Appendix 5

Quality and Safety Improvement Plan

Brighton and Sussex University Hospitals NHS Trust

24th June 2016

KEY
Implemented, clearly evidenced and externally approved
On Track to deliver
Some issues – narrative disclosure
Not on track to deliver

Brighton and Sussex University Hospitals NHS Trust – Improvement Plan: June 6th – August 30th 2016

Findings and Actions	Leads	Progress against 30th August deadline	Status	Rag Rating	KPI and performance
Section 29A Warning Notice 6.6.16 1. 'You are not ensuring the systems to assess, monitor, and mitigate risks to people receiving the care and treatment as inpatients and outpatients are operating effectively' Findings: Governance **GOV1.1** Your trust board of directors receives conflicting and inaccurate evidence of assurance about the risks to patients using your services; we saw little or no evidence of robust discussions and challenges at board level to the risks posed to patients using services. We reviewed trust board minutes from April 2015 – April 2016	**NED Lead:** Tony Kildare, Chair **Executive Lead:** Dr Gillian Fairfield, CEO **Significant other leads:** Dom Ford, Director of Corporate Affairs (DF) Wendy Cookson, Director of Improvement (WC) Lyn Allinson, Head of Risk Management (LA) **External**: East Sussex Fire and Rescue Service (fire assessment risk only)	**17th June 2016**			
		GOV1.1.1 A revised Board Committee structure, agreed at Board on 25th April. New committee structure to go 'live' through June 2016 . This will include a new Risk Committee (TK/GF/DF)	30.6.16 Commenced		All Board members able to articulate key organisational risks; Review of risks minuted at each Board
		GOV1.1.2 Executive Director Portfolios formalised at Board 31st May	31.5.16 Complete		Clearly articulated accountabilities for Executive Directors
		GOV1.1.3 Board development programme to commence with substantive Chair appointment. (TK/GF/DF)	No date proposed		TBC
		GOV1.1.4 Well-Led review to be commissioned (GF/DF)	TBC		Recommendations completed in line with CQC improvement deadlines
		GOV1.1.5 The new Director Clinical Governance post went to advert nationally on 17.6.16. An interim arrangement is in discussion (WC)	Advert 17.6.16 Closing date 30.6.16		Start date for interim fill and substantive
		GOV1.1.6 A complete review of all outstanding corporate risks commenced 13.6.16 with focussed support from experienced risk and governance director (GF/DF)	BAF and corporate risk register to July 2016 Trust Board		All corporate risks updated: Process in place to maintain risks
		See also GOV1.6.1			
		24th June 2016			
		GOV1.1.1 Risk Committee first formal meeting w/c 4.7.16	w/c/4.7.16		
		GOV1.1.5 Four external expressions of interest. One telephone conversation and possible visit w/c 27.6. One visit arranged 27.6.	Closing date 30.6.16 Interview date 8.7.16		Start date for interim fill and substantive

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Findings and Actions	Leads	Progress against 30th August deadline	Status	Rag Rating	KPI and performance
Section 29A Warning Notice 6.6.16 2. 'You are not ensuring the systems to assess, monitor, and improve the care and treatment, privacy and dignity of people attending your hospital as inpatients and outpatients are operating effectively' Findings : Governance **GOV2.2** Your trust board of directors receives conflicting and inaccurate evidence of assurance about the care and needs of patients, and we saw little or no evidence of robust discussions and challenges at board level of the care given or the responsiveness to people's needs. We reviewed trust board minutes from April 2015- April 2016.	**NED Lead:** Tony Kildare, Chair **Executive Lead:** Dr Gillian Fairfield, CEO **Significant other leads:** Helen Weatherill, Operational Director of HR (HW); Dom Ford, Director of Corporate Affairs (DF); Wendy Cookson, Director of Improvement (WC)	**17th June 2016**			
		See GOV 1.1.1 Re A revised Board Committee structure commenced in June (TK/GF/DF)	30.6.16		
		GOV2.2.1 The revised Clinical Governance structure has been agreed in principle and is outlined in the portfolio paper for May Board. New post of Director of Clinical Governance to be advertised externally w/c 13.6.16 (WC/HW). **See GOV1.1.5**	17.6.16		
		GOV2.2.2 All committees below Board Committees redesigned, ToR renewed and Chairs reviewed. To be completed by 30.6.16 to 'go live' in July	30.6.16 31.7.16		
		See GOV1.1.3 re BDP (DF)			
		24th June 2016			
		GOV2.2.2 First Quality and Performance Committee on 23.6.16. ToR for committees below Board Committees agreed with minor changes. Work on meeting structure below these continues for completion 31.7.16	23.6.16 Complete 31.7.16		

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Findings and Actions	Leads	Progress against 30th August deadline	Status	Rag Rating	KPI and performance
Section 29A Warning Notice 6.6.16 3. 'You are not ensuring the systems to assess, monitor, improve the patient treatment times were met in line with national timescales ' Findings : Governance **GOV3.3** Your trust board of directors receives conflicting and inaccurate evidence of assurance about the Referral to Treatment Time (RTT) target of 18 weeks and the 12 hour breach target (decision to admit) in ED across the Trust services. We saw little or no evidence of robust discussions and challenges at board level of the need to meet these targets and strategies to achieve this. We reviewed trust board minutes from April 2015- April 2016.	**NED Lead:** Tony Kildare, Chair **Executive Lead:** Dr Gillian Fairfield, CEO Mark Smith, COO (MS) **Significant other leads:** Dom Ford, Director of Corporate Affairs Wendy Cookson, Director of Improvement **External support:** System- wide response	**17th June 2016**			
		GOV3.3.1 An interim Performance Director commences in post 17.6.16 2 days a week until August 2016 (GF)	Commenced 17.6.16		Revised performance dashboard and process from floor to Board
		GOV3.3.2 An interim Chief Information Officer commences in post w/c 27.6.16 (GF)	w/c 27.6.16		
		GOV3.3.2 A performance monitoring system to be implemented using and integrated score-card approach across the clinical directorates, with a transparent process of escalation within the reporting with mitigations and actions (GF)	Dates TBC from new post holder		
		GOV3.3.3 A general performance management approach of reports/dashboards across the organisation to support the COO and operational teams (GF)	Dates TBC from new post holder		
		GOV3.3.4 Integrated performance reports for Board and Exec and a clear ward to Board link with assurance of accurate and transparent information to Board.(MS)	Dates TBC from new post holder		
		GOV3.3.5 Review capacity and capability of the information team and data flows MS)	Dates TBC from new post holder		

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Section 29A Warning Notice 6.6.16 1. 'You are not ensuring the systems to assess, monitor, and mitigate risks to people receiving the care and treatment as inpatients and outpatients are operating effectively' Findings : Governance **GOV1.2** There was a governance framework in place in ED with responsibilities defined that monitored the outcome of audits, complaints, incidents however it was unclear how this fed into the wider governance structure within the trust **GOV1.3** Patients were not always protected from avoidable harm because there was no system to ensure trust wide learning from incidents or to take action where poor infection control practices were identified.	**NED Lead:** Tony Kildare, Chair **Executive Lead:** Dr Gillian Fairfield, CEO **Significant other leads:** Dr Stephen Holmberg, Medical Director (SH), Dom Ford, Director of Corporate Affairs (DF) Wendy Cookson, Director of Improvement (WC); Mel Ottewill, Head of Clinical Investigations(MO)	**17th June 2016**			
		See GOV1.1 and 1.2			
		GOV1.2.1 The floor to Board clinical governance restructure will include Risk and Safety managers aligned to each directorate but managed from the central clinical governance function, a standardised approach to directorate governance meetings, and will incorporate all functions including complaints and Health and Safety for a fully. Integrated approach. Director of Clinical governance post advertised 16.6.16 and proposal for restructure to Quality and Performance Committee 23rd June 2016 (SH/WC)	16.6.16 Closing date TBC 23.6.16 Completed		Board members and ward staff will be able to articulate the clinical governance structure and give an example of learning
		24th June 2016			
		See GOV2.2.1 Quality Committee agreed the ToR with agreed amendments and the subcommittee structure.	31.7.16		
		17th June 2016			
		For IPC learning see IPC1.5			Board members and ward staff will be able to articulate the clinical governance structure and give an example of learning
		GOV1.3.1 Actions to improve learning required from discussion with Head of Patient Safety (due w/c 20.6.16) (WC/MO)	w/c 20.6.16		
		24th June 2016			
		The Trust has commissioned RIPW training commencing on 4th July for 24 staff over 3 training sessions. This will result in expertise in the Trust commencing 24 workshops using RIPW methodology incorporating other methodologies including error-reduction Lean, Human Factors etc. The new Trust Improvement Academy will lead the work. How the Trust can immediately effect learning are being explored and detailed w/c 27.6.16			

