Brighton and Sussex University Hospitals NHS Trust

Meeting of the Board of Directors

09:00am to 10.45am on Wednesday 27th September 2017
Boardroom, St. Mary's Hall, Royal Sussex County Hospital

AGENDA – MEETING IN PUBLIC

1.	9:00	**Welcome and Apologies for Absence**		Chair
2.	9:00	**Declarations of Interests**		All
3.	9:05	**Minutes of Board Meeting held on 26th July 2017** To approve	Enclosure	Chair
4.	9:10	**Matters Arising from the Minutes** To note	Enclosure	Chair
5.	9:10	**Chief Executive's Report** To receive and agree any necessary actions	Enclosure	MG
		PERFORMANCE		
6.	9:20	**Quality Report** To note and agree any necessary actions	Enclosure	GF/NR
7.	9:30	**Organisational Development and Workforce** To note and agree any necessary actions	Enclosure	DFa
8.	9:40	**Performance Report** To note and agree any necessary actions	Enclosure	PL
9.	9:50	**Financial Performance Report** To note and agree any necessary actions	Enclosure	KG
		PATIENT SAFETY/EXPERIENCE ITEMS		
10.	10.00	**Infection Prevention and Control Annual Report** To note and agree any necessary actions	Enclosure	NR
		OTHER ITEMS		
11.	10.20	**Emergency Planning Resilience and Response Assurance Report** To note and agree any necessary actions	Enclosure	EB
12.	10.30	**Other Business**	Verbal	Chair
13.	10.45	**Resolution into Board in Private:** To pass the following resolution, "that the Board now meets	Verbal	Chair

		in private due to the confidential nature of the business to be transacted"		
14.	10.40	**Date of Next Meeting** The next meeting in public of the Board of Directors is scheduled to take place in the Boardroom, St. Mary's Hall, Royal Sussex County Hospital, on 29 November 2017.		Chair
15.	10.40	**Close of Meeting**		Chair
16.	10.40	**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

Andy Gray
Corporate Governance Director

Brighton and Sussex University Hospitals NHS Trust

Minutes

Minutes of the Board of Directors meeting held on 26th July 2017 at 10.00 in the Boardroom, St. Mary's Hall, Royal Sussex County Hospital

Minutes

Present:

Mike Viggers	Chairman
Kirstin Baker	Non-Executive Director
Graham Hodgson	Non-Executive Director
Professor Malcolm Reed	Non-Executive Director
Mike Rymer	Non-Executive Director
Joanna Crane	Non-Executive Director
Martin Sinclair	Non-Executive Director
Patrick Boyle	Non-Executive Director Advisor
Marianne Griffiths	Chief Executive
Denise Farmer	Chief OD and Workforce Officer
Karen Geoghegan	Chief Financial Officer
Evelyn Barker	Managing Director

In attendance:

Caroline Davies	Director of Nursing (BSUH)
Steve Drage	Deputy Medical Director (Safety and Quality)
Renee van der Most	Consultant Anaesthetist (item PB 7/17/6)
Andy Gray	Corporate Governance Director
Dominic Ford	Director of Corporate Governance and Board Secretary

GENERAL BUSINESS

PB7/17/1 Welcome and Apologies

Apologies were received from George Findlay, Chief Medical Officer, Nicola Ranger, Chief Nurse, Lizzie Peers and Jon Furmston, Non-Executive Director Advisors.

PB7/17/2 Declarations of interest

There were no declarations of interest

PB7/17/3 Minutes of Previous Meeting

The minutes of the meeting held on 29th May 2017 were approved as a correct record.

PB7/17/4 Matters Arising

The matters arising were noted

PB7/17/5 Chief Executive's report

Marianne Griffiths introduced the Chief Executive's report advising that the £30m emergency floor development had been approved by NHSI. The first phase would

provide 35 additional ambulatory spaces, and would be in place before Christmas. The floor over A&E would house the new 70 short stay beds and would be built next year. The third phase would enable decant and open up the current space and would be completed by the end of next year. Marianne thanked all the staff who had contributed to the development and approval of the programme which would contribute significantly to improving patient flow and capacity in the hospital.

Marianne further advised that the new oversight arrangements were working effectively and the meeting in June had received the Trust single improvement plan. A further meeting would be held on 2nd August.

The radiotherapy unit in Eastbourne opened on 25th July. 5 new machines would now be in place by September at the new unit in Eastbourne, Preston Park and the Royal Sussex County Hospital. The Trust had also attended the HASC meeting in West Sussex in July to discuss the development of radiotherapy in West Sussex. The HASC was supportive of the plans and discussions were taking place to push this forward, including with Portsmouth Hospitals NHS Trust. A joint plan should be ready in September for the development of a new unit in Chichester. **PL**

Management and leadership had been strengthened in BSUH, with the first round of new appointments based on the commitment to patient care as the top priority for the organisation. Some functions would be shared between the Trusts. The new arrangements would also speed up decision-making.

The consultation on the clinical leadership was also nearing conclusion, the outcome of which would be reported to the next Board. A new Divisional structure would be introduced, strengthening the existing arrangements.

The CQC report would be received shortly and it was hoped that this will show improvement but was not expected to take the Trust out of special measures. The longer-term issues around leadership and culture and governance would also need to be addressed to ensure sustainable improvement.

A royal visit had taken place on 19th July commemorating ten years of the RACH and 50 years of the Rockinghorse Charity. The visit also celebrated the outstanding work undertaken at the hospital

Marianne also reported that she had visited the booking hub and observed the very important improvements made which were of great significance for patients. The team would be invited to a future Board meeting to discuss the improvements they had made. **AG**

The Children's critical care team had been highly commended in the HSJ patient safety awards and would be presenting their work to the AGM. The nuclear medicine team had also been recognized at the Annual Nuclear Medicine Conference where the team had won 2 prizes and made several presentations to the conference.

Joanna Crane asked about the view of the other participants in the oversight arrangements and Marianne Griffiths advised that feedback had been positive but it was also important that the requirements and obligations on the regulators were met though the new arrangement. Pete Landstrom added that feedback had also supported the view that this approach oversight would enable real progress to be made.

The Board noted the report

PERFORMANCE

PB7/17/6 Quality Report

Steve Drage introduced the Quality Report advising the Board that the crude mortality rate was stable or decreasing, however the HSMR and SHMI had continued to trend upwards although it remained below the national average. No specific diagnostic group or alert had explained the increase and mortality after, for example, hip fractures and renal failure were very positive.

The requirement on the Trust of *Learning from Deaths* was being implemented using structured judgement reviews. There was particular focus on deteriorating patients to ensure rapid escalation and response linked to the objectives of the Patient First programme. There had been good progress on closing safety alerts. 10 Serious Incidents had been reported in Quarter 1, and there was a thematic concern around delays in patients being assessed and treated, which was being reviewed in detail.

Caroline Davies added that falls and pressure damage rates continued to be very low. The safety thermometer score was 97% in June and further work was being undertaken around safe catheterisation. The Friends and Family Test (FFT) responses had identified issues around post-natal care but other satisfaction levels were good and the in-patient score was 96%. Response rates remained low at 13% and 18% in in-patient areas and A&E respectively and an improvement workshop would be held next week to discuss improvements to the experience of patients. This would include improving the FFT responses. Mixed sex accommodation breaches had reduced month on month and a new escalation procedure introduced.

Mike Rymer noted the concern around the persistent rise in mortality which would need to be kept under review. Mike also asked about tissue viability and the issues around nursing documentation identified in the report. Caroline Davies advised that there had been no grade 3 or 4 incidents reports, however grade 2 incidents had increased and the Chief Nurse would be working with staff to rationalise the required documentation to enable staff to focus on nursing care.

Marianne Griffiths advised that it would be helpful to include in the further iteration of the quality report benchmarking data around FFT and the response rates. **CD**
Marianne further noted that work would be undertaken to improve incident reporting and that incident reporting rates might increase as a consequence. The Trust was focused on work around deteriorating patients including sepsis as part of the True North objectives and IT solutions would be required to support the work around observation and escalation. Steve Drage added that this was currently being piloted on 2 wards.

Joanna Crane asked about the use of the term catastrophic. Steve Drage advised that this was the national classification as applied within the Trust. Mike Viggers noted that the QRC chairs would discuss this classification outside the meeting. Joanna also asked about compliance with the WHO checklist and Steve Drage advised that the Directorate Lead Nurse was working to reinforce compliance particularly in areas outside the main theatres. Pete Landstrom reported that there was now a single leadership point for all theatres which would support improvement.

Martin Sinclair asked about the quality of data reported in the scorecard and Mike Viggers noted that internal audit could be used to assess and strengthen data quality and reporting.
Mike Viggers concluded by noting the importance of the work about learning from deaths, the adverse trend in mortality rates, and the work which was underway

around deteriorating patients and sepsis. Mike further noted the importance of work to improve incident reporting and asked for issues around access to be incorporated in the next review of mortality. **SD**

MV noted the excellent work around falls, and the work to be done around tissue viability. Performance around the safety thermometer was very positive. There was a strong focus on MSA as a priority. However work was also required to improve FFT responses.

Organ donation annual report

Renee van der Most, introduced the organ donation annual report, advising the Board on the composition of the team supporting organ donation in the Trust and the very good results achieved in the last year. The number of donors had increased, together with the number of patients receiving transplants. The average donor rates were very positive compared to the UK average. There had also been a significant increase in the number of patients transplanted. BSUH was also a pilot in heart retrieval and the results had been very positive to date. The key performance indicators were reviewed at the organ donation committee and all parts of the process were reviewed, including family liaison and consent. The Trust had improved in all areas with very good referral and consent rates. The testing results and shortfalls were very clear as was the testing process. Some patients had been unstable to test. Discussions with family members were undertaken systematically and sensitively. Year on year rates had improved. The Trust had done outstandingly well for deaths after circulatory death and rates were very positive there too compared to the national average. The presence of specialist nurses on the unit had also helped significantly. There had been an increase in the number of donors, excellent referral and consent rates, and specialist nurses were more embedded, with strengthened teaching opportunities. However there were challenges around office space in the ICU which the Board agreed would be addressed urgently. **EB**

MV asked about recruitment to the specialist nurse roles and Renee advised that there were national recruitment problems, which were also experienced locally; and Mike also welcomed the referral and consent rates and the number of lives which were enhanced through the work of the team.

Kirstin Baker asked about any other challenges and Renee advised that the work was complicated and sensitive and communication and decision-making was continually reinforced, through teaching and work with families.

Martin Sinclair asked about general awareness of organ donation and Renee advised that new patient representatives were now members of the Organ Donation Committee and contributing to its on-going work to raise awareness. This included publicity campaigns.

Malcolm Reed asked about the education of trainees and students around organ donation and Renee advised that work was planned regionally and with the University.

Mike Viggers concluded by thanking the team for this excellent work and noting that the Trust was committed to raising education and awareness around organ donation, including in partnership with WSH.

Complaints annual report

Caroline Davies introduced the complaints annual report, advising that the number

of complaints had largely remained stable. The complaints and PALS team had been restructured in the past year which had enhanced early resolution of concerns. This had also reduced formal complaints and the Trust would achieve its 85% response time target by the end of the year.

There was a particular focus on complaints related to staff attitudes. Complaints were shared with line managers and members of staff to ensure learning and this would be developed further in the patient experience improvement work.

There was a low rate of referrals to the PSHO reflecting the quality of complaints responses. 4 complaints had been partly upheld and 2 fully upheld by the PHSO. Work would also be undertaken to better capture the plaudits from patients and families, only part of which were reflected in the report. There were patient experience panels on each site, chaired by Health Watch which had been reformatted and was supporting improvement in the experience of patients. Caroline also noted the significant improvements in the national in-patient survey year on year.

Mike Rymer asked about cross-directorate learning and Caroline advised that the cross-cutting themes around communication and staff attitudes were presented in nursing and management forums, although this could be strengthened. Directorates also received individual reports on complaints and themes in their area.

Joanna Crane asked about the cultural dynamics in complaints and Caroline advised that this was analysed by protected characteristics and represented on the patient experience panels.

Patrick Boyle asked about the terminology used around upholding complaints and whether this was appropriate in making judgements about complaints and the individual experience. Caroline advised that this was not communicated in the response to patients which were not judgemental in their tone. Denise Farmer also noted the importance of corporate learning regarding, for example, communication and recruitment, for example. Marianne Griffiths noted that improvement in the FFT score was also one of the breakthrough objectives and welcome the improvements in the patient survey and the positive messages around care and dignity in the report.

Mike Viggers thanked the team and noted the focus in resolving concerns early, the work led by the Chief Nurse to improve the experience of patients and the aligned review of the governance of patient experience.

PB7/17/7 Organisational development and workforce

Denise Farmer introduced the Month 3 report on organizational development and the workforce and advised the Board of the energetic progress on recruitment and retention which was focused on nursing and the allied health professions.

The consultation on strengthening the management arrangements in the clinical divisions had concluded and themes from the responses received were being collated. There was overall positive support for the proposals and with feedback on the need to retain the best of the current directorate arrangements. The senior posts would be recruited into shortly with a focus on the expectations and skills of the roles.
The Board at its seminar in June had received an update on phase 1 of the People Opportunities work. The Board had welcomed the report and was committed to moving the recommendations forward in four areas: Board development and improving diversity and respect; facilitating conversations with the networks to

improve the organisation, using their expertise and experiences; the contribution to the People Strategy; senior leadership, engagement and communication.

Joanna Crane asked about the context for employment in the general population and its impact on recruitment, and it was agreed that this would be reviewed following the meeting.

Mike Rymer asked about mandatory training and the non-compliance of some bank staff with the training requirements and Denise Farmer confirmed that staff would come of the books if they were not trained.

Kirstin Baker asked about on-going workforce transformation and also noted the reduction in appraisal rates and feedback from staff about the quality of some appraisals. Denise advised that a more detailed update would be provided to the oversight committee in September and would be shared with the Board prior to the meeting. The appraisal policy would be refreshed and training would need to be undertaken. Clarity was required and greater visibility around mandatory training. The workforce transformation projects would be reviewed and refocused and key projects taken forward with the Chief Nurse.

Mike Viggers concluded noting the importance of the work underway around retention and of the engagement of the Board with the People Opportunities work.

PB7/17/8 Performance report

Pete Landstrom reported on Month 3 performance advising the Board of continued improvements in elective care but challenges around flow and capacity in the second half of the month. June had been a busy month with a 1% increase in A&E attendances but 10% increase in admissions. Delayed Transfers of Care (DTOCs) had started to reduce but had increased again most recently to 7.5%.

A&E performance was 86.5% in June. There were no 12 hour breaches and none had occurred in the previous 6 months. Non-elective flows had improved until the latter part of the month and the challenges in patient flow had continued into July. This had resulted in higher bed occupancy.

The particular challenge to patient flow was at RSCH. The approval of the business case for the Emergency Floor was very welcome and would support improvements in patient flow in the staged implementation of the business case. The expansion and redevelopment of the urgent care centre and revised clinical models would also support improved performance and patient experience.

The Trust was compliant against 6 of the 8 cancer metrics in May, but was below the Single Oversight Framework trajectory requirement for 62 day treatment of 85% with actual performance for May at 81.8%.There were issues around CT and diagnostic availability in June and work was being undertaken to recover the position.

RTT performance had improved but was below the national standard. Long waits were a particular concern. 96 patients in June had been waiting longer than 52 weeks, predominantly in general surgery. There were significant shortfalls in capacity and work was being undertaken around patient flows and their solutions, with local partners. The reporting of RTT had been signed off by NHSI and IST which would enable a ‘clean’ waiting list. Only 500 additional patients had been added to the waiting list following completion of this work.

The Trust had continued to maintain compliance with the diagnostic waits standard.

Marianne Griffiths added that the oversight committee and CCG had committed to reducing delayed discharges to 1% and the Trust would be chairing a challenge event to facilitate improvement in this area. A review of the digestive disease service would be undertaken to address the issues in that service with formal terms of reference.

Mike Rymer asked about cancer waits and the tertiary work and Pete Landstrom advised on the challenge in ensuring timely referrals particularly from East Sussex which caused delays in the tertiary service.

Joanna Crane asked about the increase in OP activity and whether this would be funded. Pete Landstrom advised that some high volume procedures had changed in their classification and the Trust activity plans were understood by the CCG. Karen Geoghegan confirmed that the activity plan had been rebased on the Month 12 position and agreed with commissioners.

Mike Viggers concluded by noting the work ongoing to reduce delayed transfers of care, the improved position on 12 hour breaches, the changes to urgent and emergency services, and the need to report on individual problematic specialties within the cancer network.

PB7/17/9 Financial performance report

Karen Geoghegan reported on the Month 3 financial position, noting that the Finance and Investment Committee had discussed the Month 3 report in detail and advised the Board that there was a year to date favourable position of £0.2m with a financial risk rating of four.

