Brighton and Sussex University Hospitals NHS Trust

Meeting of the Board of Directors

9:30am to 12:00pm on Wednesday 24th October 2018
Meeting Room, Level 6, Trust Headquarters, Royal Sussex County Hospital, Brighton

AGENDA – MEETING IN PUBLIC

1.	9.30	**Welcome and Apologies for Absence** To note		Chair
2.	9.30	**Declarations of Interests** To note		All
3.	9.30	**Minutes of Board Meeting held on 25th July 2018** To approve	Enclosure	Chair
4.	9.35	**Matters Arising from the Minutes** To note	Enclosure	Chair
5.	9.40	**Chief Executive's Report** To note and agree any necessary actions	Enclosure	Marianne Griffiths
		PERFORMANCE REPORTS		
6.	9.55	**Quality Performance** To note and agree any necessary actions	Enclosure	George Findlay/ Nicola Ranger
7.	10.05	**Operational Performance** To note and agree any necessary actions	Enclosure	Pete Landstrom
8.	10.15	**Organisational Development and Workforce Performance** To note and agree any necessary actions	Enclosure	Denise Farmer
9.	10.25	**Financial Performance** To note and agree any necessary actions	Enclosure	Karen Geoghegan
		QUALITY REPORTS		
10.	10.35	**Learning from Deaths – Q2 2018/19** To note and agree any necessary actions	Enclosure	George Findlay
11.	10.50	**Infection Prevention and Control Annual Report** To approve	Enclosure	Nicola Ranger
		OPERATIONAL REPORTS		
12.	11.05	**Emergency Planning, Resilience and Response** To note and agree any necessary actions	Enclosure	Pete Landstrom
13.	11.20	**WRES Action Plan** To note and agree any necessary actions	Enclosure	Denise Farmer

GOVERNANCE REPORTS

14.	11.30	**Clinical Audit Annual Report** To note and agree any necessary actions	Enclosure	George Findlay
15.	11.40	**Board Assurance Framework** To approve	Enclosure	David Haycox
16.	11.50	**Use of Trust Seal** To note	Enclosure	David Haycox
17.	11.55	**Any Other Business**	Verbal	Chair
		Resolution into Board in Private: To pass the following resolution: "That the Board now meets in private due to the confidential nature of the business to be transacted".	Verbal	Chair
18.	12.00	**Date of Next Meeting** The next meeting in public of the Board of Directors is scheduled to take place on Wednesday 30th January 2019 in Lecture Theatre 1, Euan Keat Education Centre, Princess Royal Hospital, Lewes Road, Haywards Heath RH16 4EX.	Verbal	Chair
19.	12.00	**Close of Meeting**	Verbal	Chair
		Questions from members of the public Following the close of the meeting there will be an opportunity for members of the public to ask questions about the business considered by the Board.	Verbal	Chair

Brighton and Sussex University Hospitals NHS Trust

Minutes

Minutes of the Board of Directors (Public) meeting held at 10.00am on Wednesday 25th July 2018 in Lecture Theatre 1, Euan Keat Education Centre, Princess Royal Hospital, Lewes Road, Haywards Heath RH16 4EX

Present:	Patrick Boyle	Interim Chair
	Kirstin Baker	Non-Executive Director
	Malcolm Reed	Non-Executive Director
	Mike Rymer	Non-Executive Director
	Martin Sinclair	Non-Executive Director
	Jon Furmston	Non-Executive Director Advisor
	Lizzie Peers	Non-Executive Director Advisor
	Marianne Griffiths	Chief Executive
	Denise Farmer	Chief Workforce and Organisational Development Officer
	George Findlay	Chief Medical Officer
	Karen Geoghegan	Chief Financial Officer
	Pete Landstrom	Chief Delivery and Strategy Officer
	Nicola Ranger	Chief Nursing and Patient Safety Officer
In attendance:	David Haycox	Interim Group Company Secretary
	Sally Reeves	Assistant Board Secretary
	Barbara Harris	Head of Equality, Diversity and Inclusion

PB/07/18/1 Welcome and Apologies **Action**

1.1 The Chair welcomed those present to the meeting.

1.2 Apologies were received from Joanna Crane.

PB/07/18/2 Declarations of Interest

2.1 There were no declarations of interest.

PB/07/18/3 Minutes of Previous Meeting

3.1 The minutes of the meeting held on 30th May 2018 were approved as an accurate record.

PB/07/18/4 Matters Arising

4.1 The matters arising were noted. A number of actions were closed and the remainder covered by items on today's agenda or at future Board meetings.

4.2 **PB01/18/7.8:** Denise Farmer acknowledged that follow up is still required on local housing options for essential workers. It was noted by the Board that this has become part of a longer term piece of work and that feedback will be brought back to Board at a later date.

PB/07/18/5 Chief Executive's Report

5.1 Marianne Griffiths presented the report, which was previously circulated, and was delighted to highlight a number of recent good news stories.

5.2 **Financial Special Measures**

The first piece of positive news was a welcome letter received from NHS Improvement at the beginning of July confirming that the Trust no longer needs to be in financial Special Measures. This demonstrates NHSI's confidence in the organisation, following their three-day intensive review of finance and a deep dive of Cost Improvement Programmes (CIPs). Marianne paid tribute to Karen Geoghegan for the controls, setting up the CIPs and working hard with NHSI to gain their confidence and approval, which is a fantastic achievement for the Trust at this stage. There is still a £56m deficit, but exiting financial Special Measures is a significant improvement and shows that the Trust is heading in the right direction. Marianne added that she was particularly thrilled that none of the Trust's values were compromised in achieving this.

5.3 **Workforce Racial Equality Scheme (WRES)**

The first WRES conference was held in Brighton in May and attended by over 200 people. A follow-up event was held in July to review all the WRES data and to produce an action plan, which is on the agenda for discussion at today's meeting. Marianne gave particular thanks to Babs Harris, the Trust's Head of Equality, Diversity and Inclusion, who helped to run both events. The event in July was also well attended and gave a clear indication of how willing the staff are to build an open, inclusive culture throughout the Trust.

5.4 **Leaders' Conference**

The WRES conference was followed by a Leaders' conference, which was attended by over 100 leaders from across the Trust, a number of whom spoke about their experiences using Patient First and the difference it made to people by feeling empowered.

5.5 **NHS70**

Since the last public Board meeting, the Trust has been celebrating the NHS's 70th birthday with events taking place across the region. This presented the perfect opportunity to remind everyone of the work being done at BSUH and how much it means to the people served by the NHS. It was also an opportunity to look ahead to the service changes and improvements that everyone in the Trust is making together.

5.6 **National Recognition for Staff**

BSUH has received some very welcome national attention for the care that colleagues are delivering throughout the Trust:

- BSUH is recognised as being in the top 15% of trusts in the country for helping patients with diabetes to control their blood sugar levels.
- The Trust's Radiography team has been recognised with the national 'Make it Better' award from the British Institute of Radiographers for their improvement project in the Emergency Department.
- Karen Lee, Jowers Ward Manager, has been shortlisted for a Nursing Times Award for all the work she has done on reducing falls through the introduction of picture blankets on patient beds.
- The Emergency Department has been nominated for a number of awards this year and their work on prompt cards to standardise care has been 'Highly Commended' in the Patient Safety category of the Health Service Journal awards. Marianne gave special mention to Rob Galloway, A&E Consultant, who has been inspirational in driving forward this project.

5.7 **Compassionate Care**

Marianne highlighted some examples of staff looking for new initiatives and innovations to enhance the delivery of outstanding care:

- Two members of staff, Hayley Stevenson and Shelley Trigwell, advocated for the creation of a bereavement suite at the Royal Sussex County

Hospital and led the work with two neonatal bereavement charities, Abigail's Footsteps and Oscar's Wish Foundation, together with a donation of £20,000 of work from Novus Property Solutions to build the suite.

- In addition, the Teenage Cancer Trust has funded the refurbishment of an area in the Royal Alexandra Children's Hospital to provide an age appropriate space for the routine treatment of teenage cancer patients. This widens the options for patients to enable them to receive the care they need closer to home as well as in London.

5.8 The Chair thanked Marianne for her report and commented on the visible energy that has been created at BSUH in recent months. He added that having the chance as Chair to be up close to this work has been an amazing experience as there is so much happening, and he has been struck by the enthusiasm shown by staff to make improvements and willing Patient First to come to their department. The WRES conference was another positive example where the staff took control of their event. With all this transformational work, it is no surprise that BSUH has come out of financial Special Measures. The Chair echoed Marianne's thanks to the team and is hopeful that exiting quality Special Measures will follow very soon.

5.9 Following on from the Chair's comments around Patient First, George Findlay confirmed that there are going to be around 5 or 6 new units to which Patient First will be rolled out. Patient First Fundamentals is an abridged version of the programme which can be delivered in a short space of time and will act as a link until the full programme can be rolled out.

5.10 The Board **NOTED** the Chief Executive's Report.

PERFORMANCE

PB/07/18/6 Quality Report

6.1 George Findlay highlighted key points from the report, which was previously circulated.

6.2 George referenced the table in the report detailing Key Performance Indicators (KPIs), which are slowly improving. At the end of May the 12 month rolling mortality rate was 3.32%. The in-month rate has fallen slightly, as expected, due to seasonality. George advised that there is still an issue with the provision of data from the Office of National Statistics (ONS), which is hoped will be fixed by the following month. However, there are no flags from other reports to highlight any issues.

6.3 Nicola Ranger highlighted the work being carried out at BSUH on falls and stressed that the figures are monitored very carefully. There are four wards detailed in the report, which are currently not performing as well as last year and work is being done with each one with a focus on learning.

6.4 Work is continuing on tissue viability. The rate of pressure damage per 1000 bed stay days during the period April to June was 0.86. The pressure damage rate for 2017/18 was 0.68 incidents per 1000 bed stay days.

6.5 Nicola referenced the section in the report on the Malnutrition Universal Screening Tool (MUST), which is used to identify and treat adults at risk of malnutrition. The proportion of patients receiving a full Nutritional Assessment and MUST score within four hours of admission/ transfer to their ward has been increasing over the past 12 months and in June 2018 the Trust was, for the first time, 100% compliant with everything on the MUST score.

6.6 With regard to the Friends and Family Test (FFT), BSUH continues to do well with a recommendation rate of over 90%, which is much higher than the national average. However, the Maternity recommendation rate has dropped and this is particularly in relation to a question around post natal care, which the maternity team is addressing.

6.7 Mike Rymer asked about the Trust's preparations for 'flu vaccinations as he is aware of the preparations underway in Western Sussex Hospitals NHS Trust (WSHT). Nicola responded that BSUH is already preparing vaccinators and identifying target areas, though national guidance is to be sought on swabbing patients; at BSUH only symptomatic patients were swabbed in the past, though at WSHT it was broader, resulting in more patients being identified. The Trust will feed into the national review to aid preparations. George added that, given the pressure in A&E, the Trust is likely to vaccinate patients this year as it has been quite effective for other trusts. A full learning event was held after last year, the results of which can be shared with the Board if required.

6.8 Lizzie Peers made reference to the dementia screening figures, which have declined slightly, and asked whether the reason for this reduction was clear. Nicola confirmed that she will follow up and link in with an action plan around dementia which BSUH is working on, though she added that this is not a full dementia strategy. There is also a new person in post at BSUH who will link in with the Emergency Department.
ACTION: Dementia action plan to be provided to Board in October. **NR**

6.9 The Board **NOTED** the Quality report.

PB/07/18/7 Organisational Development And Workforce

7.1 Denise Farmer highlighted key points from her report, which was previously circulated.

- **Workforce** – expenditure in June was £30.86m and is consistent with the previous month. At the end of June (Month 3) the Trust reported a pay underspend of £423k.
- **Recruitment** – divisional recruitment days continue to support the filling of vacancies for Nursing and Healthcare Assistant staff.
- **Appraisal** – the trajectory has not yet been reached. However, Denise is confident of the divisions' level of focus on appraisals and is hopeful of hitting the target in August.
- **Statutory and Mandatory Training** – work continues on STAM as the figures are still not at the level expected.
- **Turnover** – this remains a key concern. With regard to housing options, also referenced under Matters Arising, Denise stated that this is a great opportunity for the Trust to stabilise the workforce and tackle some of the vacancy issues. Full details on turnover plans will be presented to the Workforce Transformation Group.

7.2 A number of proactive events have been held over the past few months, including WRES and the leadership conference. The work from the latter will be captured and taken forward as a leadership strategy. Denise added that real time data is still not available, but will be shared initially with Board in private to ensure that the data is correct before sharing with Board in public.

7.3 Jon Furmston acknowledged the increase in the appraisal and mandatory training rates and remarked that these are important measures to determine how well people are being managed. They are also a good way for employees

to feel the structured direction in which the organisation is moving. In response to Jon's question regarding exit interviews, Denise confirmed that there is a process in place and ideally they take place as soon as the employee has given notice. Jon also asked whether the disability figures are in line with the percentage of workforce, to which Denise will respond offline as the information was not available at the time. **DF**

7.4 The Board **NOTED** the Organisational Development and Workforce report.

PB/07/18/8 Performance Report

8.1 Pete Landstrom presented the report, which was previously circulated.

8.2 **Activity**

- The Trust saw further improvements to flow in June 2018 which led to improvements in bed occupancy. There were significant improvements in throughput and performance, although BSUH has been as busy as usual.
- There has been a significant increase (9%) in attendances this year, some of which is attributable to the new Emergency Ambulatory Care Unit (EACU).
- Delayed Transfers of Care (DTOCs) have plateaued between 5% and 6%, which is an improvement from 7.2% in the same month last year, but is still too high. Discussions with system partners are ongoing to work on reducing this further.

8.3 **A&E**

- In June the BSUH system was non-compliant against the national four hour standard overall, at 88.4%. However, this is a continued improvement for the system and an increase of 0.7% from the previous month. This also exceeds the agreed improvement trajectory with NHSI and NHSE as part of the 2018/19 planning.
- The planned improvement trajectory for the system performance was 87.5% in June, which was exceeded. The Trust also exceeded its target of 83.6% as part of the system plan with Type 1 & 2 performance of 85.7%.
- The Princess Royal Hospital (PRH) achieved 95% in A&E for the second month in a row. Equally, the Royal Alexandra Children's Hospital (RACH) and the Sussex Eye Hospital delivered above 95%. At the time of reporting, system performance has improved in July to 89.4%. However, the weekend and the start of the week were extremely busy and, in the last four days, BSUH recorded attendances of over 300 patients, which is unprecedented.

8.4 **Cancer**

- The Trust was compliant in 7 of the 9 metrics in May remaining below the 62 day treatment target for GP referrals (85%).
- Referrals improved to 80% in May, an increase of 2.3% from April 2018.
- Nationally the context remains challenging: over half the Trusts in England are non-compliant against this standard, but BSUH is performing better than other tertiary centres.

8.5 **Referral to Treatment (RTT)**

- As at end of June there are still two patients waiting more than 52 weeks for treatment. The Trust is anticipating zero 52 week waits as planned for July 2018.
- There was also an improvement of 0.5% in performance against the National Constitutional Target of 92%, to just below 84%. BSUH is below the trajectory set for this year in head and neck, but improving in general.

- The Cardiac Day Case unit at RSCH is now treating more patients and has seen a 3.5% increase in the Cardiac RTT as a result.

8.6 **Diagnostic Test Waiting Times**

- The Trust compliance for June was 7.9% over 6 week waiters across all diagnostic modes, which is non-compliant against the <1% national target.
- Staff constraints and technical problems contributed to June's CT performance. There is a plan to replace the second CT scanner and a business case will be submitted soon.
- There have been short term challenges with the echocardiography workforce, but one post has successfully been recruited to, which is positive news.
- Non-obstetric ultrasound remains a significant challenge in terms of demand and capacity constraints. However, improvements in diagnostics have been made with long waiters reduced to 139 in June from 187 in May.

8.7 Pete concluded by acknowledging the efforts made by staff and thanking them for the dedication, care and attention they have given to patients in the recent busy period where patient care has been exemplary and has not wavered.

8.8 In response to Kirstin Baker's request for further information regarding DTOCs, Pete confirmed that the key constraints in the community are the shortfall of inpatient rehab beds in Brighton & Hove, gaps in specialised care and an increase in mental health crises which has impacted on the service. The issue has been escalated and there are regular calls in place with the Clinical Commissioning Group (CCG) and system partners. The national expectation is for DTOCs to be 3.5%, though the preference for BSUH would be for 1%.

8.9 The Chair thanked Pete for his report and remarked on the continuous improvement in performance. He echoed Pete's comments around the immense pressure on staff at present. The impact of aggressive patients on staff was also noted. Marianne added her thanks to the staff. With their efforts and working all hours, the Trust has potentially avoided 14 twelve-hour breaches, which might not have been the case 18 months ago. It is important for the staff to know that the Board really values what they are doing.

8.10 The Board **NOTED** the report.

PB/07/18/9 Financial Performance Report

9.1 Karen Geoghegan presented the report for Month 3, which was previously circulated, and highlighted key points.

9.2 The Trust has agreed a revised control total of £55.11m, following an offer from NHSI to BSUH to access the Sustainability Transformation Fund (STF). The Trust is now formally part of the STF framework, which consists of 70% from the control total and 30% tracked to the A&E trajectory.

9.3 In June the Trust accrued a deficit of £4.8m against a deficit plan of £4.83m. The key drivers behind this are the performance against plan for NHSE Specialised Commissioning activity and Income being £1.9m less than plan.

9.4 **Pay**

The Trust is £1.7m below plan on expenditure. Medical and Facilities & Estates (F&E) are both above plan and there is targeted improvement work in these areas. In June agency expenditure is £1.25m, which is £250k above the agency ceiling. However, the Trust has now exited the high cost agencies.

9.5 **Non-pay**
There has been a big spike in F&E due to revenue costs associated with backlog maintenance. A plan has been put together with the F&E director with the expectation of a reduction over the next couple of months.

9.6 **Efficiency**
The total efficiency requirement for the year is £30m. At Month 3, £5.09m of savings have been delivered against a target of £5.06m.

9.7 **Capital**
Capital is £11m less than Q1 due to the 3Ts programme; this amount is expected to be deferred to next year.

9.8 **Cash**
The cash balance was £18.5m against a plan of £6.7m, with creditor payments due to be made in the first two weeks of July. The cash balance improved as a result of some commissioners paying their July SLA payments in advance.

9.9 In summary, Karen remarked that exiting financial Special Measures is good news for the Trust and a great endorsement of the control and plans put in place, though delivery of this plan remains a challenge.

9.10 The Board **NOTED** the Financial Performance report.

PATIENT SAFETY/EXPERIENCE ITEMS

PB/07/18/10 Learning From Deaths

10.1 George Findlay presented the report, which was previously circulated.

10.2 In summary, there were 351 deaths reported in Q1. Overall 39 of these were subject to Structured Judgement Review (SJR). One Learning Disability (LD) death was reviewed in the previous quarter. It was noted that these deaths are usually reviewed externally, but the process is not working well and has been brought back in-house until the external process has been improved.

10.3 The SJRs cover six discreet areas of care and the concerns raised in Q1 include a lack of clerking and escalation, and an absence of recognising end of life care. A number of SJR training sessions have been held to train an additional 25 multidisciplinary colleagues. There has been good care as well and good recognition of sepsis, but the Trust acknowledges that palliative care needs to improve.

10.4 George added that he is positive about this work. There is always more the Trust can do, but the process now feels embedded and is feeding into local governance meetings.

10.5 Mike Rymer commented that he attended the End of Life Steering Group recently and, while there are concerns, there are also examples of excellent care being given. If the profile of the End of Life team can be raised, it is more likely that they can be involved earlier in a patient's care. George agreed, adding that the aim is to ensure that every doctor or nurse recognises end of life and is able to call on the team when appropriate. WSHT and BSUH are working together on this, though there are notable differences between them.

10.6 The Board **NOTED** the report.

PB/07/18/11 Overview of Patient Experience, PALS and Complaints

11.1 Nicola Ranger presented the report, which was previously circulated. The report now contains more data which can be conveniently broken down at divisional level to enable further analysis and action to be taken.

11.2 The Friends and Family Test (FFT) response rate is now 51%, the highest in England. The Trust's recommendation rate is slowly increasing. Some work is ongoing in maternity to understand the figures which have recently declined.

11.3 The report includes an overview of the Adult Inpatient Survey. BSUH scored just above average for survey return and also scored above national average on people being clear on the nurse in charge of a ward, which is important to families. Following the 2016 Inpatient survey, focus was placed on developing the discharge process for patients and 76% of the scores for questions in the Leaving Hospital section of the 2017 survey show improvement or consistency. There is continuous work in the Trust to improve this.

11.4 There have been no mixed sex breaches reported at PRH, but Mixed Sex Accommodation (MSA) is a significant pressure at RSCH and remains a crucial area of focus for the Trust. In the Inpatient Survey, BSUH scored slightly below the national average for privacy and dignity in ED. The Trust is now doing well with this and hoping for an improvement this year.

11.5 A full overview of complaints and the process is given in the report and Nicola highlighted the detail given to divisions around complaints. With regard to those complaints specifically citing staff attitude, the data has now been broken down to enable detailed follow up.

11.6 Lizzie Peers asked whether there are any quick wins to be gained around post-op. Nicola confirmed that there is work ongoing around procedure, with particular focus on a group of patients to feed back on their concerns and expectations. There is also work ongoing around pain and analgesia, with the target of administering this within 30 minutes of arrival in A&E. Work is also progressing on the wards around analgesia, specifically to negate the need for a second approver to administer the medication.

11.7 The Chair thanked Nicola for her report and plans to discuss offline with Nicola how the Non-Executive Directors can become more involved in this work.

11.8 The Board **NOTED** the report.

OPERATIONAL ITEMS

PB/07/18/12 WRES Action Plan

12.1 Denise Farmer introduced Barbara Harris (Babs), the Trust's Head of Equality, Diversity and Inclusion, who presented the WRES Action Plan. The WRES 2017 Report was also previously circulated.

12.2 The WRES Working Group was set up following the successful WRES Conference held on 29th May 2018 and two meetings have been held to date. Hundreds of ideas from the conference were reviewed by the Working Group and the outcome is the WRES Action Plan, which comprises three key themes: Communication; Appraisal, Training & Education; Recruitment & Selection.

12.3 There are nine WRES Indicators and it was noted that figures for harassment,

bullying and discrimination of BME staff are at their lowest levels on record. 2017 saw the highest percentage of BME staff believing that the Trust has equal opportunities for career progression. However, abuse from patients has been increasing and Babs highlighted a spike across the region of aggression from patients. She added that the National WRES Team are providing support, but as BSUH is not in the bottom third the Trust will not receive additional support from them.

12.4 Marianne thanked Babs for the huge amount of effort put in to the WRES work and emphasised the importance of getting this into the core of the organisation to educate the leaders. She added that it was intentional that the leadership conference followed the WRES and the Trust is investing in work through Eden Charles and the Kings Fund in making this cultural change. The action plan needs to be owned in the same way as CIP and RTT as it is a priority to the organisation.

12.5 Denise echoed Marianne's comments and suggested a metric that enables divisions to understand how it is their role and how they can make it work. When asked for their priorities at the conference, staff found it difficult as they want to do everything immediately. Consequently there is a task to order these priorities. Babs reported that staff have appreciated that promises were kept following the first conference and some of their ideas have already been taken forward, particularly around communications.

12.6 Kirstin highlighted that at the WRES follow up there were some shocking statistics that demonstrate why this work is so important. She suggested that some of the messages should be linked to Patient First around behaviours and the Board agreed that BSUH should aim to be in the top third in the country. Babs believes that this is achievable and gave an example of the North London Trust which is green across the board. Marianne suggested visiting the trust to see the work they are doing and what BSUH can learn from them. Babs agreed with Kirstin's suggestion that everyone should have WRES training, with focus on different cohorts.

12.7 Jon Furmston prompted a discussion around unconscious bias among the staff that needed to be addressed. Marianne agreed that a tiered learning strategy around this is required as some people are wary of which language to use. Reference was made to the 'Let's talk about race' leaflet, which is useful and could be an addition to the Communications strategy. It was suggested that as much of the unconscious bias starts on day one, the Trust should consider embedding this culture on an employee's first day at work in the organisation.

12.8 Nicola commented that listening to the views of the staff at the conference highlighted the numbers of people who had never sat on an interview panel, which was surprising, and consequently lots of them were unaware and possibly not trusting of the interview process. Babs agreed that a number of the staff had not seen people in leadership roles.

12.9 **ACTIONS:**

The Board agreed a number of additional steps including:

- Link messages from the WRES follow-up into Patient First around behaviours.
- Representatives from BSUH to visit North London Trust for learning.
- WRES training for all, with focus on different cohorts.
- 'Let's talk about race' leaflet to be included in the Communications strategy. **DF**

12.10 Babs requested endorsement from the Board of the Action Plan ahead of publication in August 2018. The Chair led the overwhelming support from the

Board for this work and working towards a diverse agenda.

12.11 The Board **AGREED** the Action Plan.

PB/07/18/13 Annual Report for Medical Appraisal and Revalidation

13.1 George Findlay presented the annual update with regard to medical appraisal and revalidation. The report was previously circulated and the Board was asked to approve the Statement of Compliance, confirming that the organisation is in compliance with the regulations, prior to its submission to the higher level Responsible Officer (RO).

13.2 There has been an improvement in end of year appraisal rate this year compared to the previous year:

- 2017-18 end of year appraisal rate for all doctors with a prescribed connection for revalidation 92% (vs 85% in 2016-17).
- For substantive medical and dental staff only, end of year appraisal rate was 93% (vs 93% in 2016-17).
- There is one missed appraisal in 2017-18; the Medical Director is involved with this case.

13.3 George reported that there is a lot of work ongoing with appraisal and revalidation, and there is a great team working on this. The ratio is currently one appraisal to nine staff; the aim is to get to one appraisal to six staff this year. The team works hard on quality assurance and holds three appraisal development meetings each year.

13.4 With reference to the table in Appendix B of the report detailing the appraisals audited and not accepted, Kirstin asked whether there been feedback received from colleagues. George responded that the requirement for feedback is to seek it once every revalidation cycle (every five years), although most clinicians seek feedback more frequently. It was noted that feedback needs to be received from approximately 200 patients in order to be worthwhile.

13.5 The Board **ACCEPTED** the Report and **APPROVED** the Statement of Compliance.

PB/07/18/14 Annual Report on Organ Donation

14.1 George presented the Annual Report, which was previously circulated, and highlighted key points:

- In 2017/18, 15 patients proceeded to organ donation, a reduction from 25 the previous year. This decrease is in donation after circulatory death.
- BSUH is increasingly referring patients who meet the relevant criteria to the SNOD (Specialist Nurse in Organ Donation).
- With reference to comparative data, BSUH is well within the current range, though could be improved.

14.2 George added that the Organ Donation team works well despite a few recent challenges and they are all committed to this agenda. Ideally, George would like to see the numbers of donors after circulatory death increasing. The new specialist nurse appointments will be key in aiming to increase the numbers to ensure that no potential donors are missed.

14.3 The Board **NOTED** the report.

OTHER ITEMS

PB/07/18/15 Use of Trust Seal

15.1 David Haycox presented the report for the Board to note. It is a requirement of the Trust Standing Orders (Section 8.3) that a register of sealing is maintained. Use of the Common Seal is reported to the Trust Board on a quarterly basis and the report covers the use of the seal for the period 1st May 2018 to 30th June 2018, when it was used on one occasion.

15.2 The Board **NOTED** the use of the Trust seal.

PB/07/18/16 Other Business

16.1 There was no other business to report.

PB07/18/17 Resolution into Board in Private

17.1 The Board resolved to meet in private due to the confidential nature of the business to be transacted.

PB07/18/18 Date of Next Meeting

18.1 The next meeting in public of the Board of Directors is scheduled to take place on Wednesday 24th October 2018 at 9.30am in the Meeting Room, Trust Headquarters, Royal Sussex County Hospital, Eastern Road, Brighton.

PB07/18/19 The Chair formally closed the meeting.

PB07/18/20 Questions from members of the public

20.1 The Board was asked to confirm details of the forthcoming Trust Annual General Meeting, which is being held at Trust Headquarters on Tuesday 31st July from 10.00am until 4.00pm.

20.2 A second question was submitted via email and will be responded to in writing once the relevant information becomes available. The question concerned the NHS Sussex Vascular Clinical Advisory Group and NHS Sussex Trauma Clinical Advisory Group and asked whether any public and patient representatives have been appointed to bring different perspectives and challenge.

Sally Reeves
Assistant Board Secretary
July 2018

Signed as an accurate record of the meeting

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Chair

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Date

MATTERS ARISING
BSUH Board of Directors (in Public)

AGENDA ITEM: 4

Meeting	Minute Ref	Action	Person Responsible	Deadline	Status
28th March 2018	PB02/18/6.7	**Quality Report:** report to be provided on the learning around infection control this winter.	Nicola Ranger	September 2018	To be included in the Infection Control Annual Report Agenda item – October 2018
30th May 2018	PB05/18/12.7	**Safeguarding:** Adult Safeguarding team to give a presentation to Board, as at WSHT.	Nicola Ranger	October 2018	Deferred until Safeguarding Annual Report is ready.
25th July 2018	PB07/18/6.8	**Quality Report:** Dementia Strategy to be provided to Board in October.	Nicola Ranger	October 2018	Deferred to January Board when more information will be available – added to agenda plan.
25th July 2018	PB07/18/12.9	**WRES Actions:** 1. Link messages from the WRES follow-up into Patient First around behaviours. 2. Representatives from BSUH to visit North London Trust for learning. 3. WRES training for all, with focus on different cohorts. 4. 'Let's talk about race' leaflet to be included in the Communications strategy.	Denise Farmer	October 2018	Agenda item – October 2018

Brighton and Sussex University Hospitals NHS Trust

To: Trust Board

Date of Meeting: 24th October 2018 Agenda Item: **5**

Title
Chief Executive's Report
Responsible Executive Director
Marianne Griffiths, CEO
Prepared by
CEO
Status
Public
Summary of Proposal
Update for Board Members
Implications for Quality of Care
None applicable to this report
Link to Strategic Objectives/Board Assurance Framework
None applicable to this report
Financial Implications
None applicable to this report
Human Resource Implications
None applicable to this report
Recommendation
The Board is asked to: NOTE this report
Communication and Consultation
N/A
Appendices
None

Brighton and Sussex University Hospitals NHS Trust

To: Trust Board
Date: 24th October 2018

Chief Executive's Report

Care Quality Commission Inspection
The three phases of the CQC inspection have now been completed. These involved inspections of a number of wards and departments at the Royal Sussex County and Princess Royal hospitals, a Use of Resources assessment and a 'Well Led' inspection. We look forward to receiving the final report in January and on behalf of the Board would like to thank all our staff for their hard work and support before and during the inspection.

Continuing Patient First Progress
The Wave Two teams from across Princess Royal have now all graduated from their intensive, four month Patient First Improvement System (PFIS) programme armed with new skills and tools that will help them drive continuous improvement.

In recent months, we have launched the Patient First Fundamentals programme, a two day training programme that builds capability empowering middle managers to solve problems in a Patient First environment leading to sustainable improvements.

This gives us the best possible opportunity to share everything that we're learning from Patient First quickly and widely throughout the Trust, moving us further and faster towards our True North and Breakthrough Objectives.

Improving Staff Engagement
The annual NHS Staff Survey opened on 1 October and enables staff to have their say on the operation of the Trust and their place within it.

By the middle of the month, we had become the leading Acute Trust in the country for the percentage of staff who had taken part.

Since 2017, significant progress has been made on improving communications, addressing violence and aggression, offering more Health & Wellbeing information and focusing on our culture, equality and diversity.

Throughout the year, we have also been tracking progress on staff engagement through a series of mini-surveys. The biggest increase in these mini-survey results has been in the "I would recommend BSUH to friends and family for care" question, which improved by 17%.

"I would recommend BSUH to friends and family as a place to work" increased by approximately 16% and our Trust's Breakthrough Objective – "Care of patients/service users is my organisation's top priority" – continued to climb, with a 5% increase since December last year.

Diversity matters
In August, I jointly chaired the first meeting of the Diversity Matters Steering Group alongside Denise Farmer.

During a productive first meeting, we discussed progress from our Gender and WRES (Workforce Race and Equality Standard) working groups, considered an update from the LGBTQ+ Forum and began to examine how diversity and inclusion influence all of our policies.

We have recently invested in a new Recite Me Service for our website. The service benefits anyone who has a visual impairment, literacy issues, limited proficiency in English or a learning disability or difficulty in accessing information from the website. We are also preparing to add British Sign Language support to the site to further improve its accessibility for all visitors.

Launching our 2018/19 Flu Campaign
The Trust is working hard to ensure that at least 75% of all our staff have the flu vaccination this year, up from 50% last year.

Having started our campaign in late September, over 1,500 colleagues had the jab within the first few weeks. This is already an improvement on where we were at the start of last winter.

Increasing the number of 'Flu Protected' staff will help the Trust to improve the care that we offer to our patients by reducing the time lost to sick days, and limiting the opportunity for 'flu carriers' to spread the virus. A large percentage of those with the flu never become symptomatic, and the vaccination stops them transmitting it to colleagues and patients.

Taking a moment to have the vaccination and become 'Flu Protected' is another way in which we are able to demonstrate our care for our patients.

Exercise Galileo – making sure we're prepared
The patients and communities we serve expect us to be there for them when they need it, irrespective of the circumstances we face. On 18 September 2018, after many months of planning, the Trust ran Exercise Galileo, a full communications test and a live-play emergency exercise to test our major incident plans and processes.

The exercise was very well received with a total of 95 BSUH staff participating, 33 medical students acting as casualties and support from 11 of our local health and emergency service colleagues including SECAmb.

Additional staff were on duty in Brighton to ensure normal business was not affected.

A full report will highlight those areas that went well and an action plan will be produced so that we can make improvements to our processes going forward.

Patient Feedback
"All of the staff who looked after me on the ward were efficient and progressed what needed to happen so that I could leave the hospital early under the early discharge scheme in a very timely way, but not so that I felt rushed or pressurised.

"All staff also took the time, humanity and kindness to help me and provide reassurance. This applied to everyone without exception. As one example, the gentleman and lady who served tea and coffee took the time to ask me whether I wanted my drink in a cup or a beaker each time they asked me – I know it's a small issue but things like this really made me feel like a human and that I had a voice in what was happening to me.

"All of the nursing staff helped me through some painful periods with deep kindness; I know they were busy but they always made time to talk with me and involve me in decision making."

Brighton and Sussex University Hospitals NHS Trust

To: Board of Directors

Date of Meeting: 24th October 2018 Agenda Item: **6**

Title
Quality Report Month 7
Responsible Executive Director
Dr George Findlay (Chief Medical Officer) and Nicola Ranger (Chief Nursing and Patient Safety Officer)
Prepared by
Mark Renshaw, Deputy Chief of Safety, Caroline Davies Nurse Director
Status
Public
Summary of Proposal
The report describes performance against safety and quality key performance indicators in Month 3, in the domains of safety, effectiveness and patient experience
Implications for Quality of Care
The report includes exceptions in respect of pressure ulcers which is at its highest since 2012-13 and implementation of the alert -.
Link to Strategic Objectives/Board Assurance Framework
This report incorporates key national, regional and local quality indicators relating to quality and safety providing assurance for the Board and highlighting issues of concern. **A safety and quality scorecard is appended**
Financial Implications
Future reports will include KPIs that have potential financial impact (e.g. CQUIN)
Human Resource Implications
Safer staffing levels are incorporated in the safety and quality scorecard
Recommendation
The Board is asked to NOTE the report.
Communication and Consultation
Not applicable
Appendices
None

1 INTRODUCTION

1.1 This report brings together key national, regional and local indicators relating to quality and safety. The purpose of the report is to bring to the attention of the Trust Board quality performance within Brighton and Sussex University Hospitals NHS Trust (BSUH).

KEY QUALITY OBJECTIVES

2.1 Dashboard Definitions

2.1.1 A Safety and Quality Scorecard is appended to the Board report. Key indicators are detailed in table 1. Figures are in-month figures (e.g. the number of falls reported in may) unless otherwise stated.

2.1.2 Exception reports are included under the relevant section of this report (i.e. under the broad headings Effectiveness, Safety and Experience).

2.2 Overview of Key Quality Objectives

2.2.1 The following table shows performance against key, top level quality indicators.

Table 1: key performance indicators

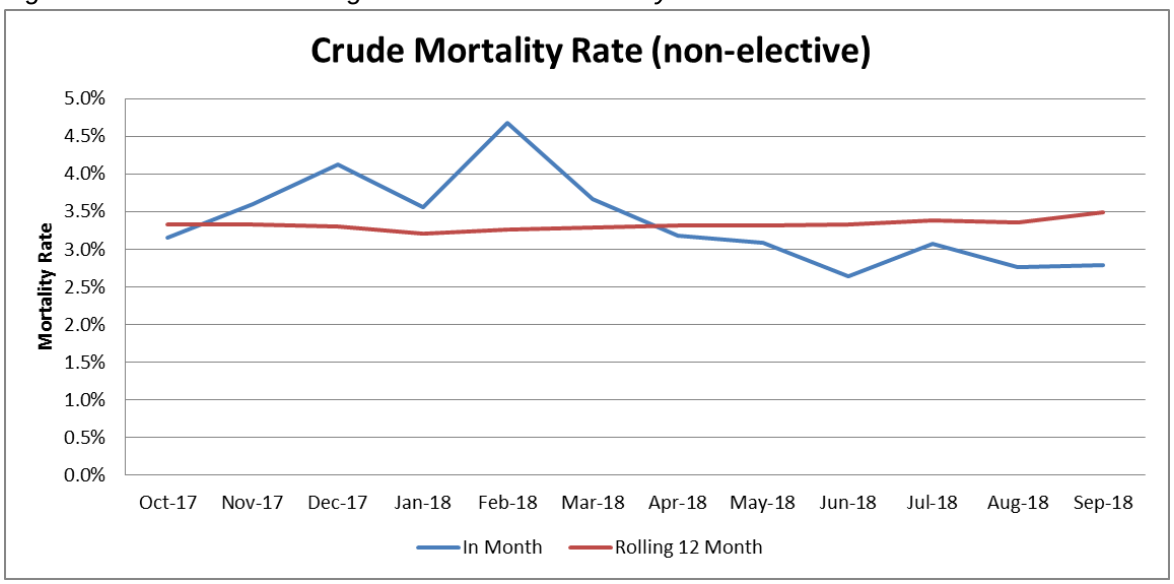
Indicator	July	August	September
Trust crude mortality rate (non-elective)	3.08%	2.77%	2.80%
Summary Hospital-Level Mortality Indicator	*Data not available*		
Hospital Standardised Mortality Ratio (Rolling)	*Data not available*		
Safety Thermometer (Harm-Free Care)	95.74	93.65	94.94
Number of Serious Incidents Requiring Investigation	2	2	1
Never Events	1	0	0
Grade 3 and 4 Pressure Ulcers	1	2	1
Falls resulting moderate, severe harm or death	2	0	1
Numbers of hospital attributable MRSA	0	1	0
Numbers of hospital C. diff cases	4	8	6
The Friends and Family Test: Percentage Recommending Inpatients	93.4%	92.4%	93.8%
The Friends and Family Test: Percentage return rate	25.8%	25.9%	29.0%
The Friends and Family Test: Percentage Recommending A&E	89.9%	90.3%	88.1%
Mixed Sex Accommodation breaches (number of breaches)	60	65	42
Formal Concerns	148	160	121

3 EFFECTIVENESS

3.1 Crude Trust Mortality – Non-Elective

3.1.1 Figure 1 below illustrates the Trusts in-month and 12 month crude mortality rate for non-elective admissions. At the end of August the 12 month rolling mortality rate was 3.36%. (crude mortality rates are influenced by seasonal variation).

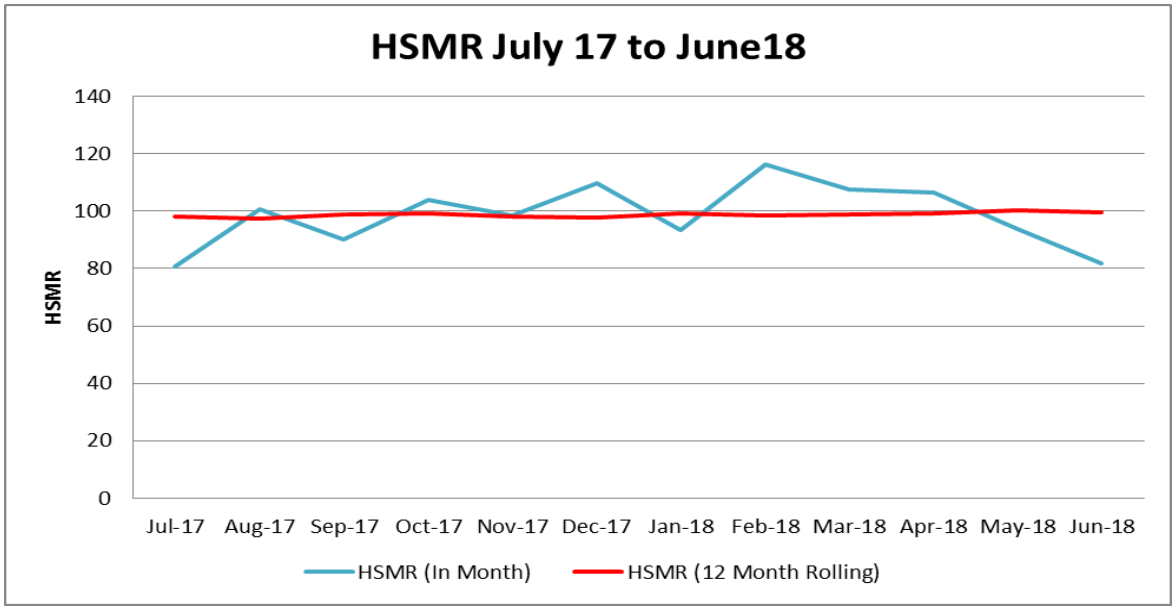
Figure 1: In-month and Rolling 12 month Crude Mortality Rate for non-elective admissions



3.2 Hospital Standardised Mortality Ratio (HSMR)

3.2.1 HSMR is only available for the month of June when 61 patients died against an expected number of 74.69 (HSMR 83.27). In the 12 months to June the HSMR was 99.26 (LCI 93.93, UCI 104.82). Figure 2 below illustrates that both the in-month and rolling HSMR has gradually risen during the past 12 months.

Figure 2: In-month and Rolling 12 month Hospital Standardised Mortality Ratio



Twelve months ago the annual HSMR was 98.23 (LCI 93.17, UCI 103.49).

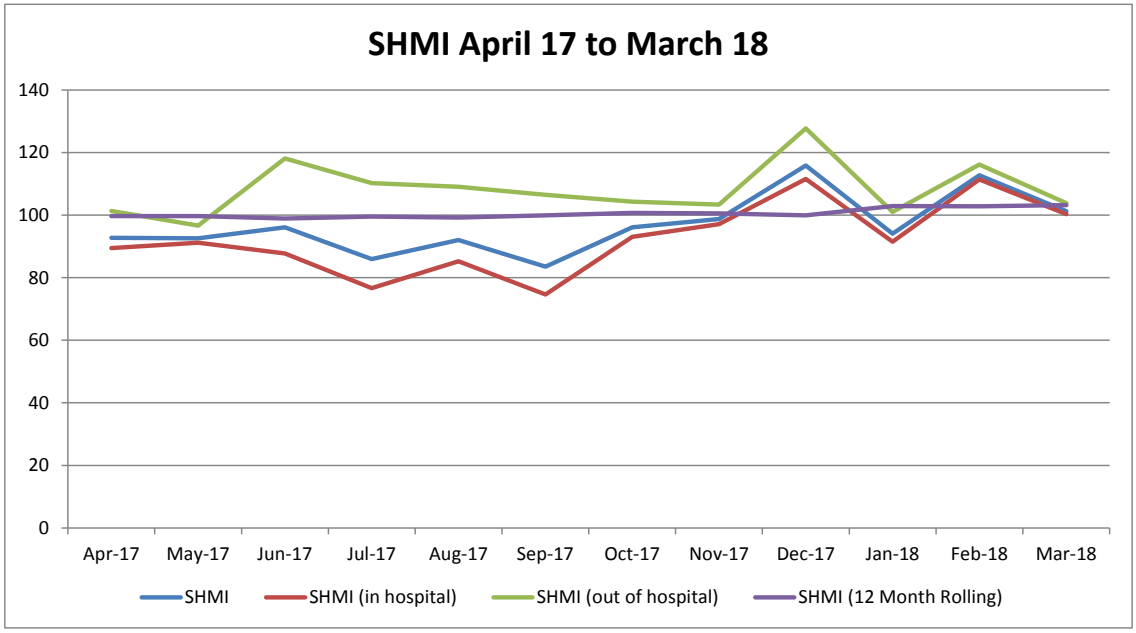
3.3 Summary Hospital-Level Mortality Indicator (SHMI)

3.3.1 The most recent data available is for the 12 months up to March 2018 when the SHMI) was 96.93, i.e. mortality is 3.07% below the expected value. Table 2 below shows the in and out of hospital SHMI for the period April 17 to March 2018. During this period 2324 patients died against an expected number of 2398. In hospital deaths make up 69% of the total number of deaths, and are 7.2% below the expected number. Out of hospitals deaths are 8% above the expected rate. The 12 month rolling SHMI, has been increasing over the past 12 months.

Table 2: SHMI

Discharge Month	SHMI	SHMI (in-hospital)	SHMI (out of hospital)	Rolling 12 Month SHMI
Apr-17	92.74	89.42	101.36	99.66
May-17	92.61	91.17	96.64	99.72
Jun-17	96.09	87.74	118.14	98.93
Jul-17	85.96	76.66	110.24	99.52
Aug-17	92.01	85.27	109.09	99.18
Sep-17	83.51	74.63	106.49	99.89
Oct-17	96.11	93.06	104.29	100.72
Nov-17	98.72	97.07	103.32	100.52
Dec-17	115.88	111.54	127.72	99.90
Jan-18	94.1	91.51	100.99	102.85
Feb-18	112.69	111.43	116.15	102.77
Mar-18	101.25	100.29	103.85	103.17
Total	96.93	92.77	108.00	101.30

Figure 3: In-month and Rolling 12 Month SHMI



4 SAFETY

4.1 Patient Safety Alerts

The following alerts are open and within the deadline

Resources to support safer modification of food and drink

Resources to support safer bowel care for patients at risk of autonomic dysreflexia

Resources to support safe and timely management of hyperkalaemia

4.2 Serious Incidents Requiring Investigation (SIRIs)

4.2.1 There were five Serious Incidents declared during the period July to September. All five incidents reported in this quarter are currently graded as moderates

4.2.2 In July a Never Event was reported in relation to a retained vaginal swab, two of the SI's involved patient falls.

4.2.3 The five SI's currently undergoing investigation are:

Title of investigation	Harm Caused
Never Event - Retained vaginal swab	Moderate
Fall on Newtimber	Moderate
Fall on Renal	Moderate
12 hour breach – 20th July 18	Moderate
Two 12 hour breaches – 23rd July 18	Moderate

4.1 Infection prevention

4.1.1 There have been no outbreaks of diarrhoea and/ or vomiting resulting in any bay or ward closures during September 2018. The Infection Prevention team are working in collaboration with the Medical Division and Clinical Site Management team to proactively manage any potential outbreaks of viral gastroenteritis and influenza. This collaboration also extends to management of a new TB pathway in relation to the outbreak detailed in 4.1.2

4.1.2 There has been a unique, unexpected transmission of Tuberculosis between a patient, a staff member and another patient. Whole genome sequencing recently revealed this transmission link and this was therefore labelled as an outbreak. Because numerous staff are involved and reporting harm, a serious incident was declared. A RIDDOR has also been sent in relation to the patient to staff transmission. Public Health England have identified this transmission as strain specific. The index patient was managed in line with policy and national guidance and staff followed this policy and guidance. The Trust is working closely with Public Health England on this issue. Currently 321 patients and 745 staff are part of this outbreak investigation and Duty of Candour.

5 Table 3: Hospital Onset/ assigned mandatory surveillance:

Infection	Jul 18	Aug 18	Sept 18	Total Since April 18	Max. amount allowed/ Reduction target 18/19
Clostridium difficile associated diarrhoea	4	8	6	28	46
MRSA blood stream infections	0	1	0	2	Zero avoidable
Escherichia coli blood stream infections	1	5	5	20	50% reduction by 2020/2021
Pseudomonas aeruginosa blood stream infections	2	2	0	5	50% reduction by 2020/2021
Klebsiella spp. Blood stream infections	4	5	2	12	50% reduction by 2020/2021

4.3 Inpatient Falls

4.3.1 The rate of inpatient falls for the past 12 months is 3.40 falls per 1000 bed stay days; this equates to 857 falls in the past year compared to 875 in the previous 12 months. The National Falls rate is 6.63 falls per 1000 bed days.

4.3.2 During the past 3 months 211 patients have fallen at a rate of 3.33 falls per 1000 bed days.

4.4 Pressure Ulcers

4.4.1 During the period July to September there were four grade 3 hospital acquired pressure ulcers incidents reported. Damage to the sacrum, buttocks and heels remains the most common form of pressure ulcers. Inadequate documentation of skin assessment and changes of position are recurring themes.

4.4.2 The rate of pressure ulcers per 1000 bed stays days during the period July to September was 1.34. The pressure ulcer rate for 2017/18 was 0.68 incidents per 1000 bed stay days.

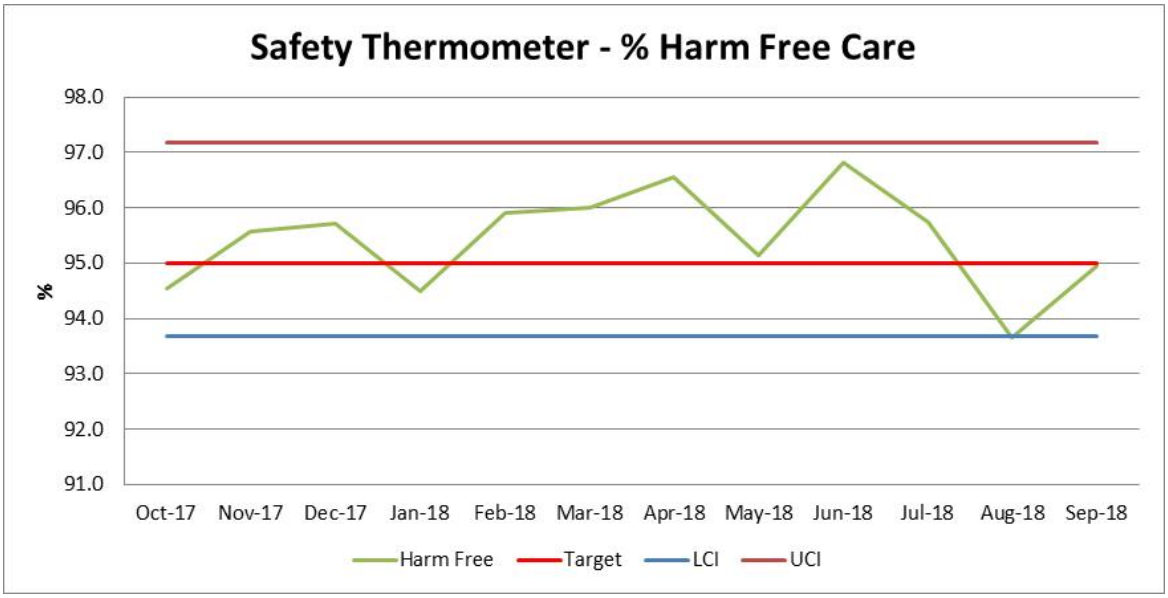
4.4.3 In June NHS Improvement published a series of recommendation on the definition and measurement of pressure ulcers. The guidance includes a recommendation that moisture associated skin damage should be counted in addition to pressure ulcers. This will have an impact of the Trusts overall rate of pressure ulcers.

