Safety & Quality Programme  
(CQC Response): Environment

Date of Update: 28-09-2016  
Completed by Caroline Snewin

PROJECT SUMMARY

DESCRIPTION
The CQC inspected BSUH in April 2016, and there were a number of issues identified that specifically related to the environment.

Some of these were raised though the CQC section 29a Warning Notice in June 2016 and others were flagged additionally through the main report when published.

OBJECTIVES:
1. Review the results of the most recent infection control audit undertaken in O/P & produce action plans to monitor required improvements
2. Improve the environment within O/P to ensure it is consistently child friendly.
3. Ensure mortuary cleaning schedules & procedures comply with national specifications for cleanliness & environmental standards
4. Review and improve major incident storage facilities & replenish stock

KEY MILESTONES

<table>
<thead>
<tr>
<th>MILESTONE</th>
<th>DUE DATE</th>
<th>STATUS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Installation of new paper towels</td>
<td>31.10.16</td>
<td>Started</td>
</tr>
<tr>
<td>1. Generic risk assessment for fans in ICU to be completed</td>
<td>30.09.16</td>
<td>Started</td>
</tr>
<tr>
<td>1. FM to add curtain change SOP and damaged commodes to cleaners handbook of audits &amp; complete risk assessment for COSH</td>
<td>30.11.16</td>
<td>Started</td>
</tr>
<tr>
<td>1. IP Awareness week w/c 19.09.16</td>
<td>23.09.16</td>
<td>Not commenced</td>
</tr>
<tr>
<td>2. Funding stream possibility from Rocking Horse being investigated and web based tools being downloaded</td>
<td>31.10.16</td>
<td>Started</td>
</tr>
<tr>
<td>3. Quarterly cleaning audits carried out</td>
<td>31.10.16</td>
<td>Started</td>
</tr>
<tr>
<td>4. Review and ratification of stock replenishment procedures</td>
<td>31.10.16</td>
<td>Started</td>
</tr>
</tbody>
</table>

KPI UPDATE

KPIs in development in line with CQC reporting requirements
Additional local KPIs will be discussed and agreed on an on going basis per action/ project stream

HIGHLIGHT REPORT

RAG Status:
Previous | Current | Forecast
A | A | A

KEY ACHIEVEMENTS / COMMENTARY

1. Installation of new hand hygiene products and SOP developed & ratified for audit
   Installation of bus stop signs completed @ RSH and partially @ PRH
   Data from hand hygiene audit presented @ IPAG, HIPC & PIMS
2. Meeting held with DLN Child Services and contacts established with Rocking Horse
3. Recent cleaning audit in July 2016 showed 92% pass rate against national standard of 90%

4. NEXT STEPS:
1. IP awareness week 19th September 2016 – review findings
2. Investigate suitable toys for O/P Sussex Eye Hospital
3. Recruitment against vacancies and training schedule review
4. Major incident procedures being reviewed by A&E in RSCH to include stock replenishment procedures

RISKS AND ISSUES (Red risks only)

Key risks and their scoring are in discussion and will confirmed over the next week.

<table>
<thead>
<tr>
<th>RISK / ISSUE DESCRIPT</th>
<th>IMPACT</th>
<th>PROBABILITY</th>
<th>OVERALL</th>
<th>Mitigation</th>
</tr>
</thead>
<tbody>
<tr>
<td>No red project risks</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

ITEMS FOR ESCALATION

None
Quality & Safety Improvement Programme: Experience

Date of Update: **27-09-2016**
Completed by Rebecca Watt

### PROJECT SUMMARY

**DESCRIPTION**
The CQC inspected BSUH in April 2016, there were a number of issues identified around patient experience. Some of which were raised though the CQC section 29a Warning Notice in June 2016 and others being flagged additionally through the main report when published.

### OBJECTIVES:

- Ensure that patient’s dignity, respect and confidentiality are maintained at all times in all areas and wards
- The trust should implement a formal feedback process to capture bereaved relatives’ views of delivery of care
- Ensure the 18 week Referral to Treatment Time is addressed so patients are treated in a timely manner and their outcomes are improved

### KEY ACHIEVEMENTS / COMMENTARY

**OBJECTIVES:**

- **Ensure that patient’s dignity, respect and confidentiality are maintained at all times in all areas and wards:**
  - Staff communication promoting use of ‘Knock & wait’ signs in all Outpatient areas – good response & take up
  - Head & neck have achieved 91% IG training compliance. 95% target by 30th Sept Trust compliance at 90%.
  - Observational audits within Outpatients, all clinic doors remain closed.
  - Safety huddle introduced in Outpatients.
  - SEH building temperature lowered in order for clinic rooms to have closed doors & be a comfortable temperature.
  - Use of cohort area within ED is monitored. A checklist is provided & reported weekly