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Findings and Actions	Leads	Progress against 30th August deadline	Status	Rag Rating	KPI and performance
Section 29A Warning Notice 6.6.16 1. 'You are not ensuring the systems to assess, monitor, and mitigate risks to people receiving the care and treatment as inpatients and outpatients are operating effectively' Findings : Governance **GOV1.4** The wards in the older buildings at RSCH had extremely difficult environments for staff to provide safe and effective care. Some of the most challenging and vulnerable patients were being cared for in premises that were no longer fit for purpose. Although the trust had a strategy for managing this, this was not carried out in practice. Risk assessments were poorly completed or out of date and did not provide assurance that risks to patients, staff and visitors were identified and managed appropriately.	**NED Lead:** Tony Kildare, Chair **Executive Lead:** Dr Gillian Fairfield, CEO Mark Smith, COO (MS) **Significant other leads:** Director of Strategy (from 11.7.16) Dale Vaughan, Director of Facilities and Estates (DV) **External:** East Sussex Fire and Rescue Service	**17th June 2016 and 24th June 2016**			
		See 1.1.6 for corporate and local risk register actions			
		See GOV1.7.1 for Trust-wide fire risk assessments			
		GOV1.4.1 The review of risk assessments, clinical governance and assurance to the Board is incorporated in actions 1.1 and 1.2. The Board will undertake an options appraisal of the viability of certain parts of the estate to deliver care in the immediate, short and longer term against the timeframes of the demolition and rebuilding of most of the aged estate (DV/GF)	Dates TBC		

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Section 29A Warning Notice 6.6.16 1. 'You are not ensuring the systems to assess, monitor, and mitigate risks to people receiving the care and treatment as inpatients and outpatients are operating effectively' Findings : Governance **GOV1.5** We were told and saw that all the environmental issues for the older buildings were on the risk register and had been "fed up the line." Staff were told by senior managers and the executive team that all the issues would be resolved during the rebuilding of the hospital. In the meantime staff and patients remained at risk from care and treatment being undertaken in an inappropriate environment. **GOV1.6** Managers told us that the acuity of patients in the Barry Building at RSCH was closely monitored as it was acknowledged the environment was inappropriate. However staff told us that due to pressures on beds their guidelines for admitting patients to these beds were frequently overridden by the bed managers. We saw examples where staff had completed incident reports due to inappropriate patients being admitted to these beds without any additional resources being put in place.	**NED Lead:** Tony Kildare, Chair **Executive Lead:** Dr Gillian Fairfield, CEO Sherree Fagge, Chief Nursing Officer (SF) Dr Stephen Holmberg, CMO (SH) Dr Mark Smith. COO (MS) **Significant other leads:** Dom Ford, Director of Corporate Affairs (DF) Lois Howell, Risk Consultant (LH)	**17th June 2016**			Regular updates to register and action plans; Risks coming onto and removed from the register with short turn arounds; Risks coming from a wide range of sources and from all services
		See GOV1.3.1 re strategic review of estate use			
		GOV1.5.1 Corrective actions against the 6 facet survey continue. All estates risks were reviewed 16.6.16. Corrections and updates to be completed by 24.6.16 and active management continued	24.6.16 Complete and ongoing		
		GOV1.5.2 An expert on risk management commenced 13.6.16 to review and redesign the corporate risk registers, enable the new Risk Committee commencing July and inform the BAF. Emergent issue to be reported to Quality and Performance Committee 28th July (DF)	28.7.16		
		24th June 2016			
		See GOV1.1.1 re Risk Committee **GOV1.5.2** Emergent risks to be discussed with CEO 28.6, full revised register at Risk Committee w/c 4.7 and at July Q&P and Board			

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Findings and Actions	Leads	Progress against 30th August deadline	Status	Rag Rating	KPI and performance
Section 31 and Section 29A Warning Notice, 6.6.16 Findings : Governance **GOV1.7** We had particular concerns that the risk of fire was not being managed appropriately. We raised this with the executive team and requested action to be taken. It was unclear that the executive were aware of this risk to patient and staff safety.	**NED Lead:** Tony Kildare, Chair **Executive Lead:** Dr Gillian Fairfield, CEO Sherree Fagge, CNO (SF) Dr Stephen Holmberg, CMO (SH) Dr Mark Smith, COO (MS) **Significant other leads:** Dale Vaughan, Director of Facilities and Estates (DV)	**17th June 2016 and 24th June 2016**			
		GOV1.7.1 Trust-wide external fire Risk Assessment commenced 9.5.16 RCSH and 23.5.16 at PRH. All out of date assessment to be completed by 7.8.16. Phase 2 (completion of all FRAs coming up for re-assessment for the rest of the year) to commence in August. Phase 1 initial report received. No Priority 1 actions (urgent and critical) in the areas assessed so far, 14 Priority 2 actions (to be corrected within1 month), 15 Priority 3 actions (within 3 months) and 2 Priority 4 actions (within 6 months). Working group commenced and reporting to CQC Steering Group weekly from 9.6.16. East Sussex Fire and Rescue Service have agreed the approach (GF). Fire ski-sheets were purchased and distributed for all beds 29.4.16	Commenced 9.5.16 and ongoing. Completion date TBC		FRAs always in date with annual plan for reassessment
		GOV1.7.2 Process for on-going FRAs – either increase in-house capacity or buy-in support	TBC		

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Section 29a Warning Notice 6.6.16 1. 'You are not ensuring the systems to assess, monitor, and mitigate risks to people receiving the care and treatment as inpatients and outpatients are operating effectively' Findings : ED **ED 1.1** There were frequent occasions during our inspection (April 4th- 8th 2016) when the number of patients requiring treatment exceeded the number of cubicles available in the emergency department (ED) at RSCH. This meant that patients spent long periods of time waiting in the 'cohort' area at RSCH, a corridor immediately adjacent to the ambulance entrance and handover bay.	**Directorate Leads:** Dr Martin Duff, Clinical Lead, ED (MD) Beverley Hales, Directorate Lead Nurse (BH) Simon Maurice, Directorate Manager (SM) David McKenna, Practice Educator (DM) **Executive leads:** Dr Stephen Holmberg, Medical Director (SH) Dr Mark Smith, Chief Operating Officer (MS **External support:** ECIP, System wide response	**17th June 2016 and 24th June 2016**			
		ED1.1.1 Integrated corridor area SOP, revised Trust and ICU escalation policies went 'live' 30.5.16. (SM/MS)	Complete		Improved 95%, 4 hour emergency pathway performance
		ED1.1.2 ECIP escalation software introduction planned. Discussions with IT ongoing (SM/MS)	Requires date by 1.7.16		
		ED1.1.3 External escalation policy, 'SHREWD' requires further review to assure alignment. Table-top exercise to be undertaken with all stakeholders. Date TBC by CCG (MS).	Requires date by 1.7.16		
		ED1.1.4 and 1.1.6 Dashboard redesign to track key measurable indicators (SM/MS) **24th June 2016** – Requires MS to expedite w/c 28.6.16	15.6.16 Overdue		
		ED1.1.5 Training on the integrated escalation policy for ED staff (SM)	Requires dates by 1.7.16		
		ED1.7 Trust-wide training programme to be developed (MS)			
		ED1.1.8 RCRPET improvements (MS) **See PER3.13.1**	TBC		
		ED1.1.9 RPIW March 2016 on acute patient pathways. Actions and KPIs required(ET/SD) 20-30 actions	TBC		
		ED1.1.10 Repatriation and DTOC patient plans, internal TAT/learning for patient 4 hour and 12 hour ED breaches. **See PER3.13**	TBC		
		ED1.1.11 CCG Improvement Plan – key deliverables to be incorporated into the Trust Improvement plan. Meeting CCG for Brighton and Hove 17.6.16 (WC) **See PER1.13.2**	KPIs related to performance section 3.		