4.4.4 A full gap analysis has been undertaken by the Tissue Viability Team and the Datix system is currently being modified to reflect the new reporting arrangements.

4.6 NHS Patient Safety Thermometer

4.6.1 The NHS Patient Safety Thermometer is used across all adult and neonatal wards. This tool looks at point prevalence of four key harms - falls, pressure ulcers, urinary tract infections and deep vein thrombosis (DVT) and pulmonary embolism (PE) in all patients on a specific day in the month. A dashboard is available to each ward showing Trust-wide and ward-level data for each individual harm as well as the harm-free care score. These numbers are also shared via the new ward screens. The rate of harm free care was 94.94 in September, 0.06% below the Trust target of 95%. For the 12 month to September the rate was 95.4%.

Figure 5: Harm free care



4.6.2 The harm-free care score for the past 12 months was 95.46 against the target of 95%. The national average is 94.2%.

4.6.3 National data relating to the NHS safety thermometer is available below:

http://www.safetythermometer.nhs.uk/

4.7 Malnutrition Universal Screening Tool MUST

The Malnutrition Universal Screening Tool (MUST) is a screening tool used to identify and treat adults at risk of malnutrition.

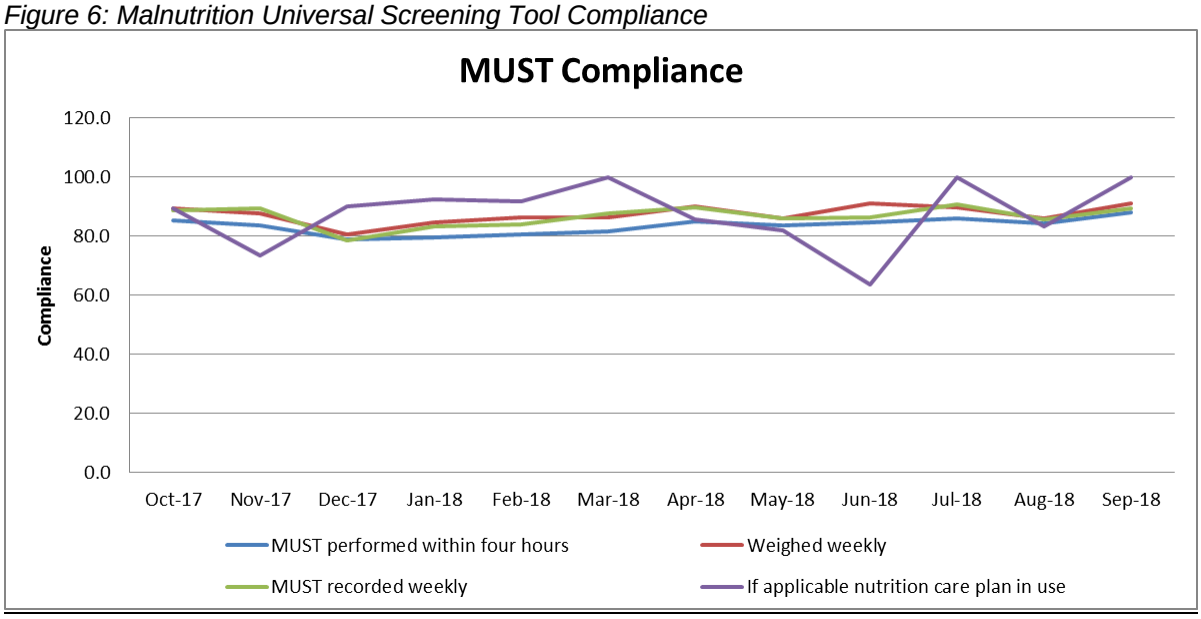
Data on MUST is captured via the Nursing Metrics database, which involves every adult ward screening 10 sets of notes each month. The analysis below is based on the review of 3792 sets of notes.

Over the past 12 months the trend for MUST performed within four hours, patient being weighed weekly and MUST recorded weekly have all been increasing (see Table 4 and Figure 6).

Table 4: Malnutrition Universal Screening Tool Compliance

Month	MUST performed within four hours	Weighed weekly	MUST recorded weekly	If applicable nutrition care plan in use
Oct-17	85.4	89.5	88.7	89.5
Nov-17	83.6	87.7	89.4	73.3
Dec-17	78.8	80.6	78.5	90.0
Jan-18	79.4	84.5	83.3	92.3
Feb-18	80.6	86.3	83.9	91.7
Mar-18	81.4	86.2	87.7	100.0
Apr-18	85.1	89.9	89.7	85.7
May-18	83.7	85.8	86.0	81.8
Jun-18	84.8	91.2	86.3	63.6
Jul-18	85.9	89.7	90.8	100.0
Aug-18	84.4	86.1	85.5	83.3
Sep-18	87.9	91.2	89.2	100.0
Total	83.4	87.4	86.6	86.0

Figure 6: Malnutrition Universal Screening Tool Compliance



5. PATIENT EXPERIENCE

5.1 PALS and Complaints

5.1.1 The Trust received an average of 143 formal concerns per month during July to September 2018/19..

5.1.2 1342 concerns were received by the Trust during July to September 2018/19 (PALs and Complaints Team).

5.1.3 Of these, 1318 concerns were resolved locally and 24 required a written response from the Medical Director or Nurse Director. During this period 98% of informal concerns were resolved within 25 working days and 73% of formal concerns were closed within 25 working days..

5.1.4 Currently the Trust has 12 formal concerns remaining open over six months.

5.1.5 The Trust currently has 5 complaints at second stage review by the Parliamentary and Health Service Ombudsman.

5.1.6 60 formal concerns citing the poor attitude of staff were reported during June - August 2018/19.

5.2 Friends and Family Test (FFT)

Patients who access hospital services are asked whether they would recommend the Trust to their friends or family if they needed similar treatment. Patients who access inpatient, outpatient, day-case, A&E and maternity are all offered the opportunity to respond to this question.

Table 4: Friends and Family Test

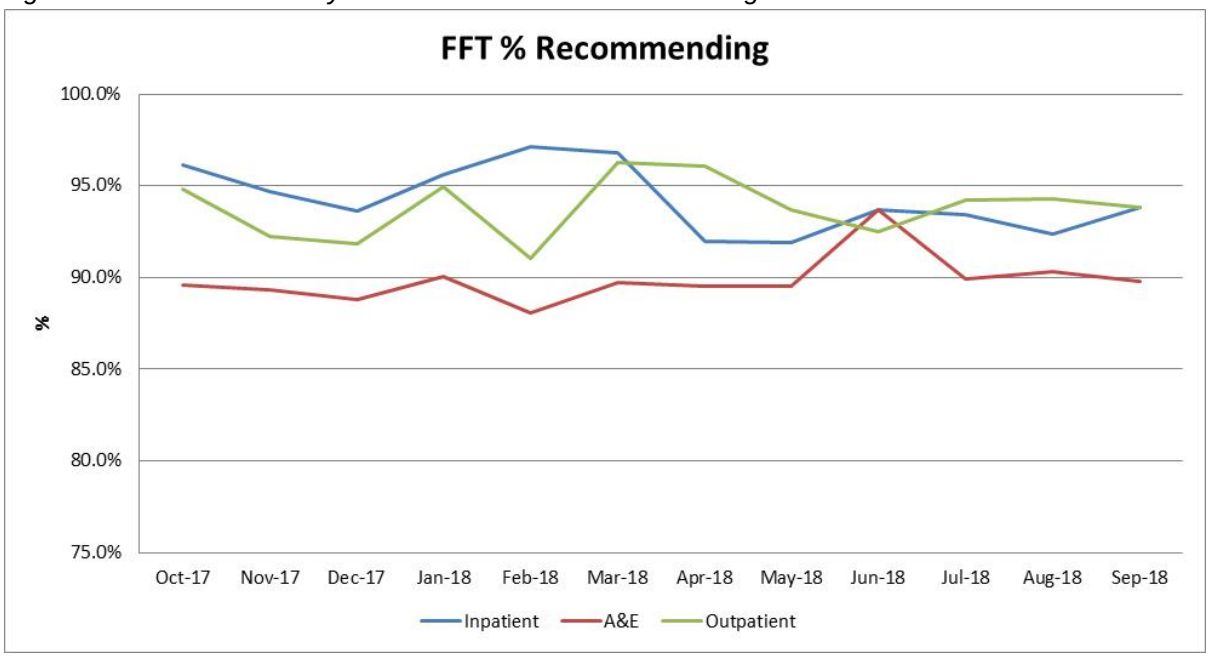
	Percentage recommending BSUH August 18	Response Rate July 18
Inpatient care	94%	29%
A&E	90%	20%
Maternity	96%	N/A
Outpatient	95%	N/A

Friends and Family Test Response Rates:

5.2.1 Since April 2018 the collection of the Trusts Friends and Family data has been managed by Healthcare Communications. There has been a decrease in the percentage of inpatients recommending, however this is anticipated due to the increase in numbers of patients now being surveyed and the change in survey methods.

5.2.2 Since April 2018 the collection of the Trusts Friends and Family data has been managed by Healthcare Communications. There has been a decrease in the percentage of inpatients recommending, however this is anticipated due to the increase in numbers of patients now being surveyed and the change in survey methods.

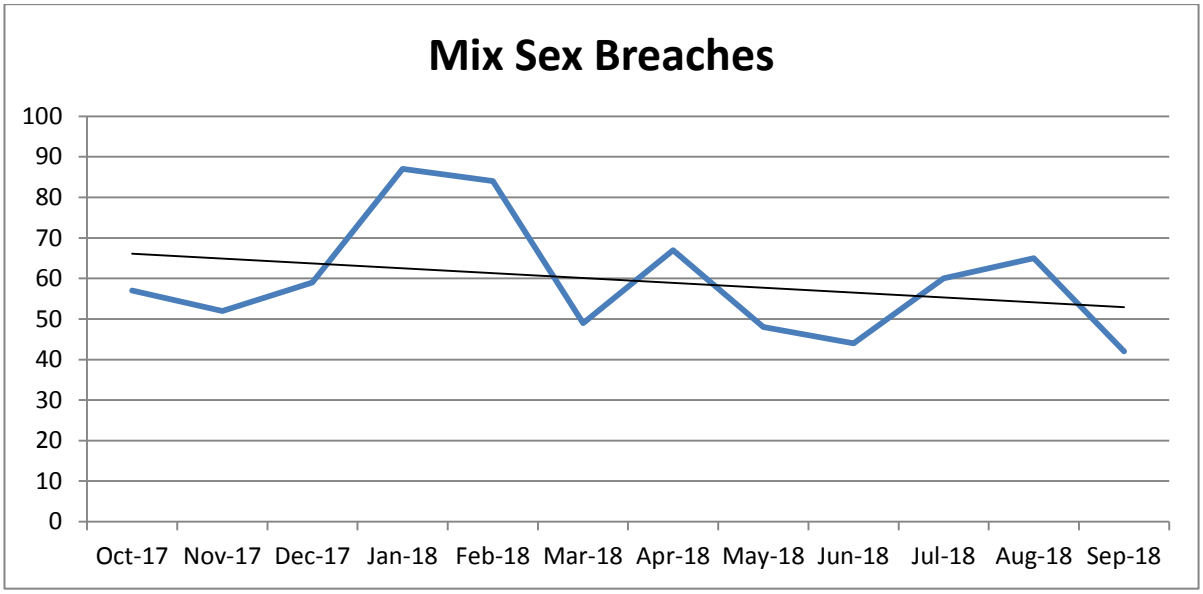
Figure 7: Friends and Family Test % of Patients Recommending



5.2.3 Mixed Sex

5.4.1 In September 42 mixed sex accommodation breaches were reported over the past 12 months the linear trend line has been decreasing. The Trust is part of the NHS mix sex collaborative and was visited by NHSi on 23rd August 2018. The first collaborative meeting was on 10th September.

5.4.1 Key areas that persistently mix are critical care neurosurgery and cardiac surgery, in September the instances of reportable mixed sex breaches were almost exclusively in cardiac, with 5 in trauma and orthopedics and 4 in neurosurgery.



6. RECOMMENDATION

6.1 The Board is asked to note the contents of this report.

QUALITY SCORECARD

	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	2018/19 YTD	2018/19 Target	Trend
MORTALITY																					
Crude Mortality - Non Elective	2.9%	3.0%	2.7%	2.5%	3.0%	2.6%	3.2%	3.6%	4.1%	3.6%	4.7%	3.7%	3.2%	3.2%	2.6%	3.1%	2.8%	2.8%	3.3%		
Crude Mortality - Non Elective - Rolling 12m	3.4%	3.4%	3.4%	3.4%	3.4%	3.4%	3.3%	3.3%	3.3%	3.2%	3.3%	3.3%	3.3%	3.3%	3.3%	3.3%	3.4%	3.4%	3.4%		
HSMR	98.24	98.04	97.86	80.89	100.59	90.11	104.1	98.64	109.69	93.55	116.41	107.5	106.33	93.66	81.67					94	
SHMI	91	91	94.38	84.01	90.58	82.6	94.5	96.18	112.58											94	
MATERNITY CARE																					
C Section Rate	33.3%	32.5%	30.1%	29.8%	29.1%	28.9%	29.8%	27.1%	28.2%	32.9%	30.7%	32.5%	31.9%	29.1%	31.6%	32.3%	30.4%	27.7%		26%	
% Mothers requiring forceps for delivery	4.6%	6.7%	5.6%	7.6%	6.2%	5.9%	8.8%	6.6%	5.9%	5.3%	8.4%	6.1%	6.2%	7.8%	7.7%	7.3%	7.9%	7.4%		15%	
% Deliveries complicated by post-partum haemorrhage	0.5%	0.6%	1.2%	1.0%	0.6%	1.1%	0.2%	0.5%	0.5%	0.0%	0.0%	0.4%	0.7%	1.2%	1.5%	0.2%	0.7%	0.5%		1%	
Maternal deaths	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	
Admission of term babies to neonatal care	5.2%	3.0%	4.0%	5.3%	4.0%	5.2%	4.7%	4.9%	3.0%	4.4%	7.6%	3.1%	5.9%	6.2%	5.0%	3.9%	5.6%			4%	
CARE OF THE ELDERLY PATIENT																					
% Emergency admissions staying over 72h screened for dementia	91.9%	93.8%	90.0%	92.6%	96.3%	95.3%	90.4%	93.1%	94.8%	91.1%	94.4%	81.4%	90.6%	88.8%	74.3%	91.7%	85.1%			90.0%	
% Patients identified as at risk of dementia for whom further investigations are	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%			90.0%	
% Patients with identified dementia referred to specialist services	93.3%	86.7%	95.0%	91.7%	82.6%	92.9%	90.9%	88.2%	89.7%	100.0%	88.9%	94.7%	97.1%	93.8%	92.0%	92.0%	88.4%			90.0%	
STROKE CARE																					
% CT Scans undertaken within 24 hours	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%				
% of Stroke patients admitted to stroke unit within 4 hours of admission	56.7%	70.2%	72.3%	68.3%	60.0%	67.2%	64.3%	61.7%	54.5%	56.6%	47.8%	56.7%	59.5%	68.3%	88.7%	78.0%	79.2%			90%	
% High risk TIA patients seen within 24 hours	85.0%	75.0%	94.4%	73.3%	71.4%	90.6%	69.2%	75.9%	73.7%	80.0%	71.4%	63.2%	56.3%	89.5%	58.6%	62.5%	73.7%	83.3%		60%	
PROMS																					
Hip Replacement - EQ5D													0.457								Data for 17/18 - Published August 2018
Hip Replacement - Oxford Hip Score													22.501								
Knee Replacement - EQ5D													0.334								
Knee Replacement - Oxford Knee Score													16.249								
SEVEN DAY SERVICE AUDIT																					
Clinical Standard 2 : Time to 1st Consultant Review									90%												Latest data available - collected Sept 17, published Dec 17
Clinical Standard 8 : Ongoing consultant review									100%												
Standard 5 : Access to Diagnostic Tests									100%												
Standard 6 : Access to Consultant directed interventions									100%												
DATA QUALITY																					
NHS IC Data validity summary	98	98	98.1	98.1	98.1	98.1	98.1	98.2	98.2	98.2	98.2	98.3	98.2	98.2	98.2	98.2	97.9				
SAFER STAFFING																					
Fill Rate - Day - RN/MW	92.1%	92.4%	91.7%	90.4%	90.5%	90.2%	91.1%	91.5%	90.1%	89.9%	89.4%	87.4%	92.7%	92.5%	90.5%	90.6%	90.1%			95.0%	
Fill Rate - Night - RN/MW	93.2%	92.6%	92.5%	91.8%	92.0%	92.3%	93.6%	93.3%	93.1%	93.2%	90.3%	92.5%	93.7%	95.2%	93.8%	92.8%	91.2%			95.0%	
Fill Rate - Day - Care Staff	96.6%	95.5%	95.5%	95.1%	94.4%	95.3%	94.6%	96.1%	96.1%	96.7%	99.8%	97.1%	96.8%	97.6%	100.5%	101.9%	102.6%			95.0%	
Fill Rate - Night - Care Staff	110.6%	112.9%	111.7%	112.1%	113.5%	112.0%	114.4%	116.0%	113.0%	114.7%	113.6%	117.1%	113.1%	112.8%	112.6%	117.0%	115.6%			95.0%	
Care Hours per Patient Day																					
% Statutory and Mandatory Training Compliance (STAM) (11 Subjects Only)										82.8%	82.3%	82.1%	83.4%	82.6%	83.3%	84.0%	90.6%				
INCIDENTS																					
Total Incidents																					
Total Serious Incidents	4	4	2	2	4	3	5	5	6	5	9	8	4	5	3	2	2	1			
Total Moderate / Severe Incidents																					
Never Events	0	0	1	0	0	0	1	0	1	0	0	1	0	0	0	1	0	0			
INFECTION CONTROL																					

MRSA	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	
C-Diff	1	3	3	9	4	5	4	9	3	7	3	5	0	7	3	4	8	6	
C-Diff with lapse in Care																			
MSSA	1	3	2	3	2	2	4	2	3	5	1	4	2	1	2	2	3	2	
E-Coli						5	2	7	4	6	6	4	5	2	2	1	5	5	
THEATRE SAFETY																			
WHO Checklist compliance - sign in													98.2	98.5	97.3	100.0	97.3	97.1	
WHO Checklist compliance - time out													100.0	98.5	98.6	100.0	93.2	100.0	
WHO Checklist compliance - sign out													98.2	90.8	94.5	96.4	95.9	100.0	
FALLS																			
Total Falls resulting in Harm	1	1	0	0	1	3	2	3	2	5	2	1	2	3	3	2	0	0	
Falls assessment in 24hrs																			
PRESURE ULCERS																			
Grade 2	18	12	16	10	17	14	17	12	18	13	15	22	21	28	16	31	37	19	
Grade 3 &4	0	0	0	1	0	2	0	0	0	2	0	0	1	2	0	1	2	1	
FRIENDS AND FAMILY TEST																			
Recommend Rate - Inpatients	96.7%	96.9%	95.4%	95.0%	96.2%	94.4%	96.2%	94.7%	93.6%	95.6%	97.1%	96.8%	92.0%	91.9%	93.7%	93.4%	92.3%	93.9%	95%
Recommend Rate - A&E	88.7%	89.4%	87.6%	86.7%	86.2%	89.4%	89.6%	89.3%	88.8%	90.0%	88.1%	87.9%	89.5%	89.0%	90.5%	89.9%	90.3%	89.8%	93%
Recommend Rate - Maternity - Antenatal Care	100.0%	100.0%	100.0%	N/A	100.0%	83.3%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	N/A	100.0%	100.0%	100.0%	100.0%	95%
Recommend Rate - Maternity - Delivery Care	96.8%	98.2%	97.1%	96.5%	98.8%	98.8%	97.8%	97.6%	98.5%	98.7%	98.7%	97.7%	96.9%	97.1%	93.8%	99.0%	97.3%	96.5%	95%
Recommend Rate - Maternity - Post Natal Ward	90.4%	94.9%	89.7%	94.9%	90.8%	96.5%	96.9%	93.9%	93.2%	92.2%	90.5%	93.8%	97.7%	96.5%	91.4%	95.3%	94.3%	93.7%	95%
Recommend Rate - Maternity - Post Natal Community	80.0%	96.5%	96.6%	91.3%	94.0%	85.7%	96.0%	90.3%	92.3%	96.9%	89.7%	93.5%	96.0%	92.3%	94.2%	91.2%	97.8%	88.6%	95%
Recommend Rate - Outpatients	93.8%	93.6%	88.8%	86.4%	98.3%	94.8%	92.2%	91.8%	94.9%	91.0%	96.3%	96.1%	93.7%	92.5%	94.2%	94.3%	93.8%	94.6%	95%
FRIENDS AND FAMILY TEST RESPONSE RATES																			
Response Rate - Inpatients	7.9%	12.1%	13.4%	11.1%	11.6%	13.4%	10.9%	14.8%	11.5%	12.6%	8.9%	11.1%	30.2%	51.6%	38.8%	25.8%	25.9%	27.8%	22.0%
Response Rate - A&E	18.1%	19.1%	19.6%	16.2%	16.9%	17.7%	16.3%	21.5%	20.2%	18.5%	17.3%	20.5%	21.5%	19.5%	18.3%	19.8%	19.7%	21.3%	22.0%
Response Rate - Delivery Care				17.3%	17.6%	18.0%	20.0%	19.6%	15.3%	16.0%	22.8%	20.4%	21.9%	25.0%	20.5%	21.9%	18.6%	21.1%	22.0%
ADVERSE EXPERIENCE																			
Clinic Cancellations <6 weeks notice	694	654	703	638	694	522	867	783	596	668	785	813	973	920	702	770	699	526	
National Cleanliness Score																			
STAFF EXPERIENCE																			
Data from Pulse Survey - Total Responses												4204	4622	3800	4483	2815	1991	1636	
% of Staff that believe Care is Top Priority of Organisation												70.0%	70.8%	69.3%	72.8%	72.9%	80.8%	78.2%	
% of Staff that would recommend BSUH to friends and family as a place for treatment												71.2%	74.4%	69.4%	75.2%	71.9%	74.4%	67.9%	
Appraisal Rate	82.8%	81.3%	80.9%	80.2%	77.7%	76.2%	76.1%	75.9%	77.0%	74.3%	71.7%	72.3%	77.1%	80.6%	83.7%	85.4%	90.1%	90.2%	90%
OTHER SAFETY METRICS																			
VTE Assessment Compliance	92.8%	92.8%	92.8%	93.3%	93.7%	93.6%	93.2%	92.9%	93.0%	93.0%	92.5%	92.6%	92.7%	93.3%	93.1%				95%
MET Call Rate per 1000 Beddays	4.72	3.70	3.40	2.94	5.12	3.23	4.53	3.60	5.26	3.67	4.59	4.41	4.41	4.34	3.62	5.15	3.11	4.09	

Brighton and Sussex University Hospitals NHS Trust

To: Board of Directors

Date of Meeting: 24th October 2018 Agenda Item: **7**

Title
Month 06, 2018-19 Performance Report
Responsible Executive Director
Pete Landstrom, Chief Delivery & Strategy Officer
Prepared by
Giles Frost, Interim Director of Performance and Information
Status
Disclosable
Summary of Proposal
The paper sets out the organisational compliance against national and local key performance metrics. The report summarises in year performance for Brighton & Sussex University Hospitals Trust, as detailed in the dedicated performance scorecard relating the NHSI Single Oversight Framework, National Constitutional Targets, and other relevant operational indicators.
Implications for Quality of Care
Describes Quality Outcome KPIs
Link to Strategic Objectives/Board Assurance Framework
Compliance with National NHS Constitutional Standards and Trust True North Objectives
Financial Implications
Describes Operational KPIs which impact on Financial Sustainability and Efficiency
Human Resource Implications
Describes Operational KPIs which impact on Workforce
Recommendation
The Board is asked to: NOTE the Trust position against the NHS National Constitutional Standards
Communication and Consultation
Not applicable
Appendices
(1) Operational Performance Scorecard

Brighton and Sussex University Hospitals NHS Trust

PERFORMANCE REPORT: MONTH 06, 2018/19

1. INTRODUCTION

1.1 This report summarises the current in year performance for Brighton & Sussex University Hospitals NHS Trust, with further detail provided in the Operational Performance Scorecard. This paper provides the Board with an update on performance on a specific basis against the NHS National Constitutional Standards.

2. SUMMARY PERFORMANCE

2.1. The Trust saw continued emergency demand pressures in September but an improvement in emergency performance despite continued bed constraints. Flow was particularly challenged at the Royal Sussex County main site.

2.2. Key operational indicators during September to note:

- 14,658 A&E attendances compared to 13,055 in September 2017 (an increase of +12.3%). Excluding A&E planned attendances and ambulatory care activity, new A&E attendances were 14,087 in September 2018 compared to 13,015 in September 2017 (an increase of +8.2%).
- 4,201 non-elective spells compared to 4,579 in September 2017 (-8.3% decrease in activity).
- Formally reportable Delayed Transfers of Care decreased to 5.7% on average in September from 6.4% August 2018.
- Average length of stay for patients increased to 5.3 days for non-elective medicine in September 2018, compared to 4.6 days in September 2017. Non-elective surgery remained static at 5.4 days September 2018, compared with 5.4 days September 2017
- Average Inpatient Bed Occupancy Trust wide was 96.4% September which peaked at 96.5% week ending 16th September. Occupancy each morning at 9am at the Royal Sussex County was on average 99.4% in September.

3. KEY AREAS OF PERFORMANCE

3.1. A&E Compliance

3.1.1. In 2018/19 as part of the national planning guidance the BSUH system has submitted an agreed recovery trajectory for A&E. This is a system level plan and includes the four Emergency Departments within the Trust, the Walk-in Centre in Brighton Station, and BSUH system patients who are treated by the Lewes Victoria and Uckfield Hospital Minor Injury Units.

3.1.2. In September the BSUH system was non-compliant against the National four hour standard overall, with 85.6% of patients waiting less than four hours from arrival at A&E to admission, transfer, or discharge. This is an improvement for the system of +1.9% from 83.7% the previous month. This level of performance was below the agreed improvement trajectory of 90.2% with NHSI and NHSE as part of the 2018/19 planning.

3.1.3. There were zero patients who waited longer than 12 hours in the ED departments from the decision to admit in September.

3.1.4. The Trust performance is an aggregate of the Royal Sussex County Hospital Emergency Department, the Princess Royal Hospital Emergency Department, the Children's Emergency Department at the Royal Alexandra Children's Hospital, and the Emergency Eye Department at the Sussex Eye Hospital. The overall performance on a site by site basis in September 2018 is outlined below:

Site	Total Patient Attendances (excluding FUP patients)	Total Patients Waiting > 4 Hours	% Patients <4 Hour
Royal Sussex County Hospital	7236	2100	71.0%
Princess Royal Hospital	3439	314	90.9%
Royal Alexandra Children's Hospital	2249	11	99.5%
Sussex Eye Hospital	1163	33	97.2%
BSUH Trust	14087	2458	82.6%
Brighton Station Walk in Centre	1541	3	99.8%
Lewes Victoria and Uckfield MIUs	1520	9	99.4%
Total Trust Catchment	17148	2470	85.6%

3.1.5. Performance at RSCH saw an improvement in performance in September 2018 of +3.9% compared with August 2018.

3.1.6. Performance at PRH was 90.9%, a drop of -0.8% and remained below 95% for the second consecutive month.

3.1.7. The Royal Alex Children's Hospital and Sussex Eye Hospital continued to exceed the National 95% target.

3.1.8. Waiting for admission to an inpatient ward remained the highest single reason for patients waiting longer than 4 hours in A&E.

3.1.9. As noted last month, a series of system-wide DTOC (Delayed Transfer of Care) summits have been established to support the reduction in delays to discharge across the acute and community hospitals. Additional community beds are being commissioned to help support winter resilience and maintain emergency flow across the health economy.

3.1.10. 'Stranded' patients (all patients with a Length of Stay of greater than 7 days) have reduced by 16 patients on average as the patients formally reportable as a delayed transfer of care have started to reduce.

3.1.11. National performance worsened by 0.8% to 88.9% from 89.7% in August 2018 with 18 trusts meeting the 95% target. Board members should note these figures also include type 3 A&E attendances (such as minor injuries units). Regionally, compliance for the South of England increased to 88.1% from 87.4% in August with NHS England South Surrey & Sussex Trusts generating aggregate compliance of 87.5%.

3.2. Cancer

3.2.1. The Trust improved in all 62 day cancer treatment targets in August, with screening compliance improving to the highest level for over 12 months. The Trust's 62 day performance for August was 70.7% against the 85% constitutional standard. The Trust treated 116.0 patients for 62 days in August against a plan of 127.0, with a total of 34.0 patients breaching the 62 day GP referral standard against a target trajectory of 25.0.

3.2.2. Regional context of the 62 day performance standard for August 2018 shows BSUH being the highest performing tertiary cancer centre and 8th in the South East England Cancer Alliances:

Regional Ranking	Trust	Cancer Centre	62 Day Performance
Surrey & Sussex Cancer Alliance			
1	Frimley Health NHS FT	No	92.36%
2	Ashford & St Peters Hospitals NHS FT	No	88.44%
3	Western Sussex Hospitals NHS FT	No	81.42%
4	Queen Victoria Hospital NHS FT	No	80.39%
5	Surrey and Sussex Healthcare NHS Trust	No	79.64%
6	Brighton & Sussex University Hospitals NHS Trust	Yes	70.69%
7	Royal Surrey County Hospital NHS FT	Yes	66.28%
8	East Sussex Healthcare NHS Trust	No	44.44%

Kent & Medway Cancer Alliance			
1	Dartford and Gravesham NHS Trust	No	90.80%
2	Medway NHS Foundation Trust	No	79.17%
3	Maidstone and Tunbridge Wells NHS Trust	Yes	67.67%
4	East Kent Hospitals University NHS FT	No	65.99%

3.2.3 A pan-divisional improvement project is continuing, focussing on improving Radiology turnaround times for scan and reporting for patients on a cancer pathway. The analysis phase of radiology performance is underway and has highlighted the area of focus for greatest impact to be the time between referral and appointment, which is currently limited by the booking process. Work is underway within the service to improve this element of the pathway.

3.2.4 An external review has been undertaken by an experienced cancer senior manager within the NHS who has identified several areas of improvement that have formed part of the cancer improvement programme. The focused work undertaken by the divisions in Lung and Colorectal pathways has started to deliver improvements, with the average diagnostic and treatment times in these pathways reducing.

3.2.5 Latest comparative nationally published data relating to August 2018 shows national aggregate compliance for 62 day cancer as 79.4% for treatment (target 85.0%). In August

2018, just over 70% of Trusts receiving GP referrals in England were non-compliant against this standard.

3.3. Referral to Treatment (RTT/18 Weeks)

3.3.1. In line with the Trust's Breakthrough Objective, there were 0 patients waiting more than 52 weeks for treatment as of the end of September.

3.3.2. The Trust was non-compliant against the National Constitutional Target of 92% with a reported position for the end of September of 81.7%. This is a deterioration compared to the previous month.

3.3.3. Compliance was significantly impacted by continued workforce capacity constraints particularly within Head and Neck specialties which account for the largest volumes of patient waiting longer than 18 weeks. Actions to support those specialties continue, with the use of insourcing where possible to support capacity. Further options to increase capacity are being explored by the surgical division, and the CCG and Trust are jointly developing a recovery plan to be submitted to NHSI/E in November 2018.

3.3.4. Latest published national data relates to August 2018 and shows national compliance has reduced to 87.2% from 87.8% in July. 58% of Trusts were non-compliant in August.

3.4. Diagnostic Test Waiting Times

3.4.1. The Trust compliance for September was 17.9% over 6 week waiters across all diagnostic modes, which is non-compliant against the national target, and a significant worsening in position since August (10.2%). This represents 1441 out of a total of 8065 patients.

3.4.2. There are two main causes of this deterioration. Non-obstetric ultrasound over 6 week waiters increased from 208 patients to 505 in September, whilst cardiac echocardiogram patients waiting over 6 weeks grew from 41 breaches to 234 in September.

3.4.3. Non-Obstetric ultra-sound is a significant challenge both in terms of demand and capacity (workforce) constraints. The Core Clinical Services Division and Imaging department are continuing to work closely with Brighton and Hove CCG to manage the direct access demand given the constraints on workforce both locally and nationally. The service suffered

significant short term sickness in September for the administrative booking team which reduced the booking capacity to 50%. This impacted on the amount of patients who could be booked and reduced the activity throughput by circa 20%. Where possible this was mitigated by clinical staff supporting the booking team. Due to the severe constraint, the Trust instigated a switch from telephoning patients to formal letters to offer choice. This also resulted in a one-off reduction in short term booking capacity.

3.4.4. The short term sickness has gradually abated into October, and recruitment has been successful to partially restore the administrative booking team. This plus additional work to counterbalance the shortfall in September is expected to begin to recover this modality's performance into November 2018. Further opportunities for additional demand management and capacity are also being reviewed at pace.

3.4.5. Echocardiograms remains significantly challenged. The service undertook 70 fewer echocardiograms in September. The service has 2 WTE vacancies which is severely impacting capacity. These workforce challenges are mirrored nationally with widespread staffing shortages for echocardiographers. The impact of patient choice over the summer also impacted on September capacity, with a high number of patients choosing to delay their diagnostic until September increasing the in-month demand. This was further compounded by an increase in inpatient demand echo imaging in September.

3.4.6. 1 WTE started in late September, and the directorate increased cross-cover from in-house staff to help further. Inpatient echoes are also now being undertaken on the ward where possible to provide additional physical capacity to help support recovery.

3.4.7. Endoscopy performance also worsened in September. Most of these patients require enhanced sedation which compounds delays as there are constraints in anesthetist capacity, and significant nurse endoscopist shortages. An in-sourced provider is providing additional capacity to the Trust to help mitigate this.

3.4.8. A task and finish recovery group consisting of performance and service leads for diagnostic modalities has commenced on a weekly basis to ensure visibility of the diagnostic waiting list position, oversee delivery of the action plan to the existing capacity challenges, plus undertaking detailed demand and capacity forecasting on a rolling basis in order to support recovery of performance.

3.4.9. The latest available National data for August 2018 shows aggregate compliance at 3.1%, a deterioration of 0.3% patients waiting less than 6 weeks than in July. South East Region aggregate compliance for August was 2.3%. Half of Acute Trusts were non-compliant in August 2018 against the constitutional standard.

4. RECOMMENDATION

4.1. The Board is asked to NOTE the Trust position against the National Constitutional Standards.

Pete Landstrom

Chief Delivery & Strategy Officer

21st October 2018

Brighton and Sussex NHS University Hospitals

OPERATIONAL PERFORMANCE SCORECARD

SEPTEMBER 2018

		Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	2018/19 YTD	2018/19 Target	Trend
NATIONAL AND OPERATIONAL PERFORMANCE TARGETS																			
O01	A&E : Four-hour maximum wait from arrival to admission, transfer or discharge*	81.9%	83.6%	84.3%	87.0%	86.3%	82.8%	82.6%	82.0%	83.2%	86.5%	87.7%	87.3%	88.0%	83.7%	85.6%	85.7%	95%	
O01A	A&E : 12 hour maximum wait from arrival to admission, transfer or discharge	0	7	6	0	1	50	27	19	36	5	0	0	3	0	0	8	0	
O02	Cancer: 2 week GP referral to 1st outpatient	94.8%	93.8%	95.1%	93.8%	94.1%	94.8%	94.0%	94.1%	93.4%	91.1%	93.0%	92.4%	86.0%	85.6%		89.8%	93%	
O03	Cancer: 2 week GP referral to 1st outpatient - breast symptoms	94.4%	96.1%	96.2%	97.7%	96.0%	94.0%	95.2%	95.8%	94.3%	96.7%	96.0%	96.5%	96.8%	96.6%		96.5%	93%	
O04	Cancer: 31 day second or subsequent treatment - surgery	100.0%	100.0%	100.0%	96.6%	97.3%	100.0%	97.1%	100.0%	100.0%	100.0%	100.0%	95.8%	100.0%	100.0%		99.3%	94%	
O05	Cancer: 31 day second or subsequent treatment - drug	100.0%	100.0%	100.0%	98.7%	100.0%	100.0%	98.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	98%	
	Cancer: 31 day second or subsequent treatment - radiotherapy	100.0%	98.6%	100.0%	98.5%	99.5%	100.0%	99.5%	100.0%	100.0%	100.0%	99.5%	96.8%	98.3%	99.4%		98.8%	94%	
O06	Cancer: 31 day diagnosis to treatment for all cancers	98.6%	99.2%	98.3%	99.6%	100.0%	98.3%	97.9%	100.0%	99.6%	100.0%	99.1%	98.3%	98.8%	98.7%		99.0%	96%	
O07	Cancer: 62 day referral to treatment from screening	80.0%	77.8%	78.4%	75.0%	78.4%	75.0%	74.3%	22.2%	38.7%	61.0%	37.0%	59.5%	68.4%	84.1%		61.6%	90%	
O08	Cancer: 62 day referral to treatment from hospital specialist	94.7%	85.7%	60.0%	72.7%	77.8%	76.9%	92.9%	72.7%	100.0%	88.9%	86.7%	91.7%	66.7%	83.3%		83.3%	90%	
O09	Cancer: 62 days urgent GP referral to treatment of all cancers	68.8%	81.4%	78.3%	80.3%	68.2%	80.3%	74.8%	73.0%	71.0%	78.7%	80.0%	70.9%	69.7%	70.7%		73.9%	85%	
O14	RTT - Incomplete - 92% in 18 weeks	87.0%	86.8%	86.0%	86.1%	86.3%	84.5%	84.6%	83.6%	83.1%	83.0%	83.4%	83.9%	83.8%	83.0%	81.7%	81.7%	92%	
	RTT - Incomplete - 52Week Waiters	80	84	71	59	47	49	28	28	9	5	2	2	0	1	0	0	0	
O15	RTT delivery in all specialties (Incomplete pathways)	13	12	12	13	13	14	12	13	13	13	13	13	15	15	15	15	0	
O16	Maximum 6-week wait for diagnostic procedures	0.6%	1.0%	0.7%	0.9%	1.3%	3.4%	4.3%	3.5%	6.1%	7.3%	6.4%	7.9%	7.6%	10.2%	17.87%	17.9%	<1%	
O17	Cancelled operations not re-booked within 28 days	5	7	9	5	4	11	15	14	12	2	8	4	16	6	12	48	0	
O18	Urgent operations cancelled for the second time	1	2	5	3	0	1	0	0	2	0	0	1	4	0	0	5	0	
O19	Clinics cancelled with less than 6 weeks notice for annual/study leave	38	43	32	62	57	40	37	85	74	92	87	62	58	61	63	423	-	
O20	Mixed Sex Accommodation breaches	22	21	67	57	52	59	87	84	49	67	48	44	60	65	42	326	0	
O33	Delayed transfers of care	8.3%	7.9%	8.1%	6.5%	5.1%	4.6%	4.9%	5.3%	4.8%	5.7%	5.2%	5.7%	5.3%	6.4%	5.7%	5.5%	3%	
IMPROVING CLINICAL PROCESSES																			
O23	% hip fracture repair within 36 hours	83.34%	57.50%	58.10%	81.12%	80.00%	65.72%	75.50%	85.46%	78.30%	87.00%	89.50%	88.60%	89.30%	84.40%	97.60%		90%	
O24	Patients that have spent more than 90% of their stay in hospital on a stroke unit+	85.00%	77.78%	82.76%	87.50%	85.25%	83.64%	84.91%	76.09%	80.00%	78.57%	85.00%	87.04%	87.50%	87.50%		85.25%	80%	

Brighton and Sussex NHS University Hospitals

OPERATIONAL PERFORMANCE SCORECARD

SEPTEMBER 2018

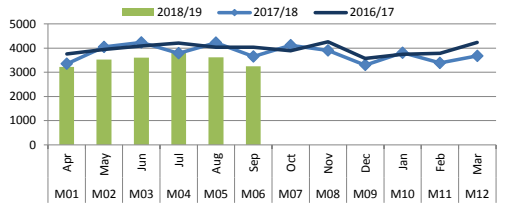
		Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	2018/19 YTD	2018/19 Target	Trend
OPERATIONAL EFFICIENCY																			
O36	Average length of stay - Elective	2.22	2.35	2.53	2.61	2.21	2.43	2.23	2.54	2.14	2.29	2.22	2.45	2.33	2.12	2.43	2.31		
O37	Average length of stay - Non-elective Surgery	4.87	5.38	5.36	4.80	4.90	5.10	5.21	6.13	5.20	5.14	5.54	5.52	4.89	5.43	5.42	5.33		
O38	Average length of stay - Non-elective Medicine	4.50	4.61	4.56	4.65	4.94	4.71	4.67	4.82	5.05	4.80	5.02	4.52	4.59	4.88	5.31	4.85		
O39	Day case rate (CQC day case basket of procedures) source: HED (reported 2-3 months in arrears)	87.2%	87.5%	86.9%	87.1%	84.9%	86.2%	85.3%	77.8%	81.6%	87.6%	87.4%	78.9%				84.9%	75.0%	
O40	Elective day of surgery rate (DOSR)	95.3%	95.1%	94.2%	95.5%	95.3%	95.2%	95.4%	93.2%	94.8%	94.9%	95.0%	94.5%	94.6%	96.3%	94.8%	95.0%	90.0%	
O41	Did not attend rate (outpatients)	6.9%	7.4%	7.3%	7.2%	7.8%	8.0%	8.2%	7.6%	8.1%	7.2%	7.4%	7.7%	7.7%	7.9%	7.8%	7.6%	6.00%	
SUSTAINABILITY																			
O43	Bank staff - % of all staff pay	5.2%	5.3%	5.8%	4.8%	5.0%	5.9%	4.9%	6.3%	5.5%	5.1%	5.5%	6.0%	5.4%	4.9%	5.3%		7%	
O44	Agency staff - % of all staff pay	3.2%	3.9%	4.3%	2.8%	3.2%	3.2%	4.0%	4.0%	4.4%	3.4%	3.5%	4.1%	4.1%	2.2%	3.1%		2%	
O46	% nurses who are registered	72.0%	71.8%	71.5%	71.8%	71.4%	71.1%	70.4%	70.5%	70.1%	69.4%	69.0%	69.1%	69.2%	69.1%	69.4%		74%	
O47	% Staff appraised	80.2%	77.7%	76.2%	76.1%	75.9%	77.0%	74.3%	71.7%	72.3%	77.1%	80.6%	83.7%	85.4%	90.1%	90.2%		85%	
O48	Sickness Absence: % Sickness(reported one month in arrears)	4.3%	4.3%	4.3%	4.2%	4.2%	4.2%	4.3%	4.2%	4.2%	4.1%	4.1%	4.1%	4.1%	4.0%			3.5%	
O49	Staff Turnover: Turnover rate (YTD position)	14.3%	14.3%	14.1%	14.2%	13.9%	13.9%	14.1%	14.3%	14.2%	14.2%	14.2%	14.1%	14.1%	14.1%	13.9%	14.1%	12%	
ACTIVITY																			
A01	Day Cases	3790	4228	3652	4122	3906	3302	3809	3385	3675	3221	3532	3612	3865	3625	3247	21102		
A02	Elective Inpatients	1299	1290	1240	1243	1305	1070	1192	1138	1268	1168	1310	1262	1221	1171	1141	7273		
A03	Non-elective inpatients	4680	4547	4579	4653	4674	4506	4727	4082	4635	4433	4521	4474	4495	4536	4201	26660		
A04	Outpatient First attendances	10169	10496	9950	10409	11282	8192	10982	9779	10387	9814	10968	11260	10899	10330	9525	62796		
A05	Outpatient Follow-up attendances	23710	24294	24133	25029	26341	19722	25891	22795	23757	22857	24127	23661	24508	23262	22557	140972		
A06	Outpatients with procedure	7362	7946	7826	7886	8580	6665	8422	7257	7828	8023	8545	7929	8349	8184	7045	48075		
A07	A&E Attendances	14037	13201	13055	13484	13698	13460	13485	12656	14516	14287	15147	15054	15894	14841	14658	89881		

Notes:

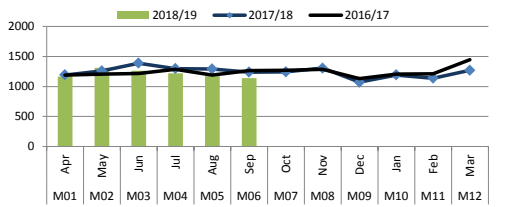
1 National reporting for these performance measures is on a quarterly basis. Data are subject to change up to the final submission deadline due to ongoing data validation and verification.
2 Data are provisional best estimates and will be amended to reflect the position signed-off in the relevant statutory returns in due course.
3 Staff sickness is reported one month in arrears.
* The Trust has included STF Footprint performance for A&E retrospectively since April 2018. This includes performance internally at the Trust, plus Brighton Station Walk In Centre, and Lews and Uckfield MIUs.

Activity Trends

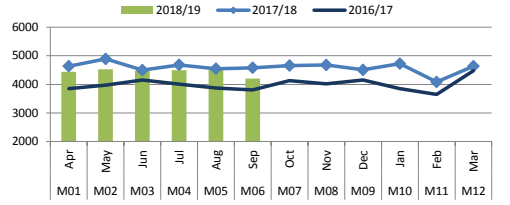
Day Cases



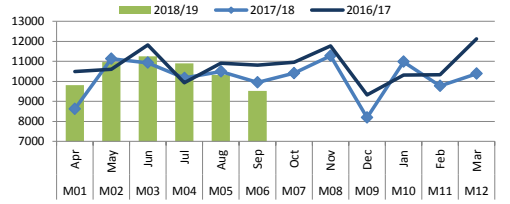
Elective Inpatients



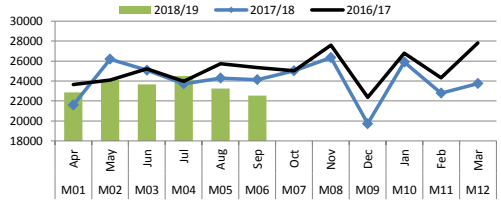
Non-elective Inpatients



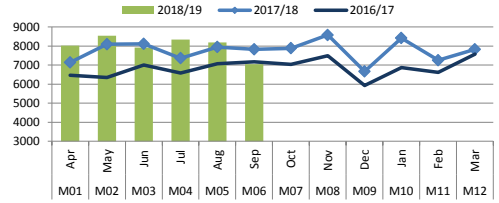
First Outpatients



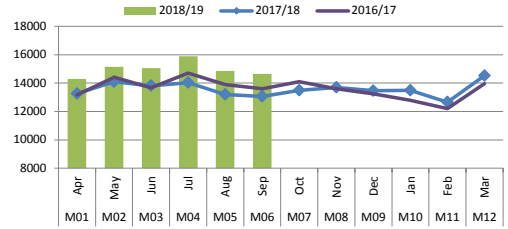
Follow-up Outpatients



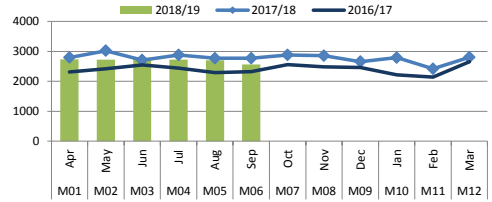
Outpatients with Procedure



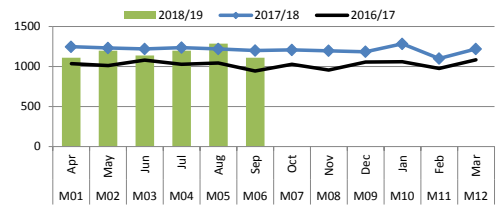
A&E Attendances



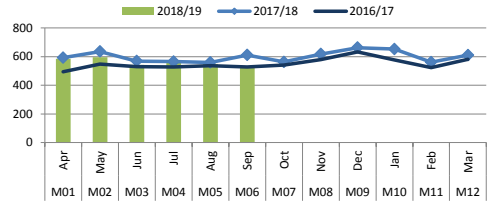
Emergency Admissions (age 0-64)



Emergency Admissions (age 65-84)



Emergency Admissions (age >85)



		M01 Apr	M02 May	M03 Jun	M04 Jul	M05 Aug	M06 Sep
Day Cases	2018/19	3221	3532	3612	3865	3625	3247
Day Cases	2017/18	3355	4050	4232	3790	4228	3652
Day Cases	2016/17	3759	3951	4096	4206	4031	4038
Day Cases	2015/16	3611	3400	3863	3865	3390	3838
Elective Inpatients	2018/19	1168	1310	1262	1221	1171	1141
Elective Inpatients	2017/18	1192	1259	1388	1299	1290	1240
Elective Inpatients	2016/17	1191	1207	1216	1284	1189	1266
Elective Inpatients	2015/16	1189	1191	1219	1329	1223	1260
Non-elective Inpatients	2018/19	4433	4521	4474	4495	4536	4201
Non-elective Inpatients	2017/18	4637	4890	4499	4680	4547	4579
Non-elective Inpatients	2016/17	3846	3977	4155	4002	3874	3800
Non-elective Inpatients	2015/16	3557	3672	3648	3857	3710	3732
First Outpatients	2018/19	9814	10968	11260	10899	10330	9525
First Outpatients	2017/18	8620	11132	10935	10169	10496	9950
First Outpatients	2016/17	10498	10612	11826	9928	10914	10811
First Outpatients	2015/16	10518	10439	12449	11735	9949	11522
Follow-up Outpatients	2018/19	22857	24127	23661	24508	23262	22557
Follow-up Outpatients	2017/18	21604	26190	25085	23710	24294	24133
Follow-up Outpatients	2016/17	23633	24089	25211	23974	25719	25335
Follow-up Outpatients	2015/16	25759	24045	28714	28587	23841	26383
Outpatients with Procedure	2018/19	8023	8545	7929	8349	8184	7045
Outpatients with Procedure	2017/18	7143	8096	8111	7362	7946	7826
Outpatients with Procedure	2016/17	6468	6355	6999	6579	7081	7175
Outpatients with Procedure	2015/16	4783	4694	5657	5576	5255	5806
A&E Attendances (age 0-64)	2018/19	14287	15147	15054	15894	14841	14658
A&E Attendances (age 0-64)	2017/18	13258	14089	13810	14037	13201	13055
A&E Attendances (age 0-64)	2016/17	13168	14407	13670	14707	13888	13599
A&E Attendances (age 0-64)	2015/16	12790	13396	13239	13868	13224	13256
A&E Attendances (age 65-8	2018/19						
A&E Attendances (age 65-8	2017/18						
A&E Attendances (age 65-8	2016/17						
A&E Attendances (age 65-8	2015/16						
A&E Attendances (age >85)	2018/19						
A&E Attendances (age >85)	2017/18						
A&E Attendances (age >85)	2016/17						
A&E Attendances (age >85)	2015/16						
Emergency Admissions (age	2018/19	2736	2723	2791	2728	2699	2563
Emergency Admissions (age	2017/18	2796	3022	2709	2878	2767	2768
Emergency Admissions (age	2016/17	2312	2418	2542	2445	2292	2327
Emergency Admissions (age	2015/16	2132	2263	2219	2314	2257	2211
Emergency Admissions (age	2018/19	1113	1201	1141	1199	1288	1112
Emergency Admissions (age	2017/18	1248	1232	1221	1237	1220	1200
Emergency Admissions (age	2016/17	1039	1012	1083	1028	1046	946
Emergency Admissions (age	2015/16	945	922	971	1018	959	1025
Emergency Admissions (age	2018/19	584	597	542	568	549	526
Emergency Admissions (age	2017/18	593	636	569	565	560	611
Emergency Admissions (age	2016/17	495	547	530	529	536	527
Emergency Admissions (age	2015/16	480	487	458	525	494	496

M07	M08	M09	M10	M11	M12
Oct	Nov	Dec	Jan	Feb	Mar
4122	3906	3302	3809	3385	3675
3895	4263	3575	3749	3790	4232
3923	3868	3545	3574	3841	3922
1243	1305	1070	1192	1138	1268
1268	1288	1129	1207	1209	1448
1377	1297	1213	1238	1233	1299
4653	4674	4506	4727	4082	4635
4129	4021	4148	3850	3643	4473
3656	3792	4112	3927	3849	4147
10409	11282	8192	10982	9779	10387
10962	11779	9325	10315	10328	12134
10559	10669	9287	9768	10946	10339
25029	26341	19722	25891	22795	23757
25025	27606	22352	26786	24337	27810
25705	26104	22941	25161	24441	24668
7886	8580	6665	8422	7257	7828
7033	7497	5927	6874	6622	7578
6225	5827	5782	6010	6472	6542
13484	13698	13460	13485	12656	14516
14093	13599	13231	12794	12209	13955
13664	13194	13230	13298	13014	14521
2882	2857	2657	2790	2420	2804
2559	2482	2458	2211	2142	2653
2169	2362	2400	2305	2285	2483
1208	1199	1186	1284	1101	1221
1029	959	1056	1061	978	1085
966	926	1134	1023	1041	1107
563	618	663	653	561	610
541	580	634	578	523	582
521	504	578	599	523	557

Brighton and Sussex University Hospitals NHS Trust

To: Meeting of the BSUH Trust Board

Date of Meeting: 24th October 2018 Agenda Item: **8**

Title
Organisational Development and Workforce Performance Board Report
Responsible Executive Director
Denise Farmer, Chief Workforce and OD Officer
Prepared by
Helen Weatherill, Director of HR
Status
Public
Summary of Proposal
This report details the Trust's performance in relation to workforce supply, development and engagement of its workforce to improve the organisations culture.
Implications for Quality of Care
There is a direct correlation between a highly engaged, performing workforce and quality of care.
Link to Strategic Objectives/Board Assurance Framework
Strategic Objective 3: People: We will value and respect all our staff equably, involve them in decisions about the services they provide and offer the training and development they need to fulfil their roles
Financial Implications
Supports effective and efficient financial performance
Human Resource Implications
As above
Recommendation
The Board is asked to: NOTE this report
Communication and Consultation
n/a
Appendices
Appendix 1: Workforce Scorecard – Month 6 2018/19

Organisational Development and Workforce Report
Month 06 2018/19 (September 2018)

1. Introduction

This paper sets out the key headlines relating to the Trust's workforce as at 30th September 2018.