- **NEXT STEPS**
  - Link in with Human Factors workshops
  - Audit of overrunning clinics to be rolled out to all OPD areas

### KEY MILESTONES

<table>
<thead>
<tr>
<th>MILESTONE</th>
<th>DUE DATE</th>
<th>STATUS</th>
</tr>
</thead>
<tbody>
<tr>
<td>‘Knock &amp; wait’ Signs for all SEH clinic doors</td>
<td>31-07-16</td>
<td>Complete</td>
</tr>
<tr>
<td>Signage to be rolled out across OPD</td>
<td>30-09-16</td>
<td>Ongoing</td>
</tr>
<tr>
<td>All team leaders to ensure staff are compliant with patient confidentiality policy</td>
<td>30-09-16</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Additional screens required for ED cohort area</td>
<td>16-09-16</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Clinic doors to remain closed in OPD when in use</td>
<td>31-08-16</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Privacy and dignity to be reviewed in Imaging. Male and female patients to be separated prior to the procedures when in gowns</td>
<td>31-10-16</td>
<td>Not commenced</td>
</tr>
<tr>
<td>Update the Policy on Chaperone Policy for Patients Undergoing Intimate Examinations and Procedures</td>
<td>30-09-16</td>
<td>Not commenced</td>
</tr>
</tbody>
</table>

### RISKS AND ISSUES (Red risks only)

- No current red risks

### ITEMS FOR ESCALATION

- No current red risks
Quality & Safety Improvement Programme: Governance

Date of Update: **29-09-2016**
Completed by Rebecca Watt

### PROJECT SUMMARY
**DESCRIPTION**
The CQC inspected BSUH in April 2016, there were a number of issues identified around governance.
Some of which were raised though the CQC section 29a Warning Notice in June 2016 and others being flagged additionally through the main report when published.

### OBJECTIVES:
- Ensure its governance systems are embedded in practice to provide a robust and systematic approach to improving the quality of services across all directorates
- Urgently facilitate and establish a line of communication between the clinical leadership team and the trust executive board
- Ensure safe and secure storage of medical records
- Further objectives outlined in full Governance Action plan

### KEY MILESTONES

<table>
<thead>
<tr>
<th>MILESTONE</th>
<th>DUE DATE</th>
<th>STATUS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical governance function restructure &amp; redesign</td>
<td>31-10-16</td>
<td>To commence</td>
</tr>
<tr>
<td>Creation of standard terms of reference for Directorate Clinical Governance Committees</td>
<td>31-10-16</td>
<td>To commence</td>
</tr>
<tr>
<td>Revision of Trust Risk Management Strategy</td>
<td>30-09-16</td>
<td>ongoing</td>
</tr>
<tr>
<td>Establish structured performance review meeting process, with standing agenda, scorecards etc</td>
<td>30-09-16</td>
<td>ongoing</td>
</tr>
<tr>
<td>Audit of compliance with Directorate Clinical Governance Standing agenda</td>
<td>31-07-16</td>
<td>complete</td>
</tr>
<tr>
<td>Appoint Clinical Governance Business Partners</td>
<td>31-12-16</td>
<td>To commence</td>
</tr>
</tbody>
</table>

### KPI UPDATE
Demonstrable changes in patient safety through improved clinical governance
RAGE report for STAM training

### KEY ACHIEVEMENTS / COMMENTARY

**OBJECTIVES:**
- Ensure its governance systems are embedded in practice to provide a robust and systematic approach to improving the quality of services across all directorates
- Urgently facilitate and establish a line of communication between the clinical leadership team and the trust executive board
- Ensure safe and secure storage of medical records
- Further objectives outlined in full Governance Action plan

**RISKS AND ISSUES (Red risks only)**

<table>
<thead>
<tr>
<th>RISK / ISSUE DESCRIPTION</th>
<th>IMPACT</th>
<th>PROBABILITY</th>
<th>OVERALL</th>
<th>Mitigation</th>
</tr>
</thead>
<tbody>
<tr>
<td>No current red risks</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### NEXT STEPS
Implement Trust wide plan for safe storage of medical records. Link in to Human Factors workshops, addressing patient confidentiality
Improvement areas identified: for performance, booking and scheduling; HR, recruitment processes; utilisation of theatres especially obstetric; LOS, repatriation of tertiary patients; IPC, culture; complaints process; medical records, responsiveness

**ITEMS FOR ESCALATION**
Confirmation roll out of EPR to Clinical Support serviceas
Safety & Quality Programme (CQC Response):
Fire Safety