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Section 29a Warning Notice 1. 'You are not ensuring the systems to assess, monitor, and mitigate risks to people receiving the care and treatment as inpatients and outpatients are operating effectively' **Findings related to the ED/unscheduled patient pathway** **ED1.2** There was a lack of assessment of patients' condition before they were placed in the 'cohort' area in the emergency department at RSCH and a lack of clinical ownership of patients in the 'cohort' area. **ED1.3** Between 1st January 2016 – 31st March 2016, a large number of patients waited in the 'cohort' area and, from information provided by the trust, the most time a patient spent in the corridor was 12 hours 53 minutes.	As for ED1.1	**17th June 2016 and 24th June 2016**			
		ED1.2.1 From 4 July 2016 all initial patient assessments will be undertaken in the new front door assessment spaces and the introduction of a PAT (Patient Assessment & Treatment (PAT) process (ECIP recommended) (MD, MS)	SOP due 24.6.16 PAT commences 4.7.16		KPI'sTBC with ECIP
		ED1.2.2 On both sites – only trained staff trained in triage allocated (recorded on allocation sheets). Trajectory on track for all band 6/7 nurses to be trained by 30th June. Next training date 24th June. Senior Band 5 staff nurses with at least 1 year ED experience at same grade, and triage training undertaking, triage at PRH site (SF/BH) – **to discuss with CQC**	On track to train all senior, experienced nurses in triage by 30.6.16 Patient assessments 16.6.16: 72% 22.6.16: 84%		100% allocation to triage of trained nurses: 100% patients in corridor have assessment
		ED1.2.3 Triumvirate visit to Medway Maritime Foundation Trust Hospital to learn from significant improvements in ED care, medical and nursing education and capital redesign 24.6.16 (MD)	24.6.16 Complete		TBC – adoption of practice and ideas to be incorporated into plan
		17th June 2016			
		1.3.1 There are data quality concerns with allocation of patients to corridor which has been corrected with the administration team. A chart in reception shows the staff the impact of changes. SECamb data identifies where patients were transferred to and shows fewer patients in corridor area. Patient numbers reviewed daily (MS) – **to discuss with CQC**	13.6.16 Complete and ongoing		No patients spend longer than 15 mins in corridor; no more than 5 patients at any one time in the corridor – to change to **NO** patients by TBC

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Findings and Actions	Leads	Progress	Date Due and Status	Rag Rating	KPI and Performance
Section 29a Warning Notice **Section 31** 1. 'You are not ensuring the systems to assess, monitor, and mitigate risks to people receiving the care and treatment as inpatients and outpatients are operating effectively' **Findings related to the ED/unscheduled patient pathway** **ED1.4** We found that the risk assessments used for placing people in the 'cohort' area were not sufficient and patients sometimes received nursing care from a combination of ambulance paramedics and ED staff without appropriate monitoring. The responsibility for ongoing care was arbitrarily allocated and confusingly signposted, as described to us, by an informal system of either leaving or taking gloves off the bottom of the respective trolley, to identify wither ED staff or ambulance staff were responsible for the care. **1.8** We observed an elderly gentleman who was left on a urine saturated sheet on a trolley for over and hour in the cohort area	As for ED1.1	**17th June 2016 and 24th June 2016**			
		ED1.4.1 Workshop to be held 5.7.16 between SECamb/CCG/BSUH to review handover process - output will be a refreshed SOP (MS)	5.7.16 Then refreshed SOP date (TBC post meeting)		Assurance of process adhered to required . TBC
		ED1.4.2 Maximum of 5 patients in the corridor at any one time during escalation. Implemented in SOP. When breached, datix to be raised (MS/BH)	No datix raised		
		ED1.4.3 A nurse and HCA assigned to corridor 24/7. Allocation sheets do not always indicate the HCA allocation. To be remedied 20.6.16	20.6.16		100% allocation of nurse and HCA to corridor
		ED1.4.4 Additional senior nursing staff support to be assigned to ED from 27.6.16. Deputy Director of Nursing visited ED daily from 13.6.16. Practice Educator and Divisional Lead Nurse addressing: • Poor compliance to NEWS from 3.6.16 with individual staff. • Poor compliance to checklist including comfort rounds	27.6.16		100% patients have NEWs documented **16.6.16: 100%** **22.6.16: 100%** Only patients with NEWs of <4 are allocated to and nursed in the corridor - **Requires data** 100% compliance on completed patient checklist **16.6.16: 72%** **22.6.16: 84%** 100% compliance with comfort rounds **16.6.16: 93%** **22.6.16: 84%**

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Section 29a Warning Notice 1. 'You are not ensuring the systems to assess, monitor, and mitigate risks to people receiving the care and treatment as inpatients and outpatients are operating effectively' **Findings related to the ED/unscheduled patient pathway** **ED1.5** We reviewed incident forms which showed multiple examples of acutely unwell patients waiting inappropriately in the 'cohort' area. **ED1.6** There were no systems in place for the management of overcrowding in the 'cohort' area. Staff were not able to provide satisfactory details of "full capacity" protocols or triggers used to highlight demand exceeding resources to unacceptable levels of patients in the area.	As for ED1.1	**17th June 2016 and 24th June 2016**			
		ED1.5.1 From 26.4.16, the nurse allocated to care for patients in the cohort/corridor area will prioritise a minimum of hourly observations and NEWS scoring (unless NEWS dictates more frequent observations), wrist bands, review of pain score, and ECG's for patients with chest pain (BH)	Introduced 26.4.16 **DATA required**		Only patients with a NEWs score of <4 will be ion the corridor area
		ED1.5.2 An Emergency Care Safety Checklist to be implemented on 9 May 2016 and will be incorporated into the Emergency Department Nursing Documentation booklet 31.7.16 due to external printing**.** The HCA will undertake 'comfort rounds' on all patients being cared for in the cohort/corridor area (BH)	Introduced 9.5.16 17.6.16: 72% 22.6.16:84% Comfort rounds: 16.6.16: 93% 22.6.16: 84%		100% compliance on completed patient checklist 100% patients in cohort will receive comfort rounds as per checklist
		17th June 2016			
		ED1.6 see ED1.3 , 1.4 and PER3.13			