2. Workforce Capacity

2.1 In September the Trust establishment stood at 8258.5 Whole Time Equivalent (WTE) whilst staff in post was 7474.4 WTE. This equates to a vacancy rate of 9.5% which is the lowest figure seen in the previous 12 month period and is sitting below the Trust target of 9.8% for this month.

Of the 748 WTE vacancies:

- 74 Medical equate to a 6% vacancy rate
- 367 Nursing equate to a 10% vacancy rate
- 110 Scientific, Technical and Therapeutic (ST&T) equate to a 9% vacancy rate
- 156 Admin & Clerical (A&C) equate to a 10% vacancy rate
- 78 Ancillary Support equate to an 11% vacancy rate

2.2 Overall at Month 6 the trust reported an underspend of £234k which further increases the Year to Date underspend to £2.2m. The biggest proportion of underspend being attributed to registered nursing (n=£182k) and admin and clerical (n=£187k). This is partially offset by Medical Workforce and Un-Registered Nursing over-expenditure. The ongoing focus of the Executive Lead Workforce Efficiency Steering Group is reducing medical spend, reducing sickness absence and turnover specifically within nursing and the un-registered workforce.

2.3 Bank spend in September was £1.66m which is now the third month spend has been below £1.7m per month. This figure is also down from 1.76 at the same time last year.

The ST&T and A&C staff groups have seen a reduction in spend over the month which is reflected by a reduction in vacancies in both of these areas over the same period. Average Bank spend is £1.67m for the 12 month period.

2.3 The Trust has an annual agency ceiling of £11.8m and is forecasting spend within the ceiling.

Agency spend has reduced £31.7k since July and stands at £97.9k for the month of September. This is the second month a reduction has been since £1.29m in July. The Nursing and ST&T staff groups have seen reductions in spend since last month; £26.3k for Nursing and £38.6k for ST&T.

The 12 month average Agency spend is £1.09m per month but over the previous 12 month period the figure has reduced from a £1.29m spend at the same point last year.

In summary, the Trust has spent £400k less across Bank and Agency staff this month than this time last year.

3. Staff Turnover

3.1 The Trust's 12 month Turnover rate (external leavers excluding Training Grade Doctors) is 13.9%. This rate is now sitting below the 12 month average of 14.1% for the first time since December 2017.

3.2 Whilst the Nursing staff group has seen a small increase over the month (13% in August to 13.3% in September) all other staffing groups have seen a reduction over the same period. The most significant of these is within Scientific, Therapeutic and Technical staff group which has seen a reduction of 1.1% over the period to 16.2% (from 17.3% in August).

3.3 The Trust has a comprehensive Leadership, Culture and Workforce Programme and improving nurse recruitment and retention is one of the key workstreams. The workstream has now be extended to cover all staff groups. A comprehensive Recruitment and Retention Strategy has been developed and is now out for consultation with relevant stakeholders.

4. Recruitment and Selection

4.1 34 International Recruitment Nurses have started with BSUH since April 18. Another 5 nurses will join us in November 2018.

4.2 The Nursing Recruitment days continue to be a success. 12 Health Care Assistants and 14 Registered Nurses were appointed at the September event.

4.3 Over the last 12 weeks the Recruitment team focused on increasing engagement via our recruitment social media platforms. The team continues to see increased engagement across our platforms and are utilising this candidate/public feedback to improve upon our candidate support services.

4.4 The Trust continues to build upon its existing Armed Forces recruitment programmes and in 2019 the team will be launching a digital platform, dedicated to any serving/ ex-armed forces individuals. This platform will not only support recruitment, but will also cover all other aspects of the Armed Forces covenant, including access to care. Due to this initiative we are being sponsored by the Armed Forces to apply for the Gold Employer recognition award and we hope to attain this for the Trust early next year. As part of this process we have built a strong working relationship with our local Field Hospitals, with the long term view of creating a programme which offers greater employment opportunities to Armed Forces Service leavers.

4.5 The Trust is also due to launch a new recruitment microsite later this year, which help inform and attract new talent to the organisation. The site will be a dedicated digital space for prospective employees to source a range of information about roles and training opportunities within the Trust.

5. Workforce Efficiency

5.1 The Trust's 12 month sickness absence rate is currently 4.03% (August 2018) and is the eighth month to have seen a month on month reduction. Average absence for the previous 12 month period is 4.17% and absence has been below this since March 2018.

5.2 Across Clinical Divisions, Children & Women has the highest level of absence within 12 months sickness (4.09%). However this area has now seen a month on month reduction in absence for the previous 8 months and overall has seen the highest reduction in absence since August 2017. The highest reduction in absence is seen within the A&C staff group from 9.67% in November 2017 to 7.5% in August 2018.

5.3 The top three recorded reasons for absence are: Stress, depression or other psychiatric at 17.4%, Cold/ Cough/ Flu & Influenza at 10.5% and Gastro-Intestinal at 8%.

Over the longer term, the 12 month trend shows that whilst the absence rate for both Cough/Cold/ Flu & Influenza and Gastro-Intestinal have remained fairly consistent, Stress/Depression or other psychiatric has seen a reduction of 1.5% since August 2017. Other musculoskeletal has also seen a reduction over the year from 9.3% in August 2017 to 7.7% in August 2018.

6. Appraisals

6.1 The Trust appraisal rate is 90.2% and at target across all the Clinical Divisions.

6.2 Regular reporting to the Divisions has ensured they have the most up to date position, with clear notification of outstanding appraisals by staff member and cost centre performance. Reporting also highlights staff with appraisals due to lapse in the current month and following 2 months. Work with the Divisions will continue to ensure appraisal rates are sustained above 90%, with any hotspot areas highlighted and plans agreed with the divisions.

7. Workforce Skills and Development

7.1 The Statutory and Mandatory (STAM) compliance rate for September 2018 has increased to 91%. This is now 1% above our target. All Clinical Divisions achieved 90%.

7.2 Frequency of reporting is now monthly as opposed to weekly. Work with the Divisions continues to ensure STAM rates are sustained above 90%, with any hotspot areas highlighted and plans agreed with the divisions.

8. Health and Wellbeing

8.1 'What's on Wellbeing' continues to be promoted in Buzz staff magazine. This raises awareness of the different elements of Wellbeing and the support available for staff. Articles for September included; combating stress at work–spotlight on the Cancer team who hold a daily mini after-action reviews after every shift, promoting 'Stoptober' – staff member's story of quitting smoking, promoting our in house smoking cessation team and promoting the healthy food changes in our staff café's and vending machines.

8.2 Health and Wellbeing Roadshows were held at PRH and RSCH. Staff came to talk to representatives from Simply Health, Fleet Solutions, Cosco, smoking cessation, the mouth care team, cycle to work, Vivup, local gyms and to hear about all the work we have done to promote Health and Wellbeing across the Trust.

8.3 Over 100 staff took part in our financial wellbeing survey. Results will be analysed and further action considered this month.

9. Equality & Diversity

9.1 Background to the Workforce Disability Standard (WDES)

Research presented to the NHS Equality and Diversity Council (EDC) in 2016 showed that disabled staff have poorer experiences in areas such as bullying and harassment and attending work when feeling ill, when compared to non-disabled staff. The EDC recommended that a Workforce Disability Standard (WDES) was introduced and added to the NHS Contract from April 2018.

The WDES will be similar to the Workforce Race Equality Standard (WRES) in that it will require organisations to take a focussed look at the outcomes for their disabled staff and where required implement changes to create a fairer, more equitable workplace for staff.

9.2 It is expected that during Autumn 2018, a matrix will be published and organisations will have until the Summer of 2019 to provide the information. The last published questions were as follows:

1. Percentage of disabled staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce.
2. Q15 Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months.
3. Q9d In the last 3 months have you ever come to work despite not feeling well enough to perform your duties?
   e) have you felt pressure from your manager to come to work?
4. Q16 Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion.
5. Q5f How satisfied are you with each of the following aspects of your job?
   f) The extent to which my organisation values my work?
6. Q20f (Appraisal): were any training, learning or development needs identified?
7. Q20g (Appraisal) Did your manager support you to receive this learning and development?
8. Q20a Did your appraisal help you improve how you did your job?
9. Q27b (Reasonable adjustment); Has your employer made adequate adjustments to enable you to carry out your work? (For reporting year)
10. Does the board meet the requirement on Board membership (referred to in the Race Equality Standard) that '*Boards are expected to be broadly representative of staff and the population they serve'*?
11. Q17 % saying they had experienced discrimination on grounds of disability.

9.3 We have a workforce of approximately 8900 staff which is broken down as follows:

- 78.6% (6995) – not disabled
- 5.9% (526) – identified as disabled
- 15.5% (1379) – either undefined or undeclared

The focus for the EDI team will be to encourage staff from the 15.5% group to confidentially inform the Trust of their disability status and encourage anyone who has a disability but has not disclosed this to do so.

9.4 The EDI team are starting a WDES Working Group and hope that this will encourage staff to become involved in helping to make BSUH more disability equitable.

9.5 The Workforce Race Equality Standard (WRES) working group continues to develop and implement the agreed action plan. This plan is being presented to the October Board as a separate paper.

10. Staff Survey

10.1 Staff survey launched on Monday 1st October 2018. Approximately 4,186 BSUH staff received their survey online via email, while 4,073 staff received paper copies. These were collected and distributed by HR and Divisional champions.

10.2 Weekly emails are sent to leaders highlighting participation rates by Division/corporate area and cost centres. Participation rates will also be published to staff via BUZZ.

10.3 Promotion of the survey has been happening throughout September via BUZZ, the Chief Executives Weekly Message, Trust brief and through posters and promotional material.

10.4 Divisional champions have been identified and the HR team is supporting divisional and satellite site events to encourage staff to complete this year's survey and raise the profile of the survey within the Trust.

10.5 Divisions launched one pagers showing 'We said, We would' in early August and are 'We said, We have' at the end of September. Buzz also featured articles highlighting the key achievements from each division.

10.6 The Trust's survey response rate with our provider in the 1st week was an encouraging 16.1%.The Trust's overall response rate target for the 2018 staff survey is more than 60%.

The Survey will run until the 30th November 2018.

11. Communications

11.1 Patient First Capability

The communications team has continued to work with the trust's leadership team to support awareness and involvement in Patient First. The aim is to ensure colleagues are aware of Patient First, believe it will support improvement and can see how they are involved. The effectiveness of the campaigns is measured by a survey on the trust's online statutory and mandatory training portal.

By 31 August 3,637 staff had been given the opportunity to take part in the survey, with 3,547 (98%) choosing to respond. The results are as follows:

2 Have you heard of Patient First?

Response	Average	Total
Yes	84%	3071
No	16%	566
Total	100%	3637/3637

3 Do you believe Patient First will help the Trust improve?

Response	Average	Total
Yes	95%	2399
No	5%	136
Total	70%	2535/3637

4 Can you see how you can contribute to improvement through Patient First?

Response	Average	Total
Yes	88%	2007
No	12%	275
Total	63%	2282/3637

Patient First continues to be promoted in a number of ways including in Buzz and bsuh.nhs.uk/patient first. Further staff drop-in sessions are planned for November/December.

11.2 **Staff Flu Vaccination Campaign**

Communications support for the annual staff flu vaccination campaign began in the final week of September.

- 27% (over 1500) of frontline staff vaccinated against flu (aim is 75%)
- In total **23%** (over 1800) of **all** BSUH staff vaccinated (including non-frontline)

Internally the campaign has been promoted via: Buzz, the Infonet, Chief Executive's Weekly Message, Trust Brief and Clinical Theme of the week. This messaging will be repeated and refreshed with updated vaccination figures detailing uptake by clinical groups and the use of staff flu fighter photos.

Externally the communications team is regularly promoting the campaign through all three BSUH social media channels (Facebook, Twitter and Instagram) and a press release was sent to all local media. The campaign was covered by the BBC on the South East Today lunchtime and evening news programme on Oct 11. Health correspondent Mark Norman filmed a staff vaccination clinic at RSCH and interviewed frontline staff including Caroline Davies, Nurse Director. The staff vaccination campaign and a second interview with Caroline Davies was the lead story on the BBC Sussex Radio Breakfast programme on Oct 12. The proactive media coverage on both TV and radio promoted positive messages of staff engagement and health messaging.

11.3 **3Ts Local Coverage**

BBC South East and ITV Meridian were invited to film on the helipad to mark the halfway point in phase 1 of the 3Ts build on Oct 9. Peter Larsen-Disney, clinical lead for 3Ts, and Dr Duncan Bootland, clinical lead for the Major Trauma Centre were both interviewed. The story aired over two days, promoting the improvements the new hospital and helipad will make to patient care and experience.

11.4 **Other Local Media Coverage**

Press releases on the roll out of free Wi-Fi across Trust sites and the Urology move to PRH were covered locally as was a release about students painting murals at The Alex.

11.5 **Proud of BSUH social media campaign**

The social media campaign #reasonstobeproud, is designed to encourage staff and the local community to share the things they are proud of. It runs across twitter, LinkedIn and Facebook and includes stories from across the organisation ranging from improvements in cardiac care to specific praise from patients and their relatives.

To date the campaign has reached more than 80, 000 people across all three social media; including 33,013 Facebook impressions and 42,310 twitter impressions. This was achieved without using paid for or supported content.

11.6 The communications team provided support for Operation Galileo, the major incident drill scenario which took place on 18 September. Support covered preparations leading up to the event in terms of informing publics and media as well as on the data itself, testing the handling procedures. Lessons learned from the exercise are being used to update the communications' protocols.

BSUH Workforce Scorecard

September 2018

Key Performance Indicators		Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	12mth position	Target	Amber	Trend
1 Workforce Capacity	*NB*																	
FTE - Budgeted		8,218.4	8,198.1	8,208.2	8,210.6	8,213.7	8,214.3	8,214.3	8,273.0	8,315.6	8,304.6	8,299.7	8,252.7	8,258.5	8,246.9			
FTE - Substantive contracted		7,285.2	7,306.7	7,356.3	7,332.8	7,352.4	7,358.9	7,372.0	7,398.9	7,407.6	7,419.6	7,494.2	7,441.6	7,474.4	7,393.0			
FTE - Substantive contracted variance from Budget		933.2	891.4	851.9	877.8	861.3	855.4	842.3	874.1	908.0	885.0	805.5	811.1	784.1	854.0			
Vacancy Factor (Substantive contracted FTE)		11.4%	10.9%	10.4%	10.7%	10.5%	10.4%	10.3%	10.6%	10.9%	10.7%	9.7%	9.8%	9.5%	10.4%	**9.8%**		
Spend - Bank as a % of total staffing		5.8%	4.8%	5.0%	5.9%	4.9%	6.3%	5.5%	5.1%	5.5%	6.0%	5.4%	4.9%	5.3%	5.4%			
Spend - Agency as a % of total staffing		4.3%	2.8%	3.2%	3.2%	4.0%	4.0%	4.4%	3.4%	3.5%	4.1%	4.1%	2.2%	3.1%	3.5%			
2 Workforce Efficiency	*NB*																	
Absence - Sickness (12 month)	1	4.3%	4.2%	4.2%	4.2%	4.2%	4.2%	4.1%	4.1%	4.1%	4.1%	4.1%	4.0%			**3.9%**		
Absence - Sickness in month		4.1%	4.3%	4.5%	4.6%	4.6%	4.1%	3.6%	3.5%	3.7%	3.7%	3.8%	3.7%		4.0%			
Absence - Maternity in month		2.4%	2.4%	2.3%	2.2%	2.2%	2.2%	2.3%	2.2%	2.2%	2.1%	2.1%	2.0%		2.2%			
Absence - Annual Leave in month		6.8%	5.7%	4.6%	7.9%	5.9%	6.6%	8.3%	6.1%	7.2%	6.0%	6.9%	8.6%		6.7%			
Absence - Special, Study & Other Leave in month		2.8%	2.8%	2.8%	2.9%	2.9%	3.0%	3.1%	3.0%	3.1%	3.1%	3.2%	3.3%		3.0%			
Absence - Total in month		16.2%	15.2%	14.1%	17.6%	15.6%	15.9%	17.2%	14.9%	16.1%	14.9%	16.0%	17.7%		16.0%			
Sickness - Short Term (< 28 days)		1.9%	2.0%	2.1%	2.1%	2.2%	1.9%	1.7%	1.7%	1.8%	1.8%	1.9%	1.8%		1.9%			
Sickness - Long Term (> 27 days)		2.2%	2.3%	2.4%	2.5%	2.5%	2.2%	1.9%	1.8%	1.9%	1.9%	2.0%	2.0%		2.1%	**2.1%**		
Sickness - Stress in month		0.8%	0.9%	0.9%	0.8%	0.6%	0.6%	0.6%	0.6%	0.6%	0.7%	0.7%	0.6%		0.7%			
Sickness - Gastro Intestinal in month		0.3%	0.3%	0.4%	0.4%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%		0.3%			
Sickness - Other Musculoskeletal in month		0.4%	0.3%	0.3%	0.2%	0.3%	0.3%	0.3%	0.3%	0.4%	0.3%	0.3%	0.3%		0.3%			
Sickness - Cough, Cold & Flu in month		0.3%	0.5%	0.5%	0.7%	1.0%	0.6%	0.4%	0.3%	0.2%	0.2%	0.1%	0.2%		0.4%			
Sickness - Back in month		0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%		0.2%			
Episodes - New sickness episodes in month		1,187	1,343	1,422	1,603	1,569	1,247	1,158	1,230	1,086	1,092	1,123	1,134		1,266			
Episodes - On-going sickness episodes in month		334	289	322	345	305	299	288	224	277	262	260	282		291			
Episodes - Total sickness episodes in month		1,521	1,632	1,744	1,948	1,874	1,546	1,446	1,454	1,363	1,354	1,383	1,416		1,557			
Triggers - 3 sickness episodes in 6 months breaches		535	564	611	676	736	747	729	709	657	597	506			589			
Triggers - 5 sickness episodes in 12 months breaches		652	615	618	593	550	546	554	552	548	552	556			528			
Triggers - Long term sickness breaches		139	143	136	102	131	116	105	110	110	111	116			110			
Triggers - Total sickness management breaches		1,326	1,322	1,365	1,371	1,417	1,409	1,388	1,371	1,315	1,260	1,178			1,227			
Triggers - Number of staff breaching one (or multiple) triggers		920	925	967	962	1,001	998	959	960	923	870	811			858			
Maternity - Number of staff on maternity leave		204	205	190	190	188	197	201	197	195	175	181	181		192			
Turnover - Trust (12 month)		14.3%	14.2%	13.9%	13.8%	14.1%	14.2%	14.2%	14.2%	14.2%	14.1%	14.1%	14.1%	13.9%	14.1%	**12.5%**		
Turnover - Medical & Dental		9.9%	9.9%	9.9%	9.8%	10.8%	10.4%	10.0%	10.4%	10.1%	9.6%	10.1%	10.4%	10.5%	10.2%			
Turnover - Nursing & Midwifery		14.5%	14.3%	13.8%	13.4%	13.5%	13.5%	13.5%	13.2%	13.0%	12.9%	13.0%	13.0%	13.3%	13.4%			
Turnover - Scientific, Therapeutic & Technical		16.1%	16.0%	15.7%	16.5%	17.2%	17.8%	17.2%	17.3%	17.8%	17.6%	17.4%	17.3%	16.2%	17.0%			
Turnover - Admin, Clerical & Estates		14.5%	14.8%	14.6%	14.4%	14.5%	14.7%	15.1%	15.4%	16.0%	15.7%	15.4%	15.4%	14.7%	15.1%			
Turnover - Support Staffing		12.7%	12.5%	12.9%	12.8%	13.1%	13.3%	13.9%	13.7%	13.2%	13.9%	14.1%	14.0%	13.7%	13.4%			
3 Training & Personal Development	*NB*																	
% of appraisals up to date (excl Medical staff)		76.2%	76.1%	75.9%	77.0%	74.3%	71.7%	72.3%	77.1%	80.6%	83.7%	85.4%	90.1%	90.2%	79.5%	**84%**		

Notes: 1 Absence data is available one month in arrears.

Brighton and Sussex University Hospitals NHS Trust

To: Trust Board

Date of Meeting: 24th October 2018 Agenda Item: **9**

Title
Finance Report on Month 6 2018/19 Position
Responsible Executive Director
Karen Geoghegan, Chief Financial Officer
Prepared by
Alan Macalister, Interim Deputy Director of Finance – Financial Management
Status
Public
Summary of Proposal
The Finance Report Month 6 2018/19 provides further detail on the in-month and year-to-date performance, and highlights key risks to delivery of the control total and mitigations. In September, the Trust incurred a deficit of £5.85m, excluding the impact of PSF; £14k better than plan. This brings the year to date deficit to £34.09m, excluding PSF; £84k better than plan.
Implications for Quality of Care
Financial planning principles have been established to ensure that expenditure budgets reflect anticipated activity levels and that agreed staffing levels are maintained.
Link to Strategic Objectives/Board Assurance Framework
Sustainability
Financial Implications
These are noted within the Finance Report on Month 6 2018/19 Position.
Human Resource Implications
N/A
Recommendation
The Trust Board is asked to NOTE: • Month 6 reported financial performance, excluding PSF is £84k ahead of plan; • the Trust has delivered the Q2 Control total excluding A&E PSF; • the position in regard to A&E PSF and the level of earnings in the current position; • the underlying performance and the key risks, and associated mitigations, to delivering the control total deficit of £55.11m.
Communication and Consultation
N/A
Appendices
1. Month 6 I&E position – subjective 2. Finance Report Month 6 2018/19

Brighton and Sussex University Hospitals NHS Trust

Report to:	Trust Board
Meeting date:	24th October 2018
Report from:	Karen Geoghegan, Chief Financial Officer
Author:	Alan Macalister, Interim Deputy Director – Financial Management
Title:	Finance Report Month 6 2018/19

Purpose

1. The purpose of this is paper is to detail the financial performance of the Trust to September 2018; highlighting income and expenditure (I&E), capital, cash management and key risks.

2. The committee is asked to note discussions are underway with NHSI regarding a clarification on the Provider Sustainability Fund (PSF) allocation for Quarter 1, associated conditions and potential financial impact are ongoing.

Executive Summary

3. In September, the Trust incurred a deficit of £5.85m, excluding PSF; £14k better than plan. This brings the year to date deficit to £34.09m, excluding PSF; £84k better than plan. This performance means that the Trust has met the gateway criterion for access to the PSF allocation and achieved the 70% attributable for delivery of the financial target year to date (£2.52m).

4. As indicated in Month 5 the Trust did not deliver the agreed A&E trajectory in September, or Q2, and as such the 30% PSF for Q2 (£618k) is excluded from the financial position.

5. The Trust delivered, and exceeded the agreed A&E trajectory for Q1 and has reported this component of PSF in the year to date position. This equates to £463k.

6. NHSI are unable to allocate the A&E component of the PSF allocation where system performance was below 90%. The Trust is challenging this position and discussions with regulators are ongoing. The year to date position assumes the Trusts challenge will be upheld; which is a risk.

7. The Trust position up to Month 6 including PSF is £31.11m deficit, reflecting £2.99m PSF earned to date. This includes the lost opportunity of £618k PSF for A&E Q2. A summary of the Month 6 and year to date performance is shown in Table 1 overleaf.

Table 1: I&E Summary and Key Financial Metrics

Values in £m	In Month			Year-to-Date		
	Plan	Actual	Variance	Plan	Actual	Variance
Income (ex PSF)	(46.43)	(45.60)	0.83	(286.92)	(282.45)	4.46
Pay	31.45	31.22	(0.23)	189.86	187.66	(2.20)
Non-pay	17.13	17.15	0.02	110.83	109.63	(1.20)
Operating Expenditure	48.58	48.37	(0.21)	300.69	297.29	(3.40)
Non-operating costs	3.17	3.11	(0.05)	18.88	18.72	(0.16)
Total Income & Expenditure	**5.31**	**5.88**	**0.57**	**32.65**	**33.56**	**0.91**
Technical adjustments	0.55	(0.03)	(0.58)	1.53	0.54	(0.99)
Net Reported Position exc PSF	**5.86**	**5.85**	**(0.01)**	**34.18**	**34.09**	**(0.08)**
PSF Income	(0.69)	(0.48)	0.21	(3.60)	(2.99)	0.62
Net Reported Position inc PSF	5.17	5.37	0.19	30.57	31.11	0.53
EBITDA	2.05	2.29	0.25	11.97	12.67	0.70
CIPs (per PMO plan)	2.52	2.58	(0.06)	12.64	12.44	0.20
Capital	14.63	8.16	6.47	63.44	35.43	28.01
Cash	0.54	(7.34)	7.88	7.28	11.37	(4.09)

8. At the end of September income is below plan by £4.46m. This includes under-performance on NHSE Income of £3.43m and £0.91m under-performance against SMSKP income. Other Operating income is below plan by £1.04m, of which £0.99m is lower than planned donated asset income. This has no impact on the achievement of the control total as donations are excluded from the calculation to determine financial performance.

9. The income shortfall is offset by underspends in operating expenditure; pay is £2.2m below plan and non-pay £1.20m lower than plan year to date.

10. The Trust's cash position of £11.37m is supported by monthly revenue deficit funding from the Department of Health (DH). The revenue loan drawdown for September was £2.3m. The year-to-date balance of revenue loans is £30.6m.

11. The cash balance remains above plan due to the receipt of STF Funding which has been retained to support future debt restructuring.

Income

12. Table 2 overleaf shows a summary of the income position for Month 6 and the year to date.

Table 2: Income Position

Values in £m	In Month			Year to Date		
	Plan	Actual	Variance	Plan	Actual	Variance
NHS Trusts Income	(0.70)	(0.79)	(0.09)	(4.22)	(4.40)	(0.18)
CCG Income	(23.98)	(24.25)	(0.27)	(146.82)	(147.20)	(0.39)
NHSE Income	(15.28)	(14.45)	0.83	(92.94)	(89.51)	3.43
SMSKP Income	(1.96)	(1.69)	0.27	(12.41)	(11.50)	0.91
Department Of Health Income	(0.47)	(0.54)	(0.07)	(2.82)	(2.88)	(0.06)
Private Patients Income	(0.43)	(0.43)	(0.01)	(2.56)	(2.36)	0.20
Injury Cost Recovery	(0.12)	(0.22)	(0.10)	(0.72)	(1.11)	(0.39)
Local Authority Income	(0.33)	(0.53)	(0.20)	(2.07)	(2.26)	(0.20)
Overseas Visitors Income	(0.02)	(0.00)	0.01	(0.10)	(0.27)	(0.17)
Other Patient Related Income	(0.18)	(0.04)	0.13	(0.88)	(0.61)	0.27
Income from Activities	(43.46)	(42.94)	0.52	(265.53)	(262.10)	3.43
Education & Training Income	(1.38)	(1.69)	(0.32)	(12.58)	(12.57)	0.01
Research & Development Income	(0.42)	(0.28)	0.15	(3.29)	(3.06)	0.23
Income Generation	(0.17)	(0.15)	0.02	(1.03)	(0.98)	0.05
Other Income	(0.99)	(0.53)	0.46	(4.50)	(3.74)	0.75
Other Operating Income	(2.97)	(2.66)	0.31	(21.39)	(20.35)	1.04
Income exc PSF	(46.43)	(45.60)	0.83	(286.92)	(282.45)	4.46
PSF Income	(0.69)	(0.48)	0.21	(3.60)	(2.99)	0.62
Total Income	(47.12)	(46.08)	1.04	(290.52)	(285.44)	5.08

NB Variances in brackets reflect overachievement of income against plan

13. In month income is £1.04m behind plan and £5.08m behind plan year-to-date. The key driver within income from activities is the performance against the plan for NHSE Specialised Commissioning activity.

14. NHSE income performance is £0.83m below plan in month; £0.91m of which relates to underperformance on PbR exclusions that has an equivalent off-set in non-pay. Activity related income performance is on plan in month; however this includes a benefit of £0.5m for Adult Critical Care relating to prior periods.

15. NHSE YTD income is behind plan by £3.43m in total. Commissioned activity under-performance totals £2.72m and is across a number of service lines including Non Elective Spells £0.6m, Neonatal £0.8m, Paediatric ITU £0.4m, Renal £0.4m and Radiotherapy £0.4m. All other service lines collectively account for £0.1m adverse to plan. PBR Exclusions are £0.86m adverse YTD and is offset in expenditure.

16. CCG contract income of £143.26m is in line with the AIC at month 6.

17. SMSKP income is behind plan in month by £0.27m (£0.91m YTD). Income will increase from October onwards as additional activity from the Western Sussex Hospitals NHS Foundation Trust commences. In addition the Trust has agreed a Memorandum of Understanding with Sussex MSK Partnership Central to increase activity volumes.

18. Education and Training income is £0.3m higher in month than plan due to a revision to undergraduate medical student numbers which has resulted in an increase above previous estimates. Other Income is behind plan YTD by £1.04m of which £0.99m relates to lower than planned Donated assets income. This reflects longer than anticipated lead in times for delivery of medical equipment approved from charitable funds.

19. PSF income is £618k lower than plan year-to-date as result of A&E performance in Q2. The table below shows the PSF profile for achieving the underlying financial position and A&E target.

	Condition	Split	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Total
			£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
1	Financial	70%	1,081	480	480	481	720	720	721	841	841	841	7,206
2	A&E	30%	463	206	206	206	309	309	309	360	360	360	3,088
	Total		**1,544**	**686**	**686**	**687**	**1,029**	**1,029**	**1,030**	**1,201**	**1,201**	**1,201**	**10,294**

Operating Expenditure

20. At the end of September operating expenditure is £3.4m less than plan comprising of underspends on pay £2.2m and non-pay £1.2m.

Pay

21. The in-month position is favourable against budget by £0.23m. Although pay is £2.2m underspent to date, the level of underspend year to date is reducing. Medical pay continues to overspend against budget and is doing so at an increasing rate, driven by spend across the surgical specialties in particular. At the end of September all the Divisions are adverse to budget by £1.52m, relating to Consultant pay. An analysis of Medical pay is being reviewed at divisional roadmap meetings to identify actions to reduce costs.

22. The level of overspend on Ancillary staff has improved following the successful recruitment of substantive staff and a reduction in temporary spend. Details of the variance to plan across all staff groups is shown in the table below;

Table 3: Pay Variances to Plan

£m	In Month			Year-to-Date		
	Plan	Actual	Variance	Plan	Actual	Variance
Medical & Dental Staff	9.01	9.27	0.26	54.82	56.33	1.52
Nursing & Midwifery	11.72	11.55	(0.17)	71.28	69.96	(1.33)
Other Healthcare Staff	4.18	4.33	0.15	25.58	25.29	(0.29)
Management	1.55	1.66	0.12	8.89	8.97	0.07
Administrative & Clerical	3.00	2.82	(0.18)	18.13	17.13	(1.00)
Ancillary Staff	1.34	1.29	(0.05)	8.12	8.23	0.11
Maintenance & Works	0.21	0.23	0.02	1.40	1.41	0.02
Other Staff	0.44	0.06	(0.38)	1.64	0.35	(1.30)
Total pay	**31.45**	**31.22**	**(0.23)**	**189.86**	**187.66**	**(2.20)**

23. Agency expenditure in September is £0.98m, in line with plan, which brings the year-to-date expenditure to £6.34m; £0.4m above the ceiling. The ceiling has reduced by £1m from 2017/18 and meeting the 2018/19 £11.8m ceiling will require further actions to reduce expenditure. Exit from use of high cost, non-framework agencies has been delivered but continued focus on recruitment and retention strategies in addition to ensuring the application of rostering best practice across the Trust is required.

Non-pay

24. At the end of September non pay budgets are underspent by £1.2m. Clinical supplies are below plan by £0.87m reflecting lower than planned activity levels. Other non-pay is underspent due to non-recurrent benefits realised in previous months totalling £0.52m.

Non-operating Costs

25. Non-operating costs are below plan at Month 6with a combined favourable variance of £0.11m reflecting lower costs of depreciation due to slippage on the capital programme.

Underlying Performance

26. The underlying YTD financial position, excluding the impact of PSF, includes £0.5m of non-recurrent benefits. The Trust is forecasting delivery of the control total, excluding PSF. Any identified risk may require non-recurrent mitigations.

Delegated Budgets

27. A series of Executive and Director led deep-dive reviews with Divisions have commenced to scrutinise financial improvement plans and forecast trajectories and will continue in Q3 and Q4.

Efficiency Programme

28. The total efficiency requirement for the year is £30m and plans equivalent to the target have been identified in full.

29. At Month 6 £12.44m of savings have been delivered against a target of £12.65m. This represents 41% achievement of the full year plan at month 6. The plan is forecast to deliver £30m in full by the end of the year. A separate more detailed Efficiency performance paper is presented to the Finance and Investment Committee.

Cash

30. The Trust has received £30.6m of revenue deficit support loans up to September to support the year to date deficit.

31. Capital funding is a combination of Public Dividend Capital (PDC) and Capital Investment Loans. The Trust carried forward unspent PDC and Loan funding from 2017/18 amounting to £8.1m. The year to date capital loans draw down remains at £2.6m and the PDC draw down to date is £14.6m.

32. The cash balance was £11.4m against a plan of £7.3m. STF funding £8.3m received in July for 17/18 has been ring-fenced, pending options for repayment of historical loans.

Capital

33. The revised strategic capital forecast for the year is reduced to £114.9m. This follows receipt of the updated cash flow forecast from the main contractor for 3Ts and reflects

the agreed timelines for the refresh of the Outline Business Case for the Pathology new build scheme.

34. Strategic capital expenditure up to the end of September amounted to £30.9m; compared to the plan of £55.3m. An Executive led review of the 3Ts works profiling, to assess forecast expenditure, has taken place. This has resulted in a forecast which defers some capital spend from 18/19 into 19/20 whilst ensuring the timescales for the completion of Stage 1 are not compromised. NHSI have been notified of the change

35. The operational capital forecast for the year is £18.1m. Expenditure up to the end of September was lower than planned due to slippage on medical equipment purchases and an agreed change in the profiling of IM&T schemes. Expenditure up to September was £4.5m compared to the plan of £8.1m

36. It is anticipated that the scheduling of capital work will accelerate as the year progresses to reduce the variance to the plan and the Trust will deliver the capital programme.

Key Risks

37. There are a number of key risks to delivery of the £55.11m control total deficit as described below, along with mitigating actions.

NHSE Specialised Commissioning Contract

38. This is a PbR based contract so the Trust will get paid for the activity it delivers; underperformance is therefore an income risk. The agreed contract does limit the Trust's 2018/19 exposure to some legacy charging issues with transitional arrangements agreed. The year to date underperformance is a significant risk to the delivery of the plan. Activity/income meetings have been, and are being, held with the clinical Divisions to explore the reasons for the underperformance and agree opportunities for improvement and/or actions to address.

39. The risk relating to the CUR CQUIN is being managed and there have been positive discussions between the Trust and NHSE with regard an alternative CQUIN; for which agreement is yet to be finalised. The Chief Nurse is in dialogue with counterparts at NHSE. The year to date position assumes full CQUIN delivery.

Provider Sustainability Funding

40. The Trust has agreed to a £10.29m PSF allocation in 2018/19. To access this funding the Trust has to deliver the underlying control total excluding PSF to earn 70% of the allocation; with the remaining 30% contingent on A&E performance.

41. The reported position as at M6 confirms delivery of the underlying control total which results in PSF income of £480k in month (£2.98m year to date). The position includes the Q1 A&E component £463k which is subject to a clarification with NHSI. Delivery of the A&E trajectory in Q2 was more challenging and therefore not met in Q2, which is reflected in the current position.

42. The Trust is having discussions with NHSI and NHSE regarding the A&E PSF earned in Q1, which is currently subject to challenge by the Trust. There is a risk this will not be upheld and therefore may not be recognised in future months.

CCG Contract

43. An Aligned Incentive Contract has been agreed with the CCGs which manages financial risk for the Trust and the wider system. In addition there was wider agreement on partnership working opportunities that require further discussion. However, this will require the Trust to manage activity and cost within the framework of an agreed income quantum.

PAS Replacement

44. The Trust's PAS system is in the process of being replaced. If the work to do this is not completed the deadline, an additional potential payment of £1.4m will have to be made to the supplier of the current system. The dataset for the new system are required to secure payment for activity from commissioners so a smooth transition is required to ensure risks to activity capture are minimised. The project is overseen by the PAS Programme Board and is currently on track.

Efficiency Programme

45. Delivery of the £30m CIP target in full; whilst the target is fully identified there are £6.2m of schemes that are rated as higher risk due to the complexity of delivery. These schemes will be subject to more development and like the rest of the programme monitored through the PMO and the executive led efficiency steering group will provide further support and challenge. Mitigations are sought to offset any under-delivery.

Capital

46. Both the operational and strategic capital programmes are behind plan as at the end of Month 6. Work is progressing to ensure schemes are delivered as planned; oversight and scrutiny to all aspects of planning, development and implementation being provided through the executive led Capital Investment Group and 3Ts Programme Board.

Conclusions and Recommendations

47. The Trust Board is asked to note that the:

- Month 6 reported financial performance, excluding PSF is £84k ahead of plan;
- the Trust has delivered the Q2 Control total excluding A&E PSF;
- the position in regard to A&E PSF and the level of earnings in the current position;
- the underlying performance and the key risks, and associated mitigations, to delivering the control total deficit of £55.11m.

Appendix 1 - I/E Report Month 6 2018/19

	In - Month			Year to Date			Forecast		
	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
NHS Trusts Income	(704)	(789)	(85)	(4,221)	(4,400)	(180)	(8,480)	(9,588)	(1,108)
CCG Income	(23,984)	(24,250)	(266)	(146,817)	(147,204)	(388)	(293,106)	(293,480)	(374)
NHSE Income	(15,281)	(14,451)	830	(92,936)	(89,506)	3,430	(185,589)	(179,472)	6,117
SMSKP Income	(1,957)	(1,690)	267	(12,409)	(11,495)	914	(24,818)	(23,268)	1,550
Department Of Health Income	(470)	(541)	(71)	(2,815)	(2,880)	(64)	(5,636)	(5,769)	(133)
Private Patients Income	(427)	(433)	(6)	(2,563)	(2,365)	198	(5,126)	(4,606)	520
Injury Cost Recovery	(120)	(216)	(96)	(719)	(1,114)	(395)	(1,436)	(2,031)	(595)
Local Authority Income	(328)	(526)	(198)	(2,068)	(2,264)	(195)	(4,099)	(4,327)	(227)
Overseas Visitors Income	(17)	(3)	13	(100)	(270)	(170)	(200)	(349)	(149)
Other Patient Related Income	(176)	(42)	134	(881)	(606)	275	(2,454)	(1,425)	1,029
Income from Activities	**(43,463)**	**(42,942)**	**521**	**(265,529)**	**(262,104)**	**3,425**	**(530,944)**	**(524,315)**	**6,629**
Education & Training Income	(1,379)	(1,694)	(315)	(12,578)	(12,571)	7	(25,142)	(24,985)	157
Research & Development Income	(424)	(277)	147	(3,289)	(3,058)	230	(5,629)	(5,263)	366
Income Generation	(171)	(154)	17	(1,026)	(978)	48	(2,052)	(2,056)	(4)
Other Income	(1,682)	(1,014)	668	(8,099)	(6,727)	1,371	(18,360)	(16,964)	1,396
Other Operating Income	**(3,656)**	**(3,138)**	**518**	**(24,991)**	**(23,335)**	**1,656**	**(51,184)**	**(49,268)**	**1,915**
TOTAL INCOME	**(47,119)**	**(46,080)**	**1,039**	**(290,520)**	**(285,438)**	**5,082**	**(582,128)**	**(573,583)**	**8,545**
Pay - Management	1,547	1,664	116	8,891	8,966	74	17,750	17,964	214
Medical and Dental Staff	9,009	9,274	265	54,816	56,334	1,518	107,985	112,289	4,304
Nursing & Midwifery - Registered	9,255	9,073	(182)	56,527	55,061	(1,466)	112,432	109,598	(2,834)
Nursing & Midwifery - Unregistered	2,470	2,479	9	14,757	14,898	141	29,493	29,084	(410)
Pay Other Healthcare	4,182	4,332	150	25,579	25,289	(290)	50,785	50,444	(341)
Ancillary Staff	1,338	1,286	(52)	8,117	8,226	109	16,212	15,583	(630)
Administrative & Clerical	3,002	2,822	(181)	18,132	17,130	(1,001)	35,848	34,291	(1,557)
Maintenance & Works	210	226	16	1,396	1,415	19	2,794	2,877	83
Pay - Other Staff	436	60	(375)	1,644	346	(1,298)	3,632	879	(2,753)
TOTAL PAY	**31,450**	**31,216**	**(234)**	**189,859**	**187,664**	**(2,195)**	**376,931**	**373,008**	**(3,924)**
Drugs - in tariff	975	921	(55)	6,077	6,275	198	11,987	12,415	428
Drugs - PbR exclusion and CDF	6,196	5,238	(957)	34,352	33,171	(1,182)	68,495	66,790	(1,705)
Supplies and Services - Clinical - in tariff	4,305	4,232	(73)	26,998	26,131	(867)	52,820	51,248	(1,572)
Supplies and Services - Clinical - PbR exclusion	665	898	234	3,979	4,706	727	7,967	9,197	1,230
Supplies and Services General	579	497	(83)	3,538	3,491	(48)	6,948	6,928	(20)
Establishment Expenses	414	365	(48)	2,496	2,299	(197)	4,975	4,618	(357)
Transport Expenses	144	177	33	878	894	15	1,746	1,715	(31)
Premises	1,667	1,952	285	10,591	10,620	29	21,066	20,377	(689)
Purchase of Healthcare from Non NHS provider	487	453	(34)	3,100	3,372	272	5,781	6,284	503
Consultancy	(13)	(44)	(31)	631	489	(142)	1,214	741	(472)
Other Non Pay	(363)	350	713	1,613	1,544	(70)	2,480	2,512	32
CNST Premium	1,938	1,921	(17)	11,630	11,523	(107)	23,261	23,050	(211)
Education and Training	(555)	(602)	(47)	1,012	901	(111)	2,020	1,685	(335)
Operating Lease Expenditure	250	338	88	1,500	1,514	14	3,004	2,936	(68)
Services from Other NHS Bodies	422	447	25	2,327	2,589	262	4,722	5,075	353
Audit Fees	10	21	11	60	65	5	121	127	6
Trust Chair & Non-Executive Directors	8	(14)	(22)	48	45	(3)	100	89	(11)
TOTAL NON-PAY	**17,129**	**17,151**	**23**	**110,831**	**109,628**	**(1,203)**	**218,706**	**215,788**	**(2,918)**
TOTAL EXPENDITURE	**48,578**	**48,367**	**(211)**	**300,690**	**297,292**	**(3,398)**	**595,638**	**588,796**	**(6,842)**
Depreciation & Impairments	1,726	1,712	(14)	10,418	10,335	(83)	31,777	31,744	(33)
Interest Payable	990	968	(22)	5,763	5,739	(24)	12,147	12,133	(14)
Interest Receivable	(2)	(18)	(16)	(12)	(62)	(50)	(24)	(74)	(50)
PDC Dividend Payable	451	451	0	2,706	2,706	0	5,592	5,592	0
TOTAL NON OPERATING INC & EXP	**3,165**	**3,113**	**(52)**	**18,875**	**18,718**	**(157)**	**49,492**	**49,395**	**(97)**
TOTAL INCOME & EXPENDITURE	**4,624**	**5,400**	**776**	**29,045**	**30,572**	**1,527**	**63,002**	**64,608**	**1,606**
Donations Inc Charitable Funds	**(590)**	**(8)**	**582**	**(1,802)**	**(816)**	**986**	**(2,595)**	**(1,609)**	**986**
Depn. On Donated Assets	**41**	**42**	**1**	**272**	**277**	**5**	**491**	**493**	**2**
Fixed Asset Impairments	**0**	**0**	**0**	**0**	**2**	**2**	**10,000**	**10,000**	**0**
NET REPORTED POSITION	**5,173**	**5,365**	**192**	**30,575**	**31,109**	**534**	**55,106**	**55,724**	**618**
PSF	**(687)**	**(480)**	**207**	**(3,603)**	**(2,985)**	**618**	**(10,294)**	**(9,676)**	**618**
NET REPORTED POSITION exc PSF	**5,860**	**5,845**	**(15)**	**34,178**	**34,094**	**(84)**	**65,400**	**65,400**	**0**
EBITDA	**2,049**	**2,294**	**245**	**11,972**	**12,670**	**698**	**16,105**	**16,822**	**717**

Finance Report Month 06 2018/19

Summary

Brighton and Sussex University Hospitals NHS Trust

Summary

A control total deficit of £55.11m has been set by the Trust in agreement with NHSI, and the year to date position excluding PSF is £0.08m favourable to plan. Including PSF the position is £0.53m behind the year-to-date deficit plan of £30.58m. The capital programme is underspent. The Efficiency and Transformation Programme has delivered £12.44m during the first six months of the financial year.

Finance and Use of Resources Risk Rating — A

YTD

	Plan	Actual / Forecast	Variance
Year-to-date	4	3	(1)
Year-end Forecast	4	3	(1)

When the plan was submitted to NHSI the Trust was in Financial Special Measures (FSM). This resulted in an overall 4 rating due to an override in the calculation for being in FSM. The risk ratings at an overall 3 are ahead of plan as result of the Trust exiting FSM and the override being no longer applicable.

Control Total (Surplus) / Deficit £k — G

	Plan	Actual / Forecast	Variance
Year-to-date exc PSF	34,178	34,094	(84)
Year-end Forecast exc PSF	65,400	65,400	0
Year-to-date	30,575	31,109	534
Year-end Forecast	55,106	55,724	618

The Trust is £0.08m favourable to the control total excluding PSF. The Trust is reporting an overspend including PSF of £0.53m compared to the YTD plan of £30,575m. The forecast is to meet the control total excluding PSF.

Agency Ceiling £k — A

	Ceiling	Actual / Forecast	Variance
Year-to-date	5,949	6,337	388
Year-end Forecast	11,783	11,771	(12)

Agency costs of £6.34m represent 3.4% of the total pay bill and are over the Month 6 agency cap of £5.95m. Agency expenditure in Month 6 was less than in previous months.

Income £k — R

	Plan	Actual / Forecast	Variance
Year-to-date	(290,520)	(285,438)	5,082
Year-end Forecast	(582,128)	(573,583)	8,545

Total income was £46.1m in-month, £1.0m below the plan increasing the year to date under-performance to £5.08m. YTD Income from activity from specialised commissioning is behind plan by £3.6m and the MSK Partnerships is down by £0.91m. PSF income is lower than plan by £0.6m due to non achievement of the A&E component for M4-6.

Operating Costs £k — G

	Plan	Actual / Forecast	Variance
Year-to-date	300,690	297,292	(3,398)
Year-end Forecast	595,638	588,796	(6,842)

Operating costs for the year are underspent against budget, primarily due to pay costs relating to vacancies. The Forecast reflects the impact of Divisional assumptions for costs and CIPs which is being refined as part of the Trusts roadmap approach to managing the delivery of the control total.

Agency Expenditure — A

Expenditure as % of total Pay bill (YTD)	2016-17	2017-18	2018-19
Medical	0.9%	1.0%	0.7%
Nursing	0.7%	1.1%	1.2%
Other staff groups	1.0%	1.3%	1.4%
All Agency	**2.6%**	**3.4%**	**3.4%**

Agency costs are in line with the total paybill compared to the same period last year, with increases in nursing and other staff groups being offset by lower medical agency, and are £0.4m above the ceiling year to date.

Cash £k — G

	Plan	Actual	Variance
Year-to-date	7,274	11,370	4,096
Year-end Forecast	3,529	3,529	(0)

The revenue deficit funding for September was £2.3m (£30.6m YTD). Further drawdowns year to date total £2.6m in capital loans and £14.6m of PDC. The year to date cash position is ahead of plan due to receipt of £8.3m prior year STF funds which has been ring-fenced, pendind options for repayment of historical loans. The year end forecast is aligned to the year-end EFL cash control total, which is slightly above the DH maximum cash holding assumed for an organisation with revenue support.