Income was under-performing by £0.9m and the underlying factors were being monitored, including performance against the MSK contact, and also the cancer drugs fund and earnings from Research & Development. The pay bill was £1m less than planned but the run rate had been increasing and would continue to be monitored closely.

The efficiency programme had been identified in full, with risks to delivery of £2.25m and the PMO team was now supporting the operational teams in delivery. The capital programme was £13m behind plan, both for 3Ts and the operational capital programme. The cash position was £2.9m better than planned.

The Trust was forecasting delivery of the control total with risks around delivery of the efficiency programme and the pay bill and trends.

The Board noted the report

PB7/17/10 Safer nursing and midwifery staffing

Caroline Davies introduced the monthly report on safer nursing and midwifery staffing, noting a continued increase in vacancies, with 181 nurses in the pipeline and 72 health care assistants. Successful recruitment days had been held in July and would continue through the year and invitations to nurses to return to work had been issued.

The usage of agency staff remained low at just over 2%, although there had been an increase in bank staff reflecting the vacancy position. Care hours per patient day remained static and positive. Mitigations had been put in place on wards with less than 80% fill rate and there had been no reported incidents related to staffing levels.

The turnover rate remained high at 14.3% and improving the retention of staff, particularly in their first year was critical.

Mike Viggers asked about the reasons for people leaving and Denise Farmer advised that there were differences between sites and the Board would receive a report on the focus and the outcome of the retention project in September. **DF**

Graham Hodgson asked about the resourcing of HCAs on the night shift where staffing was sometimes in excess of 100% and Caroline Davies advised that this concerned 'specialling' of patients with complex needs where more staff were required.

The Board noted the report

Questions from members of the public

A member of the public asked about the stress on staff from shortfalls in nursing and Caroline Davies agreed that this was important and could have a negative impact on teams. Support was always provided within the hospital and mitigations were put in place to ensure the impact on patients was minimised.

A member of the public asked about radiotherapy in west Sussex and the planned development of the business case and its timescale and asked the Board to confirm the project was proceeding with the interim and final solution by March 2018.

Pete Landstrom advised that the fastest possible timeline had been outlined and significant progress had been made in taking forward a possible solution. Pete advised that NHSE commissioned the service and the development required commissioner support. NHSE also considered there was sufficient capacity but that it was not necessarily sighted in the most appropriate locations. Good progress had been made with NHSE through the national programme for 2 linacs to be replaced and based at St. Richards. However it was important that this planned development pathways did not destabilise existing pathways, including with Portsmouth Hospitals NHS Trust. Clinical models for the service were progressing well to dually run the unit. It was planned that Memoranda of Understanding would be submitted to the respective Boards in September. Capital funding would be required for the equipment and build and the HASCs were supportive and had written to NHSE to express their support.

The member of the public asked for confirmation that it was planned to have 2 linear accelerators and Pete Landstrom confirmed that as part of national replacement programme there would be 2 replacement linacs.

The member of the public further asked about having a member of the BSUH Board on the Radiotherapy Programme Board and it was agreed that this would be considered following the meeting. **MV**

PB7/17/11 Any other business

There was no other business

PB7/17/12 Date and time of next meeting

The next meeting will be held on Wednesday 27th September at 10.00 in the Boardroom. St. Mary's Hall at the Royal Sussex County Hospital

Dominic Ford
Director of Corporate Governance and Board Secretary
August 2017

MATTERS ARISING
Board of Directors

AGENDA ITEM: 4

Meeting	Minute Ref	Action	Person Responsible	Deadline	Status
26th April 2017	PB4/17/4	Executive Director of Nursing to report to the Board on the outcome of the acuity and dependency review	Nicola Ranger	TBC	TBC
26th July 2017	PB7/17/5	A plan for the development of radiotherapy services in West Sussex would be reported to the Board in September	Pete Landstrom	September 2017	Agenda item
	PB7/17/6	Benchmarked data on the FFT would be included in the future quality reports	Nicola Ranger	September 2017	Agenda item
	PB7/17/6	The theme around access and mortality would be incorporated in the next learning from deaths report	George Findlay	November 2017	Agenda item November
	PB7/17/6	Office space for the organ donation team would be resolved	Evelyn Barker	July 2017	
	PB7/17/10	Denise Farmer would report further on the retention project at the next Board meeting	Denise Farmer	September 2017	Agenda item

Brighton and Sussex University Hospitals NHS Trust

To: Board of Directors

Date of Meeting: 27th September 2017 Agenda Item:5

Title
Chief Executive's report
Responsible Executive Director
Chief Executive
Prepared by
Chief Executive
Status
Public
Summary of Proposal
The report highlights the first meeting of the new oversight arrangements; the initial feedback from the CQC inspection; progress with the corporate and clinical structures; and the Executive and Board away days
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 the report
Communication and Consultation
Not applicable
Appendices
None

Report to the Board of Directors, 27th September 2017
Chief Executive's report

1. Council planners give green light to £30 million A&E expansion, including 70 bed Short Stay Unit

Following NHS Improvement's approval in July, Brighton and Hove City Council's Planning Committee has now approved plans to build a new Short Stay Unit above the County Hospital's A&E Department's vehicle drop off area. The 70 bed unit will provide care for both medical and surgical patients who require a stay of two days or less in hospital.

The unit lies at the heart of a major £30 million programme of improvements for the A&E Department. The programme also includes a new Ambulatory Care Unit and the reconfiguration of the existing department. The extra capacity offered by the Short Stay Unit will help improve admissions from A&E and make it easier to get patients to the right bed, in the right department at the right time, thus improving patient care.

Site preparation works around the drop off area will start before the end of the year and the new facility is scheduled to open towards the end of 2018.

2. Achieving Hyper-Acute Stroke Unit status

After years of working closely with our local Clinical Commissioning Groups to improve stroke care for patients across Sussex, Brighton and Sussex University Hospitals has achieved Hyper-Acute Stroke Unit (HASU) status.

The additional funding made available by the CCGs has enabled us to employ more therapy staff and provide a truly seven-day service for our patients.

Along with the unit's multidisciplinary care and seven day therapy services, we are also undertaking new procedures in the treatment of stroke. Our Intra Arterial Thrombectomy (IAT) service enables our neuroradiologists and expert team to remove clots through mechanical means. Although this treatment is not suitable for all stroke patients it can make a life changing difference and is not available anywhere else in Sussex

The teams in Accident and Emergency now make very rapid assessments of all possible stroke patients, organise the CT scan and call the stroke team, saving valuable time and helping reduce disability for stroke. This allows the stroke team to work effectively ensuring patients are transferred to the stroke unit as soon as possible and within an hour. The current BSUH Stroke Unit median time to admission is 2:46 hours, compared to national median of 3:47 hours.

In the latest Royal College of Physicians Sentinel Stroke National Audit Programme (SSNAP) survey, the trust is currently Level B, putting us in the top 40% of units in the country. We are working towards being an A rated unit by spring 2018.

The HASU celebrated with a tea party for staff and patients attended by former colleague and *Bake-off* finalist Tamal Ahmed.

3. Radiotherapy services: New centre provides easier access to care

The Radiotherapy Unit in Eastbourne that fist opened its doors on 25th July is now fully operational, bringing radiotherapy services closer to home to patients in that part of East Sussex. The first patients have now completed their courses of radiotherapy.

The £14.5 million centre is an extension of the Brighton-based Sussex Cancer Centre and includes two linear accelerators (LINACs) and a CT scanner.

Providing local cancer treatment is a fundamental element of the Trust's cancer strategy. Patients have enough to deal with when they are diagnosed with cancer without having to worry about how they're going to get to their treatment every day.

4. Wellbeing for all

We increasingly know that being physically and mentally "well" makes people happier, more productive and better able to cope with whatever our days might throw at us. We have launched aa new app which allows every member of BSUH staff to assess their own wellbeing and tap into resources to help improve it.

The new app CARI (commitment and resilience index), uses a 60 question survey to assess its users' conscious and unconscious sense of wellbeing. The results are personal to each individual and highlight areas where we can take better care of ourselves or need to ask for help.

The project was developed by BSUH's deputy director of human resources, Lorissa Page in partnership with award-winning occupational psychologist, Maria Paviour, with the aim of creating a more positive culture throughout the trust and, in turn, improving patient care.

All 8,000 staff across the Trust has access to the CARI survey, enabling them to develop their own personal wellbeing profile and access support to improve individual wellbeing which, the evidence shows, will drive the highest levels of patient safety.

5. New structure to strengthen our leadership

We have published the trust's new organisational structure and shared this with staff. The structure is designed to help us work more collaboratively, improve our decision-making processes and strengthen our leadership at all levels.

This is an important step in our adoption of a Patient First approach to bring about the improvements we all want to see.

The final structure follows a period of consultation with staff from across the organisation. The trust's 12 existing clinical directorates will be brought together into five new clinical divisions, each of which will be headed by a leadership team of three: a clinical Chief of Service, a Divisional Director of Operations and a Divisional Head of Nursing/Midwifery/Professions as appropriate.

The five divisions are:

- Medicine
- Surgery
- Children's and Women's
- Specialist Services
- Central Clinical Services

Two of the main areas for improvement highlighted throughout last year's CQC reports were leadership and decision-making, so the new arrangements are an important change that will help us address those issues by providing additional senior medical, nursing, managerial and professional capacity to support the continuing work of the established directorates.

6. The Cedar Room - New Macmillan cancer information room for Mid-Sussex

Cancer patients across Mid-Sussex can get free information from a new cancer information room located in the main Outpatients department at the Princess Royal Hospital (PRH).

The Cedar Room officially opened on 11 September and will be open to the public every Monday afternoon. The project received a grant of around £20,000 from Macmillan Cancer Support and has links with the new Macmillan Horizon Centre, at the Royal Sussex County Hospital.

Lucinda Mackay, Macmillan Nurse, led the project from within PRH. The room, which doubles up as a consultation space, with information covering different cancer types, treatments and side effects as well as financial issues and emotional issues.

Previously, patients would have had to travel down to the Macmillan Horizon Centre in Brighton, ring a national helpline or speak to their Nurse Specialist, but in the Cedar room, they can browse and find the information they need.

7. CQC Inspection – Report published

Following their inspection of BSUH in April 2017, the Care Quality Commission published their report on 10 August and I am pleased to confirm inspectors recognised "significant improvements" at the Trust over the past year. The CQC now rates the Trust as 'requires improvement'.

The inspectors found improvements at both hospitals and found that the quality of caring was "good" across all services.

This is a great achievement and I am delighted that the CQC has recognised the efforts made by our staff.

At the Royal Sussex County Hospital:

- The CQC improved our rating on thirteen specific measures
- Maternity and gynaecology services moved up from 'requires improvement' to 'good'
- Urgent and emergency care services moved from 'inadequate' to 'requires improvement'
- Outpatients and diagnostic testing also moved up to 'requires improvement'
- Services for children and young people and End-of-life care were not inspected this year, as they were rated Outstanding and Good respectively in 2016.

At the Princess Royal Hospital:

- The hospital stayed in the 'requires improvement' band but saw an increase in the number of measures on which it was rated 'good' of almost 25%
- No areas of inspection were considered 'inadequate' (down from two in 2016)
- Maternity and gynaecology services moved up from 'requires improvement' to 'Good'

It is no surprise to me that the inspectors rated the quality of care across all our services as 'good'. Many of the other issues identified are due to systems that don't work properly, or buildings that are no longer fit for purpose. But we have got the quality where it counts – in our people.

We are transforming our hospitals through a massive building programme which will bring some of the oldest buildings in the NHS into the 21st century. At the same time, we're working to a programme that will deal with the issues identified by the CQC, ensuring we provide excellent care, create a positive culture across the Trust and continuously improve.

8. New Abicot gives more time to bereaved parents

Earlier in August, charity Abigail's Footsteps focussed on stillbirth bereavement, came in to the Royal Sussex to present the labour ward with a new cold cot. The new 'Abicot', bearing a name plaque in honour of baby Jenson who sadly passed away after being born at 23 weeks, was presented to the ward and Jenson's bereaved parents by TV weather forecaster Sian Lloyd.

For parents, saying goodbye to their baby who has died is a very distressing experience and many parents have shared with us their wish to spend as much time as possible with their baby before saying goodbye. The Abicot regulates the baby's temperature
which allows parents to keep their baby with them that little bit longer. We understand that there will never be enough time to say goodbye but having the new cot will help us to provide better care and compassion by extending those precious moments.

Abigail's Footsteps is also working with Lead Pregnancy Loss Midwife, Hayley Stevenson to create a calm space within the labour ward for bereaved parents

9. Organ Donation Week

The trust supported Organ Donation Week next week between 4-11 September – a week when NHS Blood and Transplant, hospitals, charities and supporters of organ donation joined together to encouraging people across the UK to talk about organ donation with their families.

Most people support organ donation and many are already on the organ donor register. But a family's support is also needed for an organ donation to go ahead. This makes it important that people talk about it with their relatives in advance, so that they know their wishes.

While thousands of people in the UK are waiting for an organ transplant, only 1 in 100 people across the UK die in circumstances where their organs can be considered for transplantation. This means every potential donor is important.

If more people join the NHS Organ Donor Register and talk to their families and ask them to support their decision to be a donor, more lives will be saved, as more families will agree to support their loved one's decision to donate.

Our chaplain Rev Canon Peter Wells led a special organ donor service on Sunday 3 September at St George's Church in Kemptown.

10. **Forty years of giving**

Abba's *'Dancing Queen'* topped the charts, the ford fiesta car went on sale, the inauguration of Concorde's London to New York route.

And finally, this summer marked Mindy Bhuller's 40th year working at the Royal Sussex County Hospital. Beginning her career in the Sussex Eye Hospital on 30 May 1977, Mindy worked in housekeeping/hosting over the years, only stopping work for one year to have her son, who is now a haematology consultant. Since March 1988, Mindy has also worked in the cashier's office at the front of the Barry Building, supporting both patients and staff. She is a much-valued member of the team and with colleagues explaining she has an enduring popularity and constant presence. We hope she works on with the eye hospital and the Trust as a whole for many more years.

Congratulations Mindy!

Marianne Griffiths
Chief Executive
September 2017

To: Board of Directors

Date of Meeting: 26th September 2017 Agenda Item: 6

Title
Quality Report Month 6
Responsible Executive Director
Dr George Findlay (Medical Director) and Nicola Ranger (Executive Director of Nursing and Patient Safety)
Prepared by
Mark Renshaw, Deputy Chief of Safety
Status
Public
Summary of Proposal
The report describes performance against safety and quality key performance indicators in Month 6, in the domains of safety, effectiveness and patient experience
Implications for Quality of Care
The report includes exceptions in respect of challenges currently being faced which include a HMSR and SHMI that is continuing to rise; a pressure damage which is at its highest since 2012-13; implementation of the alert - Restricted use of open systems for injectable medications.
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).

1.2 The paper describes performance on an exceptional basis determined by RAG (red/amber/green) ratings based on national, regional or local targets.

2 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 June) 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).

2.1.3 Only the current financial year and year to date values are RAG rated, with the exception of those metrics reported in arrears with no data in the current financial year where the most recent data-point of last year is RAG rated.

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	June 2017	July 2017	August 2017
Trust crude mortality rate (non-elective)	2.71%	2.52%	
Hospital Standardised Mortality Ratio	83.31		
Safety Thermometer (Harm-Free Care)	97.13	96.6	95.6
Number of Serious Incidents Requiring Investigation	2	2	3
Never Events	1	0	0
Grade 3 and 4 Pressure Ulcers	0	1	0
Falls resulting severe harm or death	1	0	1
Numbers of hospital attributable MRSA	0	0	0
Numbers of hospital C. diff cases	3	9	4
The Friends and Family Test: Percentage Recommending Inpatients	95.4%	95.0%	96.2%
The Friends and Family Test: Percentage Recommending A&E	87.6%	86.7%	86.2%
Mixed Sex Accommodation breaches (number of breaches)	39	22	21
Number of complaints	91	51	87

3 EFFECTIVENESS

3.1 Crude Trust Mortality

3.1.1 Crude non-elective mortality for the period June to August was 2.66%. The HEDs Comparative database reports a crude mortality rate of 3.74% for the past 12 month. This compares to a rate of 3.6% for the 12 months ending June 2016.

3.2 Hospital Standardised Mortality Ratio (HSMR)

3.2.1 HSMR is only available for the month of June when 79 patients died against an expected number of 95. In the 12 months to June the HSMR was 97.42[1] (LCI 93.4, UCI 102.7). Over the past 12 months the trend has been for the HSMR to increase. Twelve months ago the annual HSMR was 89.90 (LCI 85.2, UCI 94.8).

3.2.2 The Trust Mortality Review Group (TMRG) is overseeing the implementation of the new national requirements regarding Learning from Deaths. Two members of staff are now qualified as Structured Judgement Review trainers. In October 25 clinicians will be attending training for undertaking Structured Judgement Reviews. The Datix system has been adapted to manage the Structured Judgement Review process. A policy - responding to patient's deaths - is currently being written.