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Section 29a Warning Notice 1. 'You are not ensuring the systems to assess, monitor, and mitigate risks to people receiving the care and treatment as inpatients and outpatients are operating effectively' **Findings related to the ED/unscheduled patient pathway** **ED1.7** An incident of a patient whilst in the 'cohort', area was reported in February 2016.	As for ED1.1	**17th June 2016 and 24th June 2016**			
		ED1.7.1 Datix of this patient to be reviewed with regards to lessons learnt and recommended actions. (MD)	20.6.16		As per datix actions
		ED1.7.2 Actions from datix (MD/BH)	TBC overdue		TBC
		ED1.7.3 Rota redesign completed w/e 10.6.16 – aim to ensure Consultant cover for PAT and entire department - Date required (JY/MD)	Completed		100% Consultant cover 24/7

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Section 29a Warning Notice 1. 'You are not ensuring the systems to assess, monitor, and mitigate risks to people receiving the care and treatment as inpatients and outpatients are operating effectively' **Findings related to the ED/unscheduled patient pathway** **ED1.8** Patients presenting with a mental health illness were not adequately risk assessed prior to being placed in the 'cohort' area. There were incidents of self harm and absconsion .		**10th June 2016**			
		ED1.8.1 Mental health patient assessments. Additional Training on trajectory. Remaining 20 staff will be trained by 31st July 2016. Assessments remain low (BH)	Patient Assessments 10.6.16: 66%		100% of patient mental health assessment completed
		17th June 2016 and 24th June 2016			
		ED1.8.2 Training on trajectory – 90% staff trained. Remaining 20 staff will be trained by 31st July 2016. Consideration for separate area for care staffed by SPFT staff as an alternative use for Zone 4, in discussion with provider. Next SLA meeting 12.7.16 to be brought forward if possible. Quarterly meeting with ED poorly attended 15.6.16. To be monthly with revised ToR from July (MS/BH)	Patient assessments 16.6.16: 100% 22.6.16: 100% 22.6.16 94% staff trained		
		ED1.8.3 Mental Health Liaison service SLA meeting 12.7.16. Specific discussion required on training needs. Escalated by SH (SH)	12.7.16		TBC
		ED1.8.4 Full mental health audit to be undertaken in July (date TBC) (MS)	TBC by 1.7.16		TBC
		1.8.5 Datix. to be reviewed (MD/BH) including lessons learnt and outcomes. Plans in place to improve security in ED including close corridor as point of access for hospital during 3Ts rebuild (MS)	Date TBC		TBC

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Section 29a Warning Notice 1. 'You are not ensuring the systems to assess, monitor, and mitigate risks to people receiving the care and treatment as inpatients and outpatients are operating effectively' **Findings related to the ED/unscheduled patient pathway** **ED1.9** At PRH there was only an emergency medical consultant present in the department from 9am until 5pm Monday to Friday and no cover during evenings or weekends. We were unable to determine the status on Bank Holidays. This breached the Royal College of Emergency Medicine recommendations of having an emergency medicine consultant) present from 8.00am until midnight seven days a week.	As for ED1.1	**17th June 2016 and 24th June 2016**			
		ED1.9.1 For full compliance against Royal College of Emergency Medicine guidelines rota should contain 32 consultants. RCEM guidelines require '*Emergency Medicine Consultant shop floor presence from 08:00* ***and into the late evening up until midnight*** *seven days a week' RCEM 2010.* A business case for 25 consultants to work until 22:00 and on call cover for submission week commencing 13.6.16. There is also an extra shift 15:00 - 22:30 – PRH, week days and weekends (MD)	TBC by CQC w/c 27.6.16 w/c 13.6.16 Date TBC		

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Findings and Actions	Leads	Progress	Date Due and Status	Rag Rating	KPI and Performance
Section 29a Warning Notice 2. You are not ensuring that systems to assess, monitor, and improve the care and treatment, privacy and dignity of people attending your hospitals as inpatients and outpatients are operating effectively. **Findings related to the ED/unscheduled patient pathway** **ED 2.1** We saw that people attending both RSCH and PRH did not always receive care in line with best practice, nor care that always met individual needs and protected their privacy and dignity (multiple examples given)	**Directorate Leads:** Dr Martin Duff, Clinical Lead, ED (MD) Beverley Hales, Directorate Lead Nurse (BH) Simon Maurice, Directorate Manager (SM) David McKenna, Practice Educator (DM) **Executive leads:** Dr Stephen Holmberg, Medical Director (SH) Dr Mark Smith, Chief Operating Officer (MS **External support:** ECIP, System wide response	**17th June 2016 and 24th June 2016**			
		ED2.1.1 Review to see if Bristol Safety list is appropriate or an amended version in the interim whilst flow improves (BH)	Due date required		
		ED2.1.2 Screens for use between patients in the corridor when taking bloods etc. as a temporary barrier if a room is not available (i.e. plaster room for privacy) (MD/BH)	13.4.16 Complete		
		ED2.1.3 Redesign of current assessment area planned to be completed by 4th July 2016 to provide additional major patient cubicles (MS/SM)	Due 4.7.16		
		ED2.1.4 Screens and keyboard IT systems in each cubicle to be revised (SM)	Due 4.7.16		
		ED2.1.5 Zone 4 in RSCH ED converted in to a bay for 5 seated patients 15th April. Temporary seating in place until chairs delivered 26.6.16 (SM). Opened when ED staff available to cover. Solution for locking of area for ED use only TBC –see 1.8 (SM)	15.4.16 Complete 26.6.16 Complete		
		ED2.1.6 Patient information board in corridor area changed to an electronic screen. Awaiting delivery due 3.5.16 (SM). Board has screen saver which reduces times patient names are displayed. Swivel arm to be added to increase privacy (SM)	3.5.16 Completed		
		ED2.1.7 Specific actions at PRH ED need quantifying w/c 20.6	**Overdue**		

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Findings and Actions	Leads	Progress	Date Due and Status	Rag Rating	KPI and Performance
Section 29a Warning Notice 2. You are not ensuring that systems to assess, monitor, and improve the care and treatment, privacy and dignity of people attending your hospitals as inpatients and outpatients are operating effectively. **Findings related to the ED/unscheduled patient pathway** **ED 2.2** We saw that there was constant moving of patients within the 'cohort' area and the inspection team felt this could disorientate and confuse patients. **ED 2.3** We heard staff make assumptions and judgements about patients depending on their presenting condition; this indicated that they did not consider patients' individual needs. **ED 2.4** We did not see interactions where staff apologised to those waiting in the 'cohort' area.	As for ED2.1	**17th June 2016**			
		ED2.2.1 See ED2.1			
		17th June 2016			
		ED2.3.1 - 2.4.1 Triumvirate to reassert communication at team meetings to apologise to patients. (MD/BH/SM) As per escalation policy, if extended periods in the corridor, the on-call manager will have an frequent presence in the area, interact and apologies to patients for their experience (Exec.)	17.6.16 From date of SOP go- live		