Capital £k — A

	Plan	Actual	Variance
Year-to-date	63,437	35,428	(28,009)
Year-end Forecast	155,849	133,004	(22,845)

The revised strategic capital forecast for the year is reduced to £114.9m. This follows receipt of the updated cash flow forecast from the main contractor for 3Ts and reflects the agreed timelines for the refresh of the Outline Business case for the pathology new build scheme. The operational capital forecast is to deliver the plan.

Efficiency and Transformation Programme £k — G

	Plan	Actual / Forecast	Variance
Year-to-date	12,645	12,444	(201)
Year-end Forecast	30,000	30,000	(0)

The efficiency programme has delivered the £12.444m in the year to Month 6 which is £0.201m below the internal target and £0.746m below the NHSI target. The forecast is to achieve the full plan of £30m.

Key risks include:
To deliver the underlying control total and A&E trajectory to earn the full £10.29m Provider Sustainability Funding (PSF).
CCG contract income: the Trust will need to manage activity and cost within the framework of an agreed income quantum.
NHSE Specialised Commissioning Contract: being PbR based, the Trust will need to deliver the planned level of activity to secure the level of income assumed.
Delivery of the £30m efficiency requirement in full.
PAS replacement: if this is delayed an additional payment of £1.4m has to be made to the current supplier. Also issues with the new system may prevent submission of the required activity dataset to secure income from commissioners.

Finance Report Month 06 2018/19	Finance and Use of Resources Risk Rating	R

When the plan was submitted to NHSI the Trust was in Financial Special Measures (FSM). This resulted in an overall 4 rating due to an override in the calculation for being in FSM. The risk ratings at an overall 3 are ahead of plan as result of the Trust exiting FSM and the override being no longer applicable.

Financial Rating YTD	Plan Metric	Plan Rating	Actual Metric	Actual Rating
Capital Service Capacity	(1.1)	4	(1.1)	4
Liquidity	(20.7)	4	(24.5)	4
I&E Margin	(10.70%)	4	(10.90%)	4
Distance from Financial Plan	(0.20%)			2
Agency Spend	7.95%	1	6.52%	2
2018-19 Finance Rating after overrides		4		3

Area	Metric	Construction	Rating 1 (Best)	2	3	4 (Worst)	Weighting
Financial Sustainability	Capital Service Capacity	Revenue available for capital service / Annual debt service	2.5x	1.75x	1.25x	<1.25x	20%
	Liquidity Days	Working capital balance x 30 / Annual operating expenses	0	(7.00)	(14.00)	<(14.00)	20%
Financial Efficiency	I&E Margin	I&E Surplus or deficit / Total Operating and Non Op income	5%	3%	0%	<0%	20%
Financial Controls	Distance from Financial Plan	YTD Actual I&E Surplus/Deficit - YTD Planned I&E Surplus/Deficit / YTD Planned I&E Surplus/Deficit	0%	(1)%	(2)%	≤(2)%	20%
	Agency Ceiling	YTD Actual Agency Ceiling - YTD Planned Agency Ceiling / YTD Planned Agency ceiling	0%	25%	50%	≤50%	20%

0.107416

Finance Report Month 06 2018/19 — Surplus — G

The Trust is £0.08m favourable to the control total excluding PSF. The Trust is reporting an overspend including PSF of £0.53m compared to the YTD plan of £30,575m. The forecast is to meet the control total excluding PSF.

Year to Date

	Plan £k	Actual £k	Variance £k
(Surplus)/Deficit excluding PSF	**34,178**	**34,094**	**(84)**
(Surplus)/Deficit	**30,575**	**31,109**	**534**

Year End Forecast

	Plan £k	Forecast £k	Variance £k
(Surplus)/Deficit excluding PSF	**65,400**	**65,400**	**0**
(Surplus)/Deficit	**55,106**	**55,724**	**618**

Income for the year to date is lower than budget by £5.082m. More detail is provided in the Income dashboard.

Expenditure compared to budget is underspent for the year to September 2018, mainly in the areas of pay costs. See the operating costs dashboard for more detail.

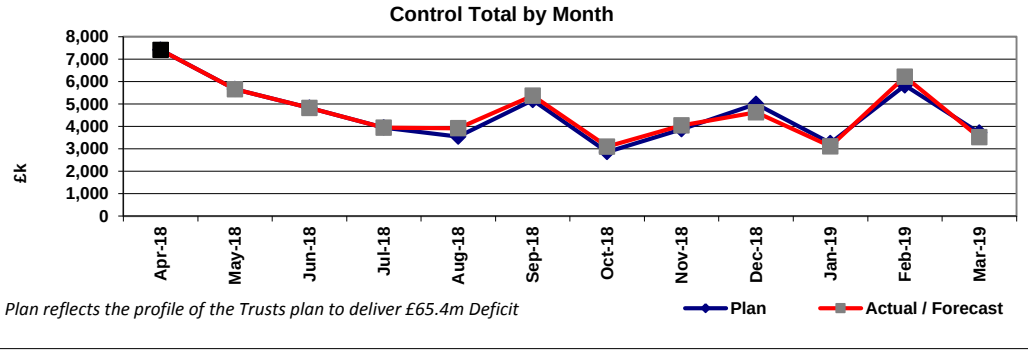
Year to Date

	PY Actual £k	Plan £k	Actual £k	Variance £k
Income	(275,271)	(290,520)	(285,438)	5,082
Pay	178,750	189,859	187,664	(2,195)
Non-Pay - in tariff	73,368	72,499	71,751	(748)
Non-Pay - PBR exclusions and CDF	37,286	38,332	37,877	(455)
EBITDA *	**14,134**	**10,170**	**11,854**	**1,684**
EBITDA %	**-5.1**	**-3.5**	**-4.2**	
Profit / Loss on Disposal of Fixed Assets	-	-	-	-
Interest Payable	4,699	5,763	5,739	(24)
Interest Receivable	(14)	(12)	(62)	(50)
Depreciation	11,287	10,418	10,333	(85)
Impairments	0	0	2	2
Public Dividend Capital	3,112	2,706	2,706	0
Net (Surplus) / Deficit	**33,218**	**29,045**	**30,572**	**1,526**
Reverse Impairment	0	0	(2)	(2)
Other Adjustments	622	1,530	539	(991)
Reverse IFRS technical charge	0	0	0	0
Performance against Control Total	**33,840**	**30,575**	**31,109**	**534**
PSF	0	(3,603)	(2,985)	618
Performance against Control Total ex PSF	**33,840**	**34,178**	**34,094**	(84)
Surplus %	**-12.3**	**-10.5**	**-10.9**	

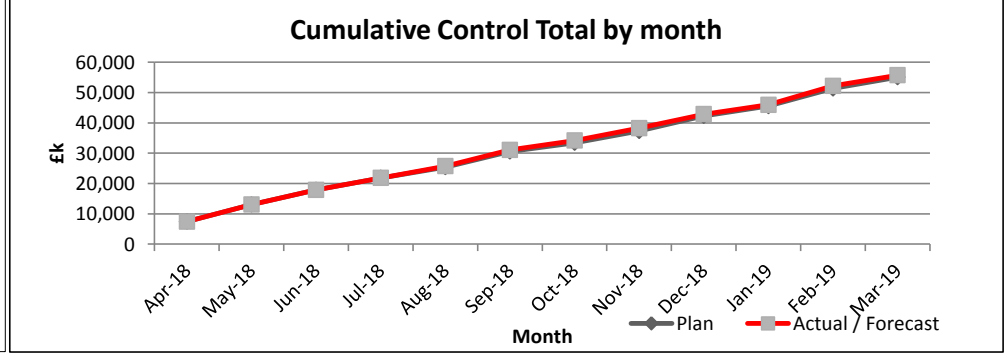
Full year

	Plan £k	Actual £k	Variance £k
Income	(582,128)	(573,583)	8,545
Pay	376,931	373,008	(3,924)
Non-Pay - in tariff	142,244	139,801	(2,444)
Non-Pay - PBR exclusions and CDF	76,462	75,988	(474)
EBITDA *	**13,510**	**15,213**	**1,703**
EBITDA %	**-2.3**	**-2.7**	
Profit / Loss on Disposal of Fixed Assets	-	-	-
Interest Payable	12,147	12,133	(14)
Interest Receivable	(24)	(74)	(50)
Depreciation	21,777	21,744	(33)
Impairments	10,000	10,000	0
Public Dividend Capital	5,592	5,592	0
Net (Surplus) / Deficit	**63,002**	**64,608**	**1,606**
Reverse Impairment	(10,000)	(10,000)	0
Other Technical Adjustments	2,104	1,116	(988)
Reverse IFRS technical charge	0	0	0
Performance against Control Total	**55,106**	**55,724**	**618**
PSF	(10,294)	(9,676)	618
Performance against Control Total ex PSF	**65,400**	**65,400**	**0**
Surplus %	**-9.5**	**-9.7**	

*** EBITDA** Earnings before Interest Taxation Depreciation and Amortisation



Plan reflects the profile of the Trusts plan to deliver £65.4m Deficit



Contract income is underperforming by £3.24m year-to-date. The underperformance relates to NHSE specialised and MSK partnership activity. The Trust has an Aligned Incentive Contract with Susses CCG's. Detailed activity plans by Specialty and point of delivery are still to be confirmed with Commissioners.

Contract Agreement 2017/18

Table 1. Total Financial Values By CCG, NHS England and Public Health

	Reported Values for September 2018			
	£'000			
	FYE Plan	YTD Plan	YTD Actual	YTD Var
Sussex CCG's	286,000	143,256	143,255	1
MSK	24,818	12,409	11,495	914
NHS England (Specialised)	168,431	84,357	80,774	3,583
NHS England (Dental & Screening)	11,658	5,829	5,618	211
Integrated Sexual Health Services	3,655	1,827	1,943	(115)
Non Contracted Activity	5,666	2,841	3,199	(359)
TOTAL COMMISSIONING INCOME	**500,228**	**250,519**	**246,284**	**4,236**

Table 3 - Reconciliation to Income Reporting

Contract Monitoring Performance -(unadjusted)	493,134	246,972	243,231	3,741
CQUIN 2.5%	10,396	5,198	5,198	0
Contract Penalties / Adjustments (Estimated)	(3,302)	(1,651)	(2,145)	494
	500,228	**250,519**	**246,284**	**4,236**
Other Income from Activities				
NHS Trust / FT Income	8,480	4,221	4,400	(180)
Commissioning Income - Non Activity	6,940	3,470	3,865	(396)
Department Of Health Income	5,636	2,815	2,880	(64)
Private Patients Income	5,126	2,563	2,365	198
Injury Cost Recovery	1,436	719	1,114	(395)
Other Patient Related (remove MSK included above)	2,454	881	606	275
Local Authority Income (remove value included above)	445	241	321	(80)
Overseas Visitors Income	200	100	270	(170)
				0
Income from Activities as reported in Income Section	**530,944**	**265,529**	**262,105**	**3,425**

Table 2. Activity and Income by Point of Delivery

	YTD Activity Volumes				YTD Income £'000			
Point of Delivery	**Plan**	**Actual**	**Var**	**%**	**Trust Plan**	**Actual**	**Var**	**%**
Daycase	25,492	21,042	4,449	-17.5%	21,448	18,429	3,019	14.1%
Elective Spells	5,726	7,253	(1,527)	26.7%	18,854	18,192	662	3.5%
Non Elective Spells	28,045	26,585	1,460	-5.2%	62,283	62,805	(522)	-0.8%
Non Elective Spells - Short Stay			0				0	
Ambulatory Care			0				0	
Elective Excess beddays	1,552	1,522	30	-2.0%	412	440	(28)	-6.8%
Non Elective excess beddays	9,544	9,648	(103)	1.1%	2,556	2,072	483	18.9%
A&E	79,070	89,881	(10,811)	13.7%	10,630	11,909	(1,279)	-12.0%
Outpatients - New	138,438	139,935	(1,497)	1.1%	10,012	10,289	(277)	-2.8%
Outpatients - Follow Up	58,495	63,200	(4,704)	8.0%	11,937	11,557	380	3.2%
Outpatient Procedures	40,811	48,688	(7,877)	19.3%	5,991	6,503	(513)	-8.6%
Outpatient Imaging	25,687	21,503	4,184	-16.3%	2,781	2,442	339	12.2%
Direct Access	1,790,204	1,841,509	(51,305)	2.9%	7,638	7,378	260	3.4%
Bowel Screening	884	2,300	(1,415)	160.1%	1,045	1,164	(119)	-11.4%
Breast Screening	0	0	0	0.0%	1,403	1,419	(16)	-1.1%
Critical Care	9,079	9,288	(209)	2.3%	17,208	16,619	589	3.4%
Maternity Pathway	5,339	5,343	(3)	0.1%	5,463	5,470	(8)	-0.1%
HIV	14,217	14,178	39	-0.3%	2,558	2,551	7	0.3%
Renal	47,793	44,207	3,586	-7.5%	6,946	6,628	318	4.6%
Other					20,039	18,864	1,175	5.9%
PbR Excluded Drugs / Devices					37,348	36,633	715	1.9%
CQUIN					5,198	5,198	0	0.0%
MRET / Readmission					(1,651)	(2,145)	494	-29.9%
AIC Contribution					424	1,868	(1,444)	-340.5%
					250,521	**246,284**	**4,236**	**1.7%**

Table 4 - Income from CCG's

	£'000		
	YTD Plan	YTD Actual	YTD Var
NHS BRIGHTON AND HOVE CCG	65,921	63,954	1,967
NHS COASTAL WEST SUSSEX CCG	7,899	8,208	(309)
NHS CRAWLEY CCG	1,599	1,681	(81)
NHS EASTBOURNE, HAILSHAM AND SEAFORD CCG	5,295	5,191	104
NHS HASTINGS AND ROTHER CCG	2,370	2,358	11
NHS HIGH WEALD LEWES HAVENS CCG	24,145	23,987	157
NHS HORSHAM AND MID SUSSEX CCG	33,936	33,943	(7)
NHS EAST SURREY	283	469	(186)
Dermatology SCDS	1,385	1,597	(212)
AIC Contribution	424	1,868	-1,444
Commissioning Income CCG's	**143,256**	**143,255**	**1**

Finance Report Month 06 2018/19 — Income — A

For the year-to-September, Income reports an underperformance of £5.08m, an deterioration of £1.04m on the previous month. The variance on income from activities has increased by £521k. As shown on the contract performance sheet activity is behind plan for day case and elective activity. In Other operating income the underperformance of £1.25m is due to lower than planned R&D and Donated income. PSF income is lower than plan by £0.6m due to not meeting the A&E target for M4-6.

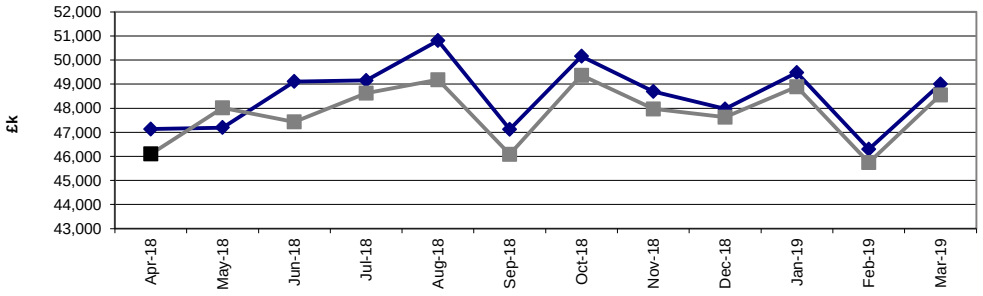
Year-to-Date

	Plan £k	Actual £k	Variance £k
Total Income	**(290,520)**	**(285,438)**	**5,082**

Activity for NHSE and for the MSK partnerships account for the underperformance on income from activity. NHSE activity is lower in critical care, neonatal and paediatric HDU as well as not delivering the expected growth in Renal and Cancer services. Research and development is behind its income target.

Year-to-Date

	PY Actual £k	Plan £k	Actual £k	Variance £k
Income				
NHS Trusts Income	(4,094)	(4,221)	(4,400)	(180)
CCG Income	(231,064)	(146,817)	(147,204)	(388)
NHSE Income	(1,750)	(92,936)	(89,506)	3,430
SMSKP Income	0	(12,409)	(11,495)	914
Department Of Health Income	(35)	(2,815)	(2,880)	(64)
Private Patients Income	(2,306)	(2,563)	(2,365)	198
Injury Cost Recovery	(678)	(719)	(1,114)	(395)
Local Authority Income	(2,506)	(2,068)	(2,264)	(195)
Overseas Visitors Income	(85)	(100)	(270)	(170)
Other Patient Related Income	(12,372)	(881)	(606)	275
Income From Activities	**(254,890)**	**(265,529)**	**(262,104)**	**3,425**
Education & Training Income	(13,538)	(12,578)	(12,571)	7
Research & Development Income	(1,815)	(3,289)	(3,058)	230
Income from Donated Reserve	0	0	0	0
Income Generation	(1,228)	(1,026)	(978)	48
Other Income	(3,800)	(4,496)	(3,742)	753
INCETI - Education & Training Income	0	0	0	0
Other Operating Income	**(20,381)**	**(21,388)**	**(20,350)**	**1,038**
TOTAL INCOME exc PSF	**(275,271)**	**(286,917)**	**(282,453)**	**4,464**
PSF	0	(3,603)	(2,985)	618
TOTAL INCOME	**(275,271)**	**(290,520)**	**(285,438)**	**5,082**
Of Which PBRX Drugs/Devices	(11,900)	(24,399)	(24,452)	(53)



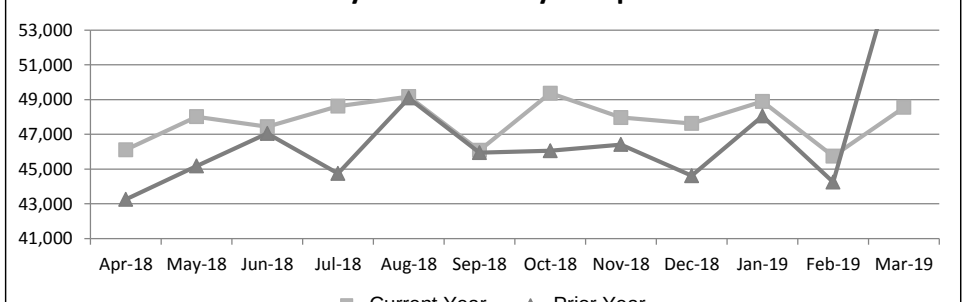
Year-end Forecast

	Plan £k	Forecast £k	Variance £k
Total Income	**(582,128)**	**(573,583)**	**8,545**

The income Forecast has been updated to reflect the on going activity under performance on the NHSE and MSK contracts. NHS Trust income is over target due to additional T&O actiivty for Western Sussex FT. Private Patient Income is behind plan. Education & Training and Research & Development are both behind plan.

Year-end Forecast

	Plan £k	Forecast £k	Variance £k
Income			
NHS Trusts Income	(8,480)	(9,588)	(1,108)
CCG Income	(293,106)	(293,480)	(374)
NHSE Income	(185,589)	(179,472)	6,117
SMSKP Income	(24,818)	(23,268)	1,550
Department Of Health Income	(5,636)	(5,769)	(133)
Private Patients Income	(5,126)	(4,606)	520
Injury Cost Recovery	(1,436)	(2,031)	(595)
Local Authority Income	(4,099)	(4,327)	(227)
Overseas Visitors Income	(200)	(349)	(149)
Other Patient Related Income	(2,454)	(1,425)	1,029
Income From Activities	**(530,944)**	**(524,315)**	**6,629**
Education & Training Income	(25,142)	(24,985)	157
Research & Development Income	(5,629)	(5,263)	366
Transfers from Donated Asset Reserve	0	0	0
Income Generation	(2,052)	(2,056)	(4)
Other Income	(8,146)	(7,368)	778
INCETI - Education & Training Income	0	0	0
Other Operating Income	**(40,970)**	**(39,672)**	**1,297**
Total Income	**(571,914)**	**(563,987)**	**7,927**
PSF	(10,214)	(9,596)	618
TOTAL INCOME	**(582,128)**	**(573,583)**	**8,545**



Finance Report Month 06 2018/19 — Operating Costs — G

Operating costs for the year are underspent against budget, primarily due to pay costs relating to vacancies. The Forecast reflects the impact of Divisional assumptions for costs and CIPs which is being refined as part of the Trusts roadmap approach to managing the delivery of the control total.

Year-to-date

	PY Actual £k	Plan £k	Actual £k	Variance £k
Pay	**178,750**	**189,859**	**187,664**	**(2,195)**
Non-pay	**110,654**	**110,831**	**109,628**	**(1,203)**
Operational Costs	**289,405**	**300,690**	**297,292**	**(3,398)**

Year-end Forecast

	Plan £k	Forecast £k	Variance £k
Pay	**376,931**	**373,008**	**(3,924)**
Non-pay	**218,706**	**215,788**	**(2,918)**
Operational Costs	**595,638**	**588,796**	**(6,842)**

Pay: costs in September were lower than in August as a result of the backdated Agenda for Change pay award in August. The Trust has 848 WTE vacancies (substantive contracted staff vs funded establishment), of which 495 are nurse vacancies. These are partly covered by bank and agency staff, which reduce the nurse vacancies to 103.

Non-pay: underspent compared to budget overall. There is an overspend showing on Purchase of healthcare from non NHS providers of £0.272m, which is due to budgets being moved to match CIPS schemes.

Year-to-date

	PY Actual £k	Plan £k	Actual £k	Variance £k
Pay				
Management	7,707	8,891	8,966	74
Medical and Dental Staff	54,483	54,816	56,334	1,518
Nursing & Midwifery - Registered	53,679	56,527	55,061	(1,466)
Nursing & Midwifery - Unregistered	13,180	14,757	14,898	141
Other Healthcare Staff	24,430	25,579	25,289	(290)
Ancillary Staff	7,120	8,117	8,226	109
Administrative & Clerical	16,434	18,132	17,130	(1,001)
Maintenance Staff	1,353	1,396	1,415	19
Other Staff	363	1,644	346	(1,298)
Total Pay	**178,750**	**189,859**	**187,664**	**(2,195)**
Non-pay				
Drugs & Medical Gases - in tariff	6,141	6,077	6,275	198
Drugs & Medical Gases - PbR exclusion and CDF	33,445	34,352	33,171	(1,182)
Supplies and Services - Clinical - in tariff	27,787	26,998	26,131	(867)
Supplies and Services - Clinical - PbR exclusion	3,842	3,979	4,706	727
Supplies and Services General	3,358	3,538	3,491	(48)
Establishment Expenses	2,246	2,496	2,299	(197)
Transport Expenses	833	878	894	15
Premises	10,868	10,591	10,620	29
Purchase of Healthcare from Non NHS provider	3,454	3,100	3,372	272
Consultancy	467	631	489	(142)
Other Non Pay/Reserves	1,682	1,613	1,544	(70)
CNST Premium	10,761	11,630	11,523	(107)
Education and Training	1,620	1,012	901	(111)
Operating Lease Expenditure	0	1,500	1,514	14
Services from Other NHS Bodies	4,048	2,327	2,589	262
Audit Fees	54	60	65	5
Trust Chair & Non-Executive Directors	50	48	45	(3)
Total Non-Pay	**110,654**	**110,831**	**109,628**	**(1,203)**
Total Expenditure	**289,405**	**300,690**	**297,292**	**(3,398)**

Full-year

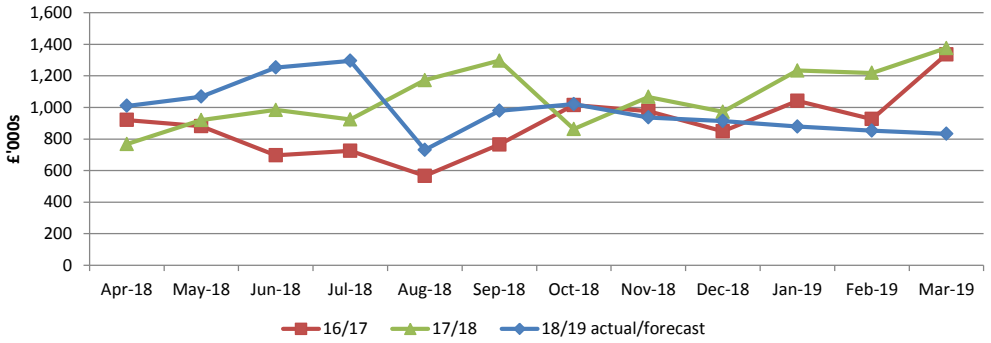
	Plan £k	Forecast £k	Variance £k
Pay			
Management	17,750	17,964	214
Medical and Dental Staff	107,985	112,289	4,304
Nursing & Midwifery - Registered	112,432	109,598	(2,834)
Nursing & Midwifery - Unregistered	29,493	29,084	(410)
Other Healthcare Staff	50,785	50,444	(341)
Ancillary Staff	16,212	15,583	(630)
Administrative & Clerical	35,848	34,291	(1,557)
Maintenance Staff	2,794	2,877	83
Other Staff	3,632	879	(2,753)
Total Pay	**376,931**	**373,008**	**(3,924)**
Non-pay			
Drugs & Medical Gases - in tariff	11,987	12,415	428
Drugs & Medical Gases - PbR exclusion and CDF	68,495	66,790	(1,705)
Supplies and Services - Clinical - in tariff	52,820	51,248	(1,572)
Supplies and Services - Clinical - PbR exclusion	7,967	9,197	1,230
Supplies and Services General	6,948	6,928	(20)
Establishment Expenses	4,975	4,618	(357)
Transport Expenses	1,746	1,715	(31)
Premises	21,066	20,377	(689)
Purchase of Healthcare from Non NHS provider	5,781	6,284	503
Consultancy	1,214	741	(472)
Other Non Pay/Reserves	2,480	2,512	32
CNST Premium	23,261	23,050	(211)
Education and Training	2,020	1,685	(335)
Operating Lease Expenditure	3,004	2,936	(68)
Services from Other NHS Bodies	4,722	5,075	353
Audit Fees	121	127	6
Trust Chair & Non-Executive Directors	100	89	(11)
Total Non-Pay	**218,706**	**215,788**	**(2,918)**
Total Expenditure	**595,638**	**588,796**	**(6,842)**

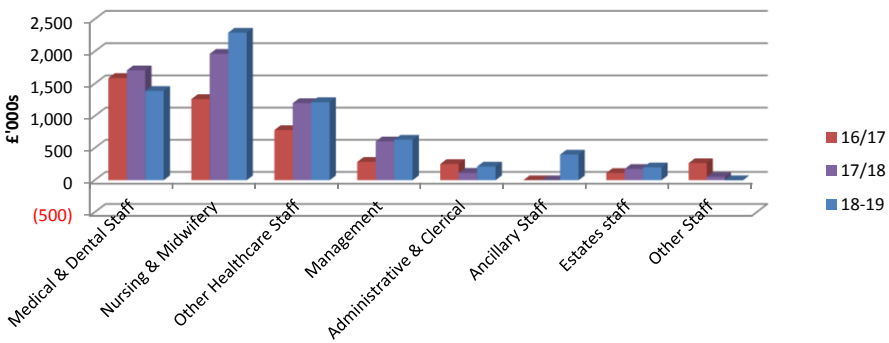
Finance Report Month 06 2018/19 — Payroll and Agency costs — G

Agency costs of £6.34m represent 3.4% of the total pay bill and are over the Month 6 agency cap of £5.95m. Agency expenditure in Month 6 was less than in previous months.

Year-to-date Agency

	16/17 £k	17/18 £k	Ceiling £k	18-19 £k	Variance £k
Medical & Dental Staff	1,589	1,708	1,556	1,389	(167)
Nursing & Midwifery	1,263	1,965	2,022	2,292	270
Other Healthcare Staff	781	1,200	1,119	1,216	97
Management	286	605	376	631	255
Administrative & Clerical	253	114	501	213	(288)
Ancillary Staff	0	0	250	400	150
Estates staff	113	177	125	199	74
Other Staff	266	52		(3)	(3)
Trust	**4,551**	**5,821**	**5,949**	**6,337**	**388**





Payroll

(Excludes non executive directors)

	Prior year actual £k	Plan £k	Actual £k	Variance £k
Medical & Dental Staff	52,776	54,499	54,945	446
Nursing & Midwifery	64,894	71,276	67,667	(3,609)
Other Healthcare Staff	23,231	25,500	24,073	(1,427)
Management	7,102	8,891	8,335	(556)
Administrative & Clerical	16,319	18,132	16,917	(1,215)
Ancillary Staff	6,876	8,025	7,826	(199)
Maintenance Staff	1,176	1,396	1,215	(181)
Other Staff	311	1,597	350	(1,247)
Trust	**172,685**	**189,316**	**181,328**	**(7,988)**

Staff in post including bank staff

	Prior year actual WTE	Plan WTE	Actual WTE	Variance WTE
Medical & Dental Staff	1,135	1,195	1,156	(39)
Nursing & Midwifery	3,414	3,557	3,454	(104)
Other Healthcare Staff	1,142	1,263	1,163	(101)
Management	196	247	213	(34)
Administrative & Clerical	1,193	1,293	1,224	(69)
Ancillary staff	594	612	599	(13)
Maintenance Staff	62	83	65	(18)
Other Staff	18	16	16	(0)
Trust	**7,754**	**8,267**	**7,890**	**(377)**

Finance Report Month 06 2018/19 — Statement of Financial Position

The Trust Statement of Financial position is produced on a monthly basis and reflects changes in asset values as well as movement in liabilities. The plan is the NHSI plan submitted in July 2018.

	1 April 18	Year-to-Date				Full-Year			
	Actual	Plan	Actual	Variance	Notes	Plan	Forecast	Variance	Notes
	£k	£k	£k	£k		£k	£k	£k	
Property, Plant and Equipment (PPE)	422,387	475,497	447,403	(28,094)	1	547,137	524,292	(22,845)	
Intangible Assets	550	459	549	90		372	372	0	
Other Assets	4,784	4,596	4,116	(480)		4,487	4,487	0	
Non Current Assets	**427,721**	**480,552**	**452,068**	**(28,484)**		**551,996**	**529,151**	**(22,845)**	
Inventories	8,788	9,196	8,978	(218)		8,360	8,360	0	
Trade and Other Receivables	48,625	45,975	48,305	2,330	2	50,901	50,901	0	
Cash and Cash Equivalents	15,872	7,275	11,370	4,095		3,529	3,529	0	
Non Current Assets Held for Sale	0	0	0	0		0	0	0	
Current Assets	**73,285**	**62,446**	**68,653**	**6,207**		**62,790**	**62,790**	**0**	
Trade and Other Payables	(68,117)	(60,854)	(73,931)	(13,077)	2	(67,301)	(67,301)	0	
Borrowings	(24,583)	(24,583)	(24,583)	0	3	(7,379)	(7,379)	0	
Other Financial Liabilities	0	0	0	0		0	0	0	
Provisions	(1,725)	(1,527)	(968)	559		(807)	(807)	0	
Other Liabilities	0	0	0	0		0	0	0	
Current Liabilities	**(94,425)**	**(86,964)**	**(99,482)**	**(12,518)**		**(75,487)**	**(75,487)**	**0**	
Borrowings	(242,341)	(283,575)	(272,953)	10,622	3	(342,020)	(331,974)	10,046	
Trade and Other Payables	(10)	(27)	(15)	12		(33)	(33)	0	
Provisions	(2,030)	(2,038)	(2,007)	31		(2,062)	(2,062)	0	
TOTAL ASSETS EMPLOYED	**162,200**	**170,394**	**146,264**	**(24,130)**		**195,184**	**182,385**	**(12,799)**	
Financed by:									
Public Dividend Capital	337,972	375,214	352,608	(22,606)	4	433,958	421,159	(12,799)	
Retained Earnings	(229,577)	(229,577)	(229,577)	0		(229,577)	(229,577)	0	
Surplus/(Deficit) for Year	0	(29,048)	(30,572)	(1,524)		(63,002)	(63,002)	0	
Revaluation Reserve	53,805	53,805	53,805	0		53,805	53,805	0	
TOTAL TAXPAYERS EQUITY	**162,200**	**170,394**	**146,264**	**(24,130)**		**195,184**	**182,385**	**(12,799)**	

1. Strategic and Operational Capital expenditure to date is behind plan and the full year variance against PPE relates to updated cashflows from external cost consultants on strategic schemes lower than planned.
2. Trade and other receivables is ahead of plan although there are some historic balances and shortfall on SLA debts in the outstanding debtors. The trade and other payables variance against plan is a combination of a reallocation of balances from provisions to accruals and the delay to loan and PDC funding for capital which has been substituted by internal resources.
3. The borrowings variance relates to delays with the Emergency schemes and pathology works. To date £2.6m in emergency loans have been drawn down. The Trust continues to review forecast expenditure relating to the loan draw downs.
4. The YTD and full-year forecast PDC variances are due to the revised forecast provided by the main contractor for the 3Ts project. This changed the phasing of amounts required on a monthly basis.

Finance Report Month 06 2018/19 — Cash — G

The 3Ts funding is drawn down to match capital expenditure, subject to utilisation of internal funding sources first. PDC of £14.6m has been drawn down to date. The Trust will continue to assess the need for additional drawdowns relative to the phasing of the 3T's project. There was also £1.9m carried forward from 2017-18 on the Emergency Capital loan. The first drawdown was in June for £2.6m. Both Strategic and Operational capital expenditure has been lower than planned which accounts for the variance against plan in the capital expenditure line and the variances on the PDC and drawdown on debt lines. It is assumed that the revised drawdown of loan funding and PDC will be used by the end of the year and that capital outturn will be the same as the revised forecast.
The revenue deficit funding drawn down to date amounts to £30.6m and is based on the actual and planned deficit taking into account PSF support. The full year drawdown is aligned to the planned deficit. The month end cash holding is above plan because £8.3m of STF funding received in July for 2017-18 has been ring-fenced, pending options for repayment of historical loans. The year end forecast is aligned to the year-end cash control total, which is slightly above the DHSC maximum cash holding assumed for an organisation with revenue support.

Year-to-date

	Plan £k	Actual £k	Variance £k
Cash Balance	**7,274**	**11,370**	**4,096**

Year-End Forecast

	Plan £k	Forecast £k	Variance £k
Cash Balance	**3,529**	**3,529**	**0**

Year-to-Date

	Plan £k	Actual £k	Variance £k
Operating deficit	(20,588)	(22,189)	(1,601)
Non Cash I&E Items	8,616	9,526	910
Movement in Working Capital	(6,665)	8,371	15,036
Provisions	(1,070)	(732)	338
Cash outflow from Operations	**(19,707)**	**(5,024)**	**14,683**
Capital Expenditure	(59,561)	(36,968)	22,593
Cash receipt from asset sales	0	0	0
Cash outflow before financing	**(79,268)**	**(41,992)**	**37,276**
PDC Received	37,242	14,636	(22,606)
PDC Repaid	0	0	0
Dividends Paid	(2,399)	(2,399)	0
Interest on Loans, PFI and capital repayments on PFI	(5,688)	(5,688)	0
Interest received	13	62	49
Drawdown on debt	43,792	33,169	(10,623)
Repayment of debt	(2,290)	(2,290)	0
Cash inflow from financing	**70,670**	**37,490**	**(33,180)**
Net Cash Inflow / (Outflow)	**(8,598)**	**(4,502)**	**4,096**
Opening Cash Balance	15,872	15,872	0
Closing Cash Balance	**7,274**	**11,370**	**4,096**

Year-End Forecast

	Plan £k	Forecast £k	Variance £k
Operating deficit	(45,287)	(46,967)	(1,680)
Non Cash I&E Items	29,182	30,137	955
Movement in Working Capital	(1,224)	(7)	1,217
Provisions	(1,814)	(1,181)	633
Cash outflow from Operations	**(19,143)**	**(18,018)**	**1,125**
Capital Expenditure	(154,768)	(132,909)	21,859
Cash receipt from asset sales	0	0	0
Cash outflow before financing	**(173,911)**	**(150,927)**	**22,984**
PDC Received	95,986	83,187	(12,799)
PDC Repaid	0	0	0
Dividends Paid	(5,105)	(5,293)	(188)
Interest on Loans, PFI and capital repayments on PFI	(12,354)	(12,354)	0
Interest received	25	74	49
Drawdown on debt	87,596	77,550	(10,046)
Repayment of debt	(4,581)	(4,581)	0
Cash inflow from financing	**161,568**	**138,584**	**(22,984)**
Net Cash Outflow	**(12,344)**	**(12,344)**	**0**
Opening Cash Balance	15,872	15,872	0
Closing Cash Balance	**3,529**	**3,529**	**0**

Finance Report Month 06 2018/19 — Capital — A

The Capital report shows Strategic and Operational Capital expenditure for the year to date and the full-year outturn compared to the plan.

Year-to-date

	Plan £k	Actual £k	Variance £k
Strategic Capital	**55,386**	**30,972**	**(24,414)**
Operational Capital	**8,051**	**4,456**	**(3,595)**
Total	**63,437**	**35,428**	**(28,009)**

Year-end actual

	Plan £k	Forecast £k	Variance £k
Strategic Capital	**137,748**	**114,903**	**(22,845)**
Operational Capital	**18,101**	**18,101**	**0**
Total	**155,849**	**133,004**	**(22,845)**

Strategic Capital Handover of L6 and L7 of the Clinical Administration Building has taken place in April. The electrical infrastructure work and external works will be completed by mid-November to take into account clinical needs. Work on the Helideck steel framework is complete 100 tonnes of scaffolding has been removed. The trauma lift will be available in March 2019. Work continues in the Hanbury building to rectify defects and to secure MHRA accreditation of the radiopharmacy in December. The main buildings work and installation for the Radiotherapy East scheme is almost complete. There remains some IT work to be completed and agreement of the final account. Work on the Emergency Floor Development continues but at relatively low level.

Operational Capital There has been minimal operational capital expenditure to date, but the plan assumed low expenditure in the first months of the year. A full year expenditure plan of £27.2 was approved by the board. The cap on operational capital is £18.1m. The approved plan allows flexibility and prioritisation of schemes within the resources available. The underspend predominantly relates to IM&T schemes; however TEC has recently approved all IM&T schemes. It is expected that the expenditure will pick up significantly in the coming months. The full year forecast is £18.1m.

	Plan £k	Actual £k	Variance £k
Source of Funds - (CRL)	**(63,437)**	**(35,428)**	**(28,009)**
Expenditure			
Strategic Capital			
3Ts	43,174	27,334	15,840
ED - Floor Development	6,640	464	6,176
ED - Backlog Maintenance	3,139	2,921	218
Pathology	1,000	44	956
Radiotherapy East	1,433	209	1,224
Total Strategic Capital	**55,386**	**30,972**	**24,414**
Operational Capital			
Medical Equipment Replacement	1,412	597	815
IM&T Infrastructure	4,226	1,407	2,819
Estates Infrastructure	1,153	779	374
Service Development	608	1,383	(775)
Charitably Funded Schemes	652	290	362
Total Operational Capital	**8,051**	**4,456**	**3,595**
(Under)/Overspend against CRL	**0**	**0**	**0**
	63,437	35,428	28,009

	Plan £k	Forecast £k	Variance £k
Source of Funds - (CRL)	**(155,849)**	**(133,004)**	**(22,845)**
Expenditure			
Strategic Capital			
3Ts	101,918	89,119	12,799
ED - Floor Development	13,907	13,907	0
ED - Backlog Maintenance	9,000	9,000	0
Pathology	11,490	1,444	10,046
Radiotherapy East	1,433	1,433	0
Total Strategic Capital	**137,748**	**114,903**	**22,845**
Operational Capital			
Medical Equipment Replacement	4,596	4,596	0
IM&T Infrastructure	5,106	5,106	0
Estates Infrastructure	3,583	3,583	0
Service Development	3,371	3,371	0
Charitably Funded Schemes	1,445	1,445	0
Total Operational Capital	**18,101**	**18,101**	**0**
(Under)/Overspend against CRL	**0**	**0**	**0**
	155,849	133,004	

Finance Report Month 06 2018/19 — Aged Debtors

The Trust debtors are a mixture of invoiced debtors, accrued income and prepayments. The level of invoiced debtors has increased by £9.8m since the end of August but this includes £6.4m for HEKSS. The value of overdue debts has increased by £1.4m. £8.6m of overdue invoices relate to BICS.

Invoiced Debtors	Within Terms 1-30 Days £k	1 Month Overdue 31-60 Days £k	2 Months Overdue 61-90 Days £k	3 Months Overdue Over 90 Days £k	Total	Current Month Over 30 Days £k	Prior Month Over 30 Days £k	Notes
CCGs	819	433	322	2,171	3,745	2,926	(384)	1
Trusts	375	328	186	1,495	2,384	2,009	1,819	2
Other NHS	7,029	54	3	(1,518)	5,568	(1,461)	323	3
Other Debtors	2,256	2,091	502	8,343	13,192	10,936	11,206	4
Private Patients	397	135	114	1,449	2,095	1,698	1,776	5
Overseas	14	11	48	387	460	446	463	
Total Invoiced Debtors	**10,890**	**3,052**	**1,175**	**12,327**	**27,444**	16,554	15,203	
Provision for Bad Debts (including RTA Provision)					(3,388)			
Accrued Income					12,691			
Prepayments					8,482			
Other Debtors					3,628			
Total Trade & Other Receivables					**48,857**			

Other Receivables	Current Month £k	Prior Month £k
Accrued Income		
Work In Progress	3,978	3,978
CCG Service Level Agreements	5,113	3,654
Injury Cost Recovery Fund	2,566	2,350
Other	1,501	3,748
Total Accrued Income	**13,158**	**13,730**
Prepayments		
Maintenance & Other Contracts	6,046	5,704
NHS Litigation	2,436	2,030
Total Prepayments	**8,482**	**7,734**

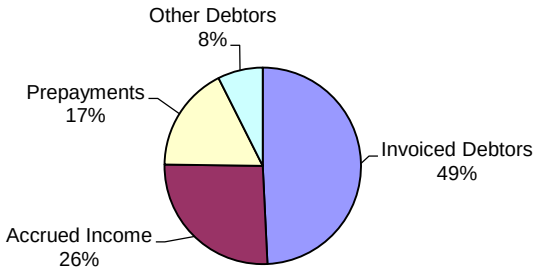
1. CCGs : the CCGs overdue balance has increased by £3.3m compared to last month. £1.5m of the Over 90 Days relates to 3Ts Transitional Support.

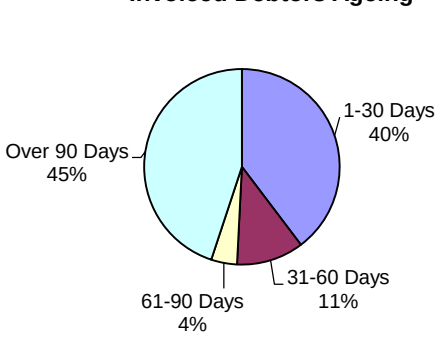
2. Trusts : the overdue debts have increased by £0.2m and reciprocal arrangements continue with local Trusts.

3. Other NHS : the overdue balance has reduced by £2m with an NHSE credit note of £1.6m being the main element of the Over 90 Days balance.

4. Other Debtors : the over 30 days balance has reduced by £0.3m. The commissioning income funding from BICS remains the main element of overdue debts (total of £8.6m) and part of this debt has been paid in October (£5m). Its anticipated that the BICS overdue debt will be paid in full by November following agreement of contracts between BICS and the associated CCGs.

5. Private Patient : the overdue debts have reduced by £0.1m.

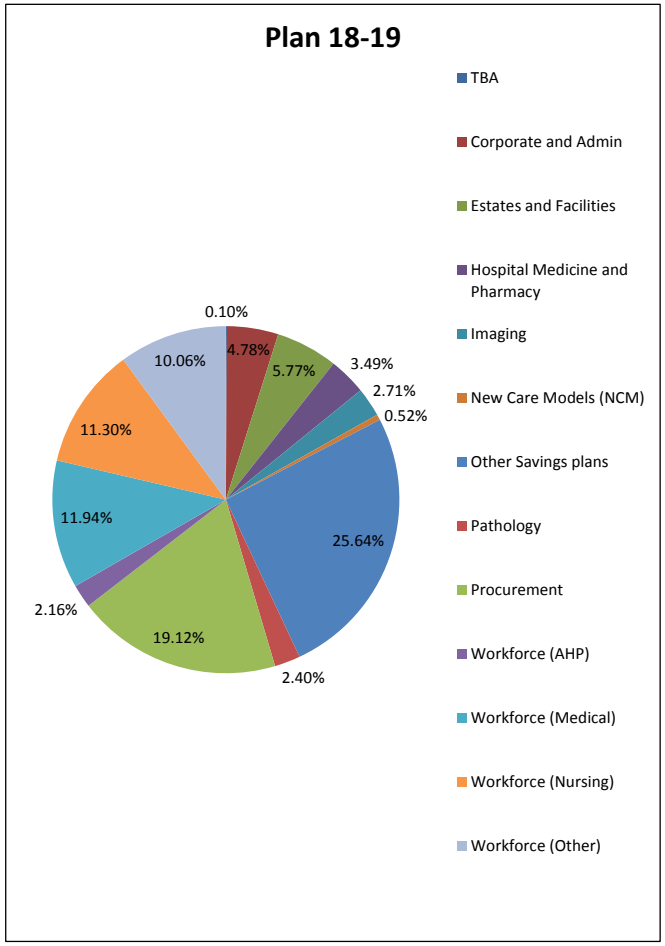




Finance Report Month 06 2018/19 — Efficiency and Transformation programme — G

The efficiency programme has delivered the £12.444m in the year to Month 6 which is £0.201m below the internal target and £0.746m below the NHSI target. The forecast is to achieve the full plan of £30m.

		Year to Date			Year End		
		Plan	Actual	Variance	Plan	Forecast	Variance
		£k	£k	£k	£k	£k	£k
Themes							
Corporate and Admin	Income (Patient Care Activities)	31	31	0	60	62	2
Corporate and Admin	Non pay	249	249	0	550	546	(4)
Corporate and Admin	Pay (Skill Mix)	373	396	23	825	820	(5)
Estates and Facilities	Non pay	426	440	14	1,102	1,099	(3)
Estates and Facilities	Pay (Skill Mix)	79	79	0	104	105	1
Estates and Facilities	Pay (WTE reductions)	144	83	(61)	283	284	1
Estates and Facilities	Income (Other operating income)	80	26	(54)	243	241	(2)
Hospital Medicine and Pha	Non pay	368	378	10	1,048	974	(74)
Imaging	Income (Patient Care Activities)	8	3	(4)	12	15	3
Imaging	Non pay	191	145	(46)	389	456	67
Imaging	Pay (Skill Mix)	123	92	(31)	412	334	(78)
New Care Models (NCM)	Income (Patient Care Activities)	13	13	(0)	12	13	1
New Care Models (NCM)	Pay (WTE reductions)	20	23	3	144	61	(83)
Other Savings plans	Income (Patient Care Activities)	524	508	(16)	2,313	1,857	(456)
Other Savings plans	Non pay	2,211	2,165	(46)	4,057	4,308	251
Other Savings plans	Pay (Skill Mix)	447	578	131	892	1,034	142
Other Savings plans	Pay (WTE reductions)	147	104	(42)	429	328	(101)
Other Savings plans	Income (Other operating income)	0	0	0	0	17	17
Pathology	Non pay	167	164	(3)	122	260	138
Pathology	Pay (Skill Mix)	25	86	61	599	388	(211)
Procurement	Non pay	2,775	2,642	(132)	5,736	6,051	315
Workforce (AHP)	Income (Patient Care Activities)	44	0	(44)	84	89	5
Workforce (AHP)	Pay (Skill Mix)	183	175	(7)	565	394	(171)
Workforce (Medical)	Pay (Skill Mix)	843	793	(50)	1,667	1,664	(3)
Workforce (Medical)	Pay (WTE reductions)	522	521	(1)	1,914	1,984	70
Workforce (Nursing)	Pay (Skill Mix)	1,115	979	(136)	2,413	2,555	142
Workforce (Nursing)	Pay (WTE reductions)	424	536	112	976	1,045	69
Workforce (Other)	Pay (Skill Mix)	502	488	(14)	1,688	1,755	67
Workforce (Other)	Pay (WTE reductions)	611	744	134	1,331	1,260	(71)
TBA	Pay (Skill Mix)	0	0	0	30	0	(30)
Efficiency Plan Total		**12,645**	**12,444**	**(201)**	**30,000**	**30,000**	**(0)**
Plan adjustment to NHSI return/Forecast Risk Adjustment		545	0	(545)			0
Efficiency Requirement in NHSI Plan		**13,190**	**12,444**	**(746)**	**30,000**	**30,000**	**(0)**



Brighton and Sussex University Hospitals NHS Trust

To: Board of Directors

Date of Meeting: 24th October 2018 Agenda Item: **10**

Title
Learning from Deaths – Q2 2018/19
Responsible Executive Director
Dr George Findlay (Chief Medical Officer) and Nicola Ranger (Chief Nursing and Patient Safety Officer)
Prepared by
Dr Stephen Drage - Deputy Medical Director: Safety and Quality, Della Morris - Safety & Quality Lead and Mark Renshaw - Deputy Chief of Safety, Rob Haigh – Medical Director
Status
Public
Summary of Proposal
This report has been produced in line with National Guidance on Learning from Deaths, to provide the Trust Board with information relating to the percentage of inpatient deaths that have been reviewed using a Structured Judgment Review and the themes and learning that are emerging from this work. As this relates to new national guidance the report also provides an update on progress made to roll this out across the Trust as well as information relating to the national and local Medical Examiner Programme.
Implications for Quality of Care
For many people death under the care of the NHS is an inevitable outcome and they experience excellent care. However, some patients experience poor care resulting from a variety of factors. The purpose of reviews of deaths which problems in care may have contributed to is to learn in order to prevent a recurrence.
Link to Strategic Objectives/Board Assurance Framework
The Trust's True North Objective is for the mortality rates (HSMR) to be in the lowest 20% of Trusts.
Financial Implications
Human Resource Implications
Recommendation
The Board is asked to NOTE the report.
Communication and Consultation
Not applicable
Appendices
None

1. Medical Examiner Programme – National Perspective

1.1 After 1st April 2019, a National Medical Examiner (ME) programme for in-hospital deaths will be implemented. In the first instance this will be a 'non-statutory' programme but the aspiration is that the role of the ME will be enacted into law within 2 years. The Royal College of Pathologists is leading on this programme. Funding details remain unconfirmed, but are initially likely to mirror current arrangements.

1.2 BSUH has been a national ME pilot site for several years

1.3 The suggested process for ME review is a brief, independent review of the medical record, followed by discussion with the referring doctor and finally a conversation with the bereaved. While not a requirement, this order of events provides the most robust level of scrutiny, allowing the ME to reach an independent view.

1.4 An on line ME training package is being updated and will in future include face to face sessions. It is not clear whether existing MEs will require re-training. IT support for the ME service is being centrally procured by the DoH.

1.5 Other 'pilot sites' have a lead ME and also employ Medical Examiner Officers who fulfil certain administrative roles. Some also run a 24/7 on call service to support urgent certification (eg: faith deaths or organ donation scenarios), although funding arrangements are unclear.

1.6 **BSUH position:**

- BSUH has an established ME service and 10 MEs appointed. This service functions in line with the National Programme. However :
    - Currently ME posts neither salaried or job planned
    - There is no dedicated administrative support, ME Officer or lead ME
    - No on call service
    - It is acknowledged that running an ME service in a site with few deaths (e.g. PRH) is challenging under current regulations (the requirement to inspect the body of the deceased and review the medical notes means this cannot be done remotely.)