3.3 Summary Hospital-Level Mortality Indicator (SHMI)

3.3.1 The latest data available covering the period June 2016 to March 2017 reports a SHMI of 97.4, i.e. mortality is 2.6% below the expected value. Like HSMR the SHMI has been steadily increasing from a low of 94.7 in May 2016.

4 SAFETY

4.1 Central Alert System (CAS) Safety Alerts

4.1.1 There was one outstanding safety alert for the Trust at the end of August - NHS/PSA/D/2016/008 - Restricted use of open systems for injectable medications.

4.1.2 This alert builds on the 2007 the National Patient Safety Agency alert Promoting safer use of injectable medications. This stipulated that injectable medicines must be drawn directly from their original ampoule or container into syringes, and then either administered immediately or, if they are not for immediate use, the syringe is labelled and checked before later use. Despite the NPSA alert, the use of 'open systems' continued in some organisations and specialities.

4.1.3 The 2016 alert required organisations to revise policies and protocols and establish systems of audit and observation to ensure an 'open system' is not used in the future as a container for injectable medication - with the exception only of embolization procedures involving embolic agents that need to be prepared openly.

4.1.4 If embolization procedures involving embolic agents that need to be prepared openly take place in an organisation, a specific protocol or procedure is required for undertaking this as safely as possible.

4.1.5 Theatres have confirmed that they are no longer using open systems for injectable medicines. However IR and the Cath Labs use open systems for contrast and saline. The Lead Nurse is in discussions with an external company about getting these into a closed system. In the short term we would have to order them in separately; in the longer term they would be included into the procedure packs. Short term and long term solutions all have cost implications

4.2 Serious Incidents Requiring Investigation (SIRIs)

4.2.1 There were seven Serious Incidents declared during the period July to August. The outcome in three of these incidents is currently graded as catastrophic, a further three are classified as moderate. Below is a list of all seven SI's:

- Pneumonia Death
- PE Death
- Compartment Syndrome Death
- Fall on Plumpton Wards
- Clostridium difficile Level 8 tower
- Never Event - Wrong site block

[1] *A value greater than 100 means that the patient group being studied has a higher mortality level than NHS average performance*

- 12 hour breach in A&E

4.3 Infection prevention and control

4.3.1 There were 9 cases of hospital-attributable Clostridium difficile during July, this included a period of increased incidence on L 8Tower, with 4 cases on the ward. This was declared an outbreak two of these were the same ribotype, this was declared as an SI and in being investigated.

4.3.2 At the end of August it was identified that two patients on L8 Tower, who had been nursed in the same bay, were positive for carbapenemase-producing Enterobacteriaceae (CPE), this is a highly resistant infection, which has been identified internationally and in several large Trusts in the North West and London. All patients on the ward have been swabbed and there have been no further positive results. The Infection Prevention Team are working closely with Public Health England.

4.3.3 On review of the patient records, root cause analysis (RCA) identified that there had been lapses in care in relation to primarily to cleaning standards; a deep clean has been undertaken of the whole ward and a trial of ultraviolet cleaning is being undertaken at the end of September.

4.3.4 The allocated Trust target limit for 2017/18 is set at 46 for the year. This equates to a rate of infection of 3.69 per 100,000 bed days.

4.3.5 There have been no hospital acquired MRSA bacteraemias for the period June to August.

4.4 Inpatient Falls

4.4.1 The adult inpatients falls rate for the period June to August was 3.34 falls per 1000 bed stay days. The actual number of falls month on month has significantly fallen ($p<0.025$) over the past 12 months. Since the launch in 2009-10 the falls rate has been reduced and this reduction has been sustained by implementing a strategy based on making fall safe behavior a habit.

4.4.2 In the 2015 report on inpatient falls produced by the Royal College of Physicians the national average is reported as 6.63 falls per 1000 bed stay days.

4.4.3 Based on the rate in 2009-10 and adjusting for patient activity, 700 fewer inpatient falls have occurred each year for the past 4 years. In total based on a falls rate of 6.11 the project has reduced the number of expected falls by 3985. As well as the human dimension, the financial implications of this reduction are significant. The 2017 publication by NHS Improvement[2] calculates the average cost of a fall at £2600 per fall, based on this figure the saving to the trust over the past 7 years equates over £10.3m.

[2] The incidence and costs of inpatient falls in hospitals July 2017

Table 2: Falls rate and number of falls 2008-17

Year	Falls	Bed Days	Rate	% difference on previous year	Annual falls saved based on 2009-10 rate
2008-09	1424	237224	6.00		
2009-10 *	1440	235629	6.11	1.81	
2010-11 **	1283	244851	5.24	-14.26	213
2011-12 ***	1174	250418	4.69	-10.53	356
2012-13	1037	262929	3.94	-15.87	569
2013-14	859	257836	3.33	-15.53	716
2014-15	900	261791	3.44	3.19	700
2015-16	876	261910	3.34	-2.71	724
2016-17	904	263587	3.43	2.54	707

* Phase 1: Organisation wide initiative

** Phase 2: Pilot on 8 wards

*** Phase 3: Scaling-up across organisation

4.5 Tissue Viability

4.5.1 There was one grade 3 pressure damage incident during the period June to August.

4.5.2 Between June and August 44 incidences of grade 2 hospital acquired pressure ulcers were reported. Damage to the sacrum, buttocks and heels remains the most common form of pressure damage. Inadequate documentation of skin assessment and changes of position is a recurring theme.

4.5.3 The rate of pressure damage per 1000 bed stays days during the period June to August was 0.65; this is 29% higher than the last financial year.

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.

4.6.2 Over the past 12 months the rate of harm free care has significantly ($p<0.028$) increased. The harm-free care score for the past 12 months was 95.4 against the target of 95%. The national average is 94.2%. The Trust currently ranks 33rd out of 129 acute trusts for patients who are harm free.

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

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

4.7 Exception Reports Relating to Patient Safety

HMSR and SHMI continue to rise.

The current rate of pressure damage for this financial year is 0.64 per 1000 bed stay days. The last time the rate was this high was in 2012-13 when the rate was 0.64.

5. PATIENT EXPERIENCE

5.1 PALS and Complaints

5.1.1 During this quarter 229 complaints were received, averaging 78 per month. This number is down on the average for the past 12 months which has been 112.

5.1.2 Vacancies within the Complaints team at the beginning of 2017 offered the opportunity to restructure our Patient Experience Services in a more cost effective way to improve the complainant pathway. Two vacant Band 6 Complaint Manager posts were converted into two Band 5 PALS Adviser posts. The team of five PALS Advisers will work closely with the Directorates, facilitating early contact with the clinical teams to ensure that patient concerns are resolved quickly via the informal route, allowing the team of complaint managers to focus on the more complex investigations which will, in turn, be resolved more quickly.

5.1.3 The Quality and Risk Committee received a Quarterly Complaints Report which provides an in-depth analysis of trends and lessons learned. The Trust is working on improving response times for complaints and has made significant improvements in the backlog of cases which was accrued during a period of long term sickness and vacancies within the department.

5.2 Friends and Family Test (FFT)

5.2.1 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 the question. Scores were above 95% for inpatients, maternity (ante-natal care and delivery care); and below 95% for A&E, maternity (post-natal care and post-natal community care, and out-patients.

Table 4: Friends and Family Test April 2017

	Percentage recommending BSUH in June - August
Inpatient care	95.6%
A&E	86.9%
Maternity Friends and Family Recommend %: Antenatal care (36 weeks)	100%
Maternity Friends and Family Recommend %: Delivery care	98.8%
Maternity Friends and Family Recommend %: Postnatal ward	90.8%
Maternity Friends and Family Recommend %: Postnatal community care	94%
Trust Friends and Family Recommend %: Outpatient	90.5%

Friends and Family Test Response Rates:

5.2.2 Response rates for in-patients remains poor, at just above 11%.

5.4 Patient Voice

5.4.1 The Patient Voice survey is completed on all adult wards. In the past 12 months 8605 questionnaires have been returned. Performance in seven out of the 13 questions asked has significantly improved over the past 12 months. These include:

- Is there someone on the hospital staff available to talk with about your worries and fears ($p<0.053$)
- Do you feel staff treat you with kindness and compassion ($p<0.016$)
- Are you given enough privacy when being examined or having discussions on the ward ($p<0.063$)
- Do the staff treating and examining you introduce themselves and explain their role ($p<0.058$)
- When you ask questions regarding your treatment and care do you get answers that you can understand ($p<0.028$)

- Do you feel that you are being treated as an individual and that your particular needs are recognised and catered for ($p<0.035$)
- Do you think the hospital staff do everything they can to manage your pain ($p<0.020$)

5.5 Exception Reports Relating to Patient Experience

5.5.1 Response rates for the Friends and Family Test are low and require improvement in all areas. The Charitable Funds Committee agreed in principle funding for the service provided by Healthcare Communications (as for A&Es and maternity), which will provide multiple means of obtaining patient feedback. The funding source has yet to be confirmed.

5.5.2 Mixed sex accommodation breaches have reduced month by month and in August BSUH reported 21, primarily in cardiac and neurosurgery. This reduction is a result of the increased management of this by the Clinical Site Team and wards.

6. CARE QUALITY COMMISSION (CQC)

6.1.1 The CQC feedback and Trust response are discussed in a separate Board agenda item.

7. RECOMMENDATION

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

Brighton and Sussex University Hospitals NHS Trust

To: Meeting of the Board of Directors

Date of Meeting: 27th September 2017 Agenda Item:7

Title
Organisational Development and Workforce Performance 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
Supports the delivery of the Trust's current corporate objectives: *excellent outcomes; great experience; empowered skilled staff; high productivity*
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
Data Report

To: Board of Directors **17 September 2017**

From: Denise Farmer, Chief Workforce and OD Officer **Agenda Item:**

FOR INFORMATION

ORGANISATIONAL DEVELOPMENT AND WORKFORCE REPORT

Month 05 2017/18 (August 17)

1.0 Introduction

This sets out the key headlines relating to the Trust's workforce at 31 August 2017.

2.0 Workforce Capacity

The Trust Establishment WTE remains at 8,195; an increase of 185 WTE from August 2016. Staff in post currently stands at 7,280 WTE which equates to a vacancy rate of 11.2%. Whilst this shows an increase in vacancy rate of 2.5% from August 2016 (then 8.7%) this figure has reduced by 0.6% from its peak of 11.8% in June 2017. There are currently 915 WTE of vacancies, of which 418 WTE are Nursing, 188 WTE are Admin & Clerical, 125 WTE are S,T&T, 120 WTE are Ancillary Support and 64 WTE are Medical. The highest vacancy rate is within Ancillary Support (17.7%). Work is ongoing to reconcile the high level of vacancies against the unfunded posts, and to develop appropriate recruitment strategies.

Bank spend was £1.59m during the month of August which is up from August 2016 (£1.07m). The average spend over the previous 12 months was £1.44m per month. Over the first five months of the Financial Year, Bank spend has increased on the same month in the previous year for every month with the exception of May 2017, which was marginally down.

Agency spend also showed a substantial increase in August 2017, at £1.17m from £0.56m in August 2016. The average Agency spend over the past 12 month period was £0.94m per month. Agency spend has been higher than the same month in the previous year, for each of the past four months.

Over the first five months of the Financial Year, Bank spend has increased by an average of £282k per month (£214k Nursing, £6k Medical and £63k Other). Over the same period, Agency spend has increased by an average of £231k per month (£96k Nursing, £24k Medical and £111k Other). Bank & Agency spend is currently running at approx. £0.5m higher per month than the previous Financial Year, and if this trend continues it will mean a £6m total increase in spend by Financial Year End.

3.0 Staff Turnover

In August 2017, the Trusts 12 month Turnover rate (external leavers excluding Training Grade Doctors) remained at 14.3%; an increase of 1.4%, from 12.9%

in August 2016, when Turnover was at its lowest over the review period. The Scientific, Therapeutic and Technical staff group has both the highest overall Turnover rate (16.0%) and shows the highest level of increase from August 2016 (up 3.3%). The Turnover rates for both Nursing and Admin & Clerical staff also remain high, standing at 14.8% and up over 1% on August 2016.

4.0 Workforce Efficiency

The Trusts 12 month sickness absence rate remains largely static at 4.27%, compared to 4.26% in July 2016. Despite the overall rate being largely unchanged the mix has altered slightly, and is now 2.01% short term / 2.26% long term compared to 1.93% short term / 2.33% long term in July 2016.

The S,T&T staff group continues to show the highest increase in sickness rates over the past 12 months, up 0.32% from 3.83% in July 2016 to 4.14%. However, the highest overall rates are still within the Ancillary support group (7.05%). Trust wide, when looking at the mix of reasons, the most prevalent are: Stress/Depression (18.4%), Cough/Cold/Flu (10.2%) and Other musculoskeletal (9.4%).

5.0 Appraisals

The Trust appraisal rate dropped to 77.7% in August, a further deterioration on the 80.9% achieved during June. Neurosciences & Stroke had the highest compliance rate at 91.5% and Research & Development had the highest increase in compliance of 15.9% from June to August. A total of 12 Directorates increased compliance in August and 10 Directorates had deterioration with Estates & Facilities the lowest at 49.9%. The Directorates with the lowest level of performance have been tasked with developing a recovery plan.

Of the 346 ward and departments 174 (46%) are at, or above 85% compliance and appraisal training continues to be available for managers.

6.0 Workforce Skills and Development

6.01 Statutory and Mandatory Training

The Trusts statutory and mandatory compliance rate for August 2017 was 80.0%. Manual Handling increased compliance by 3% from June (at 77%) and Child Protection Level 1, 2 and 3 also increased compliance by 3% in the same period (at 79%). The deterioration was due to Information Governance (at 80%) a decrease of 9% from June to August.

The number of staff who have never attended any mandatory training (and started in the Trust more than 3 months ago) is currently 21 of which:

- 12 are bank staff – the manager is working closely with the 12 individuals to support them to complete online or face to face training.
- The remaining 9 are spread across 8 wards/departments and the managers have been notified so that they can ensure these staff are supported to complete their training by the end of September.

A review of content and methods of delivery and evaluation of effectiveness is being designed and will be reported to the Board by end of year.

6.02 Recruitment and Retention

The Trust is continuing to develop robust Recruitment and Retention strategies, including international recruitment trips, the first of which is potentially scheduled for November. The team are investigating a number of different strategies including a Refer a Friend scheme, Internal Transfer process and a full Staff Benefits Statement. In addition to this, a Careers Advisory Support role has been funded and authorised for placement within BSUH by HEKSS. Exit Interview process has been reviewed, re-instated and will continue to be monitored in order to improve data and drive understanding of key areas that require focus to improve retention amongst identified staff groups.

Other developments include:

- **Armed Forces**- Work continues to employ and retain highly skilled armed forces/ ex armed forces personnel.

- **Recruitment Events**- Since July, HR Employment Services have hosted several large scale recruitment events to support the Nursing and Soft FM teams. Another PRDN recruitment event is scheduled for November 2017 and a Winter Pressures B5 Nurse and B2 HCA event booked for October 2017. The team will also be supporting a specific recruitment event for Newhaven Ward for B6/5 Nurse, B2 HCA, A&C and Soft FM in order for them to open an additional 16 beds.

  In addition the team have/ are scheduled to attend:
  - Surrey University ODP Recruitment Event
  - Job Centre Careers Event Haywards Heath
  - Job Centre Careers Event Brighton
  - Part Time Jobs Fair University of Sussex (Temporary Staffing)

6.03 Workforce Planning

Last year the Workforce information department was restructured and a new role of Workforce Intelligence Specialist was created to support planning leads and link in to HR Business Partner work with Directorates. Each year in December a Trust wide 5-year workforce plan return is required by NHSI / HEEKSS and it was important for BSUH to be able to provide accurate and timely information to support this.

A new internal planning template has been simplified to collect details around projects, roles and timescales. The Workforce Intelligence Specialist is now meeting with planning leads to discuss their plans and plot the changes in their areas. As this approach has moved away from managers having to interpret the template and input data themselves to a discussion, the timeframe for completing the return has moved from up to half a day of manager's time to around 1-2 hours. The aim is to move towards workforce planning becoming a 'business as usual' activity by keeping the planning template 'live' rather than managers seeing this as a once a year exercise.

Following this approach there has been an improvement in engagement from some areas and in these areas managers have expressed their appreciation of a more simplified process. There is still work to do to around the triangulation of Directorate generated aspirations with e.g. professional workforce strategies, clinical strategy, activity/capacity projections to ensure an affordable and realistic/recruitable workforce plan. It is also important to consider that plans need to align with educational commissioning based on an assumed split between recruit anew or grow your own.