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Findings and Actions	Leads	Progress	Date Due and Status	Rag Rating	KPI and Performance
Section 29a Warning Notice 1. 'You are not ensuring the systems to assess, monitor, and mitigate risks to people receiving the care and treatment as inpatients and outpatients are operating effectively' Also 13/13, points 2.7/8 **Findings related to the ICU** **ICU 1.1** Staffing levels on the mixed intensive care unit (ICU) and cardiac ICU units were frequently and significantly short of enough nurses to provide safe care. This unit also frequently breached the minimum staff to patient standards set by the Intensive Care Society and the Royal College of Nursing. **ICU 1.2.** The skill mix of nurses on the mixed ICU unit was often insufficient to provide specialised care to neurosurgery patients. The trust had systematically failed to respond to staff concerns about this and mitigating strategies had failed.	**Directorate Leads**: Dr James Yassin, Clinical Director (JY) Beverley Hales, Directorate Lead Nurse (BH) Simon Maurice, Directorate Lead Manager (SM) Dr Carl Hardwidge, Clinical Director, Neuro (CH) Angela Jenkinson, Directorate Lead Nurse (AJ) Peter Lane. Directorate Manager (PL) **Executive leads:** Dr Stephen Holmberg, Medical Director (SH) Sherree Fagge, Chief Nurse (SF	**17th June 2016 and 24th June 2016**			
		ICU 1.1.1 and 1.2 Recruitment. Active recruitment ongoing. 19 new band 6 nurses with neuro skills appointed since June 2015. 1 European nurse with neuro ITU skills recruited w/c 13.6 Practice educator appointed 24th May. Start date 11th July 2016 New Directorate nurse for the Acute Floor commenced 1.3.16	Trajectory against vacancies required Retention rates required		Vacancy rates reduced R&R rates improve
		ICU 1.1.2 and 1.2 Increasing skills. 20 nurses a have been through the rotation to increase neuro nursing skills as of 17.6.16 6 nurses are currently undertaking the neuro skills course as of 17.6.16	Numbers of nurses still to rotate TBC Trajectory for other nurses required		Acuity and number of neuro. patients-to-nurse ratio
		ICU 1.1.3 and 1.2 Behaviours. V&B coach programme in place.	Details to be undated for June Due 1.7.16		TBC
		ICU 1.1.4 and 1.2 Medical cover. Neurosurgical registrar presence on both ward rounds required.	Update required for June Due 1.7.16		TBC

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Findings and Actions	Leads	Progress	Date Due and Status	Rag Rating	KPI and Performance
Section 29a Warning Notice 1. 'You are not ensuring the systems to assess, monitor, and mitigate risks to people receiving the care and treatment as inpatients and outpatients are operating effectively' **Findings related to the ICU** **ICU1.3**.There was a lack of team working and skills competence in the mixed ICU unit that meant patient risks were not adequately assessed. This situation occurred when the nurse in charge overruled more junior neurological ICU nurses about specific treatment for high acuity neurosurgical patients. Several neurological ICU nurses raised this with us and told us they felt it was a dangerous precedent to set…..(example given)…the department did not monitor such events we found no evidence on the risk register.	As for ICU1.1	**17th June 2016 and 24th June 2016**			
		ICU 1.1.3 The incident has been thoroughly investigated by the ICU triumvirate and no evidence of the incident can be found. CQC have been asked for more detail to allow for learning and action to be taken	15.6.16 complete		Awaiting more information Due from CQC w/c 27.6.16
		See ICU1.1. and 1.2			

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Findings and Actions	Leads	Progress	Date Due and Status	Rag Rating	KPI and Performance
Section 29a Warning Notice 1. 'You are not ensuring the systems to assess, monitor, and mitigate risks to people receiving the care and treatment as inpatients and outpatients are operating effectively' **Findings related to the OPD** **OPD1.1** In out-patients (OPD) at RSCH we found a store cupboard in the eye hospital that contained medical records, a fridge, a toaster, a microwave and a kettle. We asked staff if a fire risk assessment had been carried out but none had. **OPD1.2** In the Sussex Eye Hospital a shutter which divided the reception area from the office where medical records were kept was broken and could not be closed. Staff told us they had reported this in August 2015, but was yet to be repaired. **OPD1.3** We saw records in outpatients at RSCH kept in unlocked trolleys and not constantly attended by staff. We found patient identifiable data which included clinical diagnoses, in an unlocked, unattended area, which related to 203 patients. This indicated records were consistently being kept insecurely.	**Directorate Leads:** Dr Christpoher Liu, CD; Jane McNevin, Directorate Manager,; Jo Kerr, Directorate Lead Nurse **Executive Leads:** Dr Steve Holmberg, Medical Director (SH); Sheree Fagge, Director of Nursing (SF) **Significant other leads:** Martin Gibson, Business and Information Governance Manager (MG)	**17th June 2016 and 24th June 2016**			
		OPD1.1.1 This was highlighted to the Trust during the April visit. Non-compliance corrected and FRA carried out. Last outstanding action to move photocopier to be completed w/c 20.6.16 (JK)	w/c 20.6.16 complete		FRA actions complete and maintained through regular audit
		OPD1.2.1 Shutter fixed 14.6.16. Escalation and prioritisation process for essential works TBC (JK/SH/SF)	14.6.16 Complete TBC		TBC
		OPD1.3.1 CL to advise all ward and OPD managers about the medical record IG compliance requirements by 21.6.16 (CL/MG)	21.6.16 Complete		100% IG compliance with medical records
		OPD1.3.2 JK/JM to explore lockable solution for OPD medical records	21.6.16 Complete		
		OPD1.3.3 STAM training compliance for IG is required to be 95%. Current position TBC and corrected **24.6.16** IG is an e-learning package. Manager to agree trajectories for staff training by 1.7.16	24.6.16: IG training for OPD 56% Trajectories by 1.7.16		

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Findings and Actions	Leads	Progress	Date Due and Status	Rag Rating	KPI and Performance
Section 29a Warning Notice Section 29A Warning Notice 6.6.16 2. 'You are not ensuring the systems to assess, monitor, and mitigate risks to people receiving the care and treatment as inpatients and outpatients are operating **Findings related to OPD** **OPD2.1** We observed poor levels of privacy and dignity for patients throughout the outpatient department. We saw a non-clinical member of staff knock and enter a clinic room without waiting, despite being told there was a patient in the room. Clinic doors were left open when patients were having their consultation, with waiting patients observing. Confidential patient information was clearly heard at reception desks. We heard a staff member discuss a patient's condition in a waiting room, whilst other patients were waiting in that area. **OPD2.2** In the Sussex Eye Hospital, we saw clinic doors were left open, whilst patients had examination. Patients waiting in corridors outside the rooms could see patients being examined. We observed eye examinations being carried out and overheard patient-doctor conversations. Some eye tests performed in corridors due to a refurbishment programme.	**Directorate Leads:** Dr Christpoher Liu, CD; Jane McNevin, Directorate Manager,; Jo Kerr, Directorate Lead Nurse **Executive Leads:** Dr Steve Holmberg, Medical Director; Sheree Fagge, Director of Nursing **Significant other leads:** Martin Gibson, Business and Information Governance Manager	**17th June 2016 and 24th June 2016**			
		OPD2.1.1 Until the estate can be reviewed for sound proofing/alternative accommodation, signs for all doors stating occupied, please knock and wait etc to be ordered (JK)	21.6.16 completed		100% compliance to confidentiality policy. Measure TBC
		OPD2.1.2 All staff to be reminded of Confidentiality Policy and standards of professional practice – RCN and MDU. Shift leaders accountable to ensure compliance (CL/JK)	21.6.16 Completed		
		OPD2.2.1 Exploring Snellen charts for all rooms (CL)	17.6.16 Overdue		
		OPD2.2.2 Nursing template for OPD inadequate, urgent review and messaging to nurses to be proactive when patients are waiting (JK/JM)	21.6.16 Overdue		