2. Learning from Deaths Dashboard

2.1 The DoH provides a dashboard for Trust's to publish data on the number of deaths that have been reviewed in their organisations. See attachment.

2.2 The table below shows the Q2 18/19 data for BSUH. LD refers to deaths in patients with learning disabilities.

2.3 The Palliative Care team continue to review the deaths of patients who were identified for an End of Life Care audit, using SJR ; this has resulted in an increase in the proportion of deaths undergoing SJR from 11% in Q1 to 21% in Q2.

	Total Deaths (not LD)	Total Deaths Reviewed (not LD)	Deaths Avoidable > 50% (not LD)	LD Deaths	LD Deaths Reviewed	LD Deaths Avoidable > 50%	Total % of deaths reviewed
July 18	123	36	0	1	2	0	31%
Aug 18	119	15	0		0	0	13%
Sept 18	110	22	0	1	0	0	20%
Total (Q2 18/19)	352	73	0	2	2	0	21%

3. Outcomes from Structured Judgement Reviews

3.1 SJRs review 6 discreet areas of care. Table 1 shows the level of care that the patients have been recorded as receiving. 123 SJRs have been input onto the database allowing analysis of themes.

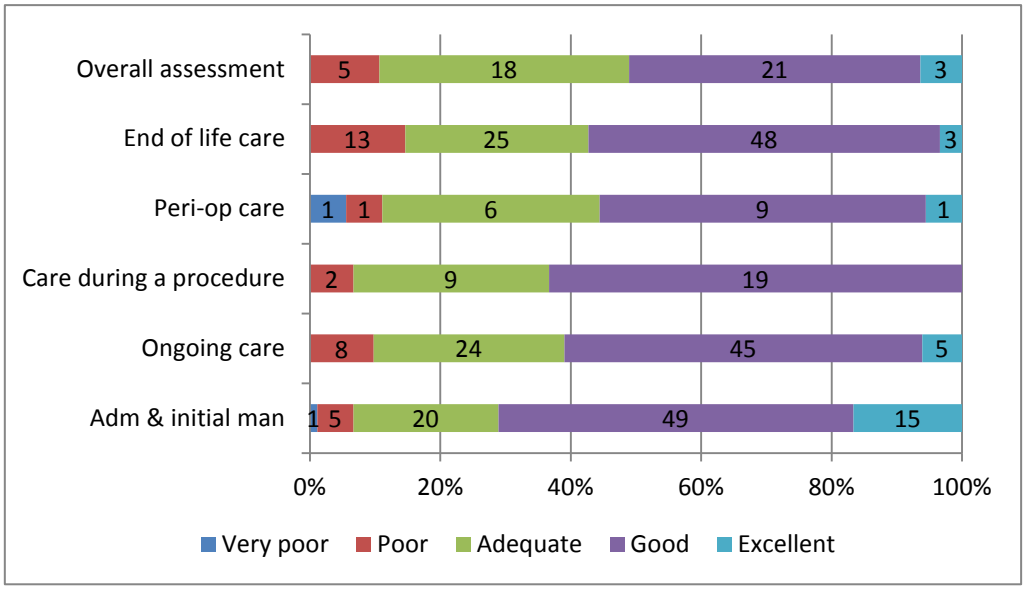


Table 1: Data labels show the number of responses for the criteria

3.2 Examples of poor care identified in Q2 reviews include the absence of a treatment escalation plan; and DNAR form completed during the initial assessment. Excellent care was noted as completion of appropriate checklists, appropriate communications and multidisciplinary team working.

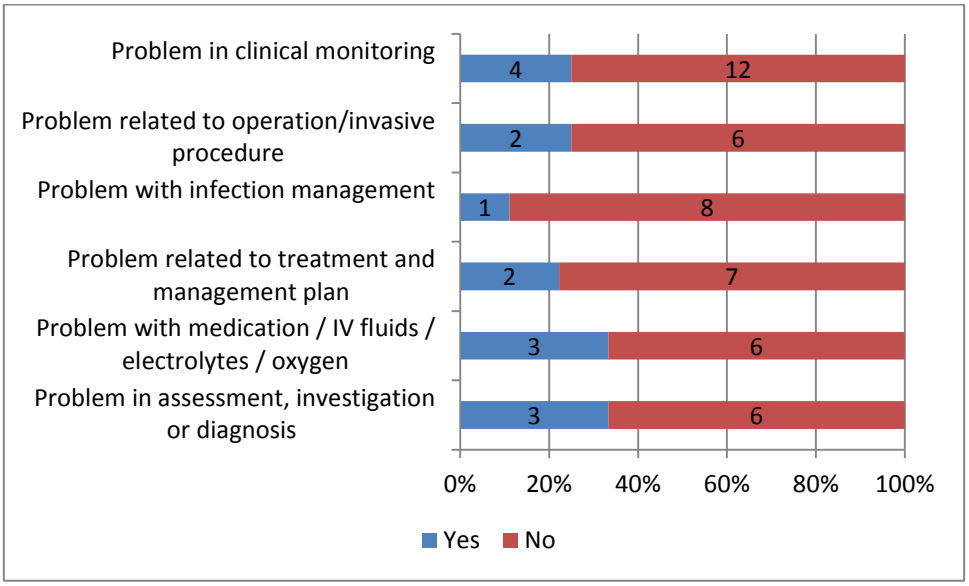
3.3 Similar themes were noted for good 'ongoing care' regarding communication where appropriate specialist advice, involvement of nutritional support team and appropriate decision making regarding high risk surgeries were noted as specific examples. Poor care included a lack of appropriately completed documentation including risk assessments and notes not in order.

3.4 No concerns were raised during Q2 regarding the care of patients during a procedure. High risk procedures were discussed prior to surgery and there was good evidence of MDT working.

3.5 Prior to surgery, well documented consent was noted. However, the WHO checklist was not always recorded as completed in all cases.

3.6 End of life care was frequently scored lowly, with patients not being seen by the palliative care team, late decisions regarding DNAR and an absence of documented conversation with the family.

3.7 Table 2 shows the results of the quantitative data collected during the SJR.



3.8 The most common 'problem' area was 'clinical monitoring' which includes 'failure to plan, to undertake or to recognise and respond to changes. The Deteriorating Patient Steering group are conducting a focused piece of work around observations which includes the introduction of NEWS 2 and the introduction of electronic observations.

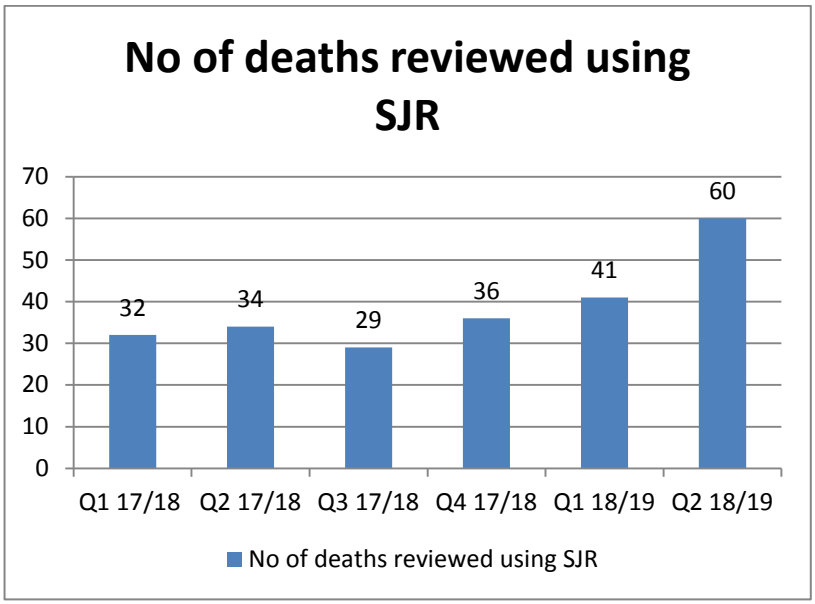
4. Roll out of Learning from Deaths Programme across BSUH

4.1 51 trained staff now undertake SJRs - including Consultants and Nurse Specialists. Further training is planned to include Allied Healthcare Professions.

4.2 The number of SJRs undertaken is increasing, due primarily to the efforts of the Palliative Care Team (conducting SJRs for a cohort of patients identified for an End of Life Care National Audit).

4.3 The SJR tool has been embedded within PANDA; this will improve the efficiency of data collection and analysis.

4.4 The lack of administrative resource to identify patients, distribute notes and monitor compliance means that the process is slow and currently SJRs are not job planned (a single SJR takes approximately one hour to complete).



4.5 The Palliative Care team have provided training to the CMTs to raise awareness in the methodology. Training has also been provided to a group of Renal Trainees from across the region.

5. Mortality Governance Arrangements

5.1 Concerns have been raised that the LeDer Programme is struggling with capacity to undertake the volume of reviews required. This has resulted in delays to reports reaching BSUH; the TMRG have therefore made the decision, to undertake in-house SJRs for all LeDer deaths to ensure timely learning from these deaths.

5.2 The TMRG continues to work closely with the Serious Incident Review group, and will be conducting SJRs into the deaths of all patients who breached the 12 hour admission target.

6. Learning from Coronial Regulation 28 letters

6.1 In order to improve learning and share lessons, the medico-legal team review the responses/outcomes to all Reg 28 letters. This now includes a section on key learning and changes made to practice.

6.2 In response to a Regulation 28 letter dated 20 July 2018, the following improvements have been made to the service at Newhaven Downs (NHD):

- standardisation of transfer pathways between BSUH and NHD
- improved communication via a new daily status sheet, highlighting risks and concerns in a structured way
- implementing specific transfer criteria using the SBARD model (Situation, Background, Assessment, Recommendation, Discharge)
- a matron visiting twice a week as well as Lead Nurse and Peer Review visits
- provision of a standard Patient Information Letter

Learning from Deaths Dashboard

Organisation	**Brighton & Sussex University Hospitals NHS Trust**
Financial Year	**2018-19**
Month	**October**

Learning from Deaths Dashboard

Purpose of the dashboard

This suggested dashboard is a tool to aid the systematic recording of deaths and learning from the care provided by NHS Trusts. Trusts may use this to record relevant incidents of mortality, deaths reviewed and lessons learnt to encourage future learning and the improvement of care.

Guidance on what should be recorded in individual fields is provided below, alongside instructions for completing and updating the dashboard. This guidance on individual fields complements the wider guidance provided in the National Framework on Learning From Deaths and separate methodology guidance on the Structured Judgement Review (SJR) as developed by the Royal College of Physicians (RCP). The dashboard is not prescriptive and Trusts may set their own definitions according to local goals and data availability, although minimum requirements are set out in the framework.

To update this dashboard - enter your data on the "Data" worksheet. The dashboard sheet is automatically updated.

Guidance on individual fields

Field No.	Field	Description of Field
Recording data on structured judgement reviews:		
1	**Total Number of Deaths in scope**	This must as a minimum include all adult inpatient deaths excluding maternity services. Where additional deaths are included (for example maternal deaths, deaths post-discharge or deaths of outpatients etc) the inclusion criteria should be made clear in this field, which can vary by trust. The total number of deaths in scope defined in this field must be used in all subsequent relevant fields in this work book. If a post-discharge period is being included in scope, (eg deaths within 30 days of discharge) then the death should be counted in the month where the death actually occurred rather than time of admittance or discharge. Note that where it has been identified that a patient has a learning disability the death should be recorded separately (see Data item 6, below).
2	**Total Number of Deaths Reviewed under the SJR methodology**	This is the total number of deaths for which the care provided to the patient has been reviewed by your Trust. This may be a combination of deaths reviewed under national and local minimum requirements and random sampling of all other deaths in scope.
3	**Total number of deaths considered to have more than a 50% chance of having been avoidable**	The Structured Judgement Review methodology, for use in relation to adult acute inpatient deaths, allows for reviewers to score a death as having a more than 50% chance of having been avoidable when this judgement is made in relation to the care provided by the trust conducting the review. This is the equivalent of a score of 3 or less. If using the RCP SJR then the number of such deaths scored in this way is equivalent to this field If not using RCP SJR, then the method used to judge whether a death was more likely than not to have been avoidable in relation to the care provided by the trust conducting the review (or another provider if appropriate) should be stated here including any definitions used. Note that if you are applying other methodologies to specific groups, such as learning disabilities patients, those methodologies may require a degree of judgement to determine whether the death was more likely than not to be avoidable. It may be appropriate to cross-reference those outputs with the processes for assessing structured judgement reviews, and if appropriate to include those outputs here. If the RCP SJR methodology is being used for structured judgement reviews Trusts are able to include monthly totals of reviewed deaths that were in each category 1 to 6. If the Trust is not using this methodology these fields can be either left blank or edited as appropriate.

Recording data on LeDeR reviews:		
4	**Total Number of Deaths in scope**	This must include all adult inpatient deaths for patients with identified learning disabilities. The total number of deaths in scope defined in this field must be used in all subsequent relevant fields. If a post-discharge period is being included in scope, (eg deaths within 30 days of discharge) then the death should be counted in the month where the death actually occurred rather than time of admittance or discharge.
5	**Total Deaths Reviewed Through the LeDeR Methodology**	Formally, the LeDeR review methodology should be applied to all of the deaths shown as 'in scope'. You should record the total number of deaths reviewed here.
6	**Total Number of deaths considered to have been potentially avoidable**	Record the total number of deaths for which review evidence leads to a conclusion that it is more likely than not that the death was potentially avoidable. This will require that a degree of judgement is applied to the outputs of the LeDeR review, and it may be appropriate to cross-reference these outputs with the processes for assessing structured judgement reviews

How to update the dashboard

To update this dashboard - enter your data on the "Data" worksheet. The dashboard sheet is automatically updated.

To update the dashboard with new data:
1. Enter data for appropriate month(s) in the Data tab. Note that the RCP1 to RCP6 and Trust comparison fields are optional and the dashboard will still function correctly if these fields are left blank.
- In the first 3 columns enter the data for your structured judgement reviews (number of deaths in scope, numbers reviewed, and numbers deemed potentially avoidable)
- You have the option of recording how many of the SJR reviews placed cases in each of the RCP1 to RCP 6 categories.
- For learning disabilities patients, enter the number of deaths in scope, numbers reviewed under the LeDeR methodology, and numbers deemed potentially avoidable

2. Change the month and year on the Front Sheet tab to the most recent month of data.
3. Change the data range on the time series charts as required by using the interactive dropdowns on the Dashboard tab (eg cell V4). Note that the time series charts are not linked to the front sheet selection and are driven entirely by the dropdowns.

Brighton & Sussex University Hospitals NHS Trust: Learning from Deaths Dashboard - October 2018-19

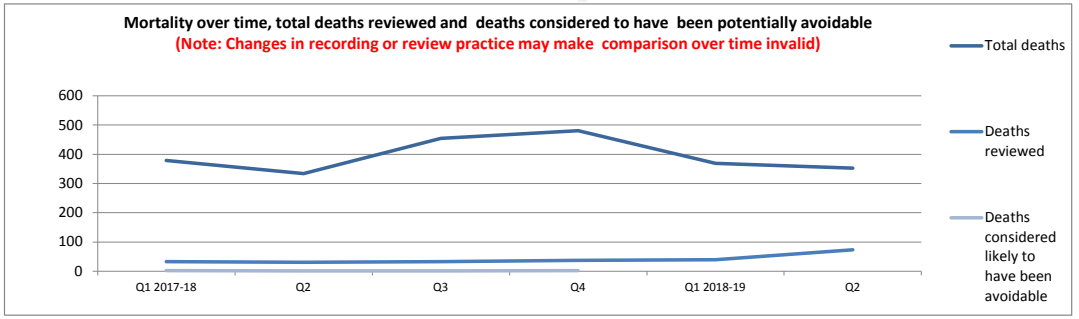
Description:
The suggested dashboard is a tool to aid the systematic recording of deaths and learning from care provided by NHS Trusts. Trusts are encouraged to use this to record relevant incidents of mortality, number of deaths reviewed and cases from which lessons can be learnt to improve care.

Summary of total number of deaths and total number of cases reviewed under the Structured Judgement Review Methodology

Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable (does not include patients with identified learning disabilities)

Total Number of Deaths in Scope		Total Deaths Reviewed		Total Number of deaths considered to have been potentially avoidable (RCP<=3)	
This Month	Last Month	This Month	Last Month	This Month	Last Month
0	110	0	22	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
0	352	0	73	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
721	1648	112	133	0	6

Time Series: Start date 2017-18 Q1 — End date 2018-19 Q2



Total Deaths Reviewed by RCP Methodology Score

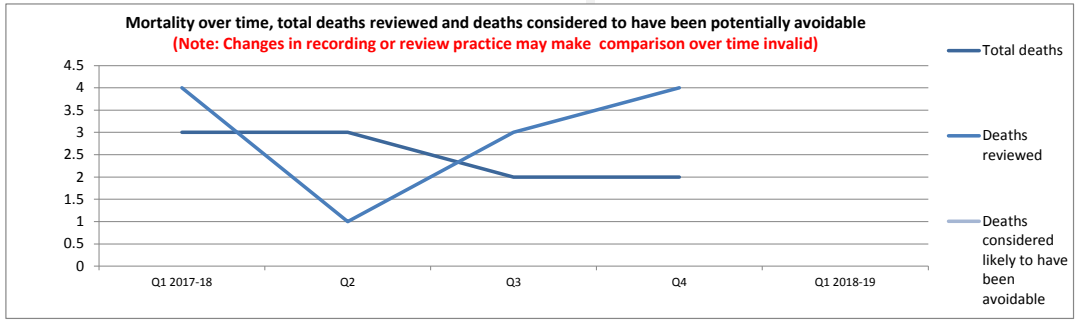
Score 1 Definitely avoidable			Score 2 Strong evidence of avoidability			Score 3 Probably avoidable (more than 50:50)			Score 4 Probably avoidable but not very likely			Score 5 Slight evidence of avoidability			Score 6 Definitely not avoidable		
This Month	0	-	This Month	0	-	This Month	0	-	This Month	0	-	This Month	0	-	This Month	0	-
This Quarter (QTD)	0	-	This Quarter (QTD)	0	-	This Quarter (QTD)	0	-	This Quarter (QTD)	0	-	This Quarter (QTD)	0	-	This Quarter (QTD)	0	-
This Year (YTD)	0	-	This Year (YTD)	0	-	This Year (YTD)	0	-	This Year (YTD)	0	-	This Year (YTD)	0	-	This Year (YTD)	0	-

Summary of total number of learning disability deaths and total number reviewed under the LeDeR methodology

Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable for patients with identified learning disabilities

Total Number of Deaths in scope		Total Deaths Reviewed Through the LeDeR Methodology (or equivalent)		Total Number of deaths considered to have been potentially avoidable	
This Month	Last Month	This Month	Last Month	This Month	Last Month
0	1	0	0	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
0	2	0	2	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
2	10	2	12	0	0

Time Series: Start date 2017-18 Q1 — End date 2018-19 Q1



Trust	Brighton & Sussex University Hospitals NHS Trust
Org Code	
Month	October
Year	2018-19

Financial Year	Month	Total Deaths (not LD)	Total Deaths Reviewed (not LD)	Deaths Avoidable > 50% (not LD)	RCP1	RCP2	RCP3	RCP4	RCP5	RCP6	LD Deaths	LD Deaths Reviewed	LD Deaths Avoidable > 50%
2017-18	April	125	13	1							3	3	0
2017-18	May	138	7	0								1	0
2017-18	June	116	13	1								0	0
2017-18	July	105	8	0							3	1	0
2017-18	August	124	14	0								0	0
2017-18	September	105	8	1								0	0
2017-18	October	136	8	0								0	0
2017-18	November	150	9	0								0	0
2017-18	December	168	16	1							2	3	0
2017-18	January	154	9	1								1	0
2017-18	February	169	4	0							2	0	0
2017-18	March	158	24	1								3	0
2018-19	April	130	29	0								0	0
2018-19	May	129	4	0								0	0
2018-19	June	110	6	0								0	0
2018-19	July	123	36	0							1	2	0
2018-19	August	119	15	0								0	0
2018-19	September	110	22	0							1	0	0
2018-19	October												
2018-19	November												
2018-19	December												
2018-19	January												
2018-19	February												
2018-19	March												

Brighton and Sussex University Hospitals NHS Trust

To: Public Board

Date of Meeting: 24th October 2018 Agenda Item: **11**

Title
Infection Prevention Annual Report 2017-2018
Responsible Executive Director
Nicola Ranger, Director of Infection Prevention and Control
Prepared by
Martin Still, Matron for Infection Prevention
Status
Public
Summary of Proposal
Summarises the work undertaken by Infection Prevention Team in the organisation for the period 1 April 2017 to 31 March 2018.
Implications for Quality of Care
Link to Strategic Objectives/Board Assurance Framework
Financial Implications
Nil
Human Resource Implications
Nil
Recommendation
The Board is asked to: APPROVE the Annual Report
Communication and Consultation
Appendices
Appendix 1: The Infection Prevention Team Appendix 2: Infection Prevention and Control governance arrangements Appendix 3: Chart 1: Trust and non-Trust apportioned MRSA Chart 2: Clostridium difficile infection burden Chart 3: Trust and Non-Trust acquired MSSA Appendix 4: Education delivered 2017-18 Appendix 5: Clinical areas involved in outbreaks

Brighton and Sussex University Hospitals NHS Trust

Report on
Infection Prevention and Control programme 2017-2018

Brighton & Sussex University Hospitals Trust Infection Prevention and Control programme 2017-2018

Contents **Page**

1.0 Executive Summary

1.1 This is the report of the Director of Infection Prevention and Control (DIPC) and summarises the work undertaken in the organisation for the period 1 April 2017 to 31 March 2018.

1.2 There were two Trust cases of MRSA blood stream infection (BSI) against a trajectory of zero. The post infection review for one case highlighted no lapse in care. The second case was Trust assigned with Trust learning around communication with patients who have chosen not to register with a GP.

1.3 There were 56 cases of BSUH Trust apportioned *Clostridium difficile* infection during this period against an objective of no more than 46 cases. Lapses in care included delays in sampling, delays with source isolation and antimicrobial stewardship. These lapses informed a *Clostridium difficile* infection Trust action plan, engaging the new Trust governance structure that is being monitored at the monthly Trust Infection Prevention Committee with the ambition to cut these lapses by 50%.

1.4 There were 31 cases of MSSA BSI during this period. It was identified that a proportion of these MSSA BSI were associated with peripheral venous cannula (PVC) and an action plan was written to address this. This action plan is being monitored at the monthly Trust Infection Prevention Committee (TIPC). The objective this year are zero PVC associated MSSA

1.5 For the year 2017-18, the IP team delivered around 74 hours of education and training via 101 sessions. Approximately 6977 staff, students (multi-disciplinary including medical and nursing) and other groups e.g. volunteers, received infection prevention education and related activities, of staff attending

1.6 Hand hygiene compliance is monitored every week in practice by departments who facilitate and undertake their own audits. Results are uploaded by departments to a web based system. This is reported and monitored by the Divisional clinical governance meetings.

1.7 BSUH continues with the mandatory Public Health England orthopaedic surgical site surveillance and works closely with the Surgical Division on this and with feedback and dissemination of results. The Cardiothoracic speciality continues to collect its own data and has rates well below the national average and will be sharing that at a national cardiothoracic network in London this December 2018

1.8 Pseudomonas and Legionella in water continues to be monitored and managed and the infection prevention team (IPT) has a good working relationship with the Facilities and Engineering staff (see Appendix 1 and 2 for the IPT and governance structures).

2.0 Summary of Infection Prevention and Control performance 2017-18

2.1 MRSA blood stream infection (BSI)

2.1.1 There were two cases of Trust apportioned MRSA blood stream infections (BSI) against a set objective of zero. (Appendix 3, Chart 1)

2.1.2 As mandated by Public Health England at that time, post infection reviews were undertaken on both cases. One case was found to have no lapses of care and credit to the speciality. The other case was Trust assigned following NHS England arbitration on a third party case. The lessons learned have been incorporated into the infection prevention team standard operating procedures and how the team communicate microbiology results to patients not registered with a General Practitioner (GP)

2.1.3 Education, training and support is ongoing with the aim to reduce infections associated with intravascular devices.

2.2 *Clostridium difficile* Infection (CDI)

2.2.1 There were 56 Trust apportioned cases of CDI (Appendix 3, Chart 2) against an objective of 46. There were 71 community apportioned cases during the same period totalling 117 cases across the healthcare economy.

2.2.2 All Trust apportioned CDI cases had a root cause analysis (RCA) with sign off by the Clinical Commissioning Group (CCG) in line with NHSi guidance (2018). The CDI action plan for 2018/19 utilises learning from the RCA process and is monitored by the Trust Infection Prevention Committee to ensure representative Trust-wide involvement with shared learning.

2.3.3 All in-patients with CDI or a history of CDI are followed up by the Infection Prevention Team (IPT). The IP team also undertake CDI specific audits. For 2018/19 the IPT are trialling staff prompt cards that reflect Human Factors training with a focus on managing the patient with CDI to meet the Trust objective of no more than 45 cases.

2.3 Meticillin sensitive *Staphylococcus aureus* (MSSA) blood stream infection

2.3.1 There is currently no nationally set objective for *Staphylococcus aureus* blood stream infection. The Trust reported 31 cases of Trust apportioned and 75 cases of Non-Trust apportioned cases during 2017-18, (Appendix 3, Chart 3).

2.3.2 As there is no nationally set objective, the clinical teams in conjunction with the IP Team undertook a RCA for Trust apportioned cases**2.4 *Escherichia coli* and other Gram-negative blood stream infections**

2.3.3 The Secretary of State for Health has launched an important ambition to reduce healthcare associated Gram-negative bloodstream infections by 50% by 2021 and reduce inappropriate antimicrobial prescribing by 50% by 2021. Gram-negative bloodstream infections are believed to have contributed to approximately 5,500 NHS patient deaths in 2015 (NHSi, 2017). The Gram-negative organisms included in this are *E. coli*, *Pseudomonas aeruginosa* and *Klebsiella spp.*

2.3.4 Clinical commissioning groups (CCGs) are leading on achieving the Quality Premium (from April 2017, for two years). During 2017-18 there were 312 *E. coli* BSI across the healthcare economy an increase of 19% on the year prior. The aim was to reduce E. coli BSIs by 10% but nationally this averaged out at an actual 2% increase. It has therefore been acknowledged that this objective is more challenging than previous objectives as the probable causes are multi-faceted and interrelated.

2.3.5 70 out of 100,000 people will acquire an *E. coli* BSI where the risk is highest in the elderly, most commonly having a urinary tract infection as the cause and not directly linked to healthcare interventions. Although 73% of *E. coli* BSI are community onset, diagnosis and subsequent treatment cost is picked up by an acute Trust nature of the disease process linking with the work on management of sepsis. Therefore there is opportunity for the CCG to reduce commissioning costs by preventing the number of community onset *E. coli* BSI that require acute Trust care approximately costing £6,000 extra for every *E. coli* BSI. There were 312 *E. coli* BSI across the healthcare economy during 2017-18. This cost Brighton and Sussex University Hospitals NHS Trust approximately £1,872,000 in treatment costs and the patient would have likely been very unwell and not have a good experience. .

2.3.6 The suggested actions to reduce *E. coli* BSIs are based on stakeholder consultation and case studies. The CCGs are expected to provide leadership in delivering the quality premium and includes self-assessment against core standards, localised surveillance, *E. coli* BSI review by RCA, development of improvement plans and audits to monitor the effectiveness

2.4 Training and Education

2.4.1 Educating healthcare workers about infection prevention and control is required by the Trust as part of its registration (Department of Health, 2015). All staff in the Trust, including volunteers, must receive a Trust induction and update that reflects national competencies as outlined by Skills for Health (2017). The General Medical Council (2015) has also published outcomes and standards that include infection prevention for doctors. Likewise, the Nursing and Midwifery Council mandate that infection prevention and control is covered on pre-registration nursing courses (Nursing and Midwifery Council, 2010).

2.4.2 For the year 2017-18, the IP team delivered around 74 hours of education and training via 101 sessions. Approximately 6977 staff, students (multi-disciplinary including medical and nursing) and other groups e.g. volunteers, received infection prevention education and related activities, of staff attending (Appendix 4 Table 1). 2.5.3 The IP team has managed to sustain educational activity throughout the year. 50% of IP updates are now completed by e-learning. A clinical Educator was appointed for IP/ IV in quarter four. The clinical educator revised the Training Needs analysis for the Trust and local service. The education summary for 2018-19 will include all IV education delivered.

2.5 Infection prevention compliance – hand hygiene

2.5.1 Hand hygiene in line with the WHO five moments (WHO, 2009) is recommended as a key intervention to prevent transmission of infections.

2.5.2 There is a dedicated Trust policy outlining practices including bare below the elbows that reflects WHO guidance.

2.5.3 This policy and hand hygiene compliance is monitored every week in practice by departments who facilitate and undertake their own audits. Results are uploaded by departments to a web based system. Wards, Directorates and Divisions thenthis is then monitored at the divisional clinical governance meetings.

2.5.4 Weekly reports are reviewed by the Nurse Director who in turn can prompt action in areas of concern.

2.5.5 The Communications Team supported the IPT with the revision, hand hygiene poster implementation.

2.5.6 This year the ward based metrics audit has been revised with a focus on infection prevention standards that monitor aspects of the infection programme of work, contribute to

specific action plans for infection prevention e.g. the MSSA BSI action plan and most importantly put patients first with the aim of infection free outcomes

2.6 Surgical Site Infection Surveillance Scheme

2.6.1 Surveillance of surgical site infections (SSI's) in orthopaedic surgery is mandated by Public Health England (PHE) for Trusts to complete at least one quarter per year by.

2.6.2 The Trust submitted data for Total Knee Replacement (TNR) surgery for quarter 4 (January – March 2018).

2.6.3 The Trust met this mandated requirement by submitting data to PHE for Total Knee Replacement surgery for quarter 4 (January – March 2018).

2.6.4 In July 2018, PHE informed the Trust that our incidence of surgical site infection (inpatient and readmission) in TKR was above the national 90th percentile with an infection rate of 0.9%.

2.6.5 The musculoskeletal Directorate and IP were already aware of this and working in collaboration to interpret the surgical site surveillance data and develop action plans

2.6.6 Surgical site surveillance of TKR continues this year

2.7. Incidents and outbreaks of infection

Serious incident reporting

2.7.1 The Serious Incident framework describes the process and procedures to help ensure serious incidents are identified correctly, investigated thoroughly and, most importantly, learned from to prevent the likelihood of similar incidents happening again (NHS1, 2015)

2.7.2 During the period 2017/18 the Trust reported two such incidents within this framework. All action plans are reviewed and monitored at the monthly Trust Infection Prevention committee with assurance to the Strategic Infection Prevention Committee and the Trust overarching patient safety agenda.

2.7.3 The first was due to two patients with the same ribotype of *Clostridium difficile* infection that could be linked in place but not at the same time. A full investigation revealed some inefficiency in cleaning that have since been rectified.

2.7.4 The second was due to a mechanical failure of a single pump that was designed at that time to deliver a measured dose of disinfectant to an isolated endoscope washer disinfector machine. Affected patients were followed up and offered testing where indicated. No patients

were found to have any infection related to this incident. The risk of this happening again is being mitigated by purchasing more modern machines where this type of possible error has been designed out.

Viral diarrhoea outbreaks

2.8.1 There were 40 bay/ ward closures due to gastroenteritis during 2017-18 (See Appendix 5 table 2).

2.8.2 Norovirus, also known as winter vomiting disease, causes gastroenteritis and is highly infectious. The virus is easily transmitted through contact with infected individuals from one person to another (PHE, 2014) and this is what results in bay/ ward closures and recommended in national policy`.

2.8.3 Outbreaks are common in semi-enclosed environments such as hospitals, nursing homes, schools and cruise ships and can also occur in restaurants and hotels.

2.8.4 The use of standard infection control precautions with the addition of transmission-based precautions were implemented in line with the Trust policy and national guidance on the management of viral diarrhoeal outbreaks.

2.8.5 The Trust requested a peer review in the management of viral infection outbreaks, the Nurse Consultant for Infection Prevention, from Frimley Park Hospital visited the Trust early in January 2018.

2.8.6 Management of gastroenteritis is a challenge with current estate, especially the Barry building with lower ratios of single rooms. However, this will be mitigated when a new building of the hospital opens in 2020. In the meantime the Trust is investigating use of temporary single room accommodation in some areas.

2.9 Surveillance of influenza

2.9.1 The Trust achieved the requirement for the CQUIN for influenza vaccination across the Trust.

2.9.2 There were four different influenza types circulating at the same time during this period resulting in more cases than expected as the national trivalent vaccine did not cover all the circulating strains.

2.9.3 As expected influenza activity increased during November and December 2017, with influenza B viruses accounting for the majority of influenza detection followed by Influenza A

(H1N1), then Influenza A (H3N2), this reflected the national picture. There was not a significant impact on clinical operations, with very few bed closures due to influenza

3.0 Other aspects of the infection prevention programme of work

3.1 Antimicrobial Stewardship

3.1.1 Antimicrobial Stewardship is an overarching system of strategies to improve the use of antibiotics to benefit patient outcomes from infection

3.1.2 Antimicrobial Stewardship remains an integral part in the Trust achieving its CDI objectives.

3.1.3 The Antimicrobial Stewardship Committee meet monthly and reports to the monthly Trust Infection Prevention Committee with assurance every three months to the Strategic Infection Prevention Committee chaired by the Director of infection prevention and Control.

3.1.4 Continued reduction in overall antimicrobial consumption and particularly broad-spectrum penicillin and carbapenem prescribing is a priority in slowing the emergence of antimicrobial resistance.

3.1.5 The pharmacy department undertake specific antimicrobial audits and the wards based metrics has been revised to include antimicrobial prescribing related audits

3.1.6 In terms of education there is a dedicated e-learning package called ARK that is introduced at the welcome day and at annual updates. All staff are encouraged to complete this and discussion is taking place around making it mandatory

3.1.7 This education is supported in practice with a secure, mobile phone or internet accessible microbial guide. The approach within in the Trust is therefore both proactive e.g. comprehensive antimicrobial prescribing guidelines harmonised across primary and secondary care, joint formulary, and reactive e.g. antimicrobial stewardship ward-rounds by infection doctors and pharmacists, audit and feedback.

3.1.8 The National Antimicrobial Resistance and Sepsis CQUIN for 2017-19 is an opportunity to further the Antimicrobial Stewardship agenda and contribute to better patient outcomes.

3.2 Facilities and Engineering

3.2.1 The IPT continued to support and provide advice to numerous schemes to develop or create facilities and services.

3.2.2 Collaborative work with the Estates and Facilities Division continues to improve monitoring and reporting on cleaning standards and maintenance and monitoring of the estate.

3.2.3 The monitoring and eradication of Pseudomonas in taps and showers continues. A system of regular shower head changes in high risk areas has been established and water outlet testing is in place.

3.2.4 The weekly operational Water Management group has led on mitigation and management of this issue with support from the IP team. The Water Safety group meets on a monthly basis, chaired by an Estates manager with representatives from Microbiology, IP and contractor services attending the meetings. Appendix 2 shows the governance arrangements

3.3 Decontamination

3.3.1 The Infection Prevention team have been involved in giving decontamination advice throughout the Trust, and attending the monthly decontamination group that reports to the monthly Trust Infection Prevention committee meetings.

3.3.2 The Trust has a Head of Decontamination as specified in the Code of Practice for Infection Prevention (Department of Health, 2015) who works closely with the IP team to ensure all policies and procedures are being adhered to.

3.3.3 The Sterile Services Departments (SSD) are fully compliant with the Medical Devices Directive 93/42/EEC annex V (sterility only) and has an auditable ISO 13485:2012 Quality Management System; for Medical Devices.

3.3.4 The Endoscope Decontamination Units (EDU) are also working within ISO 13485:2012 and are JAG registered for bowel screening. Audits of SSD's and EDU's are carried out on a regular basis by an external notified body on behalf of the MHRA.

3.3.5 The SSD at PRH has recently had five new Washer Disinfectors installed with a total capacity of nine chambers.

3.4 Occupational Health Services

3.4.1 Occupational Health (OH) provides a wide range of services including health clearance, advise on fitness for work, assessment and follow up of sharps and splashes, vaccinations and blood testing, health surveillance and physiotherapy to BSUH Trust staff.

3.4.2 Work-related vaccinations are offered in line with Department of Health (DH) “green book” guidance. OH adheres to OH standard operating procedure for administration of vaccines. Records of vaccinations given are documented in individual staff files. Work-related vaccinations are provided free of charge.

3.4.3 Staff who will be undertaking Exposure prone procedures (EPPs) as part of their role will be screened by OH before health clearance is confirmed, as per DH guidance (health clearance for tuberculosis, hepatitis B, hepatitis C and HIV: new healthcare workers).

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Appendix 1

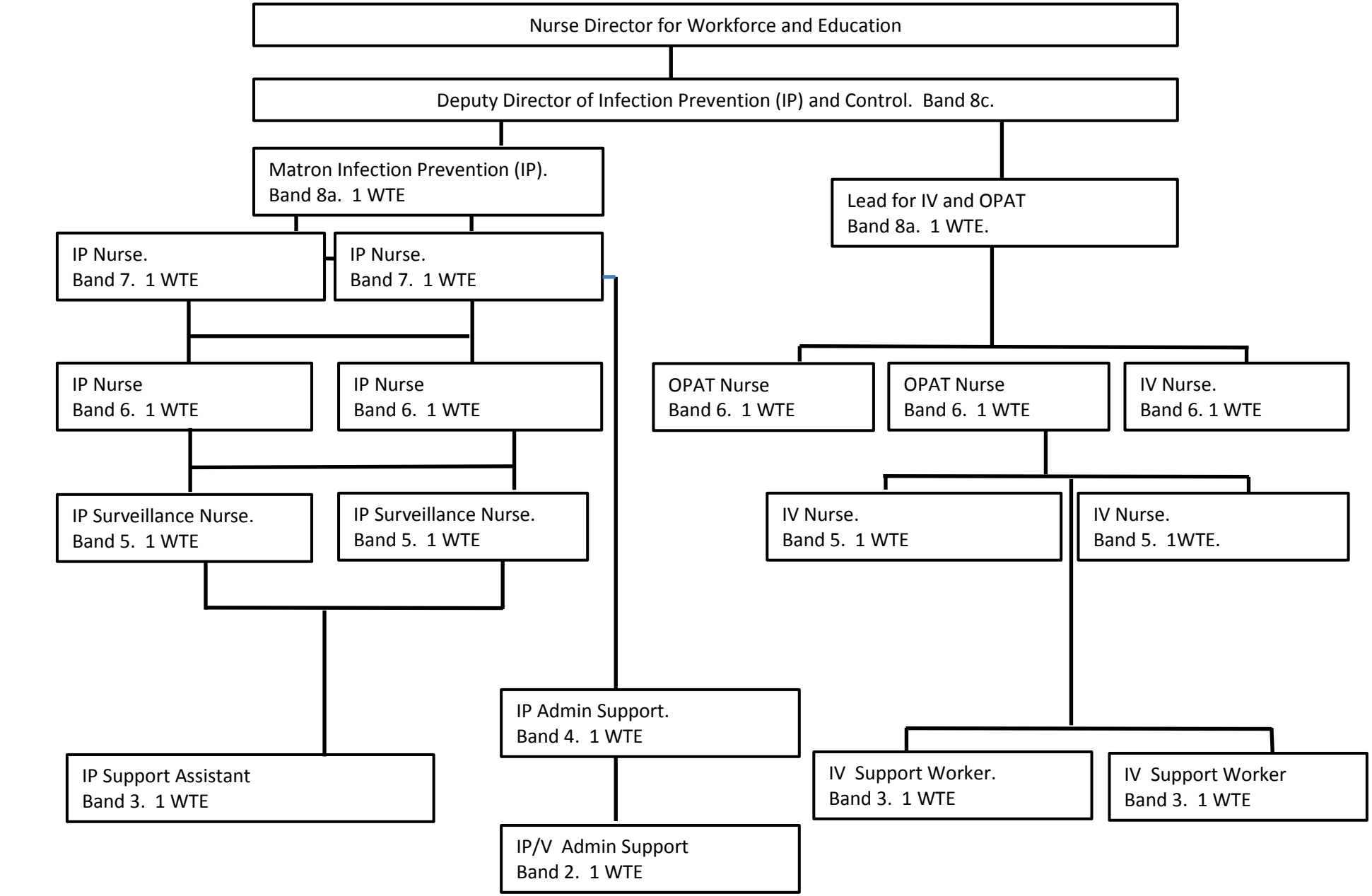
Infection Prevention Team

Competences for Infection Prevention Teams and the members within it are detailed in a document published in The Journal of Hospital Infection (Burnett, 2011). There are suggested national models for infection prevention teams, the numbers of nurses needed and associated support. However, the local structure needed will be largely dependent on activities in the local Trust. For example, BSUH is in the process of building a new wing to the hospital that requires consistent input from the IP team from the point it was conceived up until the day it has patients in it. Therefore the current structure is dynamic and likely to change dependant on Trust activity and availability of expertise. The following flowchart details the current structure of the IP and IV services that have a common manager (Director of Workforce and Education). The governance structure following that details how the IP team interfaces at multiple levels with the Trust.

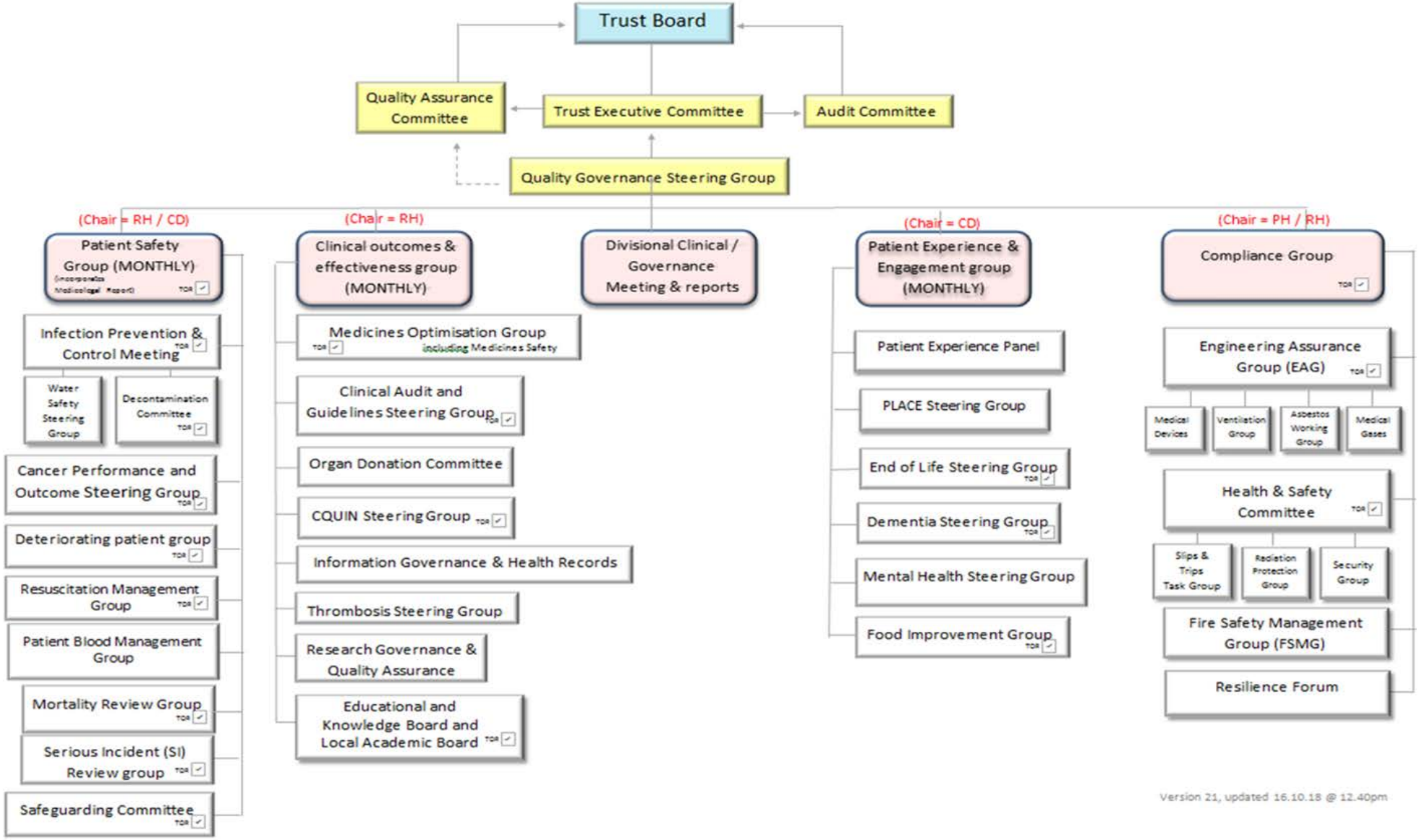
Other members of the team include:

- Microbiologists, virologists, Infectious diseases, environmental monitoring officers, matrons, infection prevention link practitioners, Occupational Health and sterile services.
- The Director of Infection Prevention and Control (DIPC) is the Chief Nurse.
- The core infection control service includes an infection control advisory service, proactive infection prevention work and education and training throughout the organisation. It also undertakes audit, policy formulation and advice, surveillance and epidemiology, outbreak and control management. A significant aspect of their work is advising on planning.
- An advisory service is operated daily and out of hours. This is provided by the on-call microbiology and virology service. The IP service plans to provide weekend cover during the winter this year.
- There is a daily brief to review clinical information and service responses. The core infection control team meets monthly to formally review infection control issues and performance.
- The Trust infection Prevention committee (TIPC) is chaired by a Director and meets monthly with representatives from Directorates and key service areas. Every third month is the Strategic Infection Prevention Committee (SIPC). The minutes are available on the intranet. This committee reports to the monthly Patient Safety Group.
- The IPT work closely with the CCG and PHE and other stakeholders; Examples include: CDI RCAs are reviewed regularly with the CCG.

Appendix 1 (cont): Infection Prevention Team



Appendix 2 – Infection Prevention and Control governance arrangements



APPENDIX 3

Chart 1: Trust and non-Trust apportioned MRSA blood stream infections (BSI) against a set objective of zero**.**

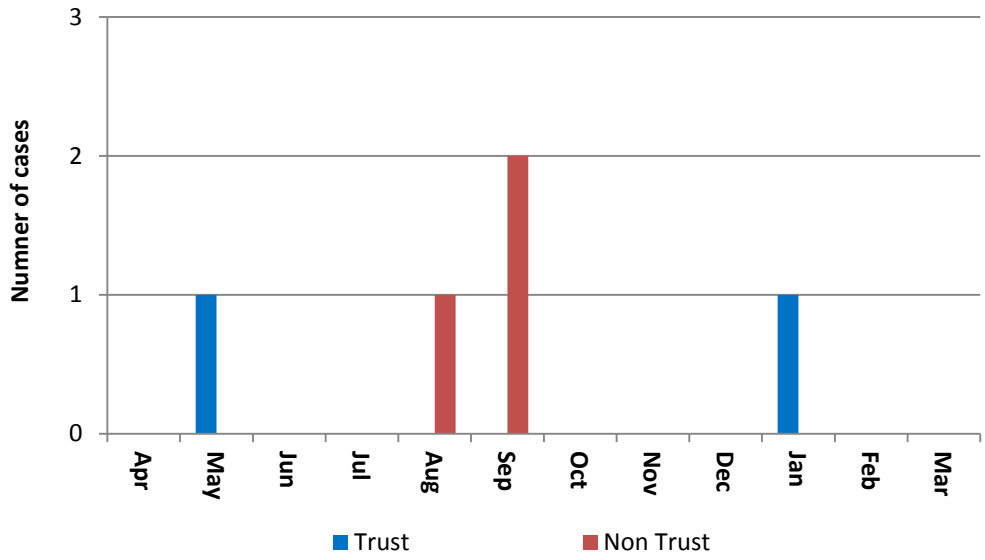
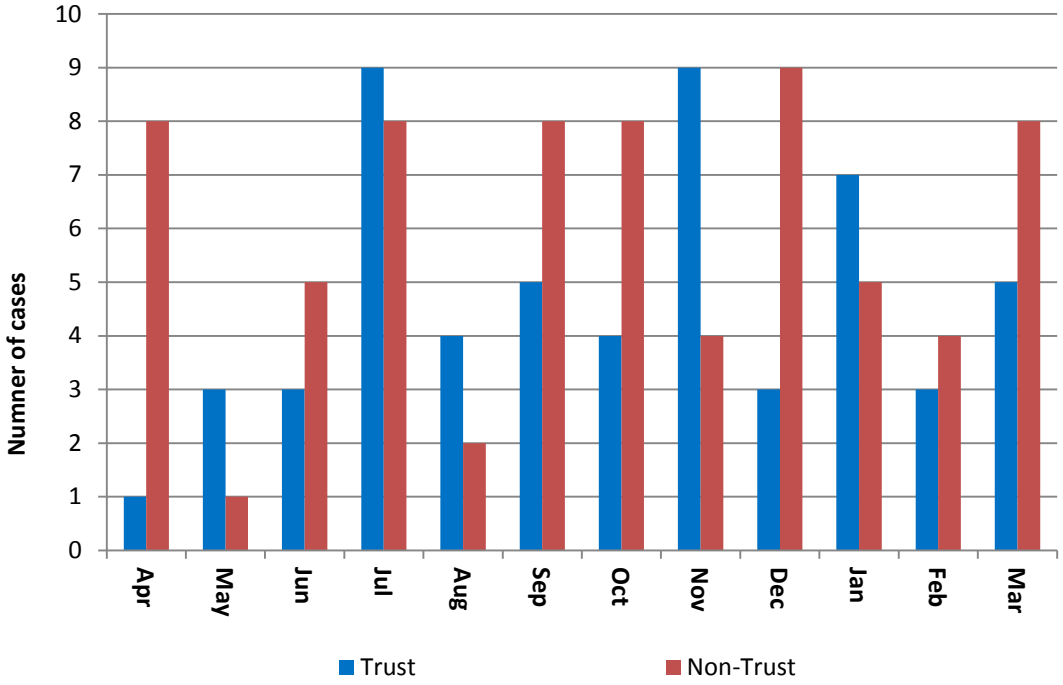
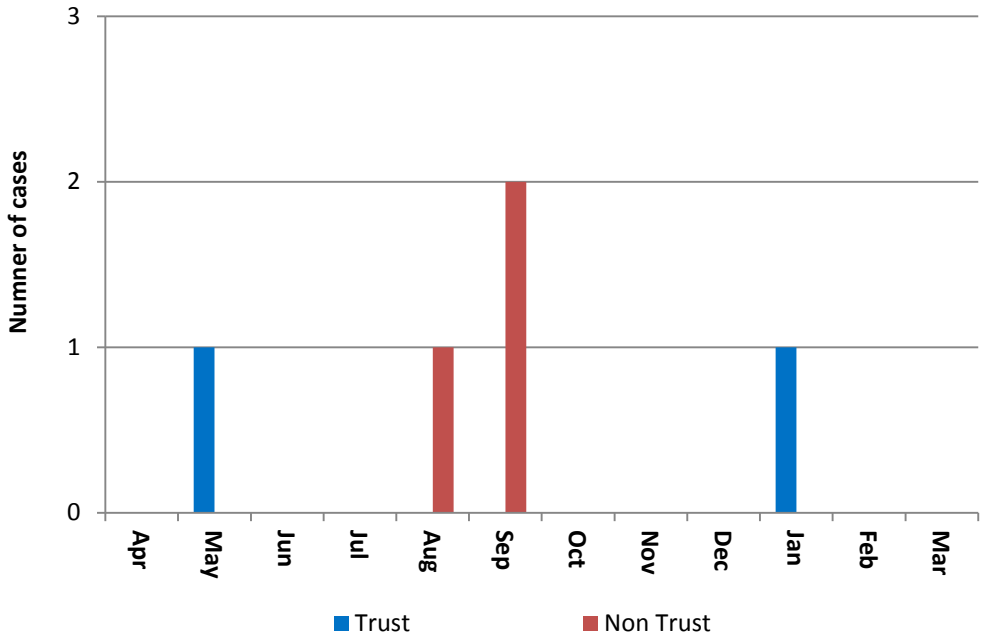


Chart 2: *Clostridium difficile* infection burden across the health economy during 2017-18, this includes Trust acquired, Community Acquired, GP and others



APPENDIX 3 (cont)

Chart 3: Trust and Non-Trust acquired MSSA blood stream infections for 2017-18



Appendix 4

Table 1 – Education delivered 2017-18

Session	Facilitator	Participants	Number of participants	Method of delivery	Learning outcomes	Frequency/ dates	sessions	Estimated Hours
Trust Induction	Learning and Development Department	All new starters to BSUH. Excludes volunteers	1202	face to face	Satisfy skills (2017) for health competency framework and passport schemes	Twice monthly. Once in Brighton, once in Haywards Heath	24	18
yearly update - clinical staff	Learning and Development Department	All clinical staff	2045	face to face (lecture style),	Staff are already expected to know skills for health competencies and these are summarised in a workbook. This is an update in relation to how BSUH is performing and to clarify any specific outcomes	several times a month	36	18
yearly update - clinical staff	IRIS	All clinical staff	2479	IRIS eLearning and a workbook	Staff are already expected to know skills for health competencies and these are summarised in a workbook. This is an update in relation to how BSUH is performing and to clarify any specific outcomes			
Three yearly update	Learning and Development Department	non-clinical staff	438	face to face (lecture style), I	Staff are already expected to know skills for health competencies and these are summarised in a workbook. This is an update in relation to how BSUH is performing and to clarify any specific outcomes	monthly	12	6
Three yearly update	IRIS	non-clinical staff	431	RIS eLearning and a workbook	Staff are already expected to know skills for health competencies and these are summarised in a workbook. This is an update in relation to how BSUH is performing and to clarify any specific outcomes			
Hand Hygiene auditor sessions	Infection Prevention and Control Team	Healthcare staff that undertake audits	42	face to face	By the end of the session an attendee will: o Be able to describe each of the five moments for hand hygiene in relation to their area o Explain/ demonstrate how to undertake a hand hygiene audit o Explain/ demonstrate how to complete the hand hygiene audit o Explain/ demonstrate how to give staff feedback in relation to hand hygiene practices, both positive and negative and record this feedback o Describe the standard operating procedure and RAG rating in relation to compliance scores and appropriate actions including escalation o Demonstrate how to upload the data to the dashboard		11	11

Session	Facilitator	Participants	Number of participants	Method of delivery	Learning outcomes	Frequency/ dates	sessions	Estimated Hours
HCA induction	Practice Development Team	healthcare assistants	50	face to face	what is infection prevention; how do organisms spread; examples of vectors/fomites; common infections in hospitals; importance of hand washing; alcohol hand rubs; environmental cleaning and the importance of; commode cleaning	monthly	4	2
Volunteers Induction Day	Voluntary Services Department			face to face	Skills for health competencies: responsibilities; hand hygiene; personal protective equipment; dealing with blood spillage; management of injury; cleaning of equipment/ environment and personal fitness for work	RSCH		
						25.04.2017	1	0.5
						26.06.2017	1	0.5
						23.08.2017	1	0.5
						19.10.2017	1	0.5
						12.12.2017	1	0.5
						PRH		
						25.05.2017	1	0.5
						18.07.2017	1	0.5
						19.09.2017	1	0.5
						23.11.2017	1	0.5
University Students	University of Brighton	BSc Year 3 Nursing	160	face to face	Revision and application of standard principles for infection prevention according to NICE (2012) clinical guideline and epic3 (2015)	18.09.2017; 19.02.2018	4	12
Medical Students	Brighton and Sussex Medical School	BSMS Module 301: Clinical Foundation Course Year 3	130	face to face lecture theatre	Satisfy skills for health (2017) competency framework and outcomes for General Medical Council (2015)	20.09.2017	1	2
Total			**6977**				**101**	**73.5**

Appendix 5

Table 2: Clinical areas involved in the outbreaks, the number of patients and staff affected, the number of bed lost days and the duration in days for the closure of the ward per outbreak.