HIGHLIGHT REPORT
Date of Update: 23-09-2016
Completed by Emma Tee

RAG Status:

<table>
<thead>
<tr>
<th>Previous</th>
<th>Current</th>
<th>Forecast</th>
</tr>
</thead>
<tbody>
<tr>
<td>R</td>
<td>A</td>
<td>A</td>
</tr>
</tbody>
</table>

KEY:
- High risk
- At risk
- On track

Brighton and Sussex University Hospitals NHS Trust

PROJECT SUMMARY

DESCRIPTION

During the BSUH CQC inspection in April, it was found that many of the Fire Risk Assessments (FRAs) were out of date, with the remainder of the assessments due to expire in late August and early September 2016.

As a result of this, a number of issues relating to fire safety were raised in the CQC section 29a Warning Notice.

OBJECTIVES:
- Ensure that all of the FRA for the Trust are brought up to date, phase one covering FRA out of date and phase two the fire risk assessments that will be out of date in August 2016.
- Work with all departments to ensure all corrective actions are resolved (Level 1 = immediate response, Level 2 = within 1 mth, Level 3 = with 3 mths, Level 4 within 6 mths, Level 0 at owners convenience.)
- Work with the Fire Safety Group to ensure the safety of patients’ visitors and staff in the environment of fire safety on site.
- Ensure that all fire risks are escalated to the Fire Safety Group and the Board.

KEY MILESTONES

<table>
<thead>
<tr>
<th>MILESTONE</th>
<th>DUE DATE</th>
<th>STATUS</th>
</tr>
</thead>
<tbody>
<tr>
<td>100% Compliance with FRA requirement (Phase 1)</td>
<td>31-08-16</td>
<td>Complete</td>
</tr>
<tr>
<td>Level 1 actions completed from Phase 1 (immediate action)</td>
<td>30-09-16</td>
<td>On Track</td>
</tr>
<tr>
<td>Level 2 actions completed (within 1 month of identification)</td>
<td>14-10-16</td>
<td>To Commence</td>
</tr>
<tr>
<td>Level 3 actions completed (within 3 months of identification)</td>
<td>16-12-16</td>
<td>To Commence</td>
</tr>
<tr>
<td>Level 4 actions completed (within 6 months of identification)</td>
<td>16-03-17</td>
<td>To Commence</td>
</tr>
<tr>
<td>Level 0 actions completed (at owners convenience)</td>
<td>31-03-17</td>
<td>To Commence</td>
</tr>
<tr>
<td>Commence Phase 2 FRA review - as they go out of date (business as usual)</td>
<td>On going</td>
<td>To Commence</td>
</tr>
</tbody>
</table>

KPI UPDATE
- KPIs in development inline with CQC reporting requirements
- Additional local KPIs – further work required to confirm.

KEY ACHIEVEMENTS / COMMENTARY

- The Trust is now 100% compliant with it’s FRA’s, all have been reviewed & are up to date (total 97 FRAs)
- 64% (62) of these updated FRA reports have been received back from the external company undertaking the assessments.
  - With the remaining 36% (35) expected by 16-09-2016.
- Additional Fire Warden courses confirmed.

NEXT STEPS:
- Final FRA reports to be received by 16-09-2016
- All new actions and their priority levels to be confirmed in the project plan by 21-09-2016
- Ongoing work to identify costings associated with each action.
- Continue with works to address actions identified – ongoing throughout project

RISKS AND ISSUES (Red risks only)

Key risks and their scoring are in discussion and will confirmed over the next week.

<table>
<thead>
<tr>
<th>RISK / ISSUE DESCRIBT</th>
<th>IMP ACT</th>
<th>PROB ABILITY</th>
<th>OVER ALL</th>
<th>Mitigation</th>
</tr>
</thead>
<tbody>
<tr>
<td>The fixed resource of the estates team may mean that the capacity available is insufficient to deliver amount of works required to meet the requirements of the Fire Risk Assessments (FRAs) within the required time frame.</td>
<td>4</td>
<td>4</td>
<td>16</td>
<td>Additional contractor resource has been agreed to support the delivery of all Estates works required to ensure compliance with fire regulations</td>
</tr>
<tr>
<td>Current Trust financial delivery may impact on ability to fund required works to bring buildings up to fire regulations standards.</td>
<td>4</td>
<td>4</td>
<td>16</td>
<td>Financial implications of the works required and staff to support this have been submitted with a circa £431k identified. CQC spend is being reviewed as identified and approved through CQC steering Group</td>
</tr>
<tr>
<td>Limited availability of sufficient course placements may prevent achievement of required levels of fire wardens in each area</td>
<td>4</td>
<td>4</td>
<td>16</td>
<td>4 additional training sessions have been confirmed and will take place during Oct, Nov and Dec. Further availability has been requested</td>
</tr>
</tbody>
</table>