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Findings and Actions	Leads	Progress	Date Due and Status	Rag Rating	KPI and Performance
Section 29a Warning Notice 1. 'You are not ensuring the systems to assess, monitor, and mitigate risks to people receiving the care and treatment as inpatients and outpatients are operating effectively' **Findings related to the outpatient (OPD) medicine management** **M.M. 1.1.** In the OPD at RSCH doctors' hand written prescriptions could only be dispensed in the hospital pharmacy. The pads were stored in unlocked clinic rooms. We saw three pads in examination room and four in the diabetic outpatient area. The pads did not have serial numbers on. No record was kept of how many prescriptions were issued each day. This was not in line with NHS Protect security of prescription forms guidance (2013).	**Directorate /Service Leads:** Mr Christopher Liu (CL); Jane McNevin, Directorate Manager (JMc); Jo Kerr, Directrate Lead Nurse: (JK); Niall Ferguson, Chief Pharmacist (NF) **Executive Leads:** Stephen Holmberg, Medical Director (SH); Dr Martin Smith, Chief Operating Officer (MS)	**17th June 2016 and 24th June 2016**			
		MM1.1.1 **8.6.16** Statement from Chief Pharmacist and Medical Director sent to triumvirate and all senior clinical staff re the safe management of prescriptions in OPD, launching the new process of securely held prescription pads which is complaint with NHS Protect, the recorded issue of blank prescriptions to clinicians during clinic, and the logging of prescriptions used. Serial numbered prescriptions on order – discussion with supplier to expedite deliver in 1 week (SH, NF). Divisional Directors spoken to by Executive team on same day at an extraordinary SMT	8.6.16 Completed 30.6.16 for revised prescription charts		
		MM1.1.2 Chief Pharmacist to outline all areas of medicine management concern in report for CEO by 30.6.16 for CEO (NF)	30.6.16		
		MM1.1.3 All PGDs will have been reviewed, retracted and governance process by 30.6.16	30.6.16		All PGDs known, agreed and monitored by pharmacy

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Findings and Actions	Leads	Progress against 30th August deadline	Status	Rag Rating	KPI and performance
Section 29a Warning Notice 6.6.16 3. 'You are not ensuring the systems to assess, monitor, and mitigate risks to people receiving the care and treatment as inpatients and outpatients are operating effectively' **Findings : Governance** **PER3.1**. The trust had failed to meet the England standard for referral to treatment (RTT) times since September 2014. **PER3.2** The trust has failed to achieve 2 wk cancer waiting times	**Executive Leads:** Dr Gillian Fairfield, CEO; Dr Mark Smith, Chief Operating Officer (MS) **External Support:** System response	**17th June 2016 and June 24.6.16**			
		PER3.1.1 The trust has agreed trajectories with NHSi which are reported at a Planned Care Board. Internally there are weekly meetings with each directorate detailing every patient's journey on the 18 week pathway (PTL meetings). There is a Clinical Review group that looks at all patients who have waited 52wks or more to assess for any harm. Data is continually checked for quality and patient pathways validated. The central booking Hub improvement action plan is also underway (MS)	Trajectory April 16: 91 - Actual: 100 Trajectory May 16: 103 – Actual 85		52wk waiting patient number trajectory for 30.8.16 is met
			Trajectory April 16: 34898 – Actual 34653 June to 17.6.16: 33685 (75%) against 34268 (72.02%)		RTT incomplete patient episode trajectory for 30.8.16 is met
		PER3.1.2 Additional capacity, repatriation of patients to local hospitals, theatre productivity and LOS work has commenced, and each speciality has specific actions dependent on the patient need and numbers			
		17th June 2016 and 24th June 2016			
		PER1.2.1 Cancer 2 week waiting patient monitoring is: • 2 week GP referral to 1st outpatient	March 16: 91.48% May 16: 94%		93% 2 week cancer waiting target met
		PER1.2.2 • 2 week GP referral to 1st outpatient: Breast symptoms	March 16: 94.05% May 16: 95.2%		

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Findings and Actions	Leads	Progress against 30th August deadline	Status	Rag Rating	KPI and performance
Section 29a Warning Notice 6.6.16 3. 'You are not ensuring the systems to assess, monitor, and mitigate risks to people receiving the care and treatment as inpatients and outpatients are operating effectively' Findings : Governance **PER3.3** The percentage of patients within two weeks with suspected lower gastrointestinal cancer was 67%. The most recent cancer meeting minutes indicated this had reduced further to 38%. **PER3.4** The percentage of patients waiting less than 31 days for treatment for cancer was below the England average from April to December 2015.	**Executive Leads:** Dr Gillian Fairfield, CEO; Dr Mark Smith, Chief Operating Officer (MS) **External Support:** System Response	**17th June 2016 and 24th June 2016**			
		PER3.3.1 Cancer 2 week waiting patient monitoring is: 2 week GP referral to 1st outpatient (colorectal)	March 2016: 90.11% May 2016: 86.3%		93% 2 week cancer waiting target met
		17th June 2016 and 24th June 2016			
		PER3.4.1 Cancer 31 day diagnosis to treatment for all cancers	March 2016: 97.4% May 2016 97.2%		96% diagnosis to treatment for all cancers

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Findings and Actions	Leads	Progress against 30th August deadline	Status	Rag Rating	KPI and performance
Section 29a Warning Notice 6.6.16 3. 'You are not ensuring the systems to assess, monitor, and mitigate risks to people receiving the care and treatment as inpatients and outpatients are operating effectively' Findings : Governance **PER3.5** The percentage of patients waiting less than 62 days for their first treatment for cancer was below the England average from April to December 2015. **PER3.6** The pathology department was not providing diagnostic results for suspected cancer in a timely way. It had met the target time for suspected breast cancer results, but not others.	**Executive Leads:** Dr Gillian Fairfield, CEO; Dr Mark Smith, Chief Operating Officer (MS) **External Support:** System response	**17th June 2016 – and 24th June 2016**			
		PER3.5.1 Cancer 62 day urgent GP referral to treatment of all cancers	March 2016: 81.9% May 2016: 77.5%		85% Cancer 62 day urgent GP referral to treatment of all cancers
		17th June 2016 and 24th June 2016			
		PER3.6.1 The IT leads for pathology and radiology are creating a dashboard for accurate and concise information can be used to effect change (MS) Timeframes TBC w/c 20.6.16	TBC		TBC

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Findings and Actions	Leads	Progress against 30th August deadline	Status	Rag Rating	KPI and performance
Section 29a Warning Notice 6.6.16 3. 'You are not ensuring the systems to assess, monitor, and mitigate risks to people receiving the care and treatment as inpatients and outpatients are operating effectively' 4. Findings : Governance **PER3.7** Data indicated 82,873 patient appointments were cancelled by the hospital in the last year 2015/16. Sixty percent of appointment cancellations were done with less than 6 weeks' notice. **PER3.8** The percentage of patients whose operations were cancelled and not treated within 28 days was 20% which was consistently higher than the England average of 5% from quarter four 2013/2014 to the first quarter 2015/2016. **PER3.9** Cancelled operations as a percentage of elective admissions had been variable over the time period, and been above the England average for four quarters between quarter four 2014/15 to quarter three 2015/16. **PER3.10** Between March 2015 and February 2016 24% of operations were cancelled with an average of 32 patients cancelled every month. Of these cancellations 40% were due to the patients cancelling themselves	**Executive Leads:** Dr Gillian Fairfield, CEO; Dr Mark Smith, Chief Operating Officer (MS) **External Support:** System response	**17th June 2016 and 24th June 2016**			
		PER3.7.1 – 3.10 At the RTT meeting w/c 20.6.16, data reporting will commence weekly on cancellation rates and the 28 day rule. A 'zero tolerance' to 6 week cancellation was introduced with all specialities on 25th May and is monitored weekly	TBC No patient cancellation within 6 weeks as of 17.6.16		<5% patient cancellations within 28 days No patients cancelled within 6 weeks of surgery date Cancellation rates will be less than TBC