The deadline for completion of returns is the 31 October 2017 to allow for data cuts prior to final submission early December 2017. During November 2017 we are required to provide a first cut submission to NHSI.

To date there are either completed or draft plans for over a third of the Trust and some areas have meetings planned. For those areas which have yet to engage, a letter with Executive support will be sent to planning leads stressing the requirement for plans and giving the deadline for completion.

7.0 Staff Survey and Engagement

7.01 2017 Staff Survey

In early October the Trust will be taking part in the annual National NHS Staff Survey which will be sent to all substantive eligible staff in the Trust and it will close on 1 December 2017. Results for the Trust should be received in early 2018.

80% of surveys will be distributed via paper and the remaining 20% will be sent online via Trust email accounts. This is a change from last year where 80% of surveys were distributed electronically and the remainder was paper. The rationale for the change in approach was to build upon and improve the Trust's response rate from 2016 which was 39.6%.

The HR team will be distributing the paper surveys the week commencing 2 October. This is an opportunity for the team to promote the value placed on the staff survey directly with teams and departments. Each department will receive a welcome pack incorporating posters, briefing packs for managers and frequently asked questions for staff. A series of drop in events across all sites during the week commencing 9 October will be held which will give staff the opportunity to complete their survey in a quiet environment away from their work area and ask any questions of the team.

In the coming weeks the Communications Team will begin publicising the staff survey launch and its importance. HR Business Partners are already promoting the survey with the directorates that they support. The response rates will be published by directorate whilst the survey is open with the aim of this encouraging and increasing the response rate.

7.02 Staff Engagement Improvement Plan (A3)

A primary focus of our work to improve staff engagement is to enable all staff to feel that care is the organisations top priority. A workshop with leaders from

a number of directorates was held using Lean problem solving methodology and A3 thinking to help us understand how we can do this.

During the next two months we will be engaging with front line staff to agree our action plan.

8.0 Staff Wellbeing

The CARI (Commitment and Resilience Index) wellbeing app was launched on the 8th September. The app provides each member of staff with their own personal wellbeing profile, staff are also signposted to the new BSUH Wellbeing microsite which hosts a range of information resources, tools and activities to help raise awareness and support the wellbeing and resilience of all 8,000 staff. BBC South East news coverage of this wellbeing approach was positively reported and seen as means of supporting our Recruitment and Retention Strategy.

The anonymised survey results offer a snapshot of wellbeing levels across the Trust and will be shared with the Executive Team to help determine where and what improvements are needed to make a difference to the wellbeing of our staff in the workplace. Focusing on the Wellbeing of the workforce will help shape a more positive culture throughout the Trust, resulting in enhanced care of our patients.

The Trust's flu vaccination campaign begins on September 28, adopting the "Flu Protected" messaging, for individuals and teams. For example, as each ward or department achieves 80% of staff vaccinated they become "Flu Protected."

More than 30 workplace vaccinators have been recruited across Royal Sussex County and Princess Royal Hospitals, who will be visiting departments to offer the vaccination to all staff. There will also be drop-in and booked clinics. Staff can also contact Occupational Health who will arrange for them to have their jab.

Throughout the campaign, we will publish internally a bi-weekly scorecard, communicating which teams have achieved "Flu Protected" status (80% vaccinated) along with myth-busting messaging.

Full information will follow in BUZZ on 4 October, with full lists of vaccinators and vaccination clinics available on the intranet from 2 October.

The flu team is still pursuing methods of funding the jab4jab scheme across BSUH. The scheme, which first ran at Birmingham Children's Hospital means that for each person vaccinated across the trust, a child in Africa will receive a tetanus vaccination through Unicef.

9.0 "Disability Confident"

Disability Confident Levels 1-3 was launched in 2016 and took over from the "Two Ticks" disability standard that employers were encouraged to join. Initially organisations who had consistently achieved their Two Ticks status were migrated over to Disability Confident Employer – Level 2 for one year.

To retain the Level 2 the Trust was required to measure the organisation's approach in the following areas :-

- Actively looking to attract and recruit disabled people
- Providing a fully inclusive and accessible recruitment process
- Offering an interview to disabled people who meet the minimum criteria for the job
- Flexibility when assessing people so disabled job applicants have the best opportunity to demonstrate that they can do the job
- Proactively offering and making reasonable adjustments as required
- Encouraging our suppliers and partner firms to be Disability Confident
- Ensuring employees have appropriate disability equality awareness.

BSUH has retained Level 2 status. This recognises the commitment of the organisation to retain staff who become disabled during their time working with us, and our commitment to employing people with disabilities.

The Trust's Equality, Diversity and Human Rights Policy and Disability Reasonable Adjustment Information were reviewed, and the work that the Recruitment Team and the Supported Employment team at Brighton and Hove City Council have undertaken to help support people with learning disabilities into BSUH was also a contributing factor in continuing to achieve this level.

Going forward the Trust now has until 2019 to become a Disability Confident Leader, Level 3.

10.0 Corporate and Clinical Restructure

The new Divisional Chiefs of Service, Divisional Directors of Operations and Head of Nursing/Professionals have now all been advertised. Applicants will be interviewed and appointed in to these roles in September and early October.

A workshop was held on 31 August to start to design new working arrangements across the Group Director, Trust Director and Chief Officer roles. The tone was incredibly positive and plans to maintain strong relationships and appropriately revised governance arrangements are being developed.

11.0 Communications and Engagement

With the support of the communications team, the Trust has been taking a more positive and confident approach to our engagement with the media, particularly with BBC South East TV.
Since the last Board meeting, this has included:

- **BSUH recruitment 26 July**
  Following the Board meeting, the Argus and BBC ran stories on our recruitment and turnover statistics. An interview with Nurse Director Caroline Davies with the BBC, ran on the regional evening news and included confirmation that the trust had recently made job offers to 200 nurses.

- **CQC report publication 10 August**
  The communications team briefed local media and shared our press statement under embargo ahead of the CQC report's publication. Interviews were facilitated with Marianne Griffiths on Meridian News before the launch and with Evelyn Barker on BBC South East Today on the day. Both were filmed on the maternity ward, which had recorded a 'good' rating with the CQC. The tone of the coverage on TV, in print and online was broadly positive, highlighting the improvements and progress recognised by the CQC.

- **Hospital transport 18 August**
  Filming was facilitated with the BBC on our renal ward for a piece about hospital transport. The BBC had interviewed a dialysis patient at home in the morning, who was waiting to be picked up and brought to RSCH, and then came to interview him here as he received his treatment.

- **Organ donor service 27 August**
  Following our approach to the show's producer, our chaplain Peter Wells went onto BBC Radio Sussex's Sunday Breakfast Show to promote the first organ donor service and to encourage people signing up to donate their organs.

- **"Inside Out" STP story 31 August:**
  Interviews on the A&E floor with Evelyn Barker and ED consultant Martin Duff with BBC South East for their Inside Out programme, where they sought to tell the story of STPs, using Brighton as an example. This was broadcast on 18 September.

- **CARI Wellbeing App launch 8 September**
  BBC South East carried out extensive filming relating to the launch of the trust's new health and wellbeing app. This was presented as a positive move to improve staff retention.

- **A&E Expansion planning approval 13 August**
  This was well covered in the Argus, highlighting the extra capacity that will be created by the construction of the short stay unit. While this didn't get onto the TV news bulletins, the BBC SE health correspondent did positively tweet about the news.

- **Social media engagement**
  The communications team has also sought to complement our media work by pushing out a series of positive stories through our social media channels, particularly Facebook and Twitter. This is designed to increase the number and range of people we reach with news and developments, as well as hear views and encourage engagement.

  This has started to show some dividends, especially where we are able to post good pictures, which tended to encourage sharing.

  For example, our 2 August Facebook post highlight NHS Improvement's go ahead for our A&E expansion was shared 11 times and reached more than 6,500 people. Our post about our improvements in Sepsis treatment on 12 September was shared 17 times and has reached more than 6,000 people.

  A steady series of stories have been promoted on Twitter. The BSUH video on "Sepsis Six" (key message: one hour to save a life) was tweeted by NHS Improvement and then re-tweeted over 150 times, including by NHS England to their 171,000 followers. The video has now been viewed more than 1,500 times.

- **Launch of new staff newsletter - Buzz**
  The communications team launched a new weekly news update, Buzz, for BSUH staff at the end of August, featuring key stories, events and interviews from across the organisation. Buzz is available on the Trust's website and copies are also printed and distributed across the trust.

Brighton and Sussex University Hospitals NHS Trust

To: Board of Directors

Date of Meeting: **Agenda Item: 8**

Title
Month 5, 2017-18 Performance Report
Responsible Executive Director
Pete Landstrom, Chief Delivery & Strategy Officer
Prepared by
Pete Landstrom, Chief Delivery & Strategy Officer
Status
Disclosable
Summary of Proposal
The paper sets out organisational compliance against national and local key performance metrics. The report summarises both in year and projected year end performance for Brighton & Sussex University Hospitals Trust, as detailed in dedicated performance scorecards relating the NHSI Single Oversight Framework and, when relevant, other operational indicators. This paper describes performance against the key Constitutional Standards.
Implications for Quality of Care
Describes Quality Outcome KPIs
Link to Strategic Objectives/Board Assurance Framework
Compliance with National NHS Constitutional Standards
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 of compliance against the National Constitutional Standards for 6 out of 8 Cancer metrics, and the 6 week Diagnostic waiting time metric, and non-compliance against the A&E and RTT waiting time metrics.
Communication and Consultation
Not applicable
Appendices
(1) Operational Performance Scorecard

To:	Trust Board	**Date:**
From:	Pete Landstrom, Chief Delivery & Strategy Officer	**Agenda Item: X**
FOR INFORMATION		

PERFORMANCE REPORT: MONTH 5, 2017/18

1 INTRODUCTION

1.1 This report summarises both current in year and projected performance for Brighton & Sussex University Hospitals NHS Trust, with further detail provided in the Operational Performance Scorecard appendix.

1.2 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 Operationally August saw static RTT performance, and whilst the Trust performed better for A&E 4 hour waits than in July, and August 2016, emergency pressures remained challenging particularly at the Royal Sussex County Hospital.

2.2 A&E 4 hour, RTT 18 week, and Cancer 62 day treatment performance were below National Constitutional Targets.

2.3 Key operational indicators during August to note:

- 13,201 A&E attendances compared to 13,888 in August 2016 (representing a reduction in demand of 4.9%).
- 4,640 non-elective spells compared to 4,468 in August 2016 (representing an increase in activity of 3.8%).
- Formally reportable Delayed Transfers of Care were 7.82% for August 2017. This is a decrease from 8.41% in July-17, but an increase compared to August 2016 (7.44%).

- Average length of stay for patients increased to 5.75 days for non-elective medicine in August 2017, compared to 5.08 days August 2016.

3 KEY AREAS OF PERFORMANCE

3.1 A&E Compliance

3.1.1 The Trust was non-compliant against the National target in August, with 83.6% of patients waiting less than four hours from arrival at A&E to admission, transfer, or discharge. There were 7 patients who waited longer than 12 hours in the A&E department from the decision to admit.

3.1.2 This is an improvement of 1.73% compared to July-17, and 2.45% August-16, but does remain significantly below the constitutional target of 95%.

3.1.3 The seven 12 hour trolley waits in August, are the first at the Trust since January-17, all of these delays occurring on the 8th August, as a result of post Pride weekend demand pressure and short term capacity issues.

3.1.4 The Trust A&E 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. Within the overall 83.6% performance, there remains variation by A&E site. Performance by site in August 2017 is outlined overleaf:

Site	Total Patient Attendances	Total Patients Waiting >4hrs	% Patients <4 hours
Royal Sussex County Hospital	7066	1828	74.1%
Princess Royal Hospital	3130	318	89.8%
Royal Alexandra Children's Hospital	1869	1	99.9%
Sussex Eye Hospital	1098	10	99.1%
Total Trust	13163	2157	83.61%

3.1.5 Performance at PRH in July was 89.8% compared to 91.5% in July.

3.1.6 The Royal Alex Children's Hospital and Sussex Eye Hospital continued to exceed the National Target.

3.1.7 To support improvement in performance at the County Hospital site, the redesign and expansion of the Urgent Care Centre (UCC) is currently underway and is on track to be completed by the end of September 2017. Planning for the £30m redesign of the County site Emergency Department and Emergency Floor development continues, with confirmation that NHS Improvement signed off the business case in the first week of July 2017. The decant of space to enable the first stage increases in Ambulatory Care capacity are currently underway, and the new ambulatory unit is on track to be open ahead of winter 2017. The development of a primary care triage area and model at PRH has also commenced and is scheduled to be completed prior to the Winter.

3.1.8 Further actions taken include an increase in senior clinical decision making cover in evenings till midnight at PRH and RSCH sites. The Trust has also commenced emergency flow improvement processes with the in-house Kaizen improvement team, targeting specialty, pathology and radiology referral times. In agreement with CCG and community stakeholders, system-wide escalation processes have been enhanced, targeting daily review of patients with complex needs, and ensuring prompt decision making supported by a newly appointed system resilience lead with the aim of reducing the numbers of patients formally delayed in the acute setting by 50%.

3.1.9 Waiting for admission to an inpatient ward remained the highest single reason for patients waiting longer than 4 hours in A&E. Difficulties in access to beds due to formal delayed transfers of care (DTOC) patients reduced slightly in August to 7.82%. In real

terms, this reflects an average of 60-70 beds occupied by patients who could be cared for in a non-acute setting.

3.1.10 Nationally and regionally A&E delivery continued to be challenging. National performance remained at 90.3% in August 2017 for all A&E types. Regionally, compliance for the South of England was 88.9%, with NHS England South (South East) Trusts (excluding BSUH) generating aggregate compliance of 92.3%.

3.2 Cancer

3.2.1 The Trust was compliant against 7 out of 9 metrics in July, and was below the Single Oversight Framework trajectory requirement for 62 day treatment (85.0%). Actual performance for July against this metric was 68.8%

3.2.2 The position for July shows the Trust was non-compliant against the following standards:

- 62 days from GP referral to treatment (68.8% against a national standard of 85.0%)
- 62 day referral to treatment from screening (80.0% against a 90% national standard)

3.2.3 Total treated patients for July was below forecast at 109.0 against a forecast plan of 132.0.

3.2.4 Within the 62-day treatment pathways several clinical specialties particularly impacted the achievement of the overall standard. These were:

- Breast – diagnostic staffing shortages have resulted in the short term cessation of the one-stop assessment clinic, which has lengthened the diagnostic phase for clinically lower risk patients. A recruitment plan has been developed to address this in the future.
- Colorectal – has had patients who have decided their own pathways through patient choice at several points in the diagnostic/outpatient phases of their pathways or due to the high complexity of their condition.
- Head & Neck – several late referrals from Western and East Sussex Hospitals
- Gynaecology – 2 late referrals from WSHT (day 31 but not worked up) and one from ESHT (day 52) as well as some delays from Pathology and Radiology caused some patients to exceed the 62 day target.
- Urology – impacted by patient choice delays and patient medical complications.

3.2.5 For context, the latest national performance data for July 2017 shows 81.4% of patients were treated within 62 days (target 85.0%) for urgent GP referrals, compared to BSUH performance of 68.8%, with 60% of Trusts in England non-compliant against this standard.

3.2.6 The provisional performance for August on the reportable targets prior to final submission, show that presently BSUH has a much improved compliance against the 62 day treatment standard at approximately 82%.

3.2.7 Early indications for the 62 day referral to treatment standard in September show an expected performance of above 80%.

3.2.8 The work undertaken to better manage the Cancer PTL from the start of March has led to a reduction in total patients being tracked (through earlier non-diagnosis of cancer, or treatment) by 40% from approx. 1600 to below 1,000. This has also meant that the volume of patients who have already breached the standard and been diagnosed has fallen by 51 to around 30. This PTL size has been sustained now for the last 7 weeks at this level.

3.2.9 Action plans are being implemented across each of the most challenged tumour sites, in addition to Pathology and Radiology. These are and will continue to be monitored closely over the coming months to ensure the effectiveness of these plans and to track their positive impact on improvement against the 62 day standard.

3.3 Referral to Treatment (RTT/18 Weeks)

3.3.1 The Trust was non-compliant against the National Constitutional Target of 92% in August with 86.8% of patients waiting less than 18 weeks. This represents a marginal (-0.2%) decrease from the published July 2017 position. The essential closure of at least one theatre at any point during the month of August, to support the on-going theatre maintenance programme, in addition to the expected seasonal reduction in elective activity has impacted on the August incomplete performance.

3.3.2 The aggregate performance comprises several clinical specialties where waiting times are below the standard. As described to Board previously, the greatest challenge in terms of backlog is within general surgery, with 739 patients waiting more than 18 weeks at the end of August. The backlog within this specialty has halved within the

last 12 months but there remains a significant challenge to continue to improve capacity and therefore compliance within the specialty.