Ward	Close status	Start date	No. Patients	No. Staff	Bed lost days	Duration of closure (days)
Pyecombe	Ward	12/05/17	6	0	18	5
TMBU	Nursery 2	26/05/17	4	0	0	5
Pyecombe	Ward	20/06/17	3	1	2	2
Vallance	Ward	29/06/17	4	1	2	1
Ardingly	Bay x 2	07/07/17	9	2	8	8
Chichester	Ward	06/10/17	3	8	5	5
Newhaven	Bay x 1	29/10/17	1	4	1	3
Hurstpierpoint	Ward	31/10/17	11	4	13	10
Twineham	Ward	04/11/17	18	5	49	12
Jowers	Bay	05/11/17	2	1	0	6
Chichester	Ward	05/11/7	6	5	20	13
Chichester	Ward	2nd wave	15	3	32	21
Chichester	Ward	3rd wave	5	1	9	7
Catherine James	Ward	17/11/17	4	0	13	8
Jowers	Bay x 1	23/11/17	2	0	0	5
AMU	Ward	24/11/17	9	0	15	10
Baily	Bay x 1	27/11/17	3	0	0	9
Catherine James	Ward	30/11/17	7	0	6	12
Soloman	Ward	04/12/17	8	2	9	4
Lindfield	Bay x 1	14/12/17	4	10	8	7
AMU	Bay	15/12/17	7	0	0	1
Vallance	Bay x 1	15/12/17	2	0	27	7
Chichester	Ward	17/12/17	8	1	9	6
Egremont	Ward	19/12/17	10	0	15	9
Baily	Bay	19/12/18	3	0	0	3
Baily	Bay	27/11/18	4	0	0	5
Pyecombe	Bay x 2	29/12/17	4	0	0	5
Emerald	Ward	11/01/18	9	0	1	8
Newhaven Downs	Bay	11/01/18	7	0	0	8
Chichester	Bay	07/02/18	7	0	6	6
AAU	Bay	08/02/18	1	0	0	2
AAU	Bay	17/02/18	7	0	0	6
Ardingly	Ward	26/02/18	11	1	0	11
L11 Gynae	Bay	24/02/18	1	0	0	5
Baily	Bay	28/02/18	8	1	0	7
Solomon	Bay	10/03/18	4	2	0	7
Level 8 Tower	Ward	11/03/18	6	7	108	8
Donald Hall	Bay	20/03/18	6	0	0	7
Vallance	Bay	22/03/18	7	0	0	6

Brighton and Sussex University Hospitals NHS Trust

To: Trust Board

Date of Meeting: 24th October 2018 Agenda Item: **12**

Title
Emergency Planning, Resilience and Response
Responsible Executive Director
Pete Landstrom
Prepared by
Natasza Lentner, Head of Resilience
Status
Public
Summary of Proposal
Note EPRR assurance rating for this year and note the subsequent action plan. Note our current major incident preparedness and the ongoing work to improve our major incident and mass casualty preparedness and business continuity preparedness.
Implications for Quality of Care
The constraints to lockdown clinical areas of the Trust poses a risk to the ability to deliver safe clinical during a declared major incident if the areas cannot be secured to prevent unauthorized access.
Link to Strategic Objectives/Board Assurance Framework
Ensuring safe and high quality care as part of the Trust's
Financial Implications
No current financial implications
Human Resource Implications
No human resource implications over and above normal business.
Recommendation
The Board/Committee is asked to: • Note our current EPRR Assurance rating of partial compliance • Note the improvements and actions undertaken and support the Resilience Team in ensuring the actions are delivered to continue to maintain our major incident preparedness.
Communication and Consultation
N/A
Appendices
Appendix 1 – 2018/19 Action Plan

Brighton and Sussex University Hospitals NHS Trust

To: Trust Board **24 October 2018**

From: Chief Operating Officer **Agenda Item: 12**

FOR INFORMATION

Emergency Planning, Resilience and Response (EPRR)

Annual Assurance and Major incident/Mass Casualty Incident Update

1. INTRODUCTION

1.1 This paper outlines our current NHSE EPRR assurance rating and subsequent action plan and updates the board on our current emergency planning, resilience and response readiness and the further work that is required.

2 NHSE EPPR ASSURANCE

2.1 Every year BSUH has to complete the NHSE EPRR assurance self-assessment.

2.2 Subsequent to our non-compliant rating in 2016 an action plan was put together and the Executive Team committed to appropriately resourcing the Resilience Team by financing a Resilience Manager post to work with the Head of Resilience. With the increased staffing resources and detailed action plan BSUH were able to achieve substantial compliance ahead of schedule in May last year.

2.3 This year's assessment is now reporting partial compliance for 2018 with 3 red ratings and 11 amber ratings. All other core standards are assessed as substantial or fully compliant.

2.4 Although we are reporting partial compliance many of the standards can be completed in the next 3 months. The Trust has secured the support of an experienced emergency planning officer working with us 2 days a week whilst the appointment of a new resilience manager is progressed following retirement. There is an action plan in place that has been peer reviewed as part of the Sussex wide peer review, and will reach substantial compliance within the next 6 months.

2.5 The action plan for these amber and red ratings which can be found in Appendix 1.

2.6 The Head of Security wrote a separate paper on the Development of Lockdown Plan & Capability in the Trust last year and he has been asked to update the board separately on our current position regarding this.

2.7 It is accepted that no Trust will be able to achieve full compliance due to national delays including Core Standard 50 as the new DPST (Data protection and Security Toolkit) requires a mid-year baseline submission to be provided at the end of October and Full year by the end of March 2019 so trust will rate this as Amber if working towards this.

3 2017/18 ACHIEVEMENTS

3.1 A major success this year was undertaking our 3 yearly live major incident exercise, Exercise Galileo. This is a legal requirement of the Trust as a Category 1 responder organisation.

3.2 The patients and communities that we serve expect us to be there for them when they need it, irrespective of the circumstances we face. As such, we as a Trust must do all that we can to ensure we are well prepared to respond to any disruptive challenges or emergencies that may arise, this includes fulfilling our legal duty to undertake regular communication tests, an annual table top exercise and a live-play exercise every three years.

3.3 As such on the 18th September 2018, after many months of planning, the Trust ran Exercise Galileo, a full communications test and a live-play emergency exercise to test our major incident plans and processes.

3.4 The exercise was very well received with a total of 95 BSUH staff participating, 33 medical students acting as casualties and support from 11 of our local health and emergency service colleagues.

3.5 There were also additional members of staff on duty to ensure normal business was not affected.

3.6 A full report will highlight those areas that went well and an action plan will be produced so that we can make improvements to our processes going forward.

4 AREAS OF PARTIAL COMPLIANCE

4.1 There are a number of Amber rating areas that should be completed within the next 3 months:

- EPRR Resource – the advert has been placed to recruit to the Resilience Manager post and supporting resource has been secured in the interim
- Pandemic influenza – this plan is being updated to align with WSHFT following joint workshops as learning from outbreaks across both organisations, and to reflect new quarantine areas within RSCH and externally whilst it is being rebuilt.
- Updates to the Mass Countermeasures Plan and Shelter and Evacuation Plan – have both been produced and signed off by the Resilience Forum and are currently progressing through the internal Trust approvals process.

4.2 There a small number of areas that are Red Ratings which are well recognised areas of challenge for all organisations to comply with. These will be ongoing activities::

- Sussex wide and local training to identify and support 24 hour access to trained Emergency Incident loggists
- Full Site Lockdown plans and capacity. The organisation has effective arrangements in place safely manage site access and egress of patients, staff and visitors to and from the organisation's facilities, and the key areas of ED

lockdown were tested within the recent Major Incident Exercise – however full site lockdown remains very challenging to achieve.

- The organisation carries out Emergency Incident training in line with a training needs analysis to ensure all staff are competent in their role; training records are kept to demonstrate this.

5 RECOMMENDATION

The Board is asked to:

- **NOTE** our current EPRR Assurance rating of partial compliance.
- **NOTE** the improvements and actions still required and support the Resilience Team in ensuring the actions are delivered to reach substantial compliance and continue to test and improve our major incident preparedness.

Natasza Lentner
Head of Resilience
26.09.18

Brighton and Sussex University Hospitals NHS Trust

Appendix 1 EPRR Action Plan Sept 2018- Aug 2019

Overall assessment:			Partially compliant				
Ref	**Standard**	**Detail**	**Self-assessment RAG**	**Action to be taken**	**Lead**	**Time-scale**	**Comments**
5	**EPRR Resource**	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource, proportionate to its size, to ensure it can fully discharge its EPRR duties.	Partially compliant	The Resilience Manager post will be advertised but there was a period of reduced capacity in the team while waiting to appoint.	Natasza Lentner	Dec-18	There was reduced capacity in the team while the Head of Resilience was on maternity for 6 months of this year. The Resilience Manager role will be also be vacant from the 29th August. The post is advertised but there will be a period of reduced capacity in the team while waiting to appoint with interim support arrangements secured.
15	**Pandemic influenza**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including Viral Haemorrhagic Fever. These arrangements should be made in conjunction with Infection Control teams; including supply of adequate FFP3.	Partially compliant	Plan is being rewritten to align with WSHT and to reflect new quarantine areas within RSCH and externally whilst it is being rebuilt.	Jane McGovern	Dec-18	The current plan is aligned to all current National Guidelines however it is being reviewed following joint learning with WHSFT. It aligns also with the local Health Economy Plans.

17	**Mass Countermeasures**	In line with current guidance and legislation, the organisation has effective arrangements in place to distribute Mass Countermeasures - including the arrangement for administration, reception and distribution, e.g. mass prophylaxis or mass vaccination. There may be a requirement for Specialist providers, Community Service Providers, Mental Health and Primary Care services to develop Mass Countermeasure distribution arrangements. These will be dependant on the incident, and as such requested at the time. CCGs may be required to commission new services dependant on the incident.	Partially compliant	Signed off by the Resilience Forum, for final approval	Chris Lynch	Dec-18	Mass Countermeasure Plans have been prepared for both sites despite the lack of National Guidance. It identifies parts of the sites that would be used for mass prophylaxis should that prove necessary.

20	**Shelter and evacuation**	In line with current guidance and legislation, the organisation has effective arrangements in place to place to shelter and / or evacuate patients, staff and visitors. This should include arrangements to perform a whole site shelter and / or evacuation.	Partially compliant	Signed off by the Resilience Forum, for final approval	Chris Lynch	Dec-18	The Whole Site Evacuation Strategy for both PRH and RSCH awaits approval. An appendix to those plans are the same establishments identified by Sussex Resilience Forum in the multi-agency Evacuation and Shelter Plan
21	**Lockdown**	In line with current guidance and legislation, the organisation has effective arrangements in place safely manage site access and egress of patients, staff and visitors to and from the organisation's facilities. This may be a progressive restriction of access / egress that focuses on the 'protection' of critical areas.	Non-compliant	Lockdown Plan is complete but it requires expenditure on self-closing doors and any adjustment as the new buildings come on line.	Simon Whitehorn Head of BSUHT Security	2 year expenditure plan and new buildings available by 2020	Lockdown has been practiced in ED

26	**EPRR Training**	The organisation carries out training in line with a training needs analysis to ensure staff are competent in their role; training records are kept to demonstrate this.	Non-compliant	The Resilience Team delivers training to staff in particular roles. This includes On call manager and Director training, volunteers, loggists, ED staff, and PRPS suit training.	Natasza Lentner		Induction is the opportunity to ensure ALL staff had awareness training when they started so that they knew their role in an incident and also and informed them where further information could be found. This is a gap in the current induction and is being addressed.
28	**Strategic and tactical responder training**	Strategic and tactical responders must maintain a continuous personal development portfolio demonstrating training in accordance with the National Occupational Standards, and / or incident / exercise participation	Partially compliant	All on call managers and directors given CPD documentation and information on the national Occupational Standards but not many currently maintain this personal document	Natasza Lentner	Sep-19	
30	**Incident Co-ordination Centre (ICC)**	The organisation has a pre identified an Incident Co-ordination Centre (ICC) and alternative fall-back location. Both locations should be tested and exercised to ensure they are fit for purpose, and supported with documentation for its activation and operation.	Partially compliant	We are currently moving the HICC to a new location which will be tested but we are still working on ensuring our back up HICC is in place	Natasza Lentner	Dec-18	HICC successfully relocated to Trust HQ and tested as part of the Live Major Incident

33	**Loggist**	The organisation has 24 hour access to a trained loggist(s) to ensure decisions are recorded during business continuity incidents, critical incidents and major incidents.	Non-compliant	Need to identify and train a pool of loggists and work with other acute trusts on solutions to this problem Recognised as a regional issue across many organisations	Natasza Lentner	Sep-19	Current loggist duties being undertaken by Resilience Team. Being taken forward as part of Sussex wide EPRR
49	**Business Impact Assessment**	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(s).	Partially compliant	Business Impact Analysis templates have been produced but some departments still need to complete theirs	Natasza Lentner	Mar-19	
50	**Data Protection and Security Toolkit**	Organisation's IT department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	Partially compliant	Await final submission next March 2019	IT Lead	Mar-19	The Data Protection and Security Toolkit was only launched in April 2018 so no Acute Trust's will have made a final submission for 2018/19 (submission date is 31st March 2019).
51	**Business Continuity Plans**	The organisation has established business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure	Partially compliant	Whilst there is an overall BC strategy in place there is still work to be done The organisation takes Business Continuity very seriously and we are working to produce service level plans for each part of the organisation. We have an additional member of staff dedicated to completing this role.	Natasza Lentner, Head of Resilience	Mar-19	

		These plans will be updated regularly (at a minimum annually), or following organisational change.					
55	**Assurance of commissioned providers / suppliers BCPs**	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and is assured that these providers arrangements work with their own.	Partially compliant	continue to work with procurement	Natasza Lentner	Mar-19	Work has been done with Procurement to ensure any new contractor has a BCP in place should their supply chain be broken. Sussex LHRP have produced a table to show where there are gaps in the process
64	**PPE disposal arrangements**	There are effective disposal arrangements in place for PPE no longer required, as indicated by manufacturer / supplier guidance.	Partially compliant	Add in to CBRN plan as an appendix		Dec-18	

Brighton and Sussex University Hospitals NHS Trust

To: Meeting of the Board of Directors

Date of Meeting: 24th October 2018 Agenda Item: **13**

Title
Workplace Race Equality Standard – 2018 Workforce Race Equality Standard (WRES) Data and the WRES Working Group Implementation of Action Plan
Responsible Executive Director
Denise Farmer, Chief Workforce and Organisational Development Officer
Prepared by
Barbara Harris, Head of Equality, Diversity and Inclusion
Status
Public
Summary of Proposal
The Workforce Race Equality Standard (WRES) is a national NHS benchmarking tool designed to help NHS organisations gauge their current state of race equality and track what progress is being made to identify and promote talented black and minority ethnic (BME) staff, as well as helping to eliminate wider aspects of discrimination in the treatment of BME staff. The Trust Board is committed to improving the experience of all of our staff and the WRES provides a specific tool to measure our progress in improving the working experience of our BME staff. The Board with the support of the whole national WRES Team held a Race Equality Conference on 29th May 2018 with 200 leaders and staff from across the organisation. The conference was open to all staff to attend. The attendees identified key areas for improvement and a WRES Working Group was established to further develop the WRES Action Plan. The first meeting of this group took place on 20th June 2018 and group table work was undertaken to discuss each one of the 9 indicators and to develop and implementation plan. Meetings continue on a monthly basis and all staff who have attended have contributed to the discussions on the development of the Plan. Three clear targets were set in our Action Plan by our WRES Working Group for achievement by 2021, namely: • **Communication** • **Education and Training** • **Recruitment and Selection** This Plan includes some new initiatives as well as building on existing work and platforms. It is a comprehensive plan which will require focus and dedicated resourcing. Our WRES Working Group believe it will make a significant contribution to redressing the current unacceptable imbalance.
Implications for Quality of Care
There are strong links between discrimination and poor patient experience and therefore addressing inequality is likely to improve patient experience and care.
Link to Strategic Objectives/Board Assurance Framework
People Strategic Objective - We value and respect all our staff equitably, involve them in decisions about the services they provide and offer the training and development they need to fulfil their roles.

Financial Implications
Resources already identified for 2018/19. A business case will be produced for 2019/20.
Human Resource Implications
As above
Recommendation
The Board/Committee is asked to: APPROVE
Communication and Consultation
N/A
Appendices
Appendix 1 – Workforce Race Equality Standard 2018 Appendix 2 – WRES Working Group Action Plan

Brighton and Sussex University Hospitals NHS Trust

Brighton and Sussex University Hospitals NHS Trust

Workforce Race Equality Standard 2018

Introduction

Recent research on race equality in the NHS workforce makes challenging reading for boards in provider organisations. Evidence shows that if you are from a black and minority ethnic background you are less likely to be appointed once shortlisted, less likely to be selected for training and development programmes, more likely to experience harassment, bullying and abuse, and more likely to be disciplined and dismissed.

Black and minority ethic staff are significantly underrepresented in senior management positions and at board level. In 2012, just 1 per cent of NHS Chief Executives came from a BME background, compared to 16 per cent BME representation in the NHS workforce. Most worryingly, despite a multitude of race equality initiatives and examples of provider good practice since the 2004 Race Equality Action Plan, many of the key indicators are either static or actually getting worse.

Leading by example: The race equality opportunity for NHS provider boards, 2014 – NHS Providers

This challenge is one that **all** NHS organisations need to meet because

- It suggests talent is being wasted through unfairness in the appointment, treatment and development of a large section of the NHS workforce
- It suggests precious resources are wasted through the impact of such treatment on the morale, discretionary effort, and other consequences of such treatment
- Research shows convincingly that such treatment adversely affects the care and treatment of all patients
- Research shows that diverse teams and leaderships are more likely to show the innovation and increase the organisational effectiveness the NHS needs
- Organisations whose leadership composition bears little relationship to that of the communities served will be less likely to deliver the patient focussed care that is needed

The NHS has responded by the introduction of the Workforce Race Equality Standard, which requires all NHS providers to start to address these issues.

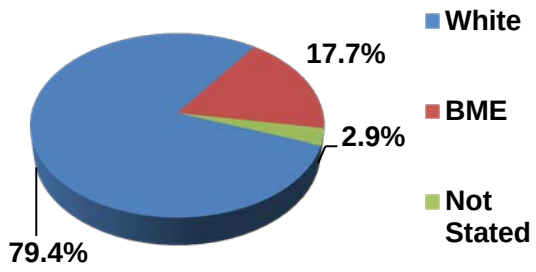
Background Information

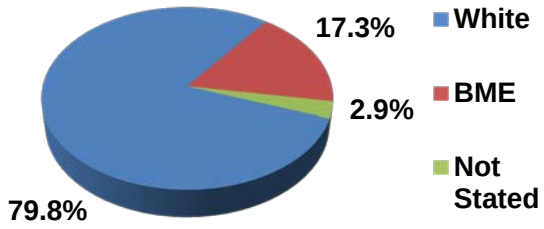
1) Total number of staff:

2017	2018
8219 headcount	8321 headcount

Proportion of BME staff employed within this organisation at the date of this report:

	2017		2018	
	Headcount	% of Staff	Headcount	% of Staff
White	6526	79.4%	6637	79.8%
BME	1454	17.7%	1440	17.3%
Not Stated	239	2.9%	244	2.9%
Total	8219	100.0%	8321	100.0%





2017 2018

2) Self-reporting

a) The proportion of total staff who have self-reported their ethnicity:

	2017		2018	
	Headcount	% of Staff	Headcount	% of Staff
Ethnicity Declared	7980	97.1%	8077	97.1%
Ethnicity Not Declared	239	2.9%	244	2.9%
Total	8219	100.0%	8321	100.0%

b) Have any steps been taken in the last reporting period to improve the level of self-reporting by ethnicity?

We collect information relating to staff ethnicity as part of the recruitment process.

c) Are any steps planned during the current reporting period to improve the level of self-reporting by ethnicity?
Whilst we appreciate that knowing 97.1% of the workforce's ethnicity is very positive, we recognise there are ways we can improve on this. We will continue to collect information relating to staff ethnicity as part of the recruitment process. In addition to contacting staff where their ethnicity is unknown and encourage them to declare their ethnicity.

3) Workforce Data

a) What period does the organisation's workforce data refer to?
1st April 2017 to 31st March 2018.

4) How is BME Defined under WRES?

In line with the categories taken from the 2001 Census:

BME Categories	Unknown	White Categories
D – Mixed white and black Caribbean	Z – not stated	A – White – British
E – Mixed white and black African	NULL	B – White – Irish
F – Mixed white and Asian	Unknown	C – Any other white background
G – Any other mixed background		
H – Asian or Asian British – Indian		
J – Asian or Asian British – Pakistani		
K – Asian or Asian British – Bangladeshi		
L – Any other Asian background		
M – Black or black British – Caribbean		
N – Black or black British – African		
P – Any other black background		
R – Chinese		
S – Any other ethnic group		

5) Population Demographic 2011 Census (Southeast England)

	Census 2011
BME	9%
White	91%
Unknown	0%

Workforce Race Equality Indicators

For each of the indicators, the standard compares the metrics for white and BME staff.

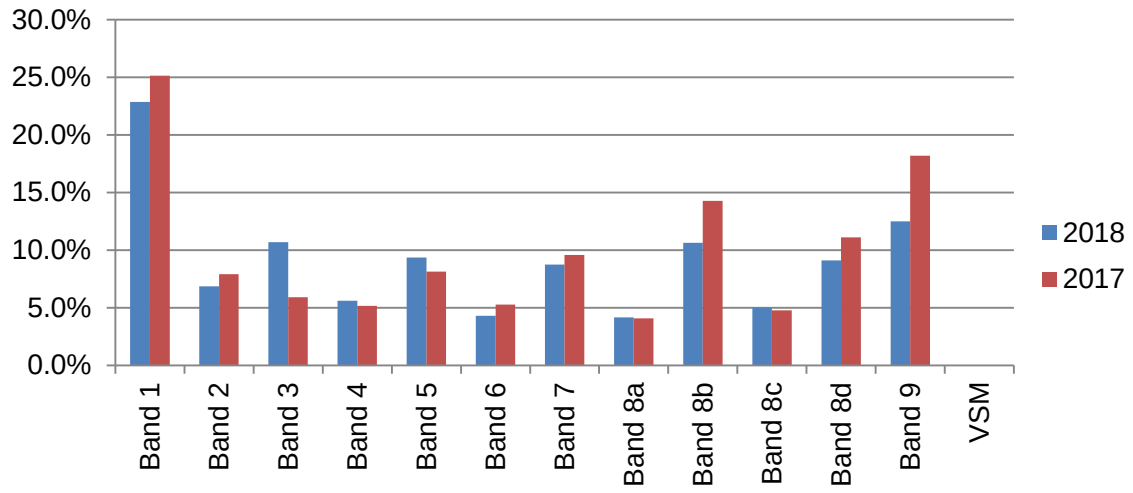
Indicator 1 - Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce

Note: Organisations should undertake this calculation separately for non-clinical and for clinical staff.

	Non-Clinical					
	White	BME	Unknown	Total	White %	BME %
Band 1	280	91	27	398	70.4%	22.9%
Band 2	340	26	14	380	89.5%	6.8%
Band 3	497	61	13	571	87.0%	10.7%
Band 4	365	22	6	393	92.9%	5.6%
Band 5	159	17	6	182	87.4%	9.3%
Band 6	128	6	6	140	91.4%	4.3%
Band 7	91	9	3	103	88.3%	8.7%
Band 8a	43	2	3	48	89.6%	4.2%
Band 8b	42	5	0	47	89.4%	10.6%
Band 8c	19	1	0	20	95.0%	5.0%
Band 8d	10	1	0	11	90.9%	9.1%
Band 9	7	1	0	8	87.5%	12.5%
VSM	9	0	2	11	81.8%	0.0%
Total	**1990**	**242**	**80**	**2312**	**86.1%**	**10.5%**

What the data tells us:

- The overall population of non-clinical BME staff is higher than the overall population statistics in the 2011 Census (10.5%).
- There appears to be an overrepresentation at 22.9% of BME staff in the lowest paid roles at Band 1.
- A fair representation can be seen at bands: 3, 8b, and 9. Although the overall number of band 9s are small.
- All other bands including VSM (very senior manager) appear to be underrepresented by BME staff.
- When comparing to the 2017 WRES report, BME representation looks like this:



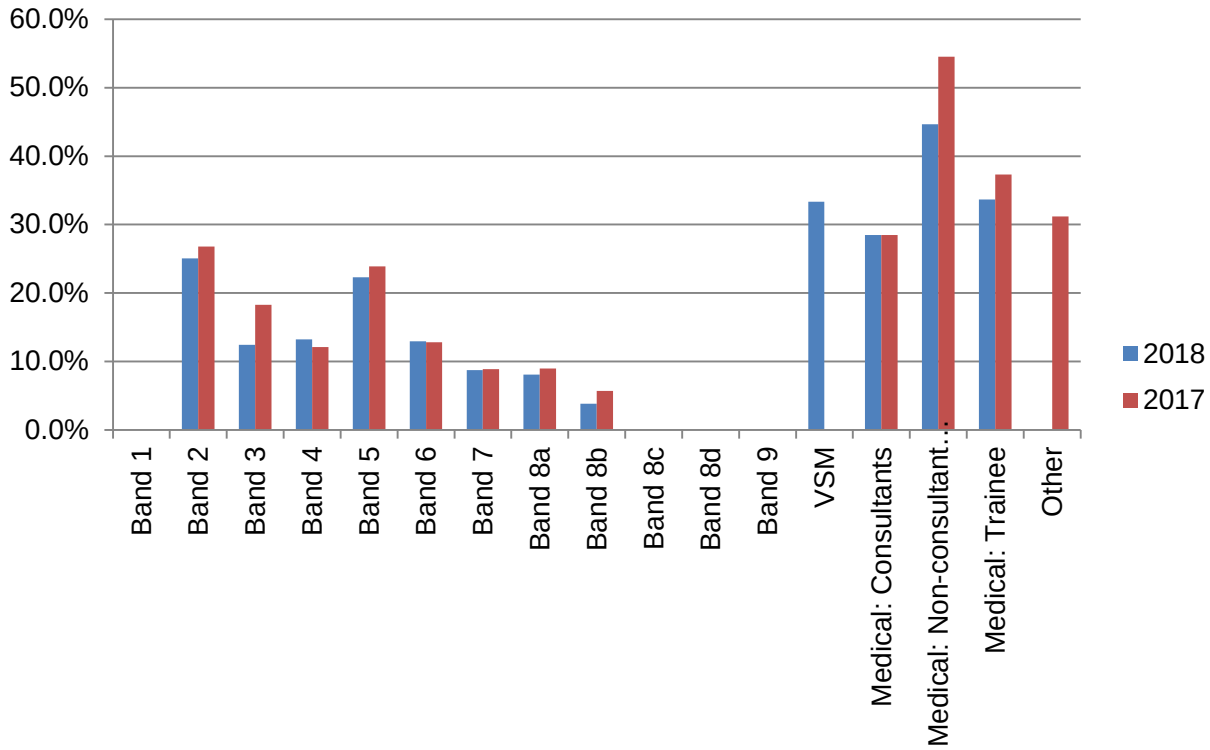
There have been increases in representation of BME staff from 2017 to 2018 in bands: 3, 4, 5 and 8c but decreases in bands: 1, 2, 6, 7, 8b, 8d and 9.

	Clinical					
	White	BME	Unknown	Total	White %	BME %
Band 1	0	0	0	0	0.0%	0.0%
Band 2	630	218	21	869	72.5%	25.1%
Band 3	212	31	6	249	85.1%	12.4%
Band 4	140	22	4	166	84.3%	13.3%
Band 5	1043	313	47	1403	74.3%	22.3%
Band 6	1023	158	37	1218	84.0%	13.0%
Band 7	595	59	21	675	88.1%	8.7%
Band 8a	141	13	7	161	87.6%	8.1%
Band 8b	48	2	2	52	92.3%	3.8%
Band 8c	19	0	0	19	100.0%	0.0%
Band 8d	8	0	0	8	100.0%	0.0%
Band 9	2	0	0	2	100.0%	0.0%
VSM	1	1	1	3	33.3%	33.3%
Medical: Consultants	321	131	8	460	69.8%	28.5%
Medical: Non-consultant career grade	29	25	2	56	51.8%	44.6%
Medical: Trainee	435	225	8	668	65.1%	33.7%
Other	0	0	0	0	0.0%	0.0%
Total	**4647**	**1198**	**164**	**6009**	**77.3%**	**19.9%**

What the data tells us:

- The overall population of non-clinical BME staff is more than the overall population statistics in the 2011 Census (9%).

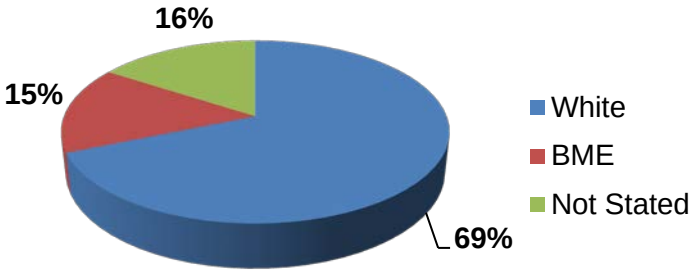
- There appears to be an overrepresentation at 25.1% of BME staff in the lowest paid clinical roles at Band 2.
- There appears to be an overrepresentation at Band 5 however, there is a low representation between bands 6-8d this which should be investigated to identify any barriers to progression.
- There is a representation of BME staff in the VSM (very senior managers) level.
- There is appears to be an overrepresentation at all levels of medical roles however, this in line with national trends for this staff group.
- All other bands are underrepresented by BME staff.
- When comparing to the previous 2017 WRES report, BME representation looks like this:



There have been increases in representation of BME staff from 2017 to 2018 in bands: 4, 6 and VSM but decreases in bands: 2, 3, 5, 7, 8a, 8b, Non-consultant grade, medical trainees and medical other.

Indicator 2 - Relative likelihood of staff being appointed from shortlisting across all posts

	Applicants		Shortlisted		Appointed		Relative Likelihood of being appointed
	Number	%	Number	%	Number	%	
BME applicants	4734	25%	84	21%	124	15%	**1.48**
White applicants	13643	71%	293	74%	551	69%	**1.88**
Not Stated / Unknown	840	4%	18	5%	127	16%	**7.06**
Total	**19217**	**100%**	**395**	**100%**	**802**	**100%**	



The likelihood of white candidates being appointed from shortlisting: 551/293=1.88

The likelihood of BME candidates being appointed from shortlisting: 124/84=1.48

The relative likelihood of white candidates being appointed from shortlisting compared to BME staff is: 1.88 (white candidates) / 1.48 (BME candidates) = **1.27 times.**

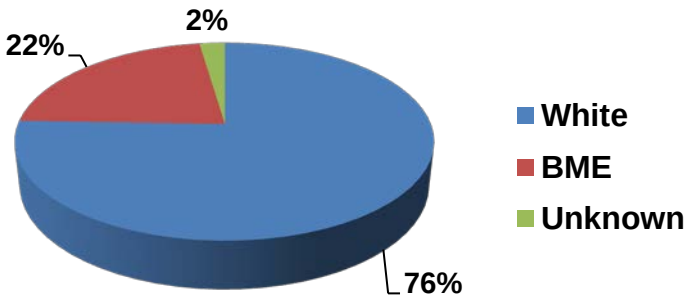
In this instance the data suggests white candidates are more likely than BME candidates to be appointed from shortlisting.

In the 2017 WRES report, the likelihood was 0.92 (in favour of BME candidates). The 2016 WRES report highlighted that there was a relative likelihood of 1.17 (in favour of white candidates) of being employed over BME staff, and the 2015 WRES report highlighted a 1.26 relative likelihood (in favour of white candidates). It would appear whilst there was a steady balancing of outcomes over earlier reports, there now appears to be more of a disproportionate appointment of white candidates.

Indicator 3 - Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation

Note: This indicator will be based on data from a two year rolling average of the current year and the previous year

	Number of Disciplinary Procedures	Number in Workforce	Relative Likelihood of entering procedure
White	65	6637	0.0098
BME	19	1440	0.0132
Unknown	2	244	0.0082



The likelihood of white staff entering the formal disciplinary process:
65 / 6637 = 0.0098

The likelihood of BME staff entering the formal disciplinary process:
19 / 1440 = 0.0132

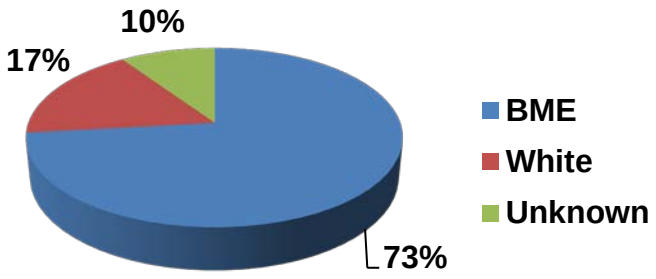
The relative likelihood of BME staff entering the formal disciplinary process compared to white staff is: 0.0132 (BME Staff) / 0.0098 (White Staff) = **1.35 times.**

In this instance the data suggests that BME staff members are more likely than white staff to enter into a formal disciplinary process.

In the 2017 WRES report, it stated that the likelihood for BME staff of 0.73, the 2016 WRES report stated there was a likelihood of 1.96 of BME staff entering into a formal disciplinary process over white staff. The 2015 WRES report stated there was a 1.52 likelihood of BME staff entering disciplinary process over white staff.

Indicator 4 - Relative likelihood of staff accessing non-mandatory training and CPD.

	Number in workforce	No. of staff accessing non-mandatory/CPD training	Relative likelihood of accessing non-mandatory/CPD training
White	6637	323	0.04867
BME	1440	76	0.05278
Unknown	244	42	0.17213
Total	8321	441	



The data supplied for 2016-17 related to applications for education funding submitted by allied health professionals and nursing and midwifery staff.

Likelihood of white staff accessing non-mandatory/CPD training:
323 / 6637 = 0.04867

Likelihood of BME staff accessing non-mandatory/CPD training:
76 / 1440 = 0.05278

Relative likelihood of white staff accessing non-mandatory/CPD training compared to BME staff: 0.04867 (White Staff) / 0.05278 (BME Staff) = **0.92 times.**

In this instance the data suggests white staff are less likely to have non-mandatory/CPD training than BME staff.

In the 2017 WRES report the likelihood was 1.79, which suggests that white staff are more likely to access training, the WRES 2016 report where the likelihood was 0.62 times and the WRES 2015 report where the likelihood was 0.89 times.

Indicator 5 - Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months – KF25 from NHS Staff Survey

Staff Survey Date	BME Staff	White Staff	National Acute Trust Average
2018	*Data available in 2019*	*Data available in 2019*	*Data available in 2019*
2017	39%	37%	28%
2016	34%	31%	27%
2015	41%	36%	28%
2014	38%	33%	28%

Whilst there has been an overall reduction for BME staff since 2015 for BME staff, the overall trend is higher than the national acute average. It is worth noting that there was an overall increase from both BME and white staff in 2017.

Indicator 6 - Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months – KF26 from NHS Staff Survey

Staff Survey Date	BME Staff	White Staff	National Acute Trust Average
2018	*Data available in 2019*	*Data available in 2019*	*Data available in 2019*
2017	30%	30%	25%
2016	37%	32%	25%
2015	44%	28%	26%
2014	30%	28%	

Since 2015 there has been a steady decrease for BME staff, in 2017 the experience of BME and White staff were equal at 30% each.

Indicator 7 - Percentage believing that trust provides equal opportunities for career progression or promotion – KF21 from NHS Staff Survey

Staff Survey Date	BME Staff	White Staff	National Acute Trust Average
2018	*Data available in 2019*	*Data available in 2019*	*Data available in 2019*
2017	71%	85%	85%
2016	64%	82%	87%
2015	68%	87%	87%
2014	44%	86%	61%

Since 2014 there has been an overall increase for BME staff (of +27%), however in 2017 the experience was still -14% compared to the national average.

Indicator 8 - In the last 12 months have you personally experienced discrimination at work from your Manager/team leader or other colleagues? Q17(b) from the Staff Survey

Staff Survey Date	BME Staff	White Staff	National Acute Trust Average
2018	*Data available in 2019*	*Data available in 2019*	*Data available in 2019*
2017	18%	8%	8%
2016	21%	8%	7%
2015	22%	7%	11%
2014	18%	8%	7%

We can observe a large disparity in the number of BME staff feeling that they have experienced discrimination at work from a manager, team leader or other colleague throughout the years. In 2017 this disparity was +10% for BME staff, compared to the national average for acute trusts.

Indicator 9 - compare the difference for white and BME staff: Percentage difference between:

(i) The organisation's Board voting membership and its overall workforce

	Overall Workforce		Voting Board Membership		
	Number in workforce	% in workforce	Number on board	% of board	% Difference
White Staff	6637	79.8%	5	83.3%	**3.5%**
BME Staff	1440	17.3%	1	16.7%	**-0.6%**
Unknown	244	2.9%	0	0.0%	**-2.9%**
Total	8321	100.0%	6	100.0%	

(ii) The organisation's Board executive membership and its overall workforce

	Overall Workforce		Executive Board Membership		
	Number in workforce	% in workforce	Number on board	% of board	% Difference
White Staff	6637	79.8%	5	83.3%	**3.5%**
BME Staff	1440	17.3%	1	16.7%	**-0.6%**
Unknown	244	2.9%	0	0.0%	**-2.9%**
Total	8321	100.0%	6	100.0%	

6. **Are there any other factors or data which should be taken into consideration in assessing progress?**

In 2016 the NHS Staff Survey was open to all BSUH Trust staff to participate in which a potential sample of circa 8,000 were permitted to participate, as opposed to a restricted sample of circa 800 in previous years.

The Trust's Annual Equality Report is also produced and the workforce data is analysed for trends across recruitment, employee relations, training and development and demographics. The report is scrutinised and approved by the Trust's Senior Management Team, and the actions feed into the Trust's Equality Objectives.

The system used to provide recruitment data, picks up all recruitment activity across a user specified period, in this instance 1 April 2017 to 31 March 2018. The system does not differentiate recruitment campaigns that start and finish within this period.

a. **Any issues of completeness of data**
   This report is based on information presented to the Trust's Board in 2018.

b. **Any matters relating to the reliability of comparisons with previous years**
   There is a discrepancy in the headcount of the 2017 BSUH workforce, the headcount is actually 8219 and not 8619.

WRES Action Plan
Agreed by WRES Working Group June/July 2018
2018-2021

NHS
Brighton and Sussex University Hospitals
NHS Trust

ONE	**Issue: BME applicants appear to be less successful through our recruitment processes than White applicants**						
	What is already in place? Shortlisting through TRAC requires rationale for shortlisting. Interview assessment sheets require scoring. At least 2 people required to shortlist.						
	Actions required	**Outcome**	**WRES indicators**	**Theme(s)**	**Lead**	**Timescale**	**Progress notes**
1.1	All Band 7 and above posts to have diverse interview panels.	Better BME representation throughout the higher bands within BSUH.	2, 7	Recruitment & Training	Abbi Denyer	Jan-19 / June-19	
1.2	Values Based Recruitment to be implemented.	To achieve a fair and equitable recruitment process.	1, 2, 7	Recruitment & Selection	Abbi Denyer	Jan-19 / Jan-20	
1.3	Monitor, review and publish the recruitment monitoring data.	To achieve a fair and equitable recruitment process and ensure no blockages in any areas.	2, 7	Recruitment & Training	Abbi Denyer	Jun-19	
1.4	Offer BME staff career development support and interview skills training.	To develop training opportunities for BME staff to aid their career development.	4,7	Education & Training	Abbi Denyer/Babs Harris	Jan-19 / Ongoing	
1.5	Recruitment images to be representative of population.	To actively encourage a greater diversity of applicants.	2, 7	Recruitment & Training	Abbi Denyer/Neil Hopkins	Mar-19	
TWO	**Issue: Staff from BME groups appear more likely to be subject to formal processes than White staff**						
	What is already in place? HR spreadsheet records all formal processes and this is recorded also on ESR						
	Actions required	**Outcome**	**WRES indicators**	**Theme(s)**	**Lead**	**Timescale**	**Progress notes**
2.1	Ensure that Trust policies are equally applied to all staff.	Fairness in the application of all policies regardless of race.	3, 8	Communication & Training	Babs Harris	Ongoing	
2.2	Ensure that those staff in leadership roles throughout the organisation are equipped to understand the complexities of race equality.	Greater understanding and knowledge of the impact of race discrimination. Reduction in racial discrimination cases.	3, 6, 8	Communuication, Appraisal & Education	Abbi Denyer/Kali Varadarajan/Babs Harris	Feb-19 / Ongoing	
THREE	**Issue: Throught the staff survey BME staff report higher levels of bullying, harassment or abuse from colleagues/managers than White staff**						

	What is already in place? Freedom to Speak Up Guardian, HELP Service, Working Together Effectively						
	Actions required	**Outcome**	**WRES indicators**	**Theme(s)**	**Lead**	**Timescale**	**Progress notes**
3.1	Initiate conversations in training and include equalities discrimination and bullying concerns within the remit of the Freedom to Speak Up Guardian.	Internal material to be developed. Staff better understand the role of the Freedom to Speak Up Guardian.	5, 6	Communication, Education & Training	Babs Harris/Caroline Owens	Since April 2018	
3.2	Highlight what our zero tolerance approach is.	Education through posters, online learning, messages from senior leaders.	5	Training	Babs Harris/Kali Varadarajan	Nov-18 / Ongoing	
FOUR	**Issue: A higher percentage of BME staff report experiencing discrimination at work in the last 12 months**						
	What is already in place? Equality, Diversity and Inclusion Policy; Equality and Diversity session at Corporate Induction and as part of Mandatory training programme. Due Regard within workforce policies.						
	Actions required	**Outcome**	**WRES indicators**	**Theme(s)**	**Lead**	**Timescale**	**Progress notes**
4.1	Develop BSUH own 'No Bystanders' film.	An organisational understanding of the impact discrimination can have.	8	Education & Training	Neil Hopkins/Babs Harris	Jan-19	
4.2	Update the Violence and Aggression Policy.	Current policy will be updated to ensure relevant to current issues.	5	Training & Communication	Abbi Denyer	Completed	
4.3	Look into unconscious bias or cultural intelligence awareness training/education.	A greater understanding of what can lead to unintentional misunderstandings in teams/departments.	All excluding 9	Education, Training & Communication	Babs Harris/Kali Varadarajan	Mar-19 / Ongoing	

Brighton and Sussex University Hospitals NHS Trust

To: Board of Directors

Date of Meeting: 24th October 2018 Agenda Item: **14**

Title
Clinical Audit Report
Responsible Executive Director
George Findlay, Chief Medical Officer and Deputy Chief Executive Rob Haigh, Medical Director
Prepared by
Della Morris – Safety & Quality Lead Mark Renshaw - Deputy Chief of Safety
Status
Public
Summary of Proposal
a) The purpose of this report is to provide an annual update on clinical audit in the Trust
Implications for Quality of Care
1. Loss of public confidence in the Trust.
Link to Strategic Objectives/Board Assurance Framework
Support of Board Assurance Framework number B1, C1
Financial Implications
1. Improving the quality of clinical care will reduce complaints and medical errors, reducing the cost of delivering care and impacts on litigation costs. 2. Loss of Commissioner confidence may result in loss of Trust business.
Human Resource Implications
1. Technical skills and experience of those undertaking audit 2. Skill and resources for subsequent improvement work. 3. Organisational, behavioural and cultural issues.
Recommendation
The Board is asked to NOTE the contents of the report.
Communication
Not applicable
Appendices
Appendix 1: Proposed Process for Managing National Clinical Audit Appendix 2: Clinical Audit Annual Programme 2018-19

Clinical Audit Report

Introduction

This paper details the Trust's Clinical Audit Programme for 2018-19, based on both national requirements and local priorities and capacity within the central Safety & Quality Team for supporting the Clinical Audit function.

It is the responsibility of all health professionals to critically review their work to ensure care is given according to the best available evidence. Clinical audit is embraced by Brighton and Sussex University Hospitals NHS Trust as a framework for reviewing and assuring the Board that the Trust is providing safe high quality care. Clinical audit also contributes towards the wider quality, safety, assurance and governance frameworks that are in place across the organisation.

Participation in clinical audit is mandated by the following regulations:

The NHS Standard Contract[1] states that:

- The provider must participate in the national clinical audits within the National Clinical Audit and Patient Outcomes Programme (NCAPOP) relevant to the Services[2]
- The provider must make national clinical audit data available to support national publication of Consultant-level activity and outcome statistics in accordance with HQIP Guidance[3]
- The provider must implement an ongoing, proportionate programme of clinical audit of the Services in accordance with Good Practice[4]

The CQC Fundamental Standards require organisations to:

- assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity[5]

The GMC state that all doctors "must take part in regular reviews and audits of the standards and performance of any team you work in, taking steps to resolve any problems."[6]

The Department of Health requires that all NHS providers publish an annual Quality Account. The Quality Account places a duty on providers to publish details of the number of National and Local Audits participated in and a description of the action the provider intends to take to improve the quality of healthcare following review of the audits.

The National Clinical Audit and Patient Outcomes Programme (NCAPOP) audits are commissioned and managed on behalf of NHS England by HQIP. NCAPOP covers two main sub-programmes: the National Clinical Audit Programme and the Clinical Outcome Review Programmes.

The National Clinical Audit programme comprises of almost 50 audits related to some of the most commonly-occurring conditions. These collect and analyse data supplied by local clinicians to provide a national picture of care standards for that specific condition. On a local level, NCAPOP audits provide local trusts with individual benchmarked reports on their compliance and performance, feeding back comparative findings to help participants identify necessary improvements for patients.

The Clinical Outcome Review Programmes (previously known as confidential enquiries), are designed to help assess the quality of healthcare, and stimulate improvement in safety and effectiveness by systematically enabling clinicians, managers and policy makers to learn from adverse events and other relevant data.

[1] NHS Standard Contract 2017/19
[2] 26.1.2 service conditions
[3] 26.1.3 service conditions
[4] 15.7.1 general conditions
[5] Good Governance 17(2)(a)
[6] General Medical Council (2012) Leadership and management for all doctors. Domain 2

Penalties for non-participation in National Clinical Audits

The commissioners have the powers to impose financial penalties should the Trust fail to participate in any NCAPOP project.

Clinical Audit Plan 2018-19

The Clinical audit programme for 2018-9 has been developed using the HQIP four-step model, as stated below. The process of prioritisation used assumes a hierarchy of importance with 1 being the most important:

Priority 1 – External "must do" audits: These are externally monitored, part of the NCAPOP and assessed by the CQC. These audits are also included in the NHS England Quality Accounts List for 2018-19.

HQIP state "It is essential to ensure that they are treated as priorities and that appropriate resources are provided to support them.