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Findings and Actions	Leads	Progress against 30th August deadline	Status	Rag Rating	KPI and performance
Section 29a Warning Notice 6.6.16 3. 'You are not ensuring the systems to assess, monitor, and mitigate risks to people receiving the care and treatment as inpatients and outpatients are operating effectively' Findings : Governance **PER3.11**The percentage of patients waiting four hours from "decision to admit" to being admitted through the ED were consistently worse than the England average for the period January 2015 - to December 2015. **PER3.12** Multiple 12 hour patient trolley breaches in ED	**Executive Leads:** Dr Gillian Fairfield, CEO; Dr Mark Smith, Chief Operating Officer (MS) **External support:** System response	**17th June 2016 and 24th June 2016**			
		PER3.11.1 and 3.12.1 There was a cluster of 31 patients between the 19-26th October who breached the 12 hour wait in the ED department. The NHSi has seen the latest report in draft which was completed in May of this year. The findings have been used at the Acute Floor weekly meeting by the COO to drive change. A dashboard is being developed to include: • Time to triage • Time spent in the corridor • Time from DTA to admission • Turn around times for radiology, haematology and pathology	**MAY 2016** RSCH FBC = 98% < 2 hours INR = 95% <2 hours PRH FBC=96%<2 hours INR<94%<2 hours		Haematology 100% turnaround times within 2 hours Pathology TBC Radiology TBC
		PER3.12.2 An RCA of a smaller cluster of 12 hour ED breach patients in April 2016 is being undertaken and results compared to enhance learning.	Due 4.7.16		TBC

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Findings and Actions	Leads	Progress against 30th August deadline	Status	Rag Rating	KPI and performance
Section 29A Warning Notice 6.6.16 3. 'You are not ensuring the systems to assess, monitor, and mitigate risks to people receiving the care and treatment as inpatients and outpatients are operating effectively' Findings : Governance **PER3.13** The percentage of patients seen within four hours in ED were consistently lower than the England average and lower than the 95% target set by the trust throughout the period from September 2013 - to December 2015	**Executive Leads:** Dr Gillian Fairfield, CEO; Dr Mark Smith, Chief Operating Officer (MS) **External support:** System response B&H CCG - Wendy Young, Head of Planned Care; Lola Banjoko, Director of Delivery and Performance	**17th June 2016 – position**			
		PER3.13.1 Trust actions • Actions from patient breach analysis – TAT etc. to be collated into single dashboard w/c 20.6.16 • Introduction of ambulatory care pathways: SAU opened April 2016 • CofE unit in AMU (12 beds) • RCRPET –single clerking implemented. LOS reduction • Escalation policy in place lined to SOP for corridor patients, ICU escalation and SHREWD system escalation plan. See **ED1.1.3**	Agreed Trust reporting from 24.6.16 Overdue		
		PER3.13.2 CCG Brighton Hove Programme • 'Proactive Care' highest risk patient attendances reductions – Nov 15. 203 'whole' patient assessments, for full roll-out 2017/18. Part of ambulance conveyance reduction – CCG to confirm planned reduction numbers w/c 20.6.16 • From Feb-IC24 likely to have addressed un-met demand not redirected patients from BSUH. Inconsistency of cover impacts on BSUH • Admission avoidance - TBC • Patient pathway redesign - TBC • Primary care changes - TBC • Improving discharge and DTOC patient reduction - TBC	CCG 2 weekly data monitoring Overdue SRG monitoring monthly 23.6.16		Reporting against improvement plans, first data cut 21st July. Trajectories required for 30th August - agreed by 5th July
		PER3.13.3 Horsham and Mid-Sussex • PRH - to meet to agree w/c 20.6.16			Overdue meeting request. TBC 1.7.16
		PER3.13.3.4 Community Programme SCFT • 'Discharge to assess' (D2A) pilot on Jowers ward BSUH – to roll out • Increased capacity not being used due to patient choice. New Haven closed to be replaced by 'Healthcare at Home' To assess usage figures			TBC
		24th June 2016			
		PER 13.2 Meeting with B&H CCG. No data sets available. Trajectories requested. To be discussed at next SRG.	TBC		TBC

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Findings and Actions	Leads	Progress	Date Due and Status	Rag Rating	KPI and Performance
Section 31 **IPC 1.5**.We observed in the assessment area staff did not decontaminate their hands between patients and did not clean equipment in between patients.	**Directorate Leads**: Dr James Yassin, Clinical Director (JY) Beverley Hales, Directorate Lead Nurse (BH) Simon Maurice, Directorate Lead Manager (SM) Suzanne Morris, Deputy DIPC (SM) Dale Vaughan, Director of Facilities & Estates(DV) Noel O'Connor, IPC Lead Nurse for ED (RSCH) **Executive leads:** Sherree Fagge, Chief Nurse (SF)	**10th June 2016 and 24th June 2016**			
		IPC 1.5.1 Daily hand hygiene audits have not been undertaken w/c 30.5.16. IPC to place 'SWOT' team for 1 week commencing 6.6.16. Disciplinary action will be taken with individual staff. Audits completed daily from 6th with marked improvement in compliance until 9.6 independent audit. Performance action commenced with individual staff. Additional hand gel dispensers installed by IPC team	**PRH** 10.6.16 - 94% 23.6.16 – 97% **RSCH** (IPC team audit) 16.6.16: 87% 22.6.16: 72% (ave)		95% compliance with hand hygiene
		17th June 2016			
		IPC1.5.2 IPC awareness has increased significantly in the department, with individuals challenged and practice improved, from 48% 2.6.16 to 87% 16.6.16. IPC have written to SECamb due to lack of hand hygiene practice amongst their crews. Dates for Trust-wide campaign to be progressed at IPAG 17.6.16	17.6.17 for IPAG Dates TBC 22.6.16:72% (ave)		
		24th June 2016			
		IPC1.5.2 Alcohol gel for personal use ordered, simulation work next week to review processes within the assessment area and IPC team continuing spot checks and individual training	1.7.16		

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Findings and Actions	Leads	Progress	Date Due and Status	Rag Rating	KPI and Performance
Section 31 **1.10** There was a lack of access to suction, oxygen, and monitoring equipment in the cohort area which placed patients at risk. **1.11** We witnessed intravenous drugs prepared on patient trolleys which were then administered. This is an infection control risk.	**Directorate Leads**: Dr James Yassin, Clinical Director (JY) Beverley Hales, Directorate Lead Nurse (BH) Simon Maurice, Directorate Lead Manager (SM) **Executive leads:** Dr Stephen Holmberg, Medical Director (SH) Sherree Fagge, Chief Nurse (SF	**17th June 2016 and 24th June 2016**			
		1.11.1 A letter has been distributed to all ED nurses reminding them of their legal obligation for safe medicine management	29.4.16 Complete		100% compliance with safe medicine management (pharmacy audit) **10.6.16 - 100%** **16.6.16 – 100%**
		1.11.2 An Emergency Care Safety Checklist was implemented on 9 May 2016 and will be incorporated into the Emergency Department Nursing Documentation booklet 31.7.16 due to external printing	9.5.16 Complete 31.7.16		100% safety checklist **16.6.16 – 72%**
		1.11.3 Planning for new drug preparation room, re-provided by the vacation of a room on 4th July from increased cubicle work. Plan to be finished 26.6.16 and is due for completion 31st July 2016	26.6.16 31.7.16		New clean prep room in ED