3.3.3 There were 84 patients waiting more than 52 weeks for treatment as of the end of August which remains a significant concern for the Trust. The majority of these cases are stoma reversal patients. The Trust is continuing to prioritise this cohort of patients, supported through additional weekend and evening sessions where possible, provision of emergency theatre lists, and increased activity at the Princess Royal Hospital to provide additional capacity for the treatment of the longest waiting patients at the Royal Sussex County Site.

3.3.4 Following on from the July update, the new PTL is now fully integrated with no issues identified in the first 8-weeks of utilisation.

3.3.5 Latest published national data relates to July 2017 and shows a decrease in national compliance, from June (90.4%) to 89.9% This figure is exclusive of independent sector providers and does not reflect a number of large acute NHS providers that currently are not reporting RTT positions as part of agreed 'special measure' arrangements. Inclusion of the last known positions for these organisations is likely to reduce the formally reported England compliance position to approximately 89.5%. Approximately 39% of Trusts were non-compliant in July.

3.4 Diagnostic Test Waiting Times

3.4.1 The Trust compliance for August was 1% over 6 week waiters across all diagnostic mode 1% national target. This represents 78 out of a total of 7,533 patients.

3.4.2 BSUH performed better than regional peers in July (the latest comparable national data); with South of England Region aggregate compliance of 2.2% and National compliance at 1.8%, compared to BSUH July performance of 0.60%. Just over a third of Trusts were non-compliant in July 2017.

4 RECOMMENDATION

4.1 The Board is asked to **NOTE** the Trust position against the National Constitutional Standards for 7 out of 9 Cancer metrics, and the 6 week Diagnostic waiting time metric performance.

4.2 The Board is asked to **NOTE** the Trust's non-compliance against the A&E and RTT waiting time metrics.

Pete Landstrom

Chief Delivery & Strategy Officer

Brighton and Sussex NHS University Hospitals

OPERATIONAL PERFORMANCE SCORECARD

AUGUST 2017

		Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	2017/18 YTD	2017/18 Target	Trend
NATIONAL AND OPERATIONAL PERFORMANCE TARGETS																					
O01	A&E : Four-hour maximum wait from arrival to admission, transfer or discharge	83.9%	86.3%	85.1%	84.1%	81.2%	83.7%	82.6%	82.1%	80.4%	77.2%	80.3%	84.4%	85.3%	86.0%	86.5%	81.9%	83.6%	84.6%	95%	
O01A	A&E : 12 hour maximum wait from arrival to admission, transfer or discharge	9	2	2	0	1	1	2	0	5	28	0	0	0	0	0	0	7	7	0	
O02	Cancer: 2 week GP referral to 1st outpatient	88.6%	93.8%	95.1%	94.7%	94.1%	94.5%	95.1%	94.1%	93.9%	90.7%	93.3%	93.4%	93.4%	94.1%	94.7%	94.8%		94.2%	93%	
O03	Cancer: 2 week GP referral to 1st outpatient - breast symptoms	97.8%	94.8%	98.8%	98.4%	96.6%	97.4%	99.4%	98.9%	97.7%	96.9%	95.9%	93.7%	96.4%	98.2%	95.0%	94.4%		96.0%	93%	
O04	Cancer: 31 day second or subsequent treatment - surgery	95.7%	95.5%	100.0%	91.3%	97.8%	97.8%	92.1%	89.7%	96.6%	95.7%	94.4%	93.9%	100.0%	100.0%	100.0%	100.0%		100.0%	94%	
O05	Cancer: 31 day second or subsequent treatment - drug	97.9%	97.6%	99.0%	100.0%	100.0%	98.7%	100.0%	98.2%	100.0%	100.0%	98.9%	100.0%	100.0%	100.0%	97.5%	100.0%		99.4%	98%	
	Cancer: 31 day second or subsequent treatment - radiotherapy	94.4%	100.0%	98.4%	97.7%	97.8%	96.3%	97.3%	97.8%	99.3%	98.2%	99.4%	100.0%	100.0%	99.4%	99.3%	100.0%		99.7%		
O06	Cancer: 31 day diagnosis to treatment for all cancers	100.0%	97.3%	99.1%	98.4%	98.6%	98.2%	98.6%	97.3%	97.2%	98.0%	97.1%	98.3%	99.1%	99.5%	100.0%	98.6%		99.3%	96%	
O07	Cancer: 62 day referral to treatment from screening	75.0%	66.0%	62.0%	73.0%	87.5%	74.2%	75.0%	96.6%	84.2%	87.2%	76.0%	73.3%	87.2%	76.7%	71.8%	80.0%		79.0%	90%	
O08	Cancer: 62 day referral to treatment from hospital specialist	100.0%	100.0%	100.0%	50.0%	50.0%	50.0%	100.0%	100.0%	100.0%	100.0%	0.0%	100.0%	88.9%	75.0%	100.0%	94.7%		91.4%	90%	
O09	Cancer: 62 days urgent GP referral to treatment of all cancers	78.1%	77.2%	81.1%	74.5%	74.7%	85.9%	77.9%	76.5%	66.7%	78.1%	68.5%	76.5%	86.1%	81.1%	74.3%	68.8%		77.8%	85%	
O14	RTT - Incomplete - 92% in 18 weeks	73.5%	74.8%	75.3%	75.3%	75.1%	76.8%	77.8%	80.1%	79.6%	81.4%	82.1%	84.2%	85.2%	86.1%	86.9%	87.0%	86.8%	86.8%	92%	
	RTT - Incomplete - 52Week Waiters	100	87	92	211	226	184	185	161	150	152	143	95	94	102	96	80	84	84	0	
O15	RTT delivery in all specialties (Incomplete pathways)	14	14	14	16	16	15	16	12	12	13	13	9	10	10	13	13		13	0	
O16	Maximum 6-week wait for diagnostic procedures	6.6%	2.6%	1.6%	2.1%	2.8%	1.0%	1.9%	1.1%	1.4%	0.8%	0.6%	0.4%	0.5%	0.9%	0.7%	0.6%	1.0%	1.0%	<1%	
O17	Cancelled operations not re-booked within 28 days	7	2	3	2	8	2	8	2	5	8	4	3	3	1	4	5		13	0	
O18	Urgent operations cancelled for the second time	0	0	0	0	0	0	0	0	0	8	3	0	0	0	2	1		3	0	
O19	Clinics cancelled with less than 6 weeks notice for annual/study leave	65	86	77	67	50	52	32	44	32	30	41	49	48	41	49	38	43	219	-	
O20	Mixed Sex Accommodation breaches	57	69	76	77	113	80	41	137	72	61	92	48	76	48	39	22	21	206	0	
O33	Delayed transfers of care	5.9%	6.7%	6.9%	6.8%	7.4%	9.6%	8.9%	9.5%	8.7%	9.8%	9.7%	9.9%	8.1%	7.4%	7.2%	8.4%	7.8%	7.6%	3%	
IMPROVING CLINICAL PROCESSES																					
O23	% hip fracture repair within 36 hours	79.00%	81.00%	77.00%	75.00%	67.00%	90.00%	88.00%	81.00%	87.00%	90.00%	73.00%	77.00%	76.90%	74.40%				75.00%	90%	
O24	Patients that have spent more than 90% of their stay in hospital on a stroke unit*	81.63%	84.48%	86.79%	83.58%	84.75%	92.16%	81.67%	92.31%	80.39%	93.48%	89.58%	84.85%	74.58%	82.76%	84.38%	84.44%		81.42%	80%	

Brighton and Sussex NHS University Hospitals

OPERATIONAL PERFORMANCE SCORECARD

AUGUST 2017

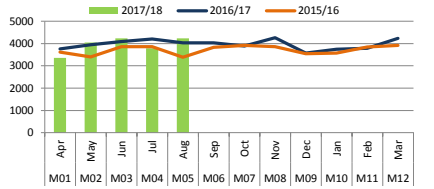
		Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	2017/18 YTD	2017/18 Target	Trend
OPERATIONAL EFFICIENCY																					
O36	Average length of stay - Elective	2.36	2.33	2.37	2.22	2.49	2.06	2.57	2.16	2.45	2.44	2.36	2.31	2.43	2.12	2.51	2.23	2.37	2.33		
O37	Average length of stay - Non-elective Surgery	4.59	4.47	3.89	4.14	4.59	4.17	4.49	4.26	4.36	4.43	4.54	4.15	3.91	4.22	4.26	4.09	4.39	4.17		
O38	Average length of stay - Non-elective Medicine	5.82	5.49	5.24	4.92	5.08	5.80	5.50	6.15	5.69	6.41	5.84	5.95	5.45	5.11	5.24	5.42	5.75	5.39		
O39	Day case rate (CQC day case basket of procedures) source: HED (reported 2-3 months in arrears)	87.4%	89.3%	89.3%	85.6%	85.8%	86.0%	81.0%	85.5%	84.5%	87.6%	85.7%	87.0%	83.0%	88.6%				86.1%	75.0%	
O40	Elective day of surgery rate (DOSR)	94.7%	93.1%	94.4%	94.2%	93.9%	94.9%	95.1%	93.8%	94.6%	94.0%	94.9%	94.8%	94.8%	95.5%	94.9%	95.3%	95.8%	95.2%	90.0%	
O41	Did not attend rate (outpatients)	8.2%	8.7%	8.8%	8.8%	8.5%	8.7%	8.0%	7.7%	8.0%	8.0%	7.5%	7.0%	6.2%	6.8%	6.7%	7.0%	7.5%	6.9%	6.00%	
SUSTAINABILITY																					
O43	Bank staff - % of all staff pay	4.2%	4.3%	4.5%	3.5%	3.8%	4.5%	5.7%	4.0%	4.3%	4.7%	5.2%	5.0%	4.5%	4.1%	5.2%	5.2%	5.3%	4.8%	7%	
O44	Agency staff - % of all staff pay	3.0%	3.1%	1.8%	2.6%	2.0%	2.5%	3.5%	3.3%	3.0%	3.4%	3.1%	4.5%	2.4%	3.1%	3.3%	3.2%	3.9%	3.2%	2%	
O46	% nurses who are registered	73.9%	73.6%	73.0%	73.3%	73.5%	73.7%	73.6%	73.6%	73.7%	73.5%	73.5%	73.4%	73.0%	72.4%	72.1%	72.0%	71.8%		74%	
O47	% Staff appraised	69.8%	70.6%	70.2%	70.4%	66.9%	71.9%	73.4%	75.7%	77.2%	79.2%	81.0%	85.0%	82.8%	81.3%	80.9%	80.2%	77.7%		85%	
O48	Sickness Absence: % Sickness(reported one month in arrears)	4.3%	4.3%	4.3%	4.3%	4.3%	4.2%	4.3%	4.3%	4.3%	4.3%	4.3%	4.3%	4.2%	4.2%	4.2%	4.3%			3.5%	
O49	Staff Turnover: Turnover rate (YTD position)	12.8%	12.8%	13.2%	13.6%	12.9%	13.3%	13.4%	13.6%	14.0%	14.2%	14.3%	14.4%	14.5%	14.6%	14.5%	14.3%	14.3%		12%	
ACTIVITY																					
A01	Day Cases	3759	3951	4096	4206	4031	4038	3895	4263	3575	3749	3790	4232	3355	4050	4232	3790	4230	19657		
A02	Elective Inpatients	1191	1207	1216	1284	1189	1266	1268	1288	1129	1207	1209	1444	1192	1259	1388	1299	1291	6429		
A03	Non-elective inpatients	4429	4629	4813	4672	4468	4388	4764	4630	4701	4427	4201	4921	4637	4890	4499	4680	4640	23346		
A04	Outpatient First attendances	10498	10612	11826	9928	10914	10811	10962	11779	9325	10315	10328	12344	8620	11132	10935	10169	10366	51222		
A05	Outpatient Follow-up attendances	23633	24089	25211	23974	25719	25335	25025	27606	22352	26786	24337	28242	21604	26190	25085	23710	23970	120559		
A06	Outpatients with procedure	6468	6355	6999	6579	7081	7175	7033	7497	5927	6874	6622	7591	7143	8096	8111	7362	7881	38593		
A07	A&E Attendances	13168	14407	13670	14707	13888	13599	14093	13599	13231	12794	12209	13955	13258	14089	13810	14037	13201	68395		

Notes:

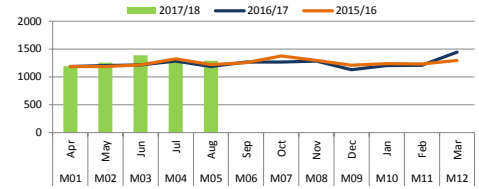
1 National reporting for these performance measures is on a quarterly basis. Data are subject to change up to the final submission deadline due to ongoing data validation and verification.
2 Data are provisional best estimates and will be amended to reflect the position signed-off in the relevant statutory returns in due course.
3 Staff sickness is reported one month in arrears.

Activity Trends

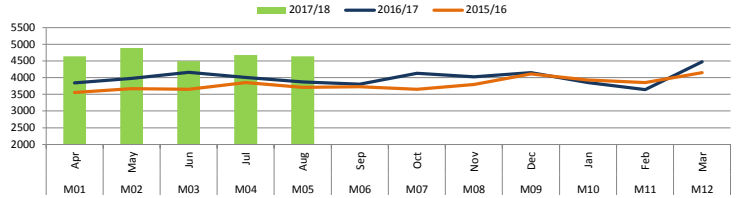
Day Cases



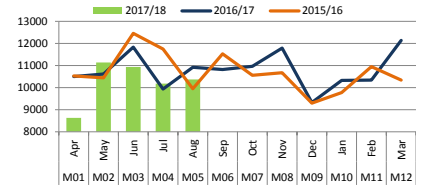
Elective Inpatients



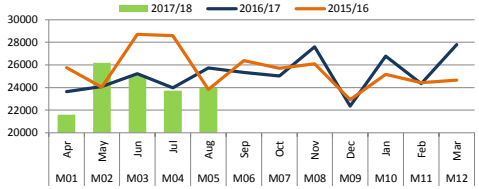
Non-elective Inpatients



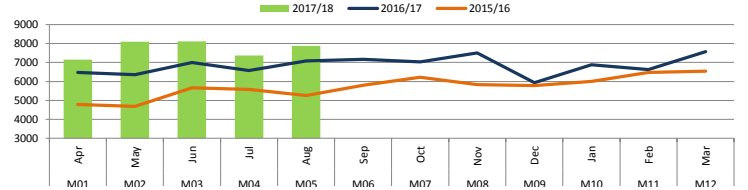
First Outpatients



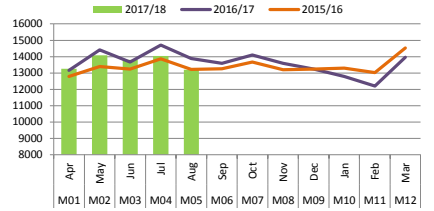
Follow-up Outpatients



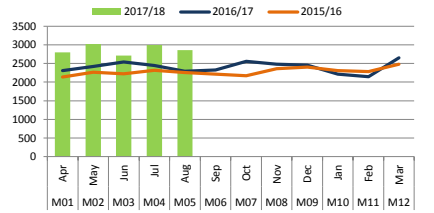
Outpatients with Procedure



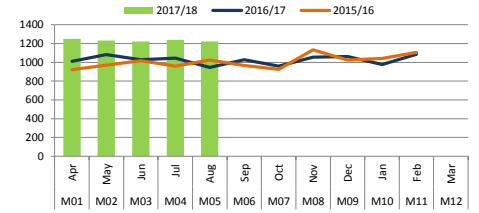
A&E Attendances



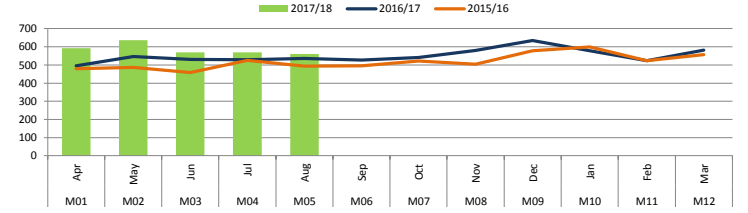
Emergency Admissions (age 0-64)



Emergency Admissions (age 65-84)



Emergency Admissions (age >85)



Brighton and Sussex University Hospitals NHS Trust

To: Trust Board Meeting

Date of Meeting: 27th September 2017 Agenda Item: 9

Title
Finance Report on Month 5 2017/18 Position
Responsible Executive Director
Karen Geoghegan, Chief Financial Officer
Prepared by
Adam Shields, Assistant Director of Finance
Status
Public
Summary of Proposal
At Month 5 the Trust is reporting a deficit of £28.39m against the deficit plan of £28.76m, a favourable year-to-date variance of £0.37m. The Finance Report on Month 5 2017/18 Position provides further detail on the Trust's financial position.
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
Financial Implications
These are noted within the Finance Report on Month 5 2017/18 Position.
Human Resource Implications
N/A
Recommendation
The Board is asked to NOTE the Finance Report on Month 5 2017/18 Position.
Communication and Consultation
N/A
Appendices
1. Month 5 I&E position - subjective 2. Month 5 I&E position – objective 3. Finance Report Month 5 2017/18

Brighton and Sussex University Hospitals NHS Trust

To: Trust Board **27/9/17**

From: Adam Shields, Assistant Director of Finance – Planning, on behalf of Karen Geoghegan, Chief Financial Officer

Agenda Item: 9.