Priority 2 – External audits that may be on the Quality Accounts List, but not NCAPOP and internal "must do" audits.

HQIP states "Many of these clinical audits will arise from governance issues or high profile local initiatives, and may include national initiatives with local relevance, without penalties for non-participation".

Priority 3 – Divisional priorities: Divisions are asked to suggest projects that are priorities for the division.

Priority 4 - Clinical interest: These are projects that emerge during the year. They cannot be determined at the outset of the financial year. They represent innovative ideas from Clinicians and can provide valuable education experience

Clinical Audit Process 2018-19

Each year Specialties are asked to agree a programme of planned clinical audit activity for the forthcoming financial year. This process is co-ordinated by both the Trust Safety and Quality Lead and Clinical Effectiveness Facilitator, with oversight by the Clinical Divisions and Clinical Audit Leads.

In February, the Safety and Quality Team compile draft speciality clinical audit plans. These plans are based on:

- Audits from the NCAPOP Programme & Quality Accounts list.
- CQUINs or Quality Account Initiatives
- Ongoing local audits, likely to continue into 2018-19

In addition, the Safety and Quality Team review the actions of all the previous year's Serious Incident Investigation Recommendations and develop a series of local audit proposals aimed at providing assurance that the chances of a recurrence are reduced.

Finally, each speciality is sent a listing of NICE guidance that is pertinent to their speciality.

The expectation is that the Local Audit Lead uses the draft project plan to establish a proposed audit plan for 2018-19, recognising that this is a 'live' programme and further clinical audits will be added during the course of the year in response to identified organisational, service and specialty needs. The expectation is that the Local Audit Leads agree this programme during April 18.

This year's plan for 2018-19 reflects agreed priority projects, based on considerations such as anticipated Trust/Divisional quality objectives, National Clinical Audits, commissioning priorities, national guidance (NICE, Patient Safety Alerts, Royal Colleges), local clinical priorities and learning from local triangulation activities and peer or other review recommendations.

Projects have been prioritised based on priority areas for clinical audit as outlined within the HQIP.

The Trust's Clinical Audit Programme proposals for 2018-19 are listed in Appendix 2 by clinical division.

Capacity

Oversight of the National Audit Programme is provided by the Safety & Quality Facilitator (0.58 WTE) who is a member of the Safety and Quality Team. Appendix 1 is based on the current Clinical Audit Policy and contains details of responsibilities of the central Safety & Quality Team, Specialities and Divisions within the new governance framework.

With the current capacity within the Safety & Quality team there is limited central oversight and assurance of the outputs of National Audits that are run as registries and do not produce annual reports. Additionally there is no central oversight and assurance regarding the Clinical Outcomes Programme[7].

Currently there is limited oversight of Local Audit. These are collated annually via the Clinical Audit plan and added to the central database. Some junior doctors also submit details of their local audits in order to receive certificates for their portfolios. However there is no dedicated Safety & Quality Facilitator time to develop this agenda or provide training and support.

Oversight of the whole programme resides with the Trust's Safety & Quality Lead (0.8WTE) whose primary function is delivery of the CQUINs programme.

At Western Sussex Hospitals the audit function is provided by 4.21 WTE. In BSUH the Clinical Audit function, PROMs and NICE is provided by 1.18 WTE.

[7] The Clinical Outcome Publication is an NHS England initiative, managed by HQIP, to publish quality measures at the level of individual consultant, team and unit level using national clinical audit and administrative data that is available on a public website.

Appendix 1: Proposed Process for Managing National Clinical Audit

Step in process	Quality and Safety Team	Audit Lead for Speciality	Speciality Lead	Division	COEG
Identify National Audits that are relevant to the Trust	Safety and Quality Facilitator coordinates				
Identify appropriate audit lead(s)	Safety and Quality Facilitator identifies				
Add audit to the central database with details of who the audit was sent to and when	Safety and Quality Facilitator uploads to Audit database				
Distribute audit requirements by email	Safety and Quality Facilitator distributes audit requirements	Speciality Lead for Audit coordinates participation			
Participation in national audit	Safety and Quality Facilitator provides support where capacity	Speciality Lead for Audit coordinates participation			
Chase after 30 days if no response to participation request	Safety and Quality Facilitator sends reminder to identified lead			Divisional Group notified of non-response	

Step in process	Quality and Safety Team	Audit Lead for Speciality	Speciality Lead	Division	COEG
Audit Report published[8]: Completion of Gap Analysis/Action Plan required	Safety and Quality Facilitator distributes audit report & Gap Analysis/Action Plan required	Speciality Lead for Audit undertakes Gap Analysis/Action Plan			
Gap Analysis/Action Plan completed	Safety and Quality Facilitator distributes audit report & completed Gap Analysis/Action Plan required to Divisional Groups	Audit lead updates compliance on Audit database	Speciality QSPE scrutinises and sign-off on completed Gap Analysis/Action Plan required.	Divisional Group scrutinise and sign-off on completed Gap Analysis/Action Plan required. Where appropriate escalate serious risks to COEG and add to the Risk Register	Review and action serious risks escalated by the Divisional Team
Chase after 30 days if no response to Gap Analysis/Action Plan request	Safety and Quality Facilitator sends reminder to identified lead			Divisional Group notified of non-response	

[8] Not all national audits produce annual reports. Some are run as Registries and data inputters are able to look up Trust data, the S&Q facilitator does not have access to this data. In other audits the data can be viewed by consultant or hospital.

Step in process	Quality and Safety Team	Audit Lead for Speciality	Speciality Lead	Division	COEG
Monitoring of Gap Analysis Action Plan	Safety and Quality Facilitator sends reminder to identified lead for any actions past deadline. Escalates as appropriate to Speciality Lead and / or Division	Updates action on database			
Monthly Report on Overall Compliance to COEG	Safety and Quality Facilitator produces report				COEG Review monthly report on national audit

The following areas are not being achieved with the current capacity within the Safety & Quality Team:

Step in process	Quality and Safety Team	Audit Lead for Speciality	Speciality Lead	Division	COEG
Ongoing audits/registries	Safety & Quality Facilitator notifies that a report is due	Reviews online data and compiles a report of the outcomes data to include a Gap Analysis/Action Plan	Speciality QSPE scrutinises report and signs off the Gap Analysis/Action Plan	Divisional Group scrutinise and sign-off. Where appropriate escalate serious risks to COEG and add to the Risk Register	Review and action serious risks escalated by the Divisional Team
Clinical Outcome Publication	Safety and Quality Facilitator monitors publication timetable and notifies specialty when data has been published Updates COEG that data has been published		Speciality QSPE scrutinises data online for all Consultants operating in BSUH. Feed outcomes up to Divisional QSPE	Divisional Group scrutinise and sign-off. Where appropriate escalate serious risks to COEG and add to the Risk Register	COEG to monitor publication timetable & receive updates from Divisions in line with national publication schedule.

Appendix 2: Clinical Audit Annual Programme 2018-19

Central Clinical Services	
Blood Transfusion	
Regular review of the auditable components of the Bloodhound system to identify any areas	SI
Breast Surgery / Surgery	
*** Increased uptake in breast screening (2017/19) - PHE CQUIN	CQUIN
*** National Audit of Breast Cancer in Older Patients (NABCOP)	National
*** Therapeutic Mammaplasty (TeaM) Study	National
Breast cancer (updated June 2016)	NICE
Cancer	
*** Head and neck oncology (DAHNO/HANA)	National
Annual rectal cancer resection audit	Audit
Audit documentation of correct laterality consistent with ensuring radiotherapy treatment	Audit
Audit of blood glucose monitoring in Neuro-oncology patients treated with dexamethasone	Audit
Audit of compliance with criteria specified within radiotherapy radiographer PGDs - on	Audit
Audit of conversion from radical to palliative lung radiotherapy	Audit
Audit of death within 30 days of administration of systemic anti-cancer treatment	Audit
Audit of death within 30 days of delivery of radiotherapy	Audit
Audit of interruptions to radiotherapy particularly Category 1 patients against RCR standards	Audit
Audit of required appointment allocation against time taken for new radiotherapy equipment	Audit
Audit of scope of practice of Radiotherapy Advanced Practitioners by supporting Consultant	Audit
Audit of systemic therapy for metastatic cancer over 15 years	Audit
Audit of the SOP for removal of non cancer patients from the 2 week wait tracking system	SI
Audit of time from diagnosis staging and chemo starting for operable oesophageal cancer	Audit
Audit post implementation of Deep Inspiration Breath Hold for radiotherapy to left sided	Audit
Audits post implementation of 'paperlight' processes in radiotherapy	Audit
Bosutinib for previously treated chronic myeloid leukaemia	NICE
Cabazitaxel for hormone-relapsed metastatic prostate cancer treated with docetaxe -	NICE
Cancer of the upper aerodigestive tract: assessment and management in people aged 16 and	NICE
Colorectal cancer	NICE
Degarelix for treating advanced hormone-dependent prostate cancer	NICE
Electronic fault logging on radiotherapy machines - ensuring system being used correctly and	Audit
Everolimus for advanced renal cell carcinoma after previous treatment	NICE
Infection control handwashing audit - radiotherapy	Audit
ISO 9001:2008 Quality Management System Audit - external and programme of internal	Audit
Laryngectomy humidification compliance	Audit
Metastatic spinal cord compression in adults	NICE
Necitumumab for untreated advanced or metastatic squamous non-small-cell lung cancer	NICE
Non-luer spinal (intrathecal) devices for chemotherapy	Safety
Nutrition and Dietetics Service Patient Questionnaire	Audit

Ongoing prospective anal cancer CRT audit	Audit
Patient Privacy & Dignity Survey in Radiotherapy	Audit
Patient Satisfaction Questionnaire (Macmillan Support Workers)	Audit
Pegaspargase for treating acute lymphoblastic leukaemia	NICE
Pemetrexed maintenance treatment for non-squamous non-small-cell lung cancer after	NICE
Programme of audits to support IRMER legislation compliance (logged in Oncology drive)	Audit
Prostate cancer	NICE
Radiotherapy Patient Experience Survey	Audit
Ramucirumab for previously treated locally advanced or metastatic non-small-cell lung cancer	NICE
Review of patients treated with Radium 223 for advanced prostate cancer	Audit
Review of patients who are diagnosed with Sarcoma to ensure that lessons learned are	SI
Review of the new reporting process to ensure that patient referrals without associated	SI
Sarcoma	NICE
Sussex wide audit of FOLFIRINOX treatment in advanced cancer of the pancreas	Audit
To evaluate patient selection for, and outcomes from, neoadjuvant treatment for patients	Audit
Trifluridine-tipiracil for previously treated metastatic colorectal cancer	NICE
Upper Gastrointestinal Patient Experience Survey	Audit
Dietetics and Nutrition	
Audit of the updated Trust's Policy to Reduce Harm Caused by Misplaced Nasogastric Feeding	SI
Nasogastric tube misplacement: continuing risk of death and severe harm	Safety
Risk of death from asphyxiation by accidental ingestion of fluid/food thickening powder	Safety
Managing the Risks during the Transitional Period to the New Iso Medical Devices	Safety
Food allergy in children and young people	NICE
Maternal and child nutrition	NICE
Nutrition support in adults	NICE
Obesity: identification, assessment and management of overweight and obesity in children,	NICE
Obesity: clinical assessment and management	NICE
Obesity in children and young people	NICE
Appropriate use of Artificial Nutrition in Stroke	Audit
Annual MUST audits to meet Quality Statement 1 - screening for those at risk of malnutrition	Audit
QISMET audit of diabetes self-management education	Audit
Retrospective 4 month service evaluation of dietetic management of Irritable Bowel Syndrome	Audit
Service evaluation audit for allergy referrals	Audit
Maternal Health Clinic Outcomes	Audit
Diabetes Insulin Pump Audit	Audit
Audit of effectiveness of paediatric 1:1 weight management service	Audit
Imaging	
Regular audit of anomaly scans is already in place and will continue to be undertaken and	SI
Audit of local imaging teams to ensure that local reviews have taken place as per the action	SI
Percutaneous radiofrequency ablation of renal cancer	NICE
Percutaneous radiofrequency ablation for primary or secondary lung cancers	NICE

Videofluroscopy	Audit
Infection Control	
Audit to ensure that water engineers of checks of the levels of chlorine dioxide in the water	SI
Addressing Rising Trends and Outbreaks in Carbapenemase producing Enterobacteriaceae	Safety
Infection control	NICE
Food hygiene	Audit
CQC hot spot	Audit
Hot spot audit during period of increased incident	Audit
Compliance with decontamination of patient equipment	Audit
Compliance with appropriate use of personal protective equipment	Audit
Ward/Department IP management	Audit
Safe storage and transportation of specimens	Audit
Theatre scrub	Audit
Compliance with sharp handling	Audit
Complaince with sharp disposal in line with EU directive	Audit
Compliance with waste management in line with EU directive	Audit
Patient led assessment of the care environment (PLACE)	Audit
CYH (opportunity/actual)	Audit
Compliance with nursing standard for care and management of peripheral venous access	Audit
Compliance with nursing standard for care and management of urinary catheters	Audit
Compliance with national standards for management of hydrotherapy pool	Audit
Compliance with national standards for the management of endoscopy decontamination	Audit
Compliance with decontamination of commode / raised toilet seats	Audit
Compliance with MRSA decolonisation	Audit
Hand hygiene (part of outbreak/PII)	Audit
Infectious Diseases	
Hepatitis C (genotype 1) - telaprevir	NICE
Hepatitis C (genotype 1) - boceprevir	NICE
Simeprevir in combination with peginterferon alfa and ribavirin for treating genotypes 1 and 4	NICE
Interventional Radiology	
Percutaneous transluminal radiofrequency sympathetic denervation of the renal artery for	NICE
Palliative Medicine	
******* National Audit for Care at the End of Life (NACEL)	National
Pathology - all labs	
Audit of the documentation for phoning abnormal blood results to AMU to ensure all results	SI
Pharmacy	
Support to minimise the risk of distress and death from inappropriate doses of naloxone	Safety
Improving Medication Error Incident Reporting and Learning	Safety
Risk of Death and severe harm from error with injectable Phenytoin	Safety
Harm from using Low molecular weight Heparins when contraindicated	Safety
Risk of distress and death from inappropriate doses of naloxone in patients on long-term	Safety
Minimising risks of omitted and delayed medicines for patients receiving homecare services	Safety

Residual Anaesthetic Drugs In Cannulae And Intravenous Lines	Safety
Addressing antimicrobial resistance through implementation of an antimicrobial	Safety
Prophylaxis against infective endocarditis: antimicrobial prophylaxis against infective	NICE
Medicines optimisation: the safe and effective use of medicines to enable the best possible	NICE
Antimicrobial stewardship: systems and processes for effective antimicrobial medicine use	NICE
Antimicrobial stewardship: changing risk-related behaviours in the general population	NICE
Controlled drugs: safe use and management	NICE
Antimicrobial stewardship	NICE
Medicines optimisation	NICE
Reducing the impact of serious infections - Sepsis and AMR (2017/19) - National CQUINs	CQUIN
Prescribing accuracy	Audit
An audit to quantify the frequency and nature of out of hours hospital discharges where the	Audit
Bio-similar reactions	Audit
Antibiotic stewardship programme	Audit
Pharmacy intervention audit	Audit
Pharmacy Transformation Programme monitoring	Audit
Medication Safety Thermometer	Audit
Anti-emetic policy	Audit
Quality Improvement Toolkit	Audit
Rate and nature of medication errors for patients sent to the discharge lounge.	Audit
Medication Security	Audit
Pharmacy Department Quality Manual - Educational Governance Specification Processes for	Audit
Discharge Lounge project	Audit
Opioid Prescribing	Audit
Audit of IV fluids on Trauma ward	Audit
Physiotherapy	
*** UK Parkinson's Audit (previously known as National Parkinson's Audit) 2017	National
Fit bumps and Beyond Outcomes Re-audit	Audit
Risk of death and serious harm byfalling from hoists	Safety
Speech and Language Therapy	
Transcutaneous Neuromuscular Electrical Stimulation (NMES) for oropharyngeal dysphagia	NICE
Awake Crainiotomy	Audit
ACD Surgery: dysphagia & voice outcomes	Audit
Oral care	Audit
A&E patient swallow screening	Audit
Swallow Outcomes	Audit
PRH Level I Swallow Screen for patients with stroke	Audit
Patient feedback questionnaire	Audit
Communication group outcomes	Audit
Children & Woman	
Children's	

Bedwetting in children and young people	NICE
Intravenous fluid therapy in children and young people in hospital	NICE
Intravenous fluid therapy in children and young people in hospital (NG29)	NICE
Looked-after children and young people	NICE
Urinary tract infection in children and young people	NICE
Cancer services for children and young people	NICE
Constipation in children and young people	NICE
Meningitis (bacterial) and meningococcal septicaemia in children and young people	NICE
Gynaecology	
Fertility problems	NICE
Heavy menstrual bleeding: assessment and management - updated August 2016	NICE
Contraception	NICE
Menopause	NICE
Heavy menstrual bleeding	NICE
Extraurethral (non-circumferential) retropubic adjustable compression devices for stress	NICE
Single-incision short sling mesh insertion for stress urinary incontinence in women	NICE
Sacrocolpopexy with hysterectomy using mesh to repair uterine prolapse	NICE
Urinary incontinence in women	NICE
Ovarian cancer	NICE
Urinary incontinence in women	NICE
Uterine suspension using mesh (including sacrohysteropexy) to repair uterine prolapse	NICE
Infracoccygeal sacropexy using mesh to repair uterine prolapse	NICE
Infracoccygeal sacropexy using mesh to repair vaginal vault prolapse	NICE
Hysteroscopy Waiting times	Audit
Cytoscopy & Cystodistension	Audit
Bladder Care	Audit
Urogynecology	Audit
IUD	Audit
Colposcopy	Audit
Laparoscopic hysterectomy (including laparoscopic total hysterectomy and laparoscopically	NICE
Hysteroscopic morcellation of uterine leiomyomas (fibroids)	NICE
Neonatology	
*** MBRRACE-UK Perinatal Mortality Surveillance Enquiry	National
*** Neonatal intensive and special care (NNAP) (subscription funded from April 2012)	National
Antibiotics for early-onset neonatal infection	NICE
Audit of Neonatal Jaundice	Audit
Hypoglycaemia Management Service Improvement Project (Hypostop)	Audit
Leaflet for Extreme Prematurity	Audit
National HIV and Syphilis Surveillance	Audit
Neonatal infection	NICE
Neonatal Jaundice	NICE
Neonatal specialist care	NICE

Neonatal Transport Service Audit	Audit
Neurodevelopmental Outcome Audit	Audit
Newborn Hearing Screening Programme (NHSP)	Audit
Newborn Infant Physical Examination Screening Programme (NIPE)	Audit
Parent Satisfaction Survey - Neonatology	Audit
Risk Of Severe Harm And Death From Infusing Total Parenteral Nutrition Too Rapidly In Babies	Safety
Therapeutic hypothermia with intracorporeal temperature monitoring for hypoxic perinatal	NICE
Obstetrics	
*** Child Head Injury Project	National
*** Diabetes (Adult): National Pregnancy in Diabetes Audit	National
*** MBRRACE Confidential Enquiry into Maternal Deaths	National
*** National Maternity and Perinatal Audit	National
Admission to NICU	Audit
Admission to TMBU/SCBU	Audit
Antenatal and postnatal mental health	NICE
Antenatal and postnatal mental health: clinical management and service guidance	NICE
Antenatal care for uncomplicated pregnancies (published March 2008, updated Jan 2017)	NICE
Antenatal care. Updated April 2016	NICE
Antenatal Risk Assessment	Audit
Audit of record keeping on the labour ward to include maternal and fetal observations	SI
Bladder Care (Womens)	Audit
Booking Appointments (Womens)	Audit
Caesarean Section	NICE
Care of women in Labour	Audit
Continuous Electronic Fetal Monitoring	Audit
Eclampsia	Audit
Ectopic pregnancy and miscarriage	NICE
Examination of Newborn	Audit
Fetal Blood Sampling	Audit
Handover of Care (Womens)	Audit
Harm from delayed updates toambulance dispatch and satellitenavigation systems	Safety
High Dependency Care	Audit
Hypertension in pregnancy	NICE
Immediate Care of the Newborn	Audit
Inducing labour	NICE
Induction of Labour	Audit
Intermittent Auscultation	Audit
Intrapartum care	NICE
Intrapartum care: care of healthy women and their babies during childbirth	NICE
IUGR	Audit
Legionella and heated birthing pools filled in advance of labour in home settings.	Safety
Maternal Antenatal Screening Tests	Audit

Maternal Transfer by Ambulance	Audit
Maternity Records	Audit
Menopause: diagnosis and management (NG23)	NICE
Mental Health (Womens)	Audit
Miscarriage	Audit
Missed Appointments (Womens)	Audit
Multiple pregnancy	NICE
Multiple Pregnancy & Birth	Audit
Multiple pregnancy: twin and triplet pregnancies	NICE
Non Obstetric Emergency Care	Audit
Obesity	Audit
Operative Vaginal Delivery	Audit
Patient Information (Womens)	Audit
Perineal Trauma	Audit
Postnatal Care	NICE
Postpartum Haemorrhage	Audit
Pre-existing Diabetes	Audit
Pregnancy and complex social factors	NICE
Preterm labour and birth	NICE
Preterm labour and birth (NG25)	NICE
Recovery (Womens)	Audit
Reduced Fetal Movements	Audit
Referral Fetal Abnormality Detected	Audit
Resources to support safercare for full-term babies	Safety
Review of the appointment for new doctors to ensure they underwent induction and that	SI
Risk Of Harm Relating To Interpretation And Action On Pcr Results In Pregnant Women	Safety
Safe midwifery staffifing for maternity settings	NICE
Severe Pre-Eclampsia	Audit
Severely Ill Women	Audit
Shoulder Dystocia	Audit
Snap-shot review in 3 months' time to check whether women requiring a second anomaly	SI
Support for Parents (Womens)	Audit
VBAC	Audit
Venous Thromboembolism	Audit
Paediatric Medicine	
*** Diabetes (Paediatric) (NPDA)	National
*** National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12)	National
*** RCEM Feverish children 2018	National
*** RCEM Pain in Children 2017	National
*** UK Cystic Fibrosis Registry	National
Asthma (severe, persistent, patients aged 6+, adults) - omalizumab (rev TA133, TA201)	NICE
Audit of NG29 Intravenous fluid therapy in children and young people in hospital	Audit
Bacterial meningitis and meningococcal septicaemia	NICE

Bronchiolitis in children	NICE
Bronchiolitis in children: diagnosis and management	NICE
Cerebral palsy in under 25s: assessment and management	NICE
Developmental follow-up of children and young people born preterm	NICE
Diabetes (type 1 and type 2) in children and young people: diagnosis and management	NICE
Diabetes in children and young people	NICE
Fever in under 5s	NICE
Feverish illness in children	NICE
Gastro-oesophageal reflux disease in children and young people: diagnosis and	NICE
Gastro-oesophageal reflux in children and young people	NICE
Human growth hormone (somatropin) for the treatment of growth failure in children (review)	NICE
Nocturnal enuresis	NICE
Omalizxumab for the treatment of severe persistent allergic asthma in children aged 6 - 11	NICE
Psychosis and schizophrenia in children and young people	NICE
Resources to Support the Safety of Girls and Women who are being treated with Valproate	Safety
Sedation in Children and Young People	NICE
Survey of staff experience to determine whether a) actions agreed as a result of this incident	SI
Transition from children's to adults' services	NICE
Transition from children's to adults' services for young people using health or social care	NICE
When to suspect child maltreatment	NICE
Paediatric Surgery	
Appendectomy post-operative collection	Audit
Quality improvement project to improve the efficiency of the enuresis pathway	Audit
How long are children waiting from decision to operate to time to induction of anaesthesia	Audit
Fluid management (NPSA guidelines)	Audit
30 day readmissions	Audit
Jaundice in newborn babies under 28 days	NICE
Medicine	
A&E	
*** National Emergency Laparotomy Audit (NELA)	National
*** RCEM Asthma (paediatric and adult) care in emergency departments 2016	National
*** RCEM Consultant sign-off 2016	National
*** RCEM Fractured Neck of Femur 2017	National
*** RCEM Vital signs in Adults (care in emergency departments) 2018	National
*** Reducing the impact of serious infections - Sepsis and AMR (2017/19) - National CQUINs	Audit
Anaphylaxis	NICE
Challenging behaviour and learning disabilities	NICE
Continue to monitor the monthly nursing metrics	SI
Domestic violence and abuse	NICE
Ensure that lessons learned from this incident are incorporated into any planned works in the	SI

Head injury	NICE
Learning disabilities: challenging behaviour	NICE
Preventing ill health by risky behaviours - alcohol and tobacco (2018/19) - National CQUIN	CQUIN
Re-Audit of the number of blood samples that are haemolysed to ensure that any	SI
Review of a sample of patients attending A&E & diagnosed with Aortic Dissection to ensure	SI
Review of the team working between the Acute Medicine Team and the ED to ensure that	SI
Risk of Death and Serious Harm from delays in recognising and treating ingestion of button	Safety
Risk of death or serious harm from accidental ingestion of pottassium permanganate	Safety
Single Clerking Paperwork	Audit
Spontaneous pneumothorax in adults	Audit
Spot check audit of bank and agency nurses to ensure that they have completed the local	SI
Spot check audit of patients in the Emergency Department to ensure appropriate actions	SI
Spot check audit of patients who have fallen in A&E to identify is post falls check list is being	SI
The investigation recommended that there should be a protocol for the treatment of adults	SI
Venom anaphylaxis - immunotherapy pharmalgen	NICE
Acute Medicine	
Venous thromboembolic diseases	NICE
Head injury	NICE
Venous thromboembolism (treatment and long term secondary prevention) - rivaroxaban	NICE
Intravenous fluid therapy in adults in hospital	NICE
Pneumonia	NICE
Transient loss of consciousness in adults and young people	NICE
Pulmonary embolism and recurrent venous thromboembolism - rivaroxaban	NICE
Transient loss of consciousness ('blackouts') in over 16s	NICE
Critical Care Outreach	
Critical illness rehabilitation	NICE
Dermatology	
*** BAD British Association of Dermatologists National Audit on the management of Bullous	National
Apremilast for treating moderate to severe plaque psoriasis	NICE
Atopic eczema in under 12s	NICE
Melanoma: assessment and management (NG14)	NICE
Omalizumab for previously treated chronic spontaneous urticaria	NICE
Psoriasis	NICE
Secukinumab for treating moderate to severe plaque psoriasis	NICE
Skin cancer	NICE
Ustekinumab for the treatment of adults with moderate to severe psoriasis	NICE
Diabetes/Endocrinology	
*** Diabetes (Adult) ND(A) (Core)	National
*** Diabetes (Adult): National Diabetes Footcare Audit	National
*** Diabetes (Adult): National Diabetes Inpatient Audit (NaDIA)	National
*** DM Foot Amputations RCA	National

******* Endocrine and Thyroid National Audit (British Association of Endocrine and Thyroid Surgeons)	National
******* Retinal screening programme 2017 / 18	National
******* UK Acromegaly Register & audit of outcomes of patients treated for acromegaly 17/18	National
Audit of acromegaly outcomes	Audit
Audit of cinacalcet use for patients with complex PHPTH	Audit
Audit of outcomes of pituitary surgery 2016	Audit
Audit of pegvisomant use for patients with acromegaly (third-line treatment)	Audit
Audit of the guidelines for the management of diabetes for patients receiving enteral feeding	SI
BSUH Surgery and Diabetes Project	Audit
Canagliflozin, dapagliflozin and empagliflozin as monotherapies for treating type 2 diabetes	NICE
Dapagliflozin in triple therapy for treating type 2 diabetes	NICE
Diabetes (type 2) - exenatide (prolonged release)	NICE
Diabetes and Enteral Feeding Audit 2016	Audit
Diabetes in adults - Updated August 2016	NICE
Diabetes in pregnancy	NICE
Diabetes in pregnancy: management from preconception to the postnatal period	NICE
Diabetic Foot (NG19)	NICE
Diabetic foot problems (replaced by NG19 August 2015)	NICE
Empagliflozin in combination therapy for treating type 2 diabetes	NICE
Enteral feeding in patients with diabetes (re-audit)	Audit
Fluid prescriptions used with insulin infusions	Audit
Gestational DM audit	Audit
Hypo Box re-audit	Audit
Liraglutide for the treatment of type 2 diabetes mellitus	NICE
Risk of severe harm and death due to withdrawing insulin from pen devices	Safety
Risk of severe harm or death when desmopressin is omitted or delayed in patients	Safety
To improve the quantity and quality of patient information from primary re to the DESP	CQUIN
Type 1 diabetes in adults: diagnosis and management (NG17)	NICE
Type 2 diabetes - Dapagliflozin combination therapy	NICE
Tenofovir disproxil fumarate for the treatment of hepatitis B	NICE
Canagliflozin in combination therapy for treating type 2 diabetes (TA315)	NICE
Type 2 diabetes in adults: management (replaces TA203 & TA248)	NICE
Elderly Medicine	
*** UK Parkinson's Audit (previously known as National Parkinson's Audit) 2017	Audit
Acute Frailty Network	Audit
Audit of observations taken following a patient fall on Emerald Ward (118312)	SI
Audit of the completion of lying and standing blood pressure and preventative falls actions on	SI
Audit of the Falls Risk Assessment to include whether all appropriate preventative actions	SI
Audit of the falls risk asssement to include preventative actions taken and observations	SI
Cake Rounds	Audit
Carer Focus Groups	Audit

Delirium	NICE
Delirium in adults	NICE
Dementia	NICE
Dementia: supporting people with dementia and their carers in health and social care	NICE
Donepezil, galantamine, rivastigmine and memantine for the treatment of Alzheimer's disease	NICE
Emerald Falls Project	SI
Home First (DIG) Project	Audit
MADE and SAFER	Audit
Mental wellbeing and independence for older people	NICE
Multimorbidity: clinical assessment and management	NICE
Older people: independence and mental wellbeing (NG32)	NICE
Osteoporosis fragility fracture	NICE
Right Care, Right Place, Each Time	Audit
Service Improvement and Innovation / Specialty Service Redesign	Audit
Small Acts of Friendship	Audit
Snaphot audit of all patients on Hurstpierpoint Ward against nursing standards for urinalysis	SI
SQiD Redesign of Delirium paperwork in Version 2 of Single Clerking Paperwork	Audit
Haematology	
*** National Comparative Audit of Blood Transfusion programme: Audit of FFP and	National
*** National Comparative Audit of Blood Transfusion programme: Audit of massive haemorrhage	National
*** National Comparative Audit of Blood Transfusion programme: Audit of maternal anaemia 2019	National
*** National Comparative Audit of Blood Transfusion programme: Red Cell & Platelet transfusion	National
*** Serious Hazards of Transfusion (SHOT): 2017 Audit of the management of patients at risk	National
Apixaban for the treatment and secondary prevention of deep vein thrombosis and/or	NICE
Sickle cell disease	NICE
Romiplostim for the treatment of chronic immune (idiopathic) thrombocytopenic purpura	NICE
Blood transfusion (NG24)	NICE
Edoxaban for preventing stroke and systemic embolism in people with non-valvular atrial	NICE
Ruxolitinib for treating disease-related splenomegaly or symptoms in adults with	NICE
Dabigatran etexilate for the treatment and secondary prevention of deep vein thrombosis	NICE
Venous thromboembolism in adults	NICE
Edoxaban for treating and for preventing deep vein thrombosis and pulmonary embolism	NICE
Sickle cell acute painful episode	NICE
Eltrombopag for the treatment of chronic immune (idiopathic) thrombocytopenic purpura	NICE
Myelofibrosis (splenomegaly, symptoms) - ruxolitinib	NICE
Venous thromboembolism in adults: diagnosis and management. Updated April 2016.	NICE
Thrombocytopenic purpura - eltrombopag	NICE
Haematology Oncology	
Non-Hodgkin's lymphoma: diagnosis and management	NICE
Azacitidine for the treatment of myelodysplastic syndromes, chronic myelomonocytic	NICE

Multiple myeloma - bortezomib (induction therapy)	NICE
Bendamustine for the first-line treatment of chronic lymphocytic leukaemia	NICE
Leukaemia (chronic myeloid, first line) - dasatinib, nilotinib and standard-dose imatinib	NICE
Bortezomib and thalidomide for the first line treatment of multiple myeloma	NICE
Rituximab for the first-line maintenancetreatment of follicular non-Hodgkin'slymphoma	NICE
Idelalisib for treating chronic lymphocytic leukaemia	NICE
Haematological cancers: improving outcomes	NICE
Ofatumumab for the treatment of chronic lymphocytic leukaemia refractory to fludarabine	NICE
Leukaemia (chronic myeloid) - bosutinib - replaced by TA401 August 2016	NICE
Leukaemia (chronic myeloid) - dasatinib, nilotinib, imatinib (intolerant, resistant)	NICE
Pomalidomide for relapsed and refractory multiple myeloma previously treated with	NICE
Lymphoma (non Hodgkin's, relapsed, refractory) - pixantrone monotherapy	NICE
Myeloma: diagnosis and management	NICE
Leukaemia (chronic lymphocytic, relapsed) - rituximab	NICE
Obinutuzumab in combination with chlorambucil for untreated chronic lymphocytic leukaemia	NICE
Ofatumumab in combination with chlorambucil or bendamustine for untreated chronic	NICE
Panobinostat for treating multiple myeloma after at least 2 previous treatments	NICE
HIV/AIDS Services	
HIV testing: increasing uptake among people who may have undiagnosed HIV	NICE
Proportion had an STI screen	Audit
Review of HIV+ pts with hypogonadism	Audit
Audit of recurrent CT and GC infections	Audit
Proportion LU patients with Hep B C serology in last year	Audit
Proportion HIV patients <40 copies	Audit
Anal Cancer and Anal Intraepithelial Neoplasia in HIV	Audit
HA PN for C4 & B	Audit
Proportion of CNC patients having an HIV test	Audit
Recall of patients with an acute STI	Audit
Review of Sunflower Clinic	Audit
Intensive Care Unit	
******* Case Mix Programme (CMP) ICNARC	National
******* Potential donor audit (NHS Blood & Transplant)	National
Anti-coagulation during renal replacement therapy	Audit
Antimicrobial stewardship (ICU)	Audit
Care bundle to reduce ventilation-association pneumonia	Audit
Delirium re-audit 2017	Audit
DoH High Impact Interventions: CVC insertion/care	Audit
DoH High Impact Interventions: Peripheral venous catheter	Audit
DoH High Impact Interventions: Prevention of spread of C.Diff	Audit
DoH High Impact Interventions: Renal catheter insertion/care	Audit
DoLS Assessment	Audit
End of life care in the ITU	Audit

Enteral feeding	Audit
Ideal body weight versus recorded body weight versus tidal volume in mechanically	Audit
Management of traumatic brain injury audit	Audit
Mechanical ventilation in non-ARDS patients	Audit
Medical emergency team audit	Audit
Medication Errors	Audit
Negative pressure wound therapy for for the open abdomen	NICE
OOHCA management	Audit
Organ donation	NICE
Out of Hours Discharges audit	Audit
Pain audit	Audit
Post-pyloric feeding in patients with severe brain injury	Audit
Referrals audit	Audit
Rehabilitation after critical illness in adults	NICE
Resources to support safer care for the deteriorating patient (adults and children)	Safety
Resources to support the prompt recognition of sepsis and the rapid initiation of treatment	Safety
Risk Of Hypothermia In Patients Receiving Continuous Renal Replacement Therapy	Safety
Risk Of Severe Harm And Death From Unintentional Interruption Of Non-Invasive Ventilation	Safety
Risk of using different airwayhumidification devices simultaneously	Safety
Sodium Abnormalities in patients with subarachnoid haemorrhage	Audit
Therapeutic hypothermia following cardiac arrest	NICE
Use of cardiac output monitors and/or ECHO in inotrope dependent patients.	Audit
VAP prevention	Audit
VTE assessments	Audit
Oncology	
*** Lung cancer (NLCA)	National
*** National Bowel Cancer Audit (NBOCA)	National
*** Oesophago-gastric cancer (NOGCA)	National
Abiraterone for castration-resistant metastatic prostate cancer previously treated with a	NICE
Abiraterone for treating metastatic hormone-relapsed prostate cancer before chemotherapy	NICE
Advanced Breast Cancer	NICE
Axitinib for treating advanced renal cell carcinoma after failure of prior systemic treatment	NICE
Azacitidine for treating acute myeloid leukaemia with more than 30% bone marrow blasts	NICE
Bevacizumab in combination with a taxane for the first-line treatment of metastatic breast	NICE
Bevacizumab in combination with capecitabine for the first-line treatment of metastatic	NICE
Bevacizumab in combination with oxaliplatin and either fluorouracil plus folinic acid or	NICE
Bevacizumab in combination with paclitaxel and carboplatin for first-line treatment of	NICE
Bone metastases from solid tumours - denosumab	NICE
Bortezomib for previously untreated mantle cell lymphoma	NICE
Breast cancer (HER2 negative, oestrogen receptor positive, locally advanced or metastatic) -	NICE
Breast cancer (metastatic hormone-receptor) - lapatinib and trastuzumab (with aromatase	NICE
Breast cancer (metastatic) - fulvestrant	NICE

Ceritinib for previously treated anaplastic lymphoma kinase positive non-small-cell lung	NICE
Cobimetinib in combination with vemurafenib for treating unresectable or metastatic BRAF	NICE
Colorectal cancer (metastatic) 2nd line - cetuximab, bevacizumab and panitumumab (review)	NICE
Crizotinib for previously treated anaplastic lymphoma kinase-positive advanced non-small-	NICE
Crizotinib for untreated anaplastic lymphoma kinase-positive advanced non-small-cell lung	NICE
Dabrafenib for treating unresectable or metastatic BRAF V600 mutation?positive melanoma	NICE
Dasatinib, nilotinib and high-dose imatinib for treating imatinib-resistant or intolerant	NICE
Dasatinib, nilotinib and imatinib for untreated chronic myeloid leukaemia	NICE
Enzalutamide for metastatic hormone?relapsed prostate cancer previously treated with a	NICE
Enzalutamide for treating metastatic hormone-relapsed prostate cancer before	NICE
Eribulin for treating locally advanced or metastatic breast cancer after 2 or more	NICE
Erlotinib and gefitinib for treating non-small-cell lung cancer that has progressed after prior	NICE
Erythropoiesis?stimulating agents (epoetin and darbepoetin) for treating anaemia in people	NICE
Everolimus for the second-line treatment of advanced renal cell carcinoma	NICE
Everolimus with exemestane for treating advanced breast cancer after endocrine therapy	NICE
Familial breast cancer	NICE
Follicular lymphoma - rituximab (review)	NICE
Gastric cancer (advanced) - capecitabine	NICE
Gastrointestinal stromal tumours - imatinib (adjuvant)	NICE
Guidance on the use of temozolomide for the treatment of recurrent malignant glioma (brain	NICE
Head and neck cancer	NICE
Hepatocellular carcinoma (advanced and metastatic) sorafenib (first line)	NICE
Ibrutinib for previously treated chronic lymphocytic leukaemia and untreated chronic	NICE
Imatinib for the adjuvant treatment of gastrointestinal stromal tumours (review of NICE	NICE
Imatinib for the treatment of unresectable and/or metastatic gastrointestinal stromal	NICE
Ipilimumab for previously untreated advanced (unresectable or metastatic) melanoma	NICE
Lenalidomide for treating myelodysplastic syndromes associated with an isolated deletion	NICE
Lung cancer (non small cell, EGFR mutation positive) - afatinib	NICE
Lung cancer (non small cell, EGFR-TK mutation positive) - erlotinib (1st line)	NICE
Lung cancer (non small cell, non squamous) - pemetrexed - replaced by TA402 August 2016	NICE
Lung cancer (non-small-cell) - pemetrexed (maintenance)	NICE
Lung cancer (non-small-cell, anaplastic lymphoma kinase fusion gene, previously treated) -	NICE
Lung cancer (non-small-cell, first line) - gefitnib	NICE
Melanoma (BRAF V600 mutation positive, unresectable metastatic) - vemurafenib	NICE
Melanoma (stage III or IV) - ipilimumab	NICE
Neutropenic sepsis	NICE
Nintedanib for previously treated locally advanced, metastatic, or locally recurrent non small	NICE
Nivolumab for previously treated advanced renal cell carcinoma	NICE
Nivolumab for treating advanced (unresectable or metastatic) melanoma	NICE
Nivolumab in combination with ipilimumab for treating advanced melanoma	NICE
Olaparib for maintenance treatment of relapsed, platinum-sensitive, BRCA mutation-positive	NICE
Osimertinib for treating locally advanced or metastatic EGFR T790M mutation-positive non-	NICE

Ovarian, fallopian tube and primary peritoneal cancer (recurrent advanced, platinum-	NICE
Paclitaxel as albumin-bound nanoparticles in combination with gemcitabine for previously	NICE
Pazopanib for the first-line treatment of advanced renal cell carcinoma	NICE
Pembrolizumab for advanced melanoma not previously treated with ipilimumab	NICE
Pembrolizumab for treating advanced melanoma after disease progression with ipilimumab	NICE
Pembrolizumab for treating PD-L1-positive non-small-cell lung cancer after chemotherapy	NICE
Pembrolizumab for untreated PD-L1-positive metastatic non-small-cell lung cancer	NICE
Pemetrexed for the first line treatment of non-small-cell lung cancer	NICE
Pertuzumab for the neoadjuvant treatment of HER2-positive breast cancer	NICE
Pomalidomide for multiple myeloma previously treated with lenalidomide and bortezomib	NICE
Prostate cancer	NICE
Prostate cancer - cabazitaxel	NICE
Radiofrequency ablation for the treatment of colorectal liver metastases	NICE
Radium-223 dichloride for treating hormone-relapsed prostate cancer with bone metastases	NICE
Ramucirumab for treating advanced gastric cancer or gastro-oesophageal junction	NICE
Sipuleucel-T for treating asymptomatic or minimally symptomatic metastatic hormone-	NICE
Sunitinib for the treatment of gastrointestinal stromal tumours	NICE
Suspected cancer	NICE
Talimogene laherparepvec for treating unresectable metastatic melanoma	NICE
Topotecan for the treatment of recurrent carcinoma of the cervix	NICE
Topotecan for the treatment of relapsed small-cell lung cancer	NICE
Topotecan, pegylated liposomal doxorubicin hydrochloride, paclitaxel, trabectedin and	NICE
Trabectedin for the treatment of relapsed ovarian cancer	NICE
Trametinib in combination with dabrafenib for treating unresectable or metastatic melanoma	NICE
Trastuzumab emtansine for treating HER2-positive, unresectable locally advanced or	NICE
Trastuzumab for the treatment of HER2-positive metastatic gastric cancer	NICE
Urothelial tract carcinoma (transitional cell, advanced, metastatic) - vinflunine	NICE
Thoracic/Respiratory Medicine	
******* Adult Asthma	National
******* Adult Bronchiectasis 2017	National
******* Adult Bronchoscopy Audit	National
******* National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme: Secondary care	National
******* NCEPOD Pulmonary Embolism	National
******* Non-invasive ventilation - adults (British Thoracic Society) 2019	National
Asthma	NICE
Audit of the use of the 'this is me documentation' on Pyecombe Ward (116399)	SI
BAL yield in ILD	Audit
Chronic obstructive pulmonary disease - roflumilast	NICE
Chronic obstructive pulmonary disease (update 2014)	NICE
Chronic obstructive pulmonary disease in adults (updated Feb 2016)	NICE
Drug allergy	NICE

Drug allergy: diagnosis and management of drug allergy in adults, children and young people	NICE
Erlotinib monotherapy for maintenance treatment of non-small-cell lung cancer	NICE
Idiopathic pulmonary fibrosis	NICE
Idiopathic pulmonary fibrosis in adults	NICE
ImmunoCAP ISAC 112 and Microtest for multiplex allergen testing	NICE
Lung Cancer (updated March 2016)	NICE
Lung cancer in adults (updated 2015)	NICE
Mepolizumab for treating severe refractory eosinophilic asthma	NICE
Motor neurone disease - non-invasive ventilation (replaced by NG42)	NICE
NIV audit	Audit
Pneumonia in adults	NICE
Review of Patients Voice data and comments with particular reference to respectful and	SI
Tuberculosis (replaced by NG33)	NICE
Tuberculosis (replaces CG117)	NICE

Specialist Services

Cardiology

*** Cardiac Rhythm Management (CRM)	National
*** Congenital Heart Disease (CHD)	National
*** Coronary angioplasty (PCI)	National
*** Myocardial Ischaemia National Audit Project (MINAP)	National
*** National Audit of Cardiac Rehabilitation	National
*** National Heart Failure Audit	National
Acute coronary syndromes in adultsAcute coronary syndromes in adults	NICE
Acute heart failure	NICE
Acute heart failure: diagnosis and management in adults	NICE
Alirocumab for treating primary hypercholesterolaemia and mixed dyslipidaemia	NICE
Angiogram / Angioplasty service review	Audit
Atrial fibrilation - dronedarone	NICE
Atrial fibrillation	NICE
Atrial fibrillation - dabigatran etexilate	NICE
Atrial fibrillation (stroke prevention) - rivaroxaban	NICE
Atrial fibrillation: the management of atrial fibrillation (CG180) June 2014 NICE guidelines	NICE
Barriers and facilitators to accessing the BSUH inpatient smoking cessation service in acute	Audit
Bioresorbable stent implantation for treating coronary artery disease	NICE
Chest pain of recent onset	NICE
Chronic heart failure	NICE
Chronic heart failure - ivabradine	NICE
Chronic heart failure in adults	NICE
Dual?chamber pacemakers for symptomatic bradycardia due to sick sinus syndrome without	NICE
EPS / PPM service review	Audit
Evolocumab for treating primary hypercholesterolaemia and mixed dyslipidaemia	NICE
Extracorporeal membrane oxygenation (ECMO) for acute heart failure in adults	NICE

Ezetimibe for treating primary heterozygous-familial and non-familial hypercholesterolaemia	NICE
Familial hypercholesterolaemia: identification and management (Publised August 2008;	NICE
Heart failure service review	Audit
Hyperglycaemia in acute coronary syndromes	NICE
Hypertension	NICE
Imaging service review	Audit
Implantable cardioverter defibrillators and cardiac resynchronisation therapy for	NICE
Insertion of a subcutaneous implantable cardioverter defibrillator for prevention of sudden	NICE
Lipid modification: cardiovascular risk assessment and the modification of blood lipids	NICE
Management of stable angina - updated August 2016	NICE
MINAP service review	Audit
Myocardial infarction with ST-segment elevation	NICE
Myocardial infarction: secondary prevention	NICE
Optical coherence tomography to guide percutaneous coronary intervention	NICE
Percutaneous closure of patent foramen ovale for recurrent migraine	NICE
Percutaneous closure of patent foramen ovale for recurrent paradoxical embolism in divers	NICE
Percutaneous closure of patent foramen ovale to prevent recurrent cerebral embolic events	NICE
Percutaneous laser coronary angioplasty	NICE
Percutaneous mitral valve annuloplasty	NICE
Percutaneous occlusion of the left atrial appendage in non-valvular atrial fibrilation for the	NICE
Prasugrel for the treatment of acute coronary syndromes with percutaneous coronary	NICE
Prasugrel with percutaneous coronary intervention for treating acute coronary syndromes	NICE
Primary angioplasty service review	Audit
Risks of Associating ECG Records with Wrong Patients	Safety
Rivaroxaban for preventing adverse outcomes after acute management of acute coronary	NICE
Sacubitril valsartan for treating symptomatic chronic heart failure with reduced ejection	NICE
Secondary prevention after a myocardial infarction	NICE
Stable Angina	NICE
Stroke and systemic embolism (prevention, non-valvular atrial fibrillation) - apixaban	NICE
Structural heart service review	Audit
TAVI service review	Audit
Ticagrelor for preventing atherothrombotic events after myocardial infarction	NICE
Transapical transcatheter mitral valve-in-valve implantation for a failed surgically implanted	NICE
Transcatheter aortic valve implantation for aortic stenosis	NICE
Unstable angina and NSTEMI	NICE
Cardiothoracic Surgery	
******* National Adult Cardiac Surgery Audit (ACS)	National
Percutaneous balloon cryoablation for pulmonary vein isolation in atrial fibrillation	NICE
Off-pump coronary artery bypass grafting	NICE
Thoracoscopic exclusion of the left atrialappendage (with or without surgical ablation)for	NICE
Transcatheter valve-in-valve implantation for aortic bioprosthetic valve dysfunction	NICE
Sutureless Aortic Valve Replacement for aortic stenosis	NICE
Audit of the Chest Drain checklist implemented in cardio-thoracic	SI

Neuro Medicine	
Spot check review of medical notes to ensure that AMT score is recorded on admission as per	SI
Spot check review of the nursing notes to ensure:	SI
Spot check audit to ensure that there is a member of staff in each bay at all times	SI
Audit of cases referred to the GP specialist to ensure that only patients with headaches are	SI
Multiple sclerosis (relapsing-remitting) - alemtuzumab	NICE
Multiple sclerosis (relapsing) - teriflunomide	NICE
Headaches in over 12s	NICE
Daclizumab for treating relapsing-remitting multiple sclerosis	NICE
Low back pain and sciatica in over 16s: assessment and management	NICE
Prosthetic intervertebral disc replacement in the cervical spine	NICE
Multiple Sclerosis	NICE
Retigabine for the adjunctive treatment of partial onset seizures in epilepsy	NICE
Epilepsies: diagnosis and management (updated Feb 2016)	NICE
Multiple sclerosis	NICE
Dimethyl fumarate for treating relapsing?remitting multiple sclerosis	NICE
Epilepsy in adults	NICE
Headaches	NICE
Outcomes of Botox treatment for Headaches	Audit
Neuro Surgery	
*** Multi-disciplinary team management of cerebral metastases in the UK	National
*** National Neurosurgery Audit Programme	National
Epiduroscopic lumbar discectomy through the sacral hiatus for sciatica	NICE
Neurosurgical Cancellations	Audit
Snapshot audit of patients on the wards' falls risk assessments to include whether all	SI
Rehabilitation	
*** Renal replacement therapy (Renal Registry)	National
*** Specialist rehabilitation for patients with complex needs following major injury (NCASRI)	National
Acute kidney injury	NICE
Acute kidney injury	NICE
Anaemia management in people with chronic kidney disease	NICE
Chronic kidney disease	NICE
Chronic kidney disease in adults	NICE
Chronic kidney disease: managing anaemia (NG8)	NICE
Continue to monitor the monthly nursing metrics regarding discharge planning	SI
Hyperphosphataemia in chronic kidney disease	NICE
Hypertension in adults	NICE
Peritoneal dialysis	NICE
Renal replacement therapy services for adults	NICE
Repeat the review of staffing levels on the ward during the night to ensure that any	SI
Resources to support the care of patients with acute kidney failure	Safety
Standardising the early identification of Acute Kidney Injury	Safety