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Findings and Actions	Leads	Progress	Date Due and Status	Rag Rating	KPI and Performance
Section 31 **1.12** There was no medical leadership or responsibility for patients in the cohort area. **1.13** We saw that there was an overall lack of responsibility for the patients in the cohort areas. **1.14** We were not assured that nursing and medical leaders had an awareness of the medical condition of patients within the cohort area. **1.15** At The Princess Royal hospital location we found there was one trained nurse looking after three seriously ill patients in the resuscitation area of the Emergency Department **1.16** We observed a paramedic giving handover of an acutely ill patient to a health care assistant (at PRH)	**Directorate Leads**: Dr James Yassin, Clinical Director (JY) Beverley Hales, Directorate Lead Nurse (BH) Simon Maurice, Directorate Lead Manager (SM) **Executive leads:** Dr Stephen Holmberg, Medical Director (SH) Sherree Fagge, Chief Nurse (SF)	**17th June 2016 and 24th June 2016**			
		1.12-1.14 For Nurses see ED1.5			
		1.12 – 1.14 There is consultant cover is 24/7 for both Eds. RSCH has 2 consultants from 8am-10pm and 1 from 10pm to 8am in the department. The consultant wears a red top for easy identification and carries a DEC phone. At PRH consultant cover is from 9am-5pm and registrar cover from 5pm to 9am. There is a business case to extend the consultant numbers from 14 to 25 (RCEM recommendation is 32) being presented to the Trust w/c 20.6.16. There are 'board rounds' to discuss all patients in the department multiple times a day and the patients in the corridor are of particular concern. The escalation response by the organisation and the system is crucial.	TBC due to SMT cancellation 20.6.16 due to communication requirements of senior team		Observational audits Datix
		1.15.1 Update 27.05.16 Staff establishments benchmarked against NICE guidance. Outcome evidence Doc 41. Finance and Business Investment Committee 23.6.16	23.6.16 (minutes not available 24.6.16)		Establishment agreed. 100% fill rate Reduction in incidents
		1.16.1 Update 3.06.16 HCA and Nurse in charge interviewed. Practice of trained nurse only handover and escalation to outreach team if additional trained staff required for seriously ill patients discussed. New Matron at PRH to ensure widely communicated and adhered to during team meetings, senior nurse meetings, to individuals during shifts and by observation	3.6.16 Complete and ongoing		Observational audit
		1.16.2 SECamb response received. Letter in response requesting assurance that their crews would ensure a safe handover of patients to a trained nurse as per protocol sent 17.6.16	17.6.16 Complete 24.6.16 no response		

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Findings and Actions	Leads	Progress	Date Due and Status	Rag Rating	KPI and Performance
Section 31 **1.17** At the Royal Sussex County Hospital resus department we had concerns that the staff working within resus were not appropriately trained. The Adult Major Trauma Centre Measures state there should be a nurse trained in Advanced Nursing Trauma Course (ATNC) or equivalent available for major trauma 24/7.The information provided to us demonstrated non-compliance in this measure.	**Directorate Leads**: Dr James Yassin, Clinical Director (JY) Beverley Hales, Directorate Lead Nurse (BH) Simon Maurice, Directorate Lead Manager (SM) **Executive leads:** Dr Stephen Holmberg, Medical Director (SH) Sherree Fagge, Chief Nurse (SF)	**17th June 2016**			
		1.17.1 update of 6.5.16: Staff allocation is non-compliant. Only 1 ATNC trained nurse in the establishment. Training and retraining commenced Trauma Lead Consultant and peer-review lead aware. **Update 10.6.16:**1 day refresher training 12.7.16 for 1 member of staff and 4 day courses start 13th September 2016	12.7.16 13.9.16		1 ATNC nurse trained on each shift at RSCH ED
		1.1.7.2 Peer review (due 30.6.16) evidence meeting with CEO w/c 13.6.16 with Lead Consultant for Trauma to discuss gaps in MTC requirements and Trust response	w/c 13.6.16 Complete Outcome required		TBC actions from meeting

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Findings and Actions	Leads	Progress	Date Due and Status	Rag Rating	KPI and Performance
Section 29A Warning Notice 6.6.16 **Also letter 13th April, point 2.5 and 6** 1. 'You are not ensuring the systems to assess, monitor, and mitigate risks to people receiving the care and treatment as inpatients and outpatients are operating **REC1.1** The recovery area at RSCH in the operating theatres was being used for emergency medical patients to reduce the pressure on the overcrowded ED and to help meet the emergency department's targets such as 12 hour waits. Some patients were transferred from the HDU to recovery to allow admission to HDU and some patients were remaining in recovery when there was no post-operative bed available. We were told and saw evidence in records that some patients were discharged home directly from the recovery area. **REC1.2** Some patients were kept in the recovery area for anything between four hours and up to three days with some being discharged home directly from the recovery area. **REC1.3** Whilst staff working in the recovery area were highly trained in looking after patients recovering from an anaesthetic they were not trained to look after emergency high dependency medical patients and ventilated patients when they were transferred directly to the recovery area.	**Directorate Leads** James Yassin, Clinical Director Beverley Hales, Directorate Lead Nurse (BH) Simon Maurice, Directorate Manager (SM) Dr Rasanayagam Romesh, Clinical Director (RR) Margaret Flynn, Directorate Lead Nurse MF) David Owers, Directorate Manager (DO) **Executive Leads** Dr Stephen Holmberg, Medical Director (SH) Sherree Fagge, Chief Nurse (SF)	**10th June 2016**			
		2.5.1 Update 13.4.16: With immediate effect no ED patients are admitted directly to theatre recovery. At bed meetings, step-down patients are prioritized for beds to enable at least 1 ICU bed. Overton ward (medicine) refurbishment into a L1 ward area for BiPAP patients who do not require HDU, and who come from AMU. The Trust has also responded to HEKSS in the issue of recovery usage.	13.4.16 100% achieved and maintained		No patient will be admitted into theatre recovery from ED, ICU or HDU
		17th June 2016 and 24th June 2016			
		2.5.1 and REC1.1-1.3 The adherence to the ICU policy, of freeing 1 x ICU bed, is not being adhered to, increasing pressure on the HDU and ICU bed availability. Agreement with MS,RR,JY to enforce 17.6.16 and review patient care within the Trust with the recovery use ban w/c 20.6.16 24th June 2016: SH to lead discussion with CDs regarding changes to ICU policy and process for using recovery for short periods during 3-way transfers (SH)	w/c20.6.16 Preliminary discussions complete w/c 27.6.16		
		10th June 2016 and 24th June 2016			
		2.5.2 The escalation protocol for ITU/HDU patients incorporated into Trust escalation policy 3.6.16.	3.6.16 Complete		
		REC2.6.1 Update 20.5.16: A patient waited 82 hours in RSCH recovery in June 2015. Data sent to CQC on 22.4.16. Notes pulled for harm review by Medical Director (completed 27.4.16). Datix raised **Update 13.5.16:** The investigation demonstrated that the patient did not stay in recovery for 82hrs, there were two admissions patient in recovery 1hr 3min and 5hrs 37mins. Report sent to CQC with plan submission, reference DOC 27.	Complete Awaiting CQC feedback w/c 27.6.16		

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Findings and Actions	Leads	Progress	Date Due and Status	Rag Rating	KPI and Performance
Section 29A Warning Notice 6.6.16 **Also letter 13th April, point 2.5 and 6** 2. 'You are not ensuring the systems to assess, monitor, and improve the care and treatment, privacy and dignity of people attending your hospitals and inpatients are operating effectively' **REC2.1** At RSCH patients were being kept in the recovery area of operating theatres for significant periods of time. This is because the trust was attempting to reduce the number of patients moved within 12 hours out of the emergency department (ED), lack of beds on the high dependency unit (HDU) and lack of beds in other areas of the trust **REC2.2** Some patients could be kept in the recovery area for over 4 hours and upto 3 days with some patients being discharged home directly from the recovery area. Patients did not have the privacy when they needed it and did not have free access to washing and toilet facilities, could not move freely around the recovery area and could not see their relatives whilst in the area	**Directorate Leads** James Yassin, Clinical Director Beverley Hales, Directorate Lead Nurse (BH) Simon Maurice, Directorate Manager (SM) Dr Rasanayagam Romesh, Clinical Director (RR) Margaret Flynn, Directorate Lead Nurse MF) David Owers, Directorate Manager (DO) **Executive Leads** Dr Stephen Holmberg, Medical Director (SH) Sherree Fagge, Chief Nurse (SF)	**17th June 2016** **See REC1.1 – 1.3**			