FOR INFORMATION AND APPROVAL

Finance Report on Month 5 2017/18 Position

Executive Summary
Month 5 Performance

At Month 5 the Trust is reporting a deficit of £28.39m against the deficit plan of £28.76m, a favourable year-to-date variance of £0.37m.

Forecast outturn is to deliver the agreed Control Total deficit of £65.4m. Key risks to delivery include:

Income

- Securing the level of contract income included in the plan
- Delivery of CQUIN in full
- Continuation of R&D income underperformance would mean an income shortfall of £1.4m (partly mitigated through reduced costs)

Operational costs

- Delivery of the £20m Efficiency Programme in full
- Ensuring all unfunded posts are matched to the current funded establishment
- Corporate and Clinical restructuring will increase the pay run-rate in the short-term (although this has been reflected in the plan)
- Financial governance processes are in place, but still need to be embedded and refined
- Work on the 3Ts build and Estates backlog maintenance could have an operational impact on costs and income

1. Introduction

1.1. This report covers the financial performance of the Trust to August 2017 and addresses income and expenditure, capital, cash management and key risks.

2. I&E Summary and Key Financial Metrics

£000s	In-Month			Year-to-Date		
	Plan	Actual	Variance	Plan	Actual	Variance
Income	(47,865)	(49,089)	(1,224)	(229,927)	(229,328)	598
Pay	31,555	30,137	(1,419)	151,576	148,491	(3,085)
Non-pay	17,701	19,394	1,693	91,140	92,673	1,534
EBITDA	1,391	442	(950)	12,789	11,836	(954)
Non-operating costs	3,296	3,271	(25)	16,187	15,871	(315)
Total	4,687	3,713	(974)	28,976	27,707	(1,269)
Technical adjustments	3	839	837	(217)	683	901
Adjusted Total	4,689	4,552	(138)	28,758	28,390	(368)
CIPs (per PMO plan)	1,174	1,108	(66)	4,749	4,699	(50)
Capital	9,870	3,042	(6,828)	43,866	18,558	(25,308)
Cash				3,297	9,201	5,905

NB In-month and Year-to-Date "Plan" reflect the Trust's agreed Control Total deficit of £65.4m

3. Summary

3.1. The year-to-Month 5 position is a favourable variance to budget of £0.37m, with an actual deficit of £28.39m against a deficit plan of £28.76m.

3.2. For Month 5 components of the plan have been refined to reflect the finalised efficiency plan and approved business cases. The overall deficit and monthly phasing remain unchanged, but the values of component quanta – income, pay and non-pay – have been adjusted.

3.3. The Trust is not earning income up to planned levels. This is offset by underspending on operational and non-operational expenditure.

3.4. A detailed analysis of the Trust's financial Income and Expenditure performance by subjective category is shown in Appendix 1 and by organisational unit in Appendix 2.

3.5. The Trust's cash position is supported by monthly revenue deficit funding from the Department of Health and capital investment loans and PDC for the capital programme. The August revenue funding was £4.8m and the September funding will be £5.5m. Thereafter the funding will continue throughout the year up to the level of the planned deficit.

4. Month-on-Month Movements

4.1. Table 1 on the next page shows the movement in actuals compared to Month 4.

Table 1: Run-rate changes compared to Month 4	£000s
Activity income	(3,114)
Challenges provision	0
PBR exclusions & CDF income	(375)
Outsourcing income	(55)
SIFT income	258
Other income (PP, R&D etc.)	(222)
Pay	829
Outsourcing	55
Drugs in tariff	339
PBR exclusions & CDF expenditure	375
Consumables in tariff expenditure	280
Other non-pay	888
Non-operating Costs & Technical Adjustments	192
Total movement	**(551)**

NB The impact of increased donations income has been stripped out of the movement

4.2. The increase in activity income includes £2m for income earned in Month 4, including for PbR exclusions, but not recognised in that month.

5. Income

5.1. Income for the year-to-date reports an underperformance across all categories of £0.6m, an improvement of £1.22m in-month. Income from patient activity is based on 4 months actuals with an estimate for August and a provision is held for contract adjustments and challenges.

5.2. The main drivers behind the £0.6m year-to-date variance to plan are:

Income	Variance to Plan, £m	Comment
PbR exclusions	-1.71	Offset by expenditure above plan
Donations	-0.89	Benefit removed in technical adjustments
NHS Trust	0.33	
SMSKP contract	0.40	
Injury Cost Recovery	0.42	
R&D	0.59	Partly offset by expenditure underspends
CDF drugs	1.21	Offset by expenditure below plan
Net of other items	0.25	
	0.60	

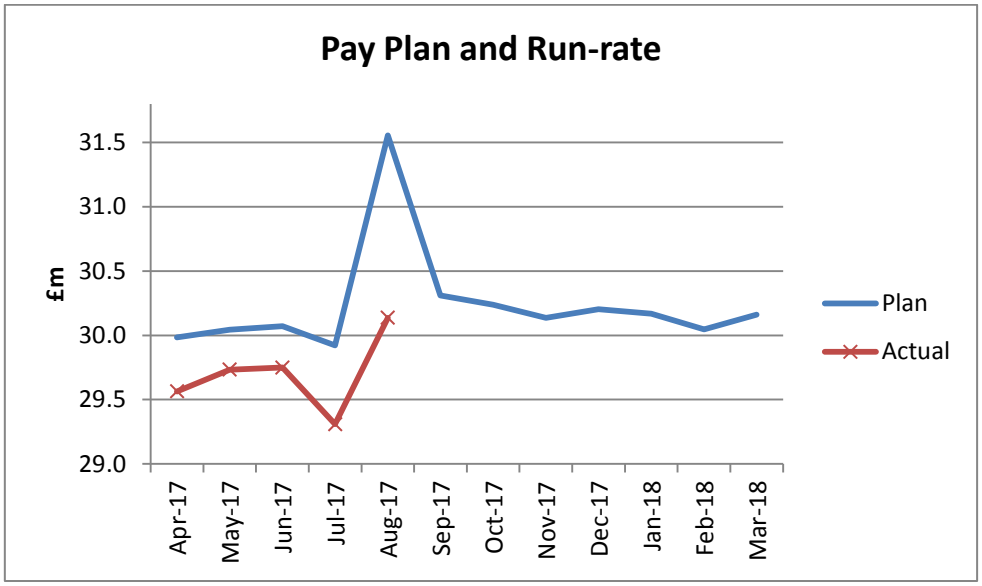
6. Expenditure Year-to-date

6.1. Operating Expenditure is underspent year-to date by £1.55m driven by a pay underspend of £3.09m which is partly offset by a non-pay overspend of £1.53m.

Pay

6.2. The pay underspend comprises underspends in most staff categories with the exceptions of SAS Doctors, Ancillary Staff and Other.

6.3. The pay run-rate increased by £0.83m from Month 4 with the most significant expenditure increases being on Medical and Dental staff (£0.43m) and Nursing and Midwifery (£0.40m).



NB The plan spike in August reflects adjustment of the plan as per paragraph 3.2.

6.4. The increase in Medical and Dental expenditure is mainly in training grades (£0.31m). This may relate to the August rotation, which saw an increased number of Junior Doctors being employed under the new contract, as well as FY1 shadowing costs.

6.5. The increase in Nursing and Midwifery expenditure is partly due to August bank holiday pay enhancements which are fully budgeted, but there has also been an increase in the volume of agency staff being used and a significant increase in the cost per agency WTE reflecting increasing use of non-framework agency staff – see Table 2.

6.6. The Trust's overall agency expenditure cap for 2017/18 is the same as last year at £12.8m. The profiled cap for the year-to-Month 4 is £5.33m and expenditure is below this at £4.8m. This represents 3.2% of total pay expenditure.

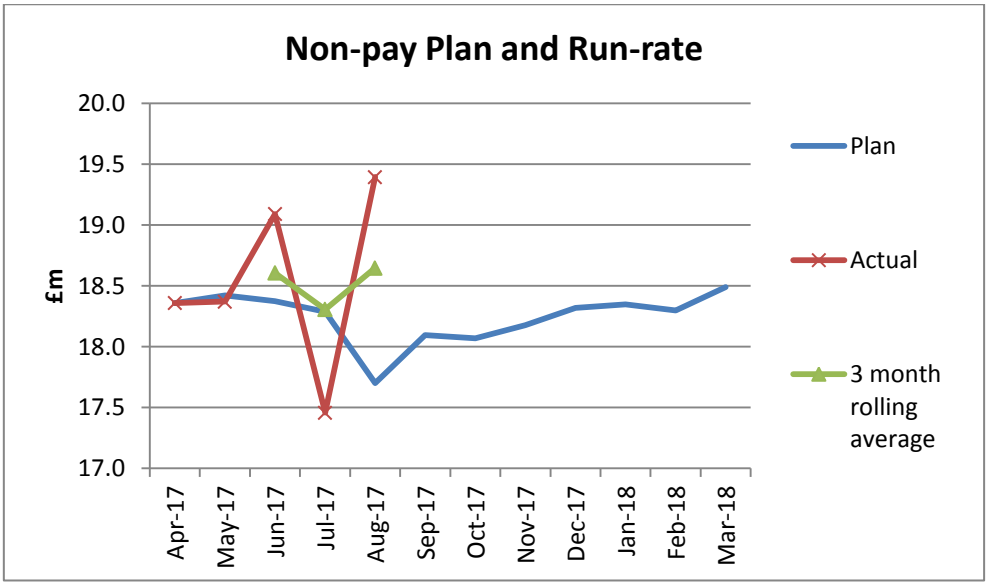
Table 2: Registered Nursing & Midwifery Run-rates

Scenario	S / B / A	M01	M02	M03	M04	M05	M05 v M04
£000s	Substantive	8,146	8,299	7,896	7,878	8,021	143
	Bank	680	421	684	577	615	39
	Agency	257	250	253	309	438	**130**
		9,083	8,970	8,833	8,763	9,074	311
Contracted WTE	Substantive	2,332.9	2,310.4	2,293.2	2,283.7	2,278.7	(5.0)
Worked WTE	Substantive	2,247.7	2,226.4	2,221.3	2,210.6	2,204.0	(6.6)
	Bank	138.8	153.0	186.3	165.6	158.6	(7.1)
	Agency	40.5	37.4	42.4	48.4	59.2	**10.9**
		2,426.9	2,416.8	2,450.0	2,424.6	2,421.8	(2.8)
£ / Worked WTE	Substantive	3,624	3,728	3,555	3,564	3,639	75
	Bank	4,901	2,751	3,674	3,482	3,881	399
	Agency	6,354	6,692	5,967	6,382	7,396	**1,014**
		3,743	3,712	3,605	3,614	3,747	133

Non-pay

6.7. Year-to-date non-pay is £1.53m overspend against plan. The main cause is an over spend of £1.21m on "PbR exclusion and CDF drugs" which is offset by income.

6.8. The non-pay run-rate increased in by £1.94m in Month 5 driven by: a reported increase in PbR exclusion and CDF drugs expenditure of £0.54m, an increase in premises costs of £0.51m, an increase in in-tariff drug costs of £0.34m and recognition of the Trust's contribution to year-to-date STP costs of £0.17m.



Non-operating costs

6.9. Non-operating costs are underspent by £0.32m year-to-date, primarily due to interest payments being lower than planned.

7. Performance Against Delegated Budgets

7.1. Year-to-date the Clinical Directorates are collectively overspent against delegated budgets by £2.22m, an in-month deterioration of £1.91m. £0.29m of this relates to budget adjustments following agreement of efficiency programme savings. Corporate Directorates are underspent by £1.27m. Details are in Appendix 2.

7.2. Eleven Clinical Directorates have signed off 17/18 activity and finance plans. The exception is the Abdominal Surgery and Medicine Directorate which is currently undergoing an external review.

8. Efficiency Programme

8.1. The PMO has been working with Directorates to develop the efficiency plan to deliver £20m savings. Most schemes are now identified, agreed and reflected in delegated budgets. The remainder of the efficiency programme will be fully embedded in operational budgets for Month 6 reporting.

8.2. The Month 5 position is a £0.05m underachievement of CIPS against the internal plan, and the forecast is to deliver the targeted savings. Development of the schemes identified as higher risk will continue and progress will be monitored by the CIPS steering group.

CIPS £000s					
Year-to-Date			Full-Year		
Plan	Actual	Variance	Plan	Forecast Outturn	Forecast Outturn Variance
4,749	4,699	(50)	20,000	20,000	0

8.3. A separate detailed report on the efficiency programme is presented to the Finance and Investment Committee.

9. Risks

9.1. A number of risks to delivery of the Control Total deficit are outlined below. Identification of further risks and opportunities will continue to enable appropriate actions to be taken.

9.2. Income

- Securing the level of contract income included in the plan; the contracts signed at December '16 are lower than plan across all commissioners. A series of Executive led discussions with commissioners has been taking place to close this gap and mitigate risk to delivery of the forecast income for the year. It is expected that this gap will reduce significantly in the forthcoming weeks as this work concludes.
- Risk of delivery of CQUIN
- R&D income is 32% behind plan year-to-date; continuation of this level of underperformance would mean an income shortfall of £1.4m (partly mitigated through reduced costs).

9.3. Operating Expenditure

- There remain a significant number of unfunded posts, the cost pressure from which is currently being offset by vacancies which are not being backfilled. A programme of work to resolve this issue is underway to absorb costs within the current funded establishment.
- Work is on-going to finalise agreement on the 17/18 SIFT related BSMS charge.
- Delivery of the £20m CIP target in full.
- Financial governance processes are in place, but still need to be embedded and refined.
- Work on the 3Ts build and Estates backlog maintenance may have an operational impact on costs and income.

9.4. Non-operating expenditure

- Since the Control Total deficit plan has been delivered for consecutive months year-to-date, the Trust has secured a reduction in the interest rate payable on future loans.
- A detailed review of projected depreciation costs suggests there may be further opportunity to reduce expenditure.

10. Cash

10.1. The Trust received £4.8m of revenue deficit funding in August and a further £5.5m has been paid over in September. The full year's revenue deficit funding is equal to the planned deficit of £65.35m. The monthly drawdowns are based on a review by NHSI of revenue results to date and the forecast revenue results for the remainder of the year.

10.2. Capital funding is mainly as PDC. The funding basis for ED and the Emergency Backlog Maintenance is reflected as PDC based on advice from NHSI, but the funding approach has yet to be confirmed. Pathology remains as investment loan.

10.3. The other strategic schemes are pending approval from NHSI so the timing of the cash flows for these schemes is uncertain, but the estimated income and expenditure is included in the overall cashflow.

10.4. Slippage on Operational Capital may affect the value of drawdown in September.

11. Capital

11.1. The capital expenditure profile for 3Ts was re-phased in July following discussion with NHSI due to slippage in the overall scheme which occurred in 2016/17. The total forecast expenditure for 17/18 is £45.9m. The buildings work and the equipment installation is complete for the Eastbourne Radiotherapy scheme, but there remains some IT work to close off the scheme. The ED scheme has now been approved by NHSI, but the source of funds is still subject to DH approval. Emergency Capital for Backlog Maintenance and Pathology remain subject to NHSI approval.

11.2. The revised Operational Capital Programme is progressing slowly with some schemes still in work plan stage rather than implementation. Oversight of all aspects of the capital programme is through the newly formed Executive led Capital Expenditure Group.