Tolvaptan for treating autosomal dominant polycystic kidney disease	NICE
Vasular Access	Audit
Renal	
*** BAUS Urology Audits: Nephrectomy	National
Stroke Rehabilitation	
*** Sentinel Stroke National Audit Programme (SSNAP): SSNAP Clinical Audit / Post Acute	National
Disability Scores and Outcomes in Stroke Patients on SRC	Audit
Mechanical clot retrieval for the treatment of acute ischaemic stroke	NICE
Mortality, Re-admission and Recurrent Stroke Rates	CQUIN
Rates of Aspiration Pneumonia and UTI following Acute Stroke	Audit
Standardised On-Ward Falls Assessment Tool	Audit
Stroke (acute, ischaemic) - alteplase	NICE
Stroke in adults; Updated April 2016	NICE
TIA Management & Outcomes Audit on the Stroke Unit	Audit
Time for anticoagulation reversal in ICH	Audit
VTE Risk Assessment on the Stroke Unit	CQUIN
Vascular	
*** National Vascular Registry (elements will include CIA, National Vascular Database, AAA,	National
*** PROMS: Varicose Veins	National
Peripheral arterial disease	NICE
Cilostazol, naftidrofuryl oxalate, pentoxiylline and inositol nicotinate for the treatment of	NICE
Endovascular stent-grafting of popliteal aneurysms	NICE
Lower limb peripheral arterial disease	NICE
Varicose veins in the legs	NICE
Varicose veins in the legs	NICE
Clopidogrel and modified-release dipyridamole for the prevention of occlusive vascular	NICE
Ultrasound-guided foam sclerotherapy for varicose veins	NICE
Surgery	
Anaesthetics	
Transition from the Luer Connector to NRFit for Intrathecal and Epidural Procedures	Safety
Hypothermia: prevention and management in adults having surgery	NICE
Surgical site infection	NICE
BM monitoring in neurosurgical patients who are presecribed steroids	Audit
HDU handovers	Audit
Outcomes following amputation	Audit
Group and Save sampling for elective surgery	Audit
Digestive Diseases	
*** Increasing uptake in bowel screening (2017/19) - PHE CQUIN	Audit
Do people who have appendectomies with normal histology	Audit
Service Evaluation of Ileo anal pouch practices and results	Audit
JAG Haemostasis after Endoscopic	CQUIN
JAG Review of ERCP procedures	CQUIN

JAG Caecal Intubation Rates (CIR)	CQUIN
JAG Operators numbers for 2nd half of 2015	CQUIN
JAG Peg Placement Audit	CQUIN
JAG Bowel Prep Audit	CQUIN
JAG Adenoma & Polyp Detection Rate in Colonoscopies	CQUIN
JAG Repeat OGD for Gastric Ulcers	CQUIN
JAG Biopsies of Diarrhoea Audit	CQUIN
JAG Comfort Scores Audit	CQUIN
JAG Colon Sedation and Analgesia Audit	CQUIN
JAG Operators numbers for 2015	CQUIN
Increasing uptake in bowel screening (2017/19) - PHE CQUIN	CQUIN
JAG Polyp Recovery	CQUIN
JAG Successful intubation and completion of OGD	CQUIN
JAG Completion of intended ERCP	CQUIN
******* Inflammatory Bowel Disease (IBD) Registry Biologics Audit	National
******* PROMS: Hernia Repair	National
Infliximab, adalimumab and golimumab for treating moderately to severely active ulcerative	NICE
Electrical stimulation of the lower oesophageal sphincter for treating gastro-oesophageal	NICE
Dyspepsia and gastro?oesophageal reflux disease	NICE
Ledipasvir-sofosbuvir for treating chronic hepatitis C	NICE
Gallstone disease	NICE
Sofosbuvir for treating chronic hepatitis C	NICE
Lubiprostone for treating chronic idiopathic constipation (TA318)	NICE
Inflammatory bowel disease	NICE
Acute upper GI bleeding - updated August 2016	NICE
Single-anastomosis duodeno-ileal bypass with sleeve gastrectomy for treating morbid obesity	NICE
Endoscopic transluminal pancreatic necrosectomy	NICE
Acute upper gastrointestinal bleeding in adults	NICE
Peginterferon alfa and ribavirin for the treatment of chronic hepatitis C (part review of	NICE
Insertion of a collagen plug to close an abdominal wall enterocutaneous fistula	NICE
Single?incision laparoscopic cholecystectomy	NICE
Ulcerative colitis	NICE
Crohn's disease - infliximab (review) and adalimumab (review of TA40)	NICE
Transanal total mesorectal excision of the rectum	NICE
Daclatasvir for treating chronic hepatitis C	NICE
Colonoscopic surveillance for prevention of colorectal cancer in people with ulcerative	NICE
Ombitasvir-paritaprevir-ritonavir with or without dasabuvir for treating chronic hepatitis C	NICE
Minimally invasive oesophagectomy	NICE
Non-alcoholic fatty liver disease (NAFLD): assessment and management	NICE
Cirrhosis in over 16s: assessment and management	NICE
Coeliac disease: recognition, assessment and management (NG20)	NICE
Sofosbuvir-velpatasvir for treating chronic hepatitis C	NICE

Hepatitis B (chronic)	NICE
Insertion of a magnetic-bead band for faecal incontinence	NICE
Faecal incontinence in adults	NICE
Vedolizumab for treating moderately to severely active Crohn's disease after prior therapy	NICE
Rifaximin for preventing episodes of overt hepatic encephalopathy	NICE
Crohn's disease	NICE
Elbasvir-grazoprevir for treating chronic hepatitis C	NICE
Hepatitis B	NICE
Coeliac disease	NICE
Vedolizumab for treating moderately to severely active ulcerative colitis	NICE
Naloxegol for treating opioid induced constipation	NICE
Gallstone disease	NICE
Sacrocolpopexy using mesh to repair vaginal vault prolapse	NICE
Continue to participate in the National Emergency Laparotomy Audit	SI
Audit of the care of general surgical patients who remain at PRH over the weekends to ensure	SI
Review guidelines and incorporate the recommendation for MDT meeting or case	SI
An audit against the revised guidance should be included in the forward audit plan for the	SI
Review of the Endoscopy referral & Booking process, with specific reference to shortcomings	SI
Ear Nose & Throat	
Suction diathermy adenoidectomy	NICE
Consenting for minor procedures in the ENT outpatient department	Audit
Rate of rebleeding for SPA ligation vs SPA embolization	Audit
Improved information leaflets in ENT	Audit
Coblation intracapsular tonsillotomy	Audit
Theatre efficiency (ENT)	Audit
Thyroid FNA vs histology	Audit
Audit of urgent referrals for patients with suspected head & neck cancer	Audit
Pre-operative assessment for ENT day case procedures	Audit
A prospective audit of Quinsy (peritonsillar abscess) management and outcomes following	Audit
Maxillofacial/Oral Surgery	
Review of a sample of paediatric max-fax patients on the waiting list to determine whether	SI
Ophthalmology	
******* To improve the quantity and quality of patient information from primary re to the DESP	Audit
Superflex lens A constant audit	Audit
Stitch length in adjustable sutures audit	Audit
PI Audit - power and energy	Audit
OPD patient flow audit	Audit
Audit on DCR outcomes	Audit
Audit of clinical practice in the corneal service concentrating on 'variation in practice within	Audit
Femto laser power audit	Audit
An audit of CSR patients	Audit

A reaudit of clinical coding ophthalmology clinic outcome forms	Audit
Macular hole audit	Audit
Theatre care pathway paperwork	Audit
Health equity/Diabetic screening programme audit	Audit
To improve the quantity and quality of patient information from primary re to the DESP	CQUIN
Squint outcome audit	CQUIN
*** National Ophthalmology Audit	National
Dexamethasone intravitreal implant for the treatment of macular oedema	NICE
Aflibercept for treating diabetic macular oedema	NICE
Glaucoma in adults	NICE
Ciclosporin for treating dry eye disease that has not improved despite treatment with	NICE
Macular oedema (central retinal vein occlusion) - aflibercept solution for injection	NICE
Diabetic macular oedema - fluocinolone acetonide intravitreal implant	NICE
Photochemical corneal collagen cross linkage using riboflavin and ultraviolet A for	NICE
Epiretinal brachytherapy for wet age related macular degeneration	NICE
Adalimumab and dexamethasone for treating non-infectious uveitis	NICE
Choroidal neovascularisation (pathological myopia) - ranibizumab	NICE
Dexamethasone intravitreal implant for treating diabetic macular oedema	NICE
Vitreomacular traction - ocriplasmin	NICE
Cataracts in adults: management	NICE
Macular degeneration (wet age-related) - aflibercept (1st line)	NICE
Aflibercept for treating visual impairment caused by macular oedema after branch retinal	NICE
Macular oedema (retinal vein occlusion) - ranibizumab	NICE
Implantation of a corneal graft-keratoprosthesis for severe corneal opacity in wet blinking	NICE
Macular oedema (diabetic) - ranibizumab	NICE
Diabetic macular oedema - fluocinolone acetonide intravitreal implant (rapid review of	NICE
Participation in the 201/18 PHE DES CQUIN	SI
Audit of the process of daily review, validation and booking of patients that require follow up.	SI
Participation in the 2017/18 PHE DES CQUIN	SI
Pain management	
Neuropathic pain - pharmacological management	NICE
Pre-operative Assessment Unit	
Routine preoperativative tests for elective surgery	NICE
Rheumatology	
*** Patient satisfaction survey	Audit
DAS scores for RA pts on biologics	Audit
Disease activity recording for pts with PSA/AS on biologics	Audit
Why patients switch biologics	Audit
Ustekinumab for treating active psoriatic arthritis (rapid review of technology appraisal	NICE
Rheumatoid arthritis - abatacept (2nd line) (rapid review of TA234)	NICE
Gout (tophaceous, severe debilitating, chronic) - pegloticase	NICE
Ankylosing spondylitis - golimumab	NICE

Vasculitis (anti-neutrophil cytoplasmic antibody-associated) - rituximab (with	NICE
Psoriatic arthritis (active) - ustekinumab	NICE
Osteoarthritis	NICE
Rheumatoid arthritis - tocilizumab (rapid review TA198)	NICE
Golimumab for the treatment of rheumatoidarthritis after the failure of previousdisease	NICE
Rheumatoid arthritis - abatacept (2nd line)	NICE
Certolizumab pegol for the treatment of rheumatoid arthritis	NICE
Apremilast for treating active psoriatic arthritis	NICE
Baricitinib for moderate to severe rheumatoid arthritis	NICE
TNF-alpha inhibitors for ankylosing spondylitis and non-radiographic axial spondyloarthritis	NICE
Abatacept, adalimumab, etanercept and tocilizumab for treating juvenile idiopathic arthritis	NICE
Adalimumab, etanercept, infliximab, certolizumab pegol, golimumab, tocilizumab and	NICE
Golimumab for the treatment of psoriatic arthritis	NICE
Rheumatoid arthritis in over 16s	NICE
Osteoarthritis	NICE
Rheumatoid arthritis - drugs for treatment after failure of a TNF inhibitor	NICE
Rheumatoid arthritis - tocilizumab	NICE
Psoriatic arthritis - etanercept, infliximab and adalimumab	NICE
Denosumab for the prevention of osteoporotic fractures in postmenopausal women	NICE
Theatres	
Observational audit the WHO surgical safety checklist to include the mapping and marking	SI
Audit of the process for prosthesis verification to ensure this is embedded in clinical practice	SI
Audit of junior staff undertaking the scrub role to determine whether competency has been	SI
Observational audit of the WHO Surgical Safety Checklist	SI
Observational audit of the Sign Out Count	SI
Observational audit (as noted in SI investigation) to include 'Stop Before You Block' checks once	SI
Review of competency assessments for all recovery nurses	SI
Risk of death or severe harm due to inadvertent injection of skin preparation solution	Safety
Supporting the introduction of the National Safety Standards for Invasive Procedures	Safety
Restricted Use Of Open Systems For Injectable Medication	Safety
Trauma & Orthopaedics	
******* Falls and Fragility Fractures Audit Programme (FFFAP): 3. National Hip Fracture Database	National
******* Major Trauma: The Trauma Audit & Research Network (TARN)	National
******* National Joint Registry (NJR)	National
******* PROMS: Hip replacement	National
******* PROMS: Knee Replacement	National
Arthritis of the hip (end stage) - hip replacement (total) and resurfacing arthroplasty	NICE
Audit of patient handover sheets to ensure that blood results are available for all patients	SI
Audit of patients undergoing pelvic fixation to determine whether an assessment of femoral	SI
Audit of the frequency of the MDT meeting to include the scheduling of dual operating for	SI
Audit of the use of the oozing wound protocol to ensure that it's use is embedded in clinical	SI

Belimumab for treating active autoantibody-positive systemic lupus erythematosus	NICE
Certolizumab pegol for treating rheumatoid arthritis after inadequate response to a TNF-	NICE
Collagenase clostridium histolyticum for treating Dupuytren's contracture	NICE
Fractures (complex): assessment and management	NICE
Hip Fracture	NICE
Hip fracture in adults - updated Nov 2016	NICE
Interspinous distraction procedures for lumbar spinal stenosis causing neurogenic	NICE
Low-intensity pulsed ultrasound to promote fracture healing	NICE
Major trauma: assessment and initial management	NICE
Major trauma: service delivery	NICE
Mini-incision surgery for total knee replacemenr	NICE
Minimally invasive bunion surgery - patient questionnaire	Audit
Open reduction of slipped capital femoral epiphysis	NICE
Risk of inadvertently Cutting In Line (or closed) Suction Catheters	Safety
Risk of using vacuum and suction drains when not clinically indicated	Safety
Secukinumab for active ankylosing spondylitis after treatment with non-steroidal anti-	NICE
Shoulder resurfacing arthoplasty	NICE
Spinal injury: assessment and initial management	NICE
Spot check audit of patient records on L8 Tower to determine whether up to date NOK details	SI
Surgical correction of hallux valgus using minimal access techniques	NICE
Suture fixation of acute disruption of the distal tibiofibular syndesmosis	NICE
Total distal radioulnar joint replacement for symptomatic joint instability or arthritis	NICE
Vertebral fractures - vertebroplasty and kyphoplasty	NICE
Urology	
******* BAUS Urology Audits: Percutaneous Nephrolithotomy (PCNL)	National
******* BAUS Urology Audits: Stress Urinary Incontinence Audit	National
Bladder Cancer	NICE
Bladder cancer: diagnosis and management	NICE
GreenLight XPS for treating benign prostatic hyperplasia	NICE
Lower Urinary Tract symptoms	NICE
Lower urinary tract symptoms in men	NICE
Overactive bladder - mirabegron	NICE
Sacral nerve stimulation for idiopathic chronic non-obstructive urinary retention	NICE
Transperineal template biopsy and mapping of the prostate	NICE
Urinary incontinence in neurological disease	NICE
Urinary tract infections in adults	NICE
Trust	
Improving services for people with mental health needs who present to A&E - (2017/19)	CQUIN

***=Mandatory

Brighton and Sussex University Hospitals NHS Trust

To: Trust Board

Date of Meeting: 24 October 2018 Agenda Item: **15**

Title
Board Assurance Framework
Responsible Executive Director
George Findlay, Deputy Chief Executive / Chief Medical Director
Prepared by
David Haycox, Interim Group Company Secretary
Status
Disclosable
Summary of Proposal

The updated Board Assurance Framework (BAF) was presented to the Board, in private, on 27 September following a rigorous review including a Board risk workshop in August. It was agreed that the BAF should be reported to the Board, in public, in accordance with good governance and transparency.

This report provides the Board with an updated version of the BAF that includes details of progress specifically focusing on actions due for completion by October 2018 (highlighted yellow). The Board should note that good progress has been made in addressing and completing agreed actions.

In summary in relation to actions due for completion by October 2018, there are:

Actions completed by 17 October 2018	25
Actions on track for completion by 31 October 2018	2
Actions in progress with forecast dates for completion shown	11

Additionally, the report indicates a few instances (highlighted yellow) for which it is proposed that amended and additional actions are agreed by the Board.

The Board (in public) will receive a further BAF report at the next meeting on 30 January 2019. Prior to which, Quality Assurance Committee and Finance and Investment Committee shall both receive a report at their meetings on 12 and 19 December 2018 respectively in relation to the strategic objectives and risks relevant to each Committee showing further progress. Additionally, Audit Committee shall receive a report at its meeting on 16 January 2019.

Implications for Quality of Care
The BAF supports the Trust to identify and manage strategic risks in relation to quality of care.
Link to Strategic Objectives/Board Assurance Framework
The report provides the BAF.
Financial Implications
The BAF supports the Trust to identify and manage strategic risks in relation to finance.

This report can be made available in other formats and in other languages. .

Human Resource Implications
The BAF support the Trust to identify and manage strategic risks in relation to human resources.
Recommendation
The Board is asked to: • **review and approve the Board Assurance Framework**
Communication and Consultation
The BAF has been developed in consultation with the Board, Trust Executive Committee and Divisions and will be available for Trust staff through the Trust intranet and be publically available through Board papers published on the Trust's website.
Appendices
Board Assurance Framework

This report can be made available in other formats and in other languages. .

Brighton and Sussex University Hospitals NHS Trust

BOARD ASSURANCE FRAMEWORK – OCTOBER 2018

RAG RATING EXPLANATION		
RAG RATING	**STATUS**	
Controls are in place and the Board is satisfied that they are effective because appropriate and sufficient assurances have been received	▲	Assurance levels increased
Controls are thought to be in place but the Board does not have sufficient evidence that they are effective because the assurance it receives is uncertain and/or incomplete and/or insufficient.	◄►	No change
Controls may not be in place and the Board has evidence that the risk is escalating or manifesting and/or has not received appropriate assurances in relation to the effectiveness of the controls	▼	Assurance levels reduced

Key:		
Chief Executive	CEO	Marianne Griffiths
Chief Medical Officer	CMO	George Findlay
Chief Financial Officer	CFO	Karen Geoghegan
Chief Nurse Officer	CNO	Nicola Ranger
Chief Delivery Officer	CDO	Pete Landstrom
Chief Workforce Officer	CWOD	Denise Farmer
Medical Director	MD	Rob Haigh
Finance Director	FD	Clare Stafford
Nurse Director	ND	Caroline Davies
Trust Director of Operations	DO	Ben Stevens
Human Resources Director	HRD	Helen Weatherill
Director of Strategy and Planning	DSP	Oliver Philips
Director of IM&T	DIMT	Ian Arbuthnot
Group Company Secretary	DCA	David Haycox

Monitoring Committee or Group:	
Trust Executive Committee	TEC
Finance and Investment Committee	FIC
Quality Assurance Committee	QAC
Audit Committee	AC
Patient Safety Group	PSG
Clinical Outcomes and Effectiveness Group	COEG
Patient Experience and Engagement Group	PEEG
Risk and Compliance Group	RCG
Capital Investment Group	CIG
Leadership, Culture and Workforce Programme Group	LCWP
Efficiency and Workforce Combined Steering Group	EWCSG
Other abbreviations used	
Strategic Development Reviews	SDR
Patient First Improvement System	PFIS
Trauma, Teaching and Tertiary Care Redevelopment	3Ts
NHS Improvement; NHS England	NHSI/E
Princess Royal Hospital	PRH
Statutory Compliance Audit and Risk Tool	SCART

		STRATEGIC OBJECTIVES:
1.	Patient Care	We will make delivering excellent care experience for our patients our highest priority
2.	Sustainability	We will use our resources efficiently and effectively for the benefit of our patients and their care and to ensure our services are clinically, operationally, and financially sustainable.
3.	People	We will value and respect all our staff equitably, involve them in decisions about the services they provide and offer the training and development they need to fulfil their roles
4.	Quality	We will deliver safe, high quality clinical services and demonstrate they achieve optimal clinical outcomes and deliver best practice for our patients whilst ensuring we meet regulatory standards
5.	Systems and Partnerships	We will collaborate with commissioners, local authorities, other partners and care providers to prevent ill health and plan and deliver services that meet the needs of our local population and deliver operational and NHS constitutional standards

		STRATEGIC RISKS. There is a risk that:
1.1	Patient Care	We are unable to deliver or demonstrate a continuous and sustained improvement in patient experience resulting in adverse reputational impact, and loss of market share.
2.1	Sustainability	We are unable to align or invest in our workforce, finance, estate and IM&T infrastructure effectively to support operational resilience, deliver our strategic and operational plans and improve care for patients
2,2	Sustainability	We cannot deliver ongoing efficiencies and flex our resources in an agile way resulting in an increasing or unmanaged deficit and inefficient, unaffordable and unsustainable services.
2.3	Sustainability	We are unable to meet high standards of financial stewardship meaning we cannot sustain compliance with our statutory financial duties
3.1	People	We are unable to develop and sustain the leadership and organisational capability and capacity to lead on-going performance improvement and build a high performing organisation.
3.2	People	We are unable to effect cultural change and involve and engage staff in a way that leads to continuous improvements in patient experience, patient outcomes, and staff morale and wellbeing
3.3	People	We are unable to meet our workforce requirements through the effective recruitment, development, training and retention of staff adversely impacting on patient experience and the safety, quality and sustainability of our services.
4.1	Quality	We are unable to deliver and demonstrate compliance with regulatory requirements or clinical standards adversely impacting on patient safety and our registration and accreditation by regulatory and supervisory bodies
4.2	Quality	We are unable to deliver service improvements and improve safety, care quality and outcomes for our patients or demonstrate that our services are clinically effective
5.1	Systems and Partnerships	We are unable to develop and maintain collaborative relationships with partner organisations based on shared aims, objectives, and timescales leading to an adverse impact on our ability to operate efficiently and effectively within our health economy.
5.2	Systems and Partnerships	We are unable to define and deliver the strategic intentions, plans and optimal configuration that will enable our services to be sustainable, leading to an adverse impact on their future viability.
5.3	Systems and Partnerships	We are unable to deliver and demonstrate compliance with operational and NHS constitutional standards resulting in an adverse impact on patient care and financial penalties

Strategic Objective 1 Patient Care: We will make delivering an excellent care experience for our patients our highest priority **Committee oversight:** Quality Assurance Committee	
Strategic Risk 1.1: We are unable to deliver or demonstrate a continuous and sustained improvement in patient experience resulting in adverse reputational impact, and loss of market share	
Key Controls	Patient Experience and Engagement Group to manage delivery and the provision of assurance Food Improvement Group with patient representation to manage delivery End of Life Care Group to manage delivery Patient Experience Panel co-chaired with Healthwatch to manage delivery Divisional Governance and SDR meetings to ensure compliance and manage division specific actions PFIS – to embed patient safety, quality and experience improvement techniques at ward level Patient Experience team – provide feedback from feedback and complaints to support learning and improvement action Legal team – provide feedback from inquests and claims to support learning and improvement Safety and Improvement huddles to manage day to day delivery Joint working with Healthwatch, NHSI/E Collaborative on Mixed Sex Accommodation to provide leadership support
Sources of Assurance	Quality Assurance Committee Friends and Family test data National patient survey data Complaints data Mixed Sex Accommodation data NHS constitutional standards data Quality data Patient and public feedback data including complaints Cleaning audits Healthwatch reports and feedback Regulatory reports and feedback Food quality surveys Healthwatch led environmental audits, PLACE and Six Facet Survey Legal claims data

Gaps in Control (C) or Assurance (A):			Actions:	Date/milestone	RAG	Lead	Monitoring Group
1.1.1	C	Improved controls are required to ensure ongoing delivery of patient experience improvements so that these are reflected in patient feedback and patient experience data	• Pilot and then roll out improvement projects to deliver improvements in staff attitude and greeting patients	Dec 18	◄►	ND	PEEG
			• Pilot and then roll out national Always Events programme to co-design improvements with patients	Apr 19	◄►	ND	PEEG
			• Develop programme of patient stories with learning points to support staff with planning improvement actions	~~Oct 18~~ Jan 19 In progress	◄►	CNO	PSG
			• Rollout of PFIS Wave 3/4	Oct 18 Complete	▲	CWOD	TEC
			• Implement findings from NHSI/E collaborative on Mixed Sex Accommodation	Aug 18 Complete	▲	ND	PEEG
			• Friends and Family Test and complaint themes identified at divisional level enabling divisional improvement programmes to be developed using PFIS methodology with reporting through SDR	Sep 18 Complete	▲	CNO	PEEG

Strategic Objective 2: Sustainability: We will use our resources efficiently and effectively for the benefit of our patients and their care and ensure our services are clinically, operationally, and financially sustainable

Committee oversight: Finance and Investment Committee

Strategic Risk 2.1: We are unable to align or invest in our workforce, finance, estate and IM&T infrastructure effectively to support operational resilience, deliver our strategic and operational plans and improve care for patient

Key Controls	Capital Investment Group agree capital plans and ensure the Trust prioritises and manages its capital allocation Business Case Scrutiny Panel ensure delivery, affordability and benefits realisation are achievable Estates Infrastructure Steering Group inform Strategic Capital Plan and manage delivery Capital Plan agreed by Board ensures prioritisation of estate, equipment, IM&T investment and back log maintenance Workforce Efficiency Steering Group prioritises manages delivery of workforce initiatives and efficiency programmes IM&T Strategy sets priorities for investment SDR at divisional level to provide performance management Additional £19 m capital funding secured through business case submitted to NHSI
Sources of Assurance	Finance and Investment Committee Financial reporting at divisional level to Steering Groups, Committees and Board Six Facet Survey SCART Workforce metrics reporting Environmental Audits Fire Safety reports Data Security and Protection toolkit score IT Maturity Matrix

Gaps in Control (C) or Assurance (A):			**Actions:**	**Data/milestone**	**RAG**	**Lead**	**Monitoring Group**
2.1.1	C	Effective controls are required to address the significant historic financial deficit.	• Medium Term Financial Plan Phase 1 completed April 2018. Draft Phase 2 to be developed	Oct 18 On track	◄►	CFO	FIC
			• Phase 2 plan to be finalised	Dec 18	◄►	CFO	FIC

Gaps in Control (C) or Assurance (A):			Actions:	Data/milestone	RAG	Lead	Monitoring Group
2.1.2	C	An increase in control is required to ensure that the constraints within our estate do not impede our ability to match capacity and activity so that we can meet demand and ensure the condition of our estate, plant and equipment does not impact on our resilience, operational performance or patient and staff experience	• Six Facet Survey/SCART integrated Action Plan/delivery Programme implementation	Mar 19	◀▶	CFO	EISG
			• 3Ts Programme delivery	Mar 21	◀▶	CFO	Board
			• Winter Capacity Programme implementation	Mar 19	◀▶	CDO	CIG/FIC
			• Emergency Department Redevelopment Programme	Mar 19	◀▶	CDO	TEC
			• Bed Masterplan Programme	~~Oct 18~~ Nov 18 In progress	◀▶	CDO	TEC
2.1.3	C	The controls in relation to provision of management information to support planning and operational management are insufficient because our Patient Administration System is outdated	• PAS replacement programme full implementation	Oct 18 On track	◀▶	CMO	TEC

Strategic Objective 2: Sustainability: We will use our resources efficiently and effectively for the benefit of our patients and their care and ensure our services are clinically, operationally, and financially sustainable

Committee oversight: Finance and Investment Committee

Strategic Risk 2.2: We cannot deliver ongoing efficiencies and flex our resources in an agile way resulting in an increasing or unmanaged deficit and inefficient, unaffordable and unsustainable services

Key Controls	Finance and Investment Committee Efficiency Programme Steering Group Board approved 18/19 Financial Plan that delivers agreed control total Workforce Efficiency programmes for Medical and Nursing Workforce to provide bank/agency usage oversight Risk adjusted Efficiency Programme in place to deliver required Cost Improvement Programme SDR to monitor divisional achievement of efficiency requirement Aligned Incentive Contract for 2018/19 with income guarantee to minimise risk exposure Trust's Finance functions PMO function supporting efficiency programme delivery
Sources of Assurance	Financial reporting at divisional and organisational level including income and activity reporting Annual reference cost submission Model Hospital metrics Use of Resources Framework and self-assessment Cash management reporting Efficiency programme progress reports External Audit report Internal audit programme and reports Trust exited Financial Special Measures in June 2018

Gaps in Control (C) or Assurance (A):			**Actions:**	**Data/milestone**	**RAG**	**Lead**	**Monitoring Group**
2.2.1	C	The controls in relation to efficiency are insufficient because planning does not extend beyond 18/19 and Model Hospital opportunities have not fully incorporated into plans	• Embedding rolling programme of efficiency and cost reduction with a focus on reduction in the overall spend on pay bill and aligned to Model Hospital opportunities	Dec 18	◄►	CFO	FIC

Gaps in Control (C) or Assurance (A):			Actions:	Data/milestone	RAG	Lead	Monitoring Group
2.2.2	C	There are inadequate controls of agency and temporary workforce leading to spend being above target	• Targeted efficiency programme to address agency and temporary workforce spend in 18/19. Projects being developed to address key areas of medical and nursing spend	Aug 18 Complete	▲	MD / ND	FIC
2.2.3		There is insufficient control of budgets because financial information does not support budget holders in operational decision making	• Budget holder training aligned to new divisional structures to be developed and delivered	Mar 19	◄►	CFO	FIC
			• Financial reporting to be reviewed and revised to improve understanding of performance and support timely decision making	Mar 19	◄►	CFO	FIC

Strategic Objective 2: Sustainability: We will use our resources efficiently and effectively for the benefit of our patients and their care and ensure our services are clinically, operationally, and financially sustainable **Committee oversight:** Finance and Investment Committee	
Strategic Risk 2.3: We are unable to meet high standards of financial stewardship meaning we cannot sustain compliance with our statutory financial duties	
Key Controls	Standing Financial Instructions Scheme of Delegation Local Counter fraud service work plan Bribery and corruption policy Declarations of Interest Policy Gifts and Hospitality Policy Fit and Proper Person declaration Procurement Function
Sources of Assurance	Audit Committee Finance and Investment Committee Internal Auditors reports External Auditors reports Financial reporting Regulator assessments Counter fraud investigation reports Declarations of Interest Internal audit programme and reports Quarterly procurement reporting Single Tender Waiver reporting Losses and compensations reporting External audit reports

Gaps in Control (C) or Assurance (A):			Actions:	Data/milestone	RAG	Lead	Monitoring Group
2.3.1	C	There are insufficient financial management controls because financial management resources are insufficiently aligned to business needs, budget holders are not equipped with sufficient understanding of their responsibilities in relation to financial stewardship and there are gaps in control of procurement meaning that it does not consistently deliver optimal value for the Trust	• Ensure that Financial Management supports the Trust to deliver its financial obligations by: o appointing a DD Financial Management o implementing a development programme for Finance staff	Sep 18 Complete Dec 18	▲ ▲	CFO CFO	FIC FIC
			• Refresh of the Standing Financial Instructions and the Scheme of Delegation	Mar 19	◄►	CFO	FIC
			• Budget holder training programme aligned to Trust's Standing Financial Instructions/Scheme of Delegation to be developed and delivered	Mar 19	◄►	CFO	FIC
			• Initial internal review of payroll provision and agree interventions to support sustainability	~~Oct 18~~ Dec 18 In progress	▲	CFO	FIC
			• Procurement Transformation Plan	Mar 19	◄►	CFO	FIC
2.3.2	A	The internal audit programme is not sufficiently aligned to key risks or targeted to address gaps in assurance	• Refresh of BAF and risk registers	Aug 18 Complete	▲	CFO	AC
			• Confirm alignment of annual internal audit programme to strategic risks and gaps in assurance	Sep 18 Complete	▲	CFO	AC
			• Develop Internal Audit Plan 2019/20 aligned to BAF	Mar 19	◄►	CFO	AC

Strategic Objective 3: People: We will value and respect all our staff equably, involve them in decisions about the services they provide and offer the training and development they need to fulfil their roles

Committee oversight: Quality Assurance Committee

Strategic Risk 3.1: We are unable to develop and sustain the leadership and organisational capability and capacity to lead on-going performance improvement and build a high performing organisation.

Key Controls	Executive led LCWP Steering Group and Working group LCWP supports the roll out of Patient First Divisional Leadership teams are engaged in the development of the Trust's Clinical Strategy Management contract with WSHT provides stability of Executive Leadership and corporate management New leadership structure in place and substantially recruited to includes new divisional leadership Leadership development programme for divisional leaders GGI programme supporting divisional leaders with the implementation of revised corporate/clinical governance Strengthened corporate structures including PMO, Business Planning and Continuous Improvement functions Coaching and support provided to divisional leadership, HR and Finance Business Partners through SDR to ensure focus on key deliverables PFIS provides framework for improvement capability development
Sources of Assurance	National Staff Survey data Retention, and vacancy rates in leadership teams Real time staff engagement and PFIS recognition data Organisational performance data Care Quality Commission reports

Gaps in Control (C) or Assurance (A):			**Actions:**	**Data/milestone**	**RAG**	**Lead**	**Monitoring Group**
3.1.1	C	There is a gap in control in relation to the efficacy of the new leadership structure because divisional leaders require further support and development in order to be optimally effective	• Leadership Skills audit and leadership development strategy to define leadership development programme and succession plan	~~Sep 18~~ Oct 18 Complete	▲	CWOD	LCWP Board
			• Programme to support Medical Engagement being developed	Nov 18	◄►	MD	LCWP Board

Strategic Objective 3: People: We will value and respect all our staff equably, involve them in decisions about the services they provide and offer the training and development they need to fulfil their roles **Committee oversight:** Quality Assurance Committee							
Strategic Risk 3,2: We are unable to effect cultural change and involve and engage staff in a way that leads to continuous improvements in patient experience, patient outcomes, and staff morale and wellbeing							
Key Controls	LCWP in place to support the roll out of Patient First Trust values have been defined and communicated widely as part of PFIS Equality, Diversity and Inclusion programme as part of LCWP Stonewall partnership arrangement						
Sources of Assurance	Workforce data Annual staff survey outcomes Real time staff survey data from May 2018 Care Quality Commission reports Support from National Race Equality Scheme team						
Gaps in Control (C) or Assurance (A):			**Actions:**	**Data/milestone**	**RAG**	**Lead**	**Monitoring Group**
3.2.1	C	Staff survey and cultural issues identified by CQC indicate that current controls may be insufficient to positively impact on staff morale.	• Freedom to speak up – Board assessment	Aug 18 Complete	▲	CWOD	LCWPB
			• Race Equality Scheme action plan	Sep 18 Complete	▲	CEO	
			• Stonewall audit for ranking in top employers list	Sep 18 Complete	▲	HRD	
			• Health and Wellbeing programme implementation	Aug 18 Complete	▲	CWOD	
			• Health and Wellbeing programme review	Jan 19	◄►	CWOD	
			• Implementation of project to reduce incidents of violence and aggression to staff and review effectiveness	Nov 18	◄►	CWOD	

Gaps in Control (C) or Assurance (A):			Actions:	Data/milestone	RAG	Lead	Monitoring Group
3.2.2		There are insufficient controls in place to ensure we maximise the opportunities for staff development and recruitment/retention available as a university hospital teaching trust and centre for training other health professionals	• Develop an Integrated Education Strategy with partner organisations	Dec 18	◄►	CWOD	LCWP
3.2.3	A	We don't have assurance that the LCWP is effective because comprehensive KPIs for measuring impact have not yet been defined	• Metrics to be defined as part of above programmes for 2019/20 and aligned to future reporting structures	~~Sep 18~~ Mar 19 In progress	◄►	CWOD	LCWP

Strategic Objective 3: People We will value and respect all our staff equably, involve them in decisions about the services they provide and offer the training and development they need to fulfil their roles

Committee oversight: Quality Assurance Committee

Strategic Risk 3.3: We are unable to meet our workforce requirements through the effective recruitment, development, training and retention of staff.

Key Controls	Workforce strategy that is aligned to workforce plans, delivery and efficiency plans Regular nursing establishment reviews at divisional level determine workforce requirements Vacancy, recruitment, sickness and retention monitoring and action planning at divisional level Performance management processes at divisional and directorate level Nursing and Medical Workforce Improvement Groups to deliver corporate work streams Training and resources for staff development In house temporary workforce service Agency usage controls Recruitment and retention strategies HR business partners and HR team
Sources of Assurance	Workforce data at divisional and organisational level

Gaps in Control (C) or Assurance (A):			**Actions:**	**Data/milestone**	**RAG**	**Lead**	**Monitoring Group**
3.3.1	C	Workforce metrics in some clinical areas indicate that current controls are insufficient to mitigate against shortfalls in staffing. There is insufficient control of workforce allocation and rostering	• Workforce efficiency programmes to increase focus at divisional level – action plans in development	Sep 18 Complete	▲	CWOD	EWCSG
			• Recruitment and Retention Strategy	~~Sep 18~~ Nov 18 In progress	◄►	CWOD	LCWP
			• Overall review of HR functions to ensure they are sufficiently robust to deliver workforce objectives	Sep 18 Complete	▲	CWOD	EWCSG
			• Deep dive of specific HR functions	Jan 19	◄►	CWOD	EWCSG
			• E-rostering pilot, and e-rostering business case to support full roll out	Nov 18	◄►	HRD	EXCSG

3.3.2	A	We do not have assurance that our current workforce strategy and plan is sufficient to meet the future workforce needs when our Clinical Strategy and 3Ts are deployed	• Gap analysis against Clinical Strategy, 3Ts and Operational Plan to ensure workforce plan and strategy is aligned	Nov 18	◀▶	CWOD	Board
			• Workforce Strategy and Plan are being developed and aligned to Clinical Strategy and 3Ts	Nov 18	◀▶	CWOD	Board
			• Review and update of Workforce Plan to align with Medium Term Financial Plan	Nov 18	◀▶	CWOD	Board
3.3.3		We do not have assurance that our training and development programmes are informed by the outcomes of individual appraisals and the future needs of our services	• Training and Development Strategy to be developed	Jan 19	◀▶	HRD	LCWP

Strategic Objective 4: We will deliver safe, high quality clinical services and demonstrate they achieve optimal clinical outcomes and deliver best practice for our patients whilst ensuring we meet regulatory standards **Committee oversight:** Quality Assurance Committee	
Strategic Risk 4.1: We are unable to deliver and demonstrate compliance with regulatory requirements or clinical standards adversely impacting on patient safety and our registration and accreditation by regulatory and supervisory bodies.	
Key Controls	Quality Governance Structure including: • Patient Safety Group with all divisions represented • Risk and Compliance Group • Safeguarding Group • Infection Prevention Group • Divisional governance meetings CQUIN programme reporting to CQUIN Steering Group Joint independently chaired Quality Oversight Committee meeting with CQC, NHSI and CCG CQC Improvement Plan Business Continuity and Major Incident Plans Clinical Negligence Scheme for Trusts improvement plan Quality Impact Assessments of all Cost Improvement Programmes GGI review of governance structures and input into Trust's Risk Strategy Safe staffing monitoring with clear lines of escalation to address gaps Information Governance Policy and training Accountability for delivery of quality standards clearly defined at divisional and clinical area level DIPC and Deputy DIPC Legal Team functions
Sources of Assurance	Attendance of Trust Executives and Directors at improvement and safety huddles Regulatory compliance reports including CQC Quality reporting including national and locally defined metrics National Cleaning Standards Audit Monthly Quality Peer Review, Nursing Metrics and Documentation Audit Seven Day Services Audit Healthwatch Quality and Safety Reviews Data Security and Protection Toolkit score External clinical peer review, quality assurance visits and compliance assessments for clinical standards

Gaps in Control (C) or Assurance (A):			Actions:	Data/milestone	RAG	Lead	Monitoring Group
4.1.1	C	Risk management controls are insufficient because divisional governance structures are not yet fully embedded and risk registers do not fully reflect the new divisional structure	• GGI development programme • Risk register review	Sep 18 Complete Aug 18 Complete	▲ ▲	CMO CMO	TEC TEC
4.1.2	C	There is a gap in control, identified through peer review, in our achievement of Major Trauma Service requirements.	• MTC Development Programme	Mar 19	◄►	CDO	TEC
4.1.3	C	There is a gap in the effectiveness of the controls we have in place to deliver compliance with regulatory and clinical standards and improve patient safety	• CQC Improvement Programme including: o Disseminate regular patient safety update to support learning from incidents o Map top themes from peer reviews to CQC domains and identify further improvements o Quality Special Measures Exit programme	Sep 18 Complete	◄►	CEO	Board
4.1.4	A	We do not have sufficient assurances that we are compliant with CQC standards and are making sufficient progress to exit quality special measures at the time of our next inspection	• Minimum Safety Work reviews reporting and Quality Special Measures Exit programme progress reports	Sep 18 Complete	◄►	CEO	Board
4.1.5	A	We do not have sufficient assurance that our Clinical Governance systems are embedded and effective	• Internal Audit review • Board reporting through Quality Assurance Committee and standardised reporting templates	Mar 19 Sep 18 Complete	◄► ▲	CMO CMO	AC QAC

Strategic Objective 4: We will deliver safe, high quality clinical services and demonstrate they achieve optimal clinical outcomes and deliver best practice for our patients whilst ensuring we meet regulatory standards

Committee oversight: Quality Assurance Committee

Strategic Risk 4.2: We are unable to deliver service improvements that improve care quality and outcomes for our patients

Key Controls	Quality Assurance Committee Quality Governance Steering Group Clinical Outcomes and Effectiveness Group Mortality Review Group Patient First Improvement Systems that align people to organisational and breakthrough objectives Learning from Death Policy aligned to Medical Examiner role pilot
Sources of Assurance	Quality data Mortality Data Quality scorecard Quality report to Board Learning from deaths

Gaps in Control (C) or Assurance (A):			**Actions:**	**Data/milestone**	**RAG**	**Lead**	**Monitoring Group**
4.2.1	C	There is a gap in the effectiveness of the controls we have in place to deliver improved quality outcomes for our patients through learning and acting on Clinical Audit	• Review of clinical audit programme	~~Sep 18~~ Oct 18 Complete	▲	CMO	QAC
			• Plan developed to address outputs of review	Jan 19	◄►	CMO	QAC
			• Ensure Clinical Audit actions are driven through PFIS using PDSA and Kaizen team	Jan 19	◄►	CMO	QAC
4.2.2	A	We do not have sufficient assurance that mortality and morbidity reviews are undertaken consistently and lead to improvements in care and outcomes	• Increase numbers of clinical staff trained to undertake structured judgement reviews with the aim of increasing the percentage of deaths reviewed from 11 to 20%	Dec 18	◄►	CMO	QAC
			• Morbidity and mortality reported at divisional level including reporting on Standardised Mortality Ratio at SDR	Jan 18	◄►	CMO	QAC

Strategic Objective 5: We will collaborate with commissioners, local authorities, our other partners and other care providers to prevent ill health, plan and deliver services that meet the needs of our local population and deliver operational and NHS constitutional standards **Committee oversight:** Finance and Investment Committee / Quality Assurance Committee / 3Ts Programme Board	
Strategic Risk 5.1: We are unable to develop and maintain collaborative relationships with partner organisations based on shared aims, objectives, and timescales leading to an adverse impact on our ability to operate efficiently and effectively within our health economy.	
Key Controls	Participation in STP process Management contract means leadership team is shared with WSHFT Agreed Aligned Incentive Contract with CCGs for 2018/19 including management board Formal Memorandum of Understanding agreed with QVH, WHSFT and BSH System wide NHSE/NHSI quarterly review meetings Joint independently chaired Quality Oversight Committee meeting with CQC, NHSI NSHE and CCG Participation in clinical and service networks as part of STP structures 2018/19 Operational Plan Joint pathology venture with SASH Input and checkpoints with partner organisations around development of BSUH Clinical Strategy Quarterly BSUH/SPFT Mental Health meeting
Sources of Assurance	MOU with QVH Management Contract with WSHFT AIC with CCG 2018/19 Operational Plan Draft Clinical Strategy

Gaps in Control (C) or Assurance (A):			Actions:	Data/milestone	RAG	Lead	Monitoring Group
5.1.1	C	There are insufficient controls in place to ensure our Clinical Strategy is fully aligned to local or specialist commissioning intensions at an STP level because these are insufficiently granular to allow us to plan effectively in partnership	• Final Clinical Strategy refresh to be developed including input from partners and presented to Board • Agreement from STP Clinical Senate Group that the Clinical Strategy will be received and set as the core of the emerging STP Strategy	~~Oct 18~~ Nov 18 In progress ~~Oct 18~~ Dec 18 In progress	◀▶ ◀▶	CMO / DSP CMO / DSP	TEC TEC
5.1.2	A	We do not have sufficient assurance that our partnership relationships with ESHT are robust enough to enable us to plan effectively for joint working	• Regular engagement meetings between Directors of Strategy BSUH/ESHT to ensure oversight of planning intentions	Nov 18	◀▶	DSP	TEC

Strategic Objective 5: We will collaborate with commissioners, local authorities, our other partners and other care providers to prevent ill health, plan and deliver services that meet the needs of our local population and deliver operational and NHS constitutional standards

Committee oversight: Finance and Investment Committee / Quality Assurance Committee / 3Ts Programme Board

Strategic Risk 5.2: We are unable to define our strategic intentions, service plans and optimal capacity configuration in a Clinical Strategy and Operational Plan that support the delivery of sustainable services leading to an adverse impact on our future viability

Key Controls	2018/19 Operational Plan 3Ts development - delivery and utilisation planning 2018/19 Aligned Incentive Contract PMO function supporting Corporate Projects delivery
Sources of Assurance	Progress reporting from Corporate Projects delivery structures Model Hospital benchmarking 3Ts Assurance Board 3Ts National Programme Board

Gaps in Control (C) or Assurance (A):			**Actions:**	**Data/milestone**	**RAG**	**Lead**	**Monitoring Group**
5.2.1	C	We have insufficient controls in place to ensure that our Clinical Strategy is defined in a way that leads to sustainability	• Ensure Clinical Strategy refresh process involving input from clinical divisions, linked to medium term financial plan, workforce plan 3Ts opportunities, and STP	~~Oct 18~~ Nov 18 In progress	◄►	CMO / DSP	TEC
5.2.2	C	There is a gap in our control of capacity planning meaning we are unable to undertake efficient and effective estate allocation and planning	• Develop a capacity utilisation masterplan to include all elements of current capacity plans aligned to clinical strategy and 3Ts planning	Mar 19	◄►	CDO	TEC / Board

Gaps in Control (C) or Assurance (A):			Actions:	Data/milestone	RAG	Lead	Monitoring Group
5.2.3	C	We are unable to control the availability and use of our physical infrastructure to provide optimal service delivery and decant space to allow environmental and operational improvements	• Provide structured governance and corporate oversight to all current capacity planning streams: o 3Ts development – Stage 1 and 2 planning	~~Oct 18~~ Nov 18 In progress	◄►	CDO	3Ts Board
			o ED Programme	~~Sep 18~~ Mar 19 In progress	▲	DO	TEC
			o Winter Capacity Programme including PRH	Sep 18 Complete	▲	DO	TEC
5.2.4	A	The progress reporting on the delivery of True North and Strategic initiatives is insufficient to provide assurance	• Implementation of Trust SDR assurance process, linked to Divisional SDR and performance managements – Trust SDR data and process populated monthly	Mar 19	◄►	CDO	TEC / Board

Strategic Objective 5: Systems and Partnerships – We will collaborate with commissioners, local authorities, our other partners and other care providers to prevent ill health, plan and deliver services that meet the needs of our local population and deliver operational and NHS constitutional standards **Committee oversight:** Finance and Investment Committee / Quality Assurance Committee / 3Ts Programme Board	
Risk 5.3: We are unable to deliver and demonstrate compliance with operational and NHS constitutional standards resulting in an adverse impact on patient care and financial penalties	
Key Controls	PFIS improvement methodology and process SDR Performance management processes and improvement trajectories Local A&E Delivery Board Local Planed Care Delivery Board Regional Urgent and Emergency Care Network Quality Oversight Committee NHSI Integrated Assurance Meeting Weekly Divisional RTT Delivery Meeting COO led 52 week Breakthrough Objective Performance Meeting Cancer Board Theatre Efficiency Programme
Sources of Assurance	Reporting against National and Local performance metrics monthly and daily Reporting against AIC contractual requirements Reporting against Breakthrough Objectives and True North Reporting against Theatre Efficiency Programme

Gaps in Control (C) or Assurance (A):			Actions:	Data/milestone	RAG	Lead	Monitoring Group
5.3.1	C	Underperformance against constitutional standards indicates insufficient controls are in place to manage delivery of: • A&E standards • Cancer standards • Elective standards	• Ambulance handover improvement plan including best practice implementation of FTS and Streaming	Aug 18 Complete	▲	DO	Local Area ED Board / TEC
			• ECIST support for A&E and Flow improvement programme	Jun 18 Complete	▲	DO	Planned Care Board / TEC
			• Review and develop Cancer delivery plan and trajectory with external support to internal Cancer Team and report to QAC	~~Sep 18~~ Dec 18 In progress	◄►	DO	Cancer Board / TEC / QAC
			• Theatre Efficiency Programme improvements to increase elective efficiency	Sep 18 Complete	▲	CDO	TEC
5.3.2	C	There is a gap in the controls in place to consistently deliver flow through the hospital	• Winter Capacity Planning including PRH and ED and Short stay Development Programme to support increased capacity to match current demand	Dec 18	◄►	CDO	TEC
5.3.3	A	There is a gap in the assurances we are able to provide to the system that improvement actions are resulting in measurable performance improvements	• Develop and agree system wide MFD and DTOC reduction plan including community capacity plan – with verbal update to Board	~~Sep 18~~ Oct 18 Complete	▲	CDO	Local Area ED Board / TEC

Brighton and Sussex University Hospitals NHS Trust

To: Trust Board

Date of Meeting: 24th October 2018 Agenda Item: **16**

Title
Notification of Sealed Documents
Responsible Executive Director
Marianne Griffiths, Chief Executive Officer
Prepared by
David Haycox, Interim Company Secretary
Status
Disclosable
Summary of Proposal
It is a requirement of the Trust Standing Orders (Section 8.3) that a register of sealing is maintained and use of the Common Seal is reported to the Trust Board at least annually. This report covers the period 1st July 2018 to 30th September 2018. Appendix 1 details use of the Common Seal during this period.
Implications for Quality of Care
None identified
Link to Strategic Objectives/Board Assurance Framework
Links to good governance requirements, Trust Standing Orders state reporting requirement to Trust Board.
Financial Implications
None identified
Human Resource Implications
None identified
Recommendation
The Board is asked to: NOTE use of the Trust seal
Communication and Consultation
Not applicable
Appendices
Appendix 1: Register of Use of Common Seal 1st July 2018 to 30th September 2018

Brighton and Sussex University Hospitals NHS Trust

Appendix 1

Use of Trust seal from 1st July 2018 to 30th September 2018

Register reference	Dated	Document	Signed in the presence of (1)	Signed in the presence of (2)
276	27/07/2018	Deed of Collateral Warranty: Relating to Mechanical, Electrical and Public Health Services – 3Ts Hospital. Laing O'Rourke Construction Ltd and Crown House Technologies Ltd.	Karen Geoghegan	Pete Landstrom
277	27/07/2018	Deed of Collateral Warranty: Sub-structure, Super Structure and Precast Cladding – 3Ts Hospital. Laing O'Rourke Construction Ltd and Expanded Ltd.	Karen Geoghegan	Pete Landstrom
278	27/07/2018	Deed of Collateral Warranty: Littlehampton Welding Ltd and Laing O'Rourke Ltd. Structural Steel Work at Thomas Kemp Tower – 3Ts.	Karen Geoghegan	Pete Landstrom
279	27/07/2018	Deed of Collateral Warranty: Schindler Ltd and Laing O'Rourke Ltd. Lift installations.	Karen Geoghegan	Pete Landstrom
280	27/07/2018	Deed of Collateral Warranty: Building Maintenance Units. Safe Permanent Access Ltd and Laing O'Rourke Ltd.	Karen Geoghegan	Pete Landstrom
281	27/07/2018	Deed of Collateral Warranty: Piling (3Ts) Expanded Ltd and Laing O'Rourke Construction Ltd.	Karen Geoghegan	Pete Landstrom