh the Trust appraisal process (paperwork, appraiser training etc.), which will include/references the Behavioural Blueprint.

Areas of concern for escalation.

- The proposed 2015/16 workplan/budget have been reviewed by the V&Bs Programme Board, and necessarily need to be considered in the wider context of affordability/the Trust Business Plan and new People & Wellbeing/OD Strategy. There will be a lead-in time for the '15/16 programme once approved (e.g. to recruit staff, design/tender training), so staff comms/engagement will need careful management during the hiatus.

Scheduled care (Compliance action 8)

Lead: Director of Scheduled Care and Service Transformation

This compliance action relates to the central Booking Hub ensuring that the Trust is meeting its RTT and measures related to outcomes for patient booking and appointments.

Action Plan running to time?		**Triangulated evidence provided of progress?**	

Assurance statement :

As reported since November we now have 5 high level actions. Progress to date on one to four is set out below. The fifth will follow once these initial actions are complete.

One - Ensure that we book all patients within 5 working days

For the month of March the booking hub booked on average 1030 patients a day, a 6% decrease from last month which was a combination of new and follow up appointments. On average 628 a day an increase of 8% month on month are being added to the referral management system within 24 hours of receipt.

We continue to work towards clinical triage within 48 hours. The referral team are proactively monitoring the referrals received and highlighting to the directorates any service that exceeds the target of 48 hours. Once identified, the directorates are notified so

they can take appropriate action but we are looking to develop a more robust system.

An RMS software upgrade will enable a drop down menu making it easier for consultants to use. We are now in a trial environment and are testing 2 sections – 1 is the work flow and process for triage and 2nd is the report to check on the triage target of 48 hours. Once this is completed a schedule of works for rollout will be devised and implemented from beginning of May.

In March we booked 68% of patients 0- 5 days with 85% of patients being appointed in 0 - 10 days. The booking team have requested an altered report to enable specialities to clearly see how many are being booked 0- 5 days and 6- 10 days. The hub is still experiencing issues with capacity in certain specialities and is working closely with Patient Access Managers and Directorate Managers to identify appropriate slots. **Two - Maximise use of clinic capacity with patients assigned to the right clinic first time through partial booking, triage efficiency and ensuring that the right letter with the right details reaches the patient**

The RMS software upgrade which would have allowed us to automatically populate new RMS patient records has been put on hold and needs further discussion due to increased costs from £700 with no annual maintenance fee to £8266K with an annual maintenance fee of £846 (all costs excluding VAT) identified by IT due to the interface between the RMS and the Oasis system.

The trial for the letter tracking failed due to software issues and we are working with the supplier to remedy this and expect that a new trial will take place in April with results being available for exceptions in May.

We are continuing to telephone any patient to be booked with less than 10 working days' notice to ensure they are able to make the date and have it noted in their diary.

Text reminders continue (where patients have given their mobile number). We continue to explore a two way messaging so patients can cancel by text if they are unable to attend. The current service provider will stay in place until further options have been evaluated. We are working with IT to move this forward and put in place a timescale plan for implementation.

The Booking Centre is developing a daily exception report to ensure all appointment letters are actually despatched. This means that we can be sure that all patients have been communicated with either by letter or phone in the event of a short notice appointment.

Three - An absolute focus on eliminating missed calls with all calls to be answered within one minute in the first instance

In March the booking team received an average of 1042 calls (range 842-1515) a day an increase of 5% month on month with 95% being answered within an average pick up time of 28 seconds. The team is starting to collect data on the main reasons for calls so we can address any continuing system issues and reduce the need for patients to call.

A missed / dropped call report is run daily and if a telephone number is logged as having waited over 45 seconds we will contact the caller to ensure that there query is resolved.

Detailed logging practice continues.

Four - Fully engage with our clinical directorates to minimise clinics cancelled with less than 6 weeks' notice and ensure a 6 week look ahead for all clinicians so they and the booking team have a shared understanding of the work to be done and can work together to resolve queries as they arise.

A 'look forward' report is sent weekly to directorates to review their clinic schedule. Performance in March saw 638 clinics cancelled which was a small decrease month on month, but 176 of these were with less than 6 weeks' notice impacting on 1436 patients which is a significant increase of 58%. We continue to work on the cancellation process including authorization and reasons for cancellation and our Clinical Lead will share this data with Clinical Directors. A new electronic clinic management form will be trialled, tested and launched in May.

Once this initial tranche of work is complete we will work on a continuous improvement programme to ensure that we have a patient focussed booking programme that is convenient for all patients. CCG colleagues have worked with us to help identify key changes in booking practice that they would like to see in 2015/16. These fully align with our implementation plan and we are finalising a Service Development Improvement Plan to take forward this year.

We have developed a senior role of 'Transformation Lead – Clinical Services' within the hub and the post holder, who previously deputised for the Head of Booking, is now taking the lead on various improvement projects outlined here.

The service remains with insufficient funded head count to manage the current level of service and discussion with regards to funding are continuing.

Areas of concern for escalation.

There continues to be a mismatch between demand and capacity in a number of specialities and this will continue into the first quarter of 15/16. The Trust is working to reduce wait times through its work on the delivery of the Referral to Treatment waiting standard.

There are also significant data quality issues. The new Patient Access Policy will help as will the competency based training programme to be developed and rolled out by the new Transformation Lead.

Until we can reduce the number of cancelled clinics and long waits for patients we will continue with a level of inefficiency, both in terms of re-work and dealing with important queries from patients.

KEY
Significant Assurance
Limited Assurance
Significant Risk

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