12. The Committee is asked to:

- Note the contents of this report

Adam Shields
Assistant Director of Finance – Planning
19/9/17

Appendix 1 - I/E Report Month 5 2017/18

	In Month			Year to Date		
	Plan	Actual	Variance	Plan	Actual	Variance
	£000's	£000's	£000's	£000's	£000's	£000's
NHS Trusts Income	(710)	(734)	(24)	(3,473)	(3,140)	333
Commissioning Income - Patient Activity	(39,583)	(41,000)	(1,417)	(189,714)	(191,403)	(1,688)
Commissioning Devolved Income	0	0	0	0	0	0
Commissioning Income - Non Activity	(784)	(464)	320	(4,057)	(2,771)	1,287
Department Of Health Income	(2)	0	2	(15)	(29)	(13)
Private Patients Income	(446)	(162)	284	(2,038)	(1,744)	294
Injury Cost Recovery	(205)	(105)	100	(1,042)	(622)	420
Other Patient Related Income	(1,548)	(2,130)	(582)	(11,065)	(10,510)	555
Local Authority Income	(392)	(360)	32	(1,860)	(2,111)	(251)
Overseas Visitors Income	(17)	(33)	(15)	(90)	(80)	10
Income from Activities	**(43,687)**	**(44,987)**	**(1,300)**	**(213,355)**	**(212,410)**	**945**
Education & Training Income	(2,619)	(2,388)	231	(11,321)	(11,313)	8
Research & Development Income	(374)	(214)	160	(1,870)	(1,280)	590
Income Generation	(210)	(162)	48	(1,052)	(998)	54
Other Income	(975)	(1,338)	(363)	(2,329)	(3,327)	(998)
Other Operating Income	**(4,178)**	**(4,102)**	**76**	**(16,572)**	**(16,918)**	**(346)**
TOTAL INCOME	**(47,865)**	**(49,089)**	**(1,224)**	**(229,927)**	**(229,328)**	**598**
Pay - Management	1,544	1,138	(406)	7,185	6,523	(662)
Medical and Dental Staff	9,117	9,315	198	44,752	45,008	257
Nursing & Midwifery - Registered	9,456	9,074	(382)	46,240	44,724	(1,516)
Nursing & Midwifery - Unregistered	2,431	2,245	(186)	10,980	10,936	(44)
Pay Other Healthcare	4,779	4,100	(679)	21,287	20,318	(970)
Ancillary Staff	1,167	1,168	0	5,908	5,925	17
Administrative & Clerical	2,980	2,741	(239)	14,562	13,679	(883)
Maintenance & Works	291	240	(51)	1,324	1,131	(193)
Pay - Other Staff	(209)	117	325	(661)	248	909
TOTAL PAY	**31,555**	**30,137**	**(1,419)**	**151,576**	**148,491**	**(3,085)**
Drugs & Medical Gases - in tariff	1,080	1,271	191	5,296	5,150	(146)
Drugs - PbR exclusion and CDF	5,437	5,624	187	26,777	27,990	1,213
Supplies and Services - Clinical - in tariff	4,496	4,929	433	22,334	23,464	1,130
Supplies and Services - Clinical - PbR exclusion	730	537	(193)	3,657	3,110	(547)
Supplies and Services General	614	484	(130)	2,945	2,808	(137)
Establishment Expenses	577	516	(60)	2,795	2,623	(172)
Transport Expenses	124	108	(16)	486	461	(26)
Premises	1,757	2,086	328	8,873	8,933	59
Purchase of Healthcare from Non NHS provider	524	630	106	2,830	3,021	191
Consultancy	114	207	93	506	384	(121)
Other Non Pay	(448)	301	748	227	706	478
CNST Premium	1,793	1,793	1	8,968	8,967	(0)
Education and Training	328	212	(117)	1,551	1,357	(195)
Services from Other NHS Bodies	546	684	137	3,754	3,564	(190)
Audit Fees	22	4	(19)	113	94	(20)
Trust Chair & Non-Executive Directors	5	8	3	26	42	15
TOTAL NON-PAY	**17,701**	**19,394**	**1,693**	**91,140**	**92,673**	**1,534**
TOTAL EXPENDITURE	**49,256**	**49,531**	**275**	**242,716**	**241,164**	**(1,552)**
Depreciation & Impairments	1,886	1,884	(2)	9,418	9,404	(14)
Interest Payable	885	828	(57)	4,143	3,856	(287)
Interest Receivable	(4)	(3)	0	(15)	(12)	2
Profit / Loss on Disposal of Fixed Assets						
PDC Dividend Payable	528	3,271	(25)	2,640	2,624	(16)
TOTAL NON OPERATING INC & EXP	**3,296**	**3,271**	**(25)**	**16,187**	**15,871**	**(315)**
TOTAL INCOME & EXPENDITURE	**4,687**	**3,713**	**(974)**	**28,976**	**27,707**	**(1,269)**
Donations Inc Charitable Funds	**(75)**	**(908)**	**(833)**	**(125)**	**(1,012)**	**(887)**
Depn. On Donated Assets	**73**	**69**	**(4)**	**343**	**329**	**(14)**
Fixed Asset Impairments	**0**	**0**	**0**	**0**	**0**	**0**
NET REPORTED POSITION	**4,689**	**4,552**	**(138)**	**28,758**	**28,390**	**(368)**

Appendix 2 - I/E Report Month 5 2017/18

	In Month			Year to Date		
	Plan	Actual	Variance	Plan	Actual	Variance
	£000's	£000's	£000's	£000's	£000's	£000's
Abdominal Surgery & Medicine Directorate	1,840	1,921	81	8,766	9,351	585
Acute Floor Directorate	3,630	3,792	162	17,986	17,794	(192)
Cancer Directorate	1,596	1,652	55	7,657	7,742	85
Cardiovascular Directorate	3,290	3,739	450	16,238	17,517	1,279
Central Clinical Services Directorate	4,659	5,038	379	24,290	24,397	107
Children's Services Directorate	2,245	2,310	65	10,992	11,112	119
Head & Neck Directorate	1,118	1,171	53	5,441	5,508	66
Musculoskeletal Directorate	2,092	2,082	(10)	10,599	10,133	(466)
Neurosciences & Stroke Services Directorate	1,963	2,150	187	9,582	9,709	127
Perioperative Directorate	2,701	2,832	131	13,568	13,762	194
Speciality Medicine Directorate	2,463	2,794	331	13,168	13,603	435
Women's Services Directorate	1,730	1,753	22	8,699	8,588	(111)
Clinical Services Total	**29,328**	**31,233**	**1,905**	**146,986**	**149,215**	**2,228**
Facilities and Estates	3,372	3,684	312	16,956	16,880	(77)
Chief Financial Officer	895	745	(150)	3,842	3,147	(695)
Chief Executive's Office	254	241	(13)	1,281	1,408	126
Chief Nurse's Office	417	340	(78)	2,093	1,833	(260)
Chief Operating Officer	1,476	1,471	(5)	8,253	7,724	(529)
Medical Director's Office	557	559	2	2,852	3,066	214
Strategy & Change	453	422	(31)	2,482	2,429	(53)
Corporate Services Total	**7,424**	**7,462**	**38**	**37,759**	**36,487**	**(1,273)**
Central Income	(35,980)	(37,485)	(1,505)	(174,220)	(174,037)	183
Capital Charges & Financing Costs	3,052	2,651	(400)	15,003	14,296	(707)
Central Reserves	889	(148)	(1,037)	4,089	1,748	(2,341)
Efficiency Programme	(26)	0	26	(641)	0	641
Financial Central Services	**(32,065)**	**(34,982)**	**(2,917)**	**(155,769)**	**(157,994)**	**(2,225)**
Directorate Total	**4,687**	**3,713**	**(974)**	**28,976**	**27,707**	**(1,269)**
Below the line Adjustments	3	839	837	(217)	683	901
Total	**4,689**	**4,552**	**(138)**	**28,758**	**28,390**	**(368)**

Finance Report Month 5 2017/18

Summary

Brighton and Sussex University Hospitals NHS Trust

Summary

A Control Total deficit of £65.4m has been set by the Trust in agreement with NHSI. The Trust is reporting a £28.39m deficit at Month 5, £0.4m better than plan. The capital programme is underspent and cash receipts are higher than planned. The Efficiency and Transformation Programme is delivering below plan year-to-date. The Trust is forecasting delivery of the Control Total deficit at the end of the year.

Use of Resources Metrics (SOF) — R

YTD

	Plan	Actual / Forecast	Variance
Year-to-date	4	4	0
Year-end Forecast	4	4	0

The actual/forecast ratings would be 3 based on the average scores of the components parts, but because there are 3 ratings of 4 in both year-to-date and forecast the scores are overridden to an overall 4.

Control Total (Surplus) / Deficit £k — G

	Plan	Actual / Forecast	Variance
Year-to-date	28,758	28,390	(368)
Year-end Forecast	65,349	65,279	(70)

Based on a deficit plan of £65.35m, the Trust is reporting a deficit of £28.39m compared to the YTD plan of £28.76m. The forecast is to deliver a deficit in line with the plan.

Agency Ceiling £k — G

	Ceiling	Actual / Forecast	Variance
Year-to-date	5,332	4,769	(564)
Year-end Forecast	12,798	12,444	(354)

Agency costs of £4.8m represent 3.2% of the total pay bill and are well within the year-to-Month 5 agency cap of £5.3m. However, agency expenditure increased in-month and is greater than in same period in 16/17. This is due to an inablity to substantively fill posts. The total cost of agency, bank and substantive staff was well within the Month 5 pay budget.

Income £k — R

	Plan	Actual / Forecast	Variance
Year-to-date	(229,927)	(229,328)	598
Year-end Forecast	(555,706)	(552,421)	3,284

For the year-to-August Income reports an underperformance of £0.6m, an improvement of £1.2m on the previous month. The year-end projection is to secure less income than plan by £3.3m, principally due to CDF drug expenditure being lower than was included in the plan with a corresponding reduction in associated funding. Income from patient activity is based on 4 months actual activity and an estimate for August. A provision is held for contract adjustments and challenges.

Operating Costs £k — A

	Plan	Actual / Forecast	Variance
Year-to-date	242,716	241,164	(1,552)
Year-end Forecast	581,776	578,181	(3,595)

Operating costs to Month 5 are underspending against budgets, primarily in pay costs, although the savings plans have not been fully allocated as yet. At present the assumption is that the Trust will identify the required savings, manage the identified risks and reduce expenditure and therefore come in on budget, except for PbR excluded drugs which should be offset by additional income.

Agency Expenditure — G

Expenditure as % of total Pay bill (YTD)	2015-16	2016-17	2017-18
Medical	2.0%	0.9%	0.8%
Nursing	2.8%	0.7%	1.0%
Other staff groups	2.2%	1.0%	1.4%
All Agency	**7.0%**	**2.6%**	**3.2%**

Agency costs have increased as a proportion of the total paybill compared to the same period last year and increased by £0.25m from Month 4's level.

Cash £k — G

	Plan	Actual / Forecast	Variance
Year-to-date	3,297	9,201	5,905
Year-end Forecast	3,668	3,669	1

Revenue deficit funding for the five months to 30 August amounts to £28.4m. The funding for September is £5.5m. No further capital funding has been drawn down; the next request will be in September for 3Ts PDC funding. The emergency scheme funding, which will now be PDC, is pending approval from NHSI. The favourable variance from plan is as a result some NHS settlements late in the month. The year-end level of cash holding is aligned to the year-end External Financing Limit (EFL) cash control total.

Capital £k — A

	Plan	Actual / Forecast	Variance
Year-to-date	43,866	18,558	(25,308)
Year-end Forecast	151,952	107,611	(44,341)

The capital programme is behind plan. The re-phasing of the 3Ts Programme expenditure accounts for a significant part of this, the Operational programme is in many areas at work plan stage rather than implementation. The ED, Backlog Maintenance and Pathology schemes are pending approval from NHSI and DH.

Efficiency and Transformation Programme £k — G

	Plan	Actual / Forecast	Variance
Year-to-date	4,749	4,699	(50)
Year-end Forecast	20,000	20,000	0

Whilst the majority of the efficiency plan schemes have been finalised with the Directorates, there are still some projects that need to be developed. The savings reported year-to-date are below the internal plan by £0.05m. The forecast is to achieve the £20m target after risk assessing individual forecasts down by £0.95m.

Key risks include:

1. The contract income plan is significantly higher than the signed off contracts with commissioners. This reflects a higher baseline level of activity than was assumed at the time of contract sign-off (the contract will be subject to variation due to this) and a number of specific funding issues where discussions have not yet been concluded. There is a risk that commissioners cannot afford to pay.
2. Not having identified the full CIP plan may mean there's slippage in delivery.
3. Theatre maintenance meaning the activity plan cannot be delivered in full.
4. While the control total deficit plan has been hit year-to-date, the anticipated reduction in the interest rate payable on subsequent loans backing the deficit is yet to be confirmed.
5. Corporate and Clinical restructuring may have both direct and indirect revenue consequences.

Finance Report Month 5 2017/18 **R**

Whilst the overall rating below would be 3 based on the average of the components, because there are 3 ratings of 4 in both year-to-date and forecast the score is overridden to 4.

Financial Rating YTD	Plan Metric	Plan Rating	Actual Metric	Actual Rating
Capital Service Capacity	(1.6)	4	(1.5)	4
Liquidity	(16.3)	4	(15.5)	4
I&E Margin	(12.57%)	4	(12.43%)	4
Distance from Financial Plan			0.0	1
Agency Spend	(13.80%)	1	(10.58%)	1
2017-18 Finance Rating after overrides		4		4

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%

Finance Report Month 5 2017/18 — Surplus — G

Based on a deficit plan of £65.35m, the Trust is reporting a deficit of £28.39m compared to the YTD plan of £28.76m. The forecast is to deliver a deficit in line with the plan.

Year to Date

	Plan £k	Actual £k	Variance £k
(Surplus)/Deficit	**28,758**	**28,390**	**(368)**

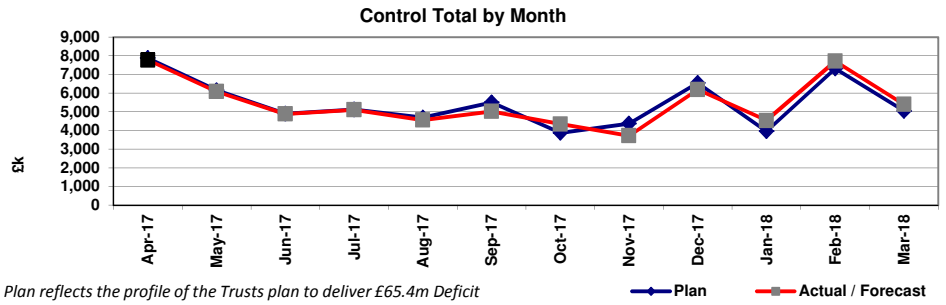
Year End Forecast

	Plan £k	Forecast £k	Variance £k
(Surplus)/Deficit	**65,349**	**65,279**	**(70)**

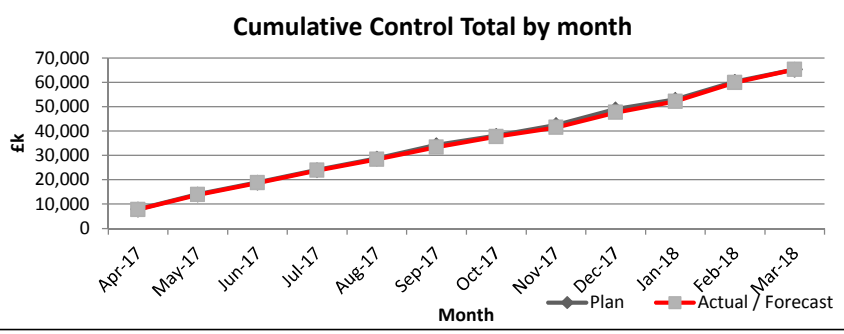
Income YTD for August was less than budget by £0.6m with a year-end forecast of underacheivement of £3.3m. More detail is provided in the Income dashboard.
Expenditure compared to budget is underspent for the period to August 2017, mainly in the areas of pay costs. This is partly offset by overspends in PBRX drugs and supplies and services.

	Year to Date				Full year			
	PY Actual £k	Plan £k	Actual £k	Variance £k	Plan £k	Actual £k	Variance £k
Income	(180,239)	(229,927)	(229,328)	598	(555,706)	(552,421)	3,284
Pay	118,354	151,576	148,491	(3,085)	362,840	360,101	(2,738)
Non-Pay - in tariff	48,340	60,705	61,573	868	144,310	145,076	766
Non-Pay - PBR exclusions and CDF	24,939	30,434	31,100	666	74,626	73,004	(1,622)
EBITDA *	**11,394**	**12,789**	**11,836**	**(954)**	**26,070**	**25,760**	**(310)**
EBITDA %	**-6.3**	**-5.6**	**-5.2**		**-4.7**	**-4.7**	
Profit / Loss on Disposal of Fixed Assets	2,062	-	-	-	-	-	-
Interest Payable	3,027	4,143	3,856	(287)	10,896	10,341	(555)
Interest Receivable	(9)	(15)	(12)	2	(35)	(33)	2
Depreciation	7,520	9,418	9,404	(14)	22,604	22,596	(7)
Impairments	0	0	0	0	15,500	15,500	0
Public Dividend Capital	12,601	2,640	2,624	(16)	6,336	6,040	(296)
Net (Surplus) / Deficit	**36,595**	**28,976**	**27,707**	**(1,270)**	**81,371**	**80,204**	**(1,167)**
Reverse Impairment	0	0	0	0	(15,500)	(15,500)	0
Other Adjustments	(23,839)	(217)	683	901	(522)	575	1,097
Reverse IFRS technical charge	0	0	0	0	0	0	0
Performance against Control Total	**12,757**	**28,758**	**28,390**	**(368)**	**65,349**	**65,279**	**(70)**
Surplus %	**-7.1**	**-12.5**	**-12.4**		**-11.8**	**-11.8**	

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



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



Contract performance at Month 5 is based on 4 months actual activity and an estimate for August. Measuring performance by commissioner is provisional whilst the Identification Rules, which determine which commissioner pays for activity, are finalised. It is anticipated that the values of all commissioner contracts will change once this is completed. There are also a number of outstanding contractual issues to be resolved with commissioners in the coming months. The Trust's income expectation is significantly higher than the signed contracts mainly due to these outstanding items. The Trust is working with commissioners to manage the system wide impact of competing pressures across the LHE.