ITEMS FOR ESCALATION
- Decision regarding Barry Building use and capacity required prior to significant investment in some of the major estates actions
Quality & Safety Improvement plan: Medicines Management

Date of Update: 29-09-2016
Completed by Rebecca Watt

HIGHLIGHT REPORT

RAG Status: Previous A, Current A, Forecast A

PROJECT SUMMARY

DESCRIPTION
The Medicines Management project is addressing the requirements arising from the CQC review in April. Specifically, storage of medicines, monitoring use of PGDs, correct use & storage of prescription forms, provision of Pharmacy resources.

OBJECTIVES:
- Ensure medicines are always supplied, stored & disposed of securely & appropriately
- Ensure security of hospital prescription forms is in line with NHS Protect guidance
- Ensure staff are working under appropriately approved Patient Group Directions (PGDs). Ensure PGDs are reviewed regularly and up to date
- Review analgesia authorisation for Band 5 nursing staff (PGD)
- Ensure equipment and medicines required in an emergency are stored in tamper evident containers
- Review the provision of pharmacy services across the seven day week and improve pharmacy support

KEY MILESTONES

<table>
<thead>
<tr>
<th>MILESTONE</th>
<th>DUE DATE</th>
<th>STATUS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Update prescription pad policy</td>
<td>31-07-16</td>
<td>Complete</td>
</tr>
<tr>
<td>New prescription pads with serial numbers issued to all departments</td>
<td>31-07-16</td>
<td>Complete</td>
</tr>
<tr>
<td>Band 5 nursing staff received PGD training</td>
<td>31-07-16</td>
<td>Complete</td>
</tr>
<tr>
<td>All PGDs to be reviewed, up to date authorisations required</td>
<td>31-07-16</td>
<td>Complete</td>
</tr>
<tr>
<td>Pharmacy security audit</td>
<td>12-09-16</td>
<td>Commenced</td>
</tr>
<tr>
<td>New models of 7 day Pharmacy service</td>
<td>31-10-16</td>
<td>Commenced</td>
</tr>
<tr>
<td>Sealable Resus trollies to be ordered (funding agreed, to go out to tender)</td>
<td>Tbc</td>
<td>To commence</td>
</tr>
</tbody>
</table>

KPI UPDATE
- KPIs in development inline with CQC reporting requirements
- Additional local KPIs – further work required to confirm

RISKS AND ISSUES (Red risks only)

<table>
<thead>
<tr>
<th>RISK / ISSUE DESCRIPTION</th>
<th>IMPACT</th>
<th>PROBABILITY</th>
<th>OVERALL</th>
<th>Mitigation</th>
</tr>
</thead>
</table>

ITEMS FOR ESCALATION
- Board input regarding provision of pharmacy services across the 7 day week. Significant investment required. Demand plan requirement for business as usual & site reconfiguration plans.
Safety & Quality Programme (CQC Response):
Patient Safety

Date of Update: 28-09-2016
Completed by Helen Codd

PROJECT SUMMARY
DESCRIPTION
The CQC inspected BSUH in April 2016, there were a number of issues identified with a potential risk to patient safety. These issues were raised in the CQC section 29a Warning Notice in June 2016.

OBJECTIVES:
• Ensure that the requirements identified in the CQC report are addressed.
• Ensure that all patient safety risks are escalated to the Quality and Performance Committee and the Board.

KEY MILESTONES

<table>
<thead>
<tr>
<th>MILESTONE</th>
<th>DUE DATE</th>
<th>STATUS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review of allocation criteria for patients to the Barry Building</td>
<td>09-Sep-16</td>
<td>Complete</td>
</tr>
<tr>
<td>Security doors to be installed in RESCH ED</td>
<td>21-Oct-16</td>
<td>On track</td>
</tr>
<tr>
<td>Demand &amp; capacity plan modelling for BSUH. Joint venture with SASH</td>
<td>tbc</td>
<td>To commence</td>
</tr>
<tr>
<td>DNACPR Audit</td>
<td>31-Dec-16</td>
<td>To commence</td>
</tr>
<tr>
<td>Annual consent audit</td>
<td>31-Mar-17</td>
<td>To commence</td>
</tr>
<tr>
<td>Baseline Sepsis audit</td>
<td>14-Oct-16</td>
<td>To commence</td>
</tr>
</tbody>
</table>

KPI UPDATE

<table>
<thead>
<tr>
<th>KPI</th>
<th>Performance Aug-16</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>ED checklist completed</td>
<td>89%</td>
<td>100%</td>
</tr>
<tr>
<td>NEWS score documented</td>
<td>98%</td>
<td>100%</td>
</tr>
<tr>
<td>SMART form completed</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Comfort rounds documented</td>
<td>90%</td>
<td>100%</td>
</tr>
<tr>
<td>No patients in corridor with NEWS&gt;4</td>
<td>98%</td>
<td>100%</td>
</tr>
</tbody>
</table>

RISKS AND ISSUES (Red risks only)
Key risks and their scoring are in discussion and will confirmed over the next week.

RISK / ISSUE DESCRIPT | IMPACT | PROBABILITY | OVERALL | Mitigation
--- | --- | --- | --- | ---
No red project risks | | | | |

ITEMS FOR ESCALATION
Ongoing delays for patients waiting for mental health placement
Decision required regarding use of ALERT at PRH ED
Safety & Quality Programme (CQC Response): Safer Staffing

Date of Update: 28-09-2016
Completed by Helen Codd

PROJECT SUMMARY

DESCRIPTION

The CQC inspected BSUH in April 2016, there were a number of issues identified around safer staffing.

Some of which were raised though the CQC section 29a Warning Notice in June 2016 and others being flagged additionally through the main report when published.

OBJECTIVES:

- Ensure that the requirements identified in the CQC report are addressed, see project pack for full detail.
- Includes amongst others: mandatory training, staff workload, numbers and skill mix, and cancer waiting and treatment time targets.

RISKS AND ISSUES (Red risks only)

Key risks and their scoring are in discussion and will confirmed over the next week.

KEY MILESTONES

<table>
<thead>
<tr>
<th>MILESTONE</th>
<th>DUE DATE</th>
<th>STATUS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Creation of in-house neuro competence training programme</td>
<td>07/08/2016</td>
<td>Complete</td>
</tr>
<tr>
<td>First cohort begin in-house neuro ICU competence course</td>
<td>07/09/2016</td>
<td>Complete</td>
</tr>
<tr>
<td>50% of staff on neuro ICU to be neuro trained in line with national guidance</td>
<td>31/03/2017</td>
<td>On track</td>
</tr>
<tr>
<td>Trust wide IG training compliance to be at 95%</td>
<td>31/12/2016</td>
<td>At risk</td>
</tr>
</tbody>
</table>

KPI UPDATE

<table>
<thead>
<tr>
<th>KPI</th>
<th>Performance Aug-16</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>RSCH Critical Care Vacancy Rate</td>
<td>10.5%</td>
<td>8%</td>
</tr>
<tr>
<td>RSCH Critical Care Recruitment &amp; Retention rate</td>
<td>10.6%</td>
<td>11.5%</td>
</tr>
<tr>
<td>Neuro Registrar audit</td>
<td>92%</td>
<td>100%</td>
</tr>
<tr>
<td>Trust wide IG training compliance</td>
<td>84%</td>
<td>95%</td>
</tr>
</tbody>
</table>

HIGHLIGHT REPORT

DATE OF UPDATE: 28-09-2016

RAG STATUS:

- Previous: A
- Current: A
- Forecast: A

KEY: High risk, At risk, On track

KEY ACHIEVEMENTS / COMMENTARY

OBJECTIVES:

- Funding for increase of 7 ED consultant numbers agreed in principle
- ICU have defined and made guidelines available through the Trust infonet pages, including prompt cards to standardise and improve patient care
- SOP and escalation plan for use of neuro ICU beds officially ratified on Monday 5th Sept at SMT, together with agreement of max. 7 neuro ICU beds
- 6x nurses have started training on in house neuro ICU course with Neuro Practice Educator

NEXT STEPS:

- Review options for ED cover to mitigate risk of not being able to recruit additional 7 consultants
- Quarterly review and update of ICU guidelines through the ICO standards group.
- Update neuro education strategy to reflect reduction to 7 beds
- Review of medical registrar out of hours cover
- Review and improve protocols, criteria and pathways for multi-disciplinary input to patient care
- Review and improve compliance with BDA guidance at Critical Care Units (PRH and RSCH)
- Review of CICU nursing template against national guidance
- Continue to identify, collate and review actions associated to CQC safer staffing requirements
- Further development of KPIs

RISKS AND ISSUES (Red risks only)

Key risks and their scoring are in discussion and will confirmed over the next week.

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<th>OVERALL</th>
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</thead>
<tbody>
<tr>
<td>No red project risks</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

ITEMS FOR ESCALATION

None