Contract Agreement 2017/18

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

	Reported Values for August 2017			
	£'000			
	FYE Plan	YTD Plan	YTD Actual	YTD Var
Sussex CCG's	276,167	115,790	117,548	1,758
MSK	25,666	10,404	10,241	(164)
NHS England (Specialised)	168,102	68,009	67,265	(744)
NHS England (Dental & Screening)	9,581	4,008	3,951	(57)
Intergrated Sexual Health Services	3,997	1,656	1,923	267
Non Contracted Activity	4,591	1,906	2,381	475
TOTAL COMMISSIONING INCOME	**488,104**	**201,774**	**203,309**	**1,535**

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	19,859	19,704	(156)	-0.8%	17,602	17,060	(542)	-3.1%
Elective Spells	6,315	6,384	69	1.1%	16,073	16,007	(66)	-0.4%
Elective Excess beddays	17,539	17,928	389	2.2%	249	356	107	42.8%
Non Elective Spells	1,878	1,952	74	3.9%	45,897	46,364	467	1.0%
Non Elective Spells - Short Stay	4,003	3,687	(315)	-7.9%	1,361	1,388	27	2.0%
Ambulatory Care	942	1,308	366	38.9%	3,593	3,233	(361)	-10.0%
Non Elective excess beddays	7,020	7,164	144	2.0%	1,819	1,891	72	3.9%
A&E	71,323	69,217	(2,106)	-3.0%	8,572	8,869	296	3.5%
Outpatients - New	52,632	51,504	(1,128)	-2.1%	8,601	8,182	(419)	-4.9%
Outpatients - Follow Up	121,596	122,084	488	0.4%	10,023	10,125	102	1.0%
Outpatient Procedures	34,740	38,868	4,128	11.9%	4,617	5,173	556	12.0%
Outpatient Imaging	36,719	38,343	1,624	4.4%	2,127	2,305	178	8.4%
Direct Access	6,281	6,254	(26)	-0.4%	5,634	5,951	317	5.6%
Critical Care	11,099	11,114	15	0.1%	12,219	12,685	466	3.8%
Maternity Pathway	5,009	4,308	(701)	-14.0%	4,873	4,177	(696)	-14.3%
HIV	11,670	11,854	184	1.6%	2,141	2,131	(11)	-0.5%
Renal	5,009	4,308	(701)	-14.0%	5,258	5,002	(256)	-4.9%
Other	1,673,442	1,644,862	(28,580)	-1.7%	21,123	21,320	197	0.9%
PbR Excluded Drugs / Devices					28,472	29,786	1,314	4.6%
CQUINS					3,802	3,802	0	0.0%
Provision for challenge and Risk					(927)	(2,499)	(1,572)	169.6%
Phasing correction					(1,359)		1,359	-100.0%
					201,774	**203,309**	**1,535**	**0.8%**

Table 3 - Reconciliation to Income Reporting

Contract Monitoring Performance -(unadjusted)	481,205	200,471	202,002	1,531
CQUIN 2.5%	9,125	3,802	3,802	0
Contract Penalties / Adjustments (Estimated)	(2,225)	(2,499)	(2,495)	4
	488,104	**201,774**	**203,309**	**1,535**
Other Income from Activities				
NHS Trust / FT Income	8,343	3,473	3,140	(333)
Commissioning Income - Non Activity	9,581	4,057	2,771	(1,287)
Department Of Health Income	37	15	29	13
Private Patients Income	5,153	2,038	1,744	(294)
Injury Cost Recovery	2,501	1,042	622	(420)
Other Patient Related (remove MSK included above)	1,628	661	511	(150)
Local Authority Income (remove value included above)	451	203	204	1
Overseas Visitors Income	217	90	80	(10)
Income from Activities as reported in Income Section	**516,015**	**213,354**	**212,411**	**(944)**

Table 4 - Income from CCG's

	£'000		
	YTD Plan	YTD Actual	YTD Var
NHS BRIGHTON AND HOVE CCG	53,999	54,246	247
NHS COASTAL WEST SUSSEX CCG	6,258	6,893	635
NHS CRAWLEY CCG	1,387	1,316	(71)
NHS EASTBOURNE, HAILSHAM AND SEAFORD CCG	4,592	4,487	(106)
NHS HASTINGS AND ROTHER CCG	1,821	1,964	143
NHS HIGH WEALD LEWES HAVENS CCG	19,037	19,703	666
NHS HORSHAM AND MID SUSSEX CCG	27,298	27,595	298
NHS EAST SURREY	303	261	(43)
Dermatology SCDS	1,095	1,084	(12)
Commissioning Income CCG's	**115,790**	**117,548**	**1,758**

Finance Report Month 5 2017/18 — Income — A

For the year-to-August Income reports an underperformance of £0.6m, an improvement of £1.2m on the previous month. This is mainly due to a correction to PbR exclusions income, which was understated in July. The year-end forecast is for an adverse variance of £3.3m; this is principally due to CDF drug expenditure being lower than was included in the plan with a corresponding reduction in associated funding. Income from patient activity is based on 4 months actual activity and an estimate for August. A provision is held for contract adjustments and challenges.

Year-to-Date

	Plan £k	Actual £k	Variance £k
Total Income	**(229,927)**	**(229,328)**	**598**

Year-end Forecast

	Plan £k	Forecast £k	Variance £k
Total Income	**(555,706)**	**(552,421)**	**3,284**

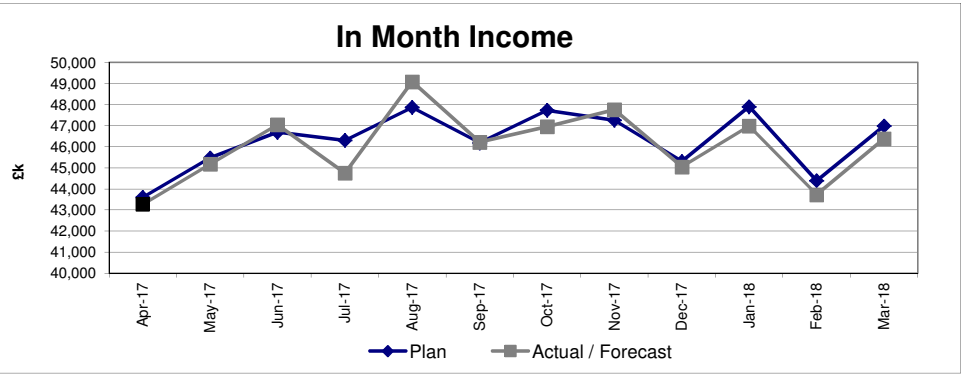
CCG activity and Other Patient Related Activity need to be considered together as the Sussex MSK Partnership income has been recategorised and there is a query as to where spinal activity should be coded. The underperformance against "Clinical Commissioning Groups - non Activity" is against the Cancer Drugs Fund which has reduced the number of drugs it funds and costs have reduced in line with this. Private Patient income is highly variable with an in month shortfall of £294k. The shortfall in research income is mainly due to commercial trials being lower than planned and is partly offset by reduced costs.

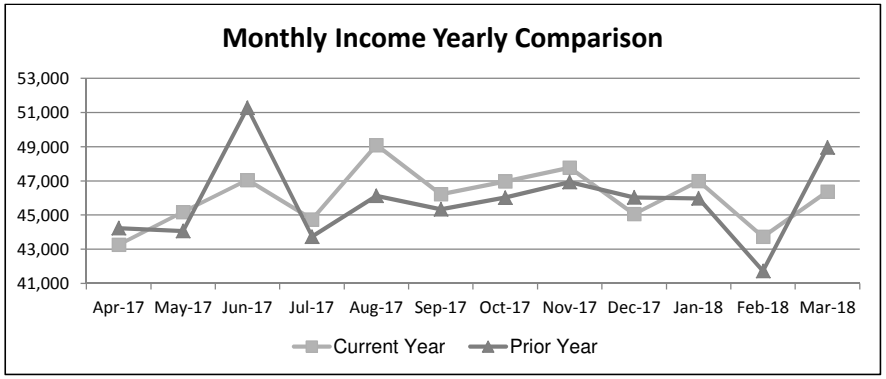
Year-to-Date

	PY Actual £k	Plan £k	Actual £k	Variance £k
Income				
NHS Trusts	(2,406)	(3,473)	(3,140)	333
Clinical Commissioning Groups - Patient Activity	(150,402)	(189,714)	(191,403)	(1,688)
Devolved Income	0	0	0	0
Clinical Commissioning Groups - non Activity	(2,307)	(4,057)	(2,771)	1,287
Clinical Commissioning Groups	(152,709)	(193,772)	(194,174)	(402)
Other NHS	(29)	(15)	(29)	(13)
Private Patients	(1,582)	(2,038)	(1,744)	294
Other Non-NHS	(518)	(1,042)	(622)	420
Other Patient Related Income	(8,380)	(11,065)	(10,510)	555
Local Authority Income	(1,751)	(1,860)	(2,111)	(251)
Overseas Visitors Income	(48)	(90)	(80)	10
Income From Activities	**(167,423)**	**(213,355)**	**(212,410)**	**945**
Education & Training Income	(8,925)	(11,321)	(11,313)	8
Research & Development Income	(1,066)	(1,870)	(1,280)	590
Transfers from Donated Asset Reserve		0	0	0
Income Generation	(836)	(1,052)	(998)	54
Other Income	(1,989)	(2,329)	(3,327)	(998)
Other Operating Income	**(12,816)**	**(16,572)**	**(16,918)**	**(346)**
Total Income	**(180,239)**	**(229,927)**	**(229,328)**	**598**
Of Which PBRX Drugs/Devices	(10,007)	(11,143)	(11,856)	(713)

Year-end Forecast

	Plan £k	Forecast £k	Variance £k
Income			
NHS Trusts	(8,343)	(8,070)	273
Clinical Commissioning Groups - Patient Activity	(458,926)	(460,333)	(1,407)
Devolved Income	0	0	0
Clinical Commissioning Groups - non Activity	(9,581)	(6,424)	3,158
Clinical Commissioning Groups	(468,507)	(466,756)	1,751
Other NHS	(37)	(50)	(13)
Private Patients	(5,153)	(5,014)	139
Other Non-NHS	(2,501)	(2,081)	420
Other Patient Related Income	(26,809)	(25,547)	1,262
Local Authority Income	(4,448)	(4,751)	(303)
Overseas Visitors Income	(217)	(194)	23
Income From Activities	**(516,015)**	**(512,464)**	**3,551**
Education & Training Income	(27,153)	(27,179)	(26)
Research & Development Income	(4,432)	(3,566)	867
Transfers from Donated Asset Reserve	0	0	0
Income Generation	(2,524)	(2,350)	174
Other Income	(5,581)	(6,863)	(1,282)
Other Operating Income	**(39,691)**	**(39,958)**	**(267)**
Total Income	**(555,706)**	**(552,421)**	**3,284**





Finance Report Month 5 2017/18 — Operating Costs — A

Operating costs to Month 5 are underspending against budgets, primarily in pay costs, although the savings plans have not been fully allocated as yet. At present the assumption is that the Trust will identify the required savings, manage the identified risks and reduce expenditure and therefore come in on budget, except for PbR excluded drugs which should be offset by additional income.

Year-to-date

	PY Actual £k	Plan £k	Actual £k	Variance £k
Pay	**118,354**	**151,576**	**148,491**	**(3,085)**
Non Pay	**73,279**	**91,140**	**92,673**	**1,534**
Operational Costs	**191,633**	**242,716**	**241,164**	**(1,552)**

Year-end Forecast

	Plan £k	Forecast £k	Variance £k
Pay	**362,840**	**360,101**	**(2,738)**
Non Pay	**218,936**	**218,080**	**(857)**
Operational Costs	**581,776**	**578,181**	**(3,595)**

Pay: costs in August were higher than in July, partly due to bank holiday pay enhancements, although are still lower than ytd budget. The Trust has around 1000 WTE vacancies (substantive contracted staff vs funded establishment), but exact figures are not available due to the junior doctor rotation in month. Some are covered by overtime and use of bank and agency staff, but the trend in the first 5 months has been that around 25% of nursing shifts have not been able to be filled.

Non-pay: overspending compared to budget overall, but includes overspends in PbR excluded and CDF drugs which is offset by additional income. The other big category of overspend is supplies and services clinical, offset with underspends across almost all other categories of expenditure. The team will be looking into this area in the following month.

The forecast assumes expenditure will be under plan overall with the exception of an overspend on clinical supplies, premises and outsourcing. The latter should be offset by income and/or reduced pay and materials costs.

Year-to-date

	PY Actual £k	Plan £k	Actual £k	Variance £k
Pay				
Management	5,385	7,185	6,523	(662)
Medical and Dental Staff	35,693	44,752	45,008	257
Nursing & Midwifery - Registered	35,650	46,240	44,724	(1,516)
Nursing & Midwifery - Unregistered	8,691	10,980	10,936	(44)
Other Healthcare	16,218	21,287	20,318	(970)
Ancillary Staff	4,757	5,908	5,925	17
Administrative & Clerical	10,938	14,562	13,679	(883)
Maintenance Staff	890	1,324	1,131	(193)
Other Staff	131	(661)	248	909
Total Pay	**118,354**	**151,576**	**148,491**	**(3,085)**
Non-Pay				
Drugs & Medical Gases - in tariff	3,879	5,296	5,150	(146)
Drugs & Medical Gases - PbR exclusion and CDF	22,366	26,777	27,990	1,213
Supplies and Services - Clinical - in tariff	18,535	22,334	23,464	1,130
Supplies and Services - Clinical - PbR exclusion	2,573	3,657	3,110	(547)
Supplies and Services General	2,324	2,945	2,808	(137)
Establishment Expenses	2,107	2,795	2,623	(172)
Transport Expenses	352	486	461	(26)
Premises	6,847	8,873	8,933	59
Purchase of Healthcare from Non NHS provider	2,390	2,830	3,021	191
Consultancy	178	506	384	(121)
Other Non Pay/Reserves	405	227	706	478
CNST Premium	7,174	8,968	8,967	(0)
Education and Training	1,145	1,551	1,357	(195)
Services from Other NHS Bodies	2,880	3,754	3,564	(190)
Audit Fees	90	113	94	(20)
Trust Chair & Non-Executive Directors	33	26	42	15
Total Non-Pay	**73,279**	**91,140**	**92,673**	**1,534**
Total Expenditure	**191,633**	**242,716**	**241,164**	**(1,552)**

Full-year

	Plan £k	Forecast £k	Variance £k
Pay			
Management	17,629	16,900	(730)
Medical and Dental Staff	107,633	107,564	(69)
Nursing & Midwifery - Registered	111,130	109,065	(2,065)
Nursing & Midwifery - Unregistered	26,338	25,809	(529)
Other Healthcare	51,670	49,316	(2,353)
Ancillary Staff	14,263	13,938	(324)
Administrative & Clerical	34,999	34,052	(947)
Maintenance Staff	3,177	2,905	(272)
Other Staff	(3,998)	553	4,551
Total Pay	**362,840**	**360,101**	**(2,738)**
Non-Pay			
Drugs & Medical Gases - in tariff	13,316	12,375	(941)
Drugs & Medical Gases - PbR exclusion and CDF	65,859	64,969	(889)
Supplies and Services - Clinical - in tariff	51,866	53,983	2,117
Supplies and Services - Clinical - PbR exclusion	8,767	8,034	(733)
Supplies and Services General	7,002	6,901	(101)
Establishment Expenses	6,857	6,424	(433)
Transport Expenses	1,124	1,104	(20)
Premises	20,824	21,093	269
Purchase of Healthcare from Non NHS provider	6,312	6,656	344
Consultancy	1,214	763	(451)
Other Non Pay/Reserves	1,220	1,443	223
CNST Premium	21,523	21,522	(0)
Education and Training	3,761	3,456	(305)
Services from Other NHS Bodies	8,957	9,018	60
Audit Fees	272	237	(34)
Trust Chair & Non-Executive Directors	63	100	37
Total Non-Pay	**218,936**	**218,080**	**(857)**
Total Expenditure	**581,776**	**578,181**	**(3,595)**

Finance Report Month 5 2017/18 — Payroll and Agency costs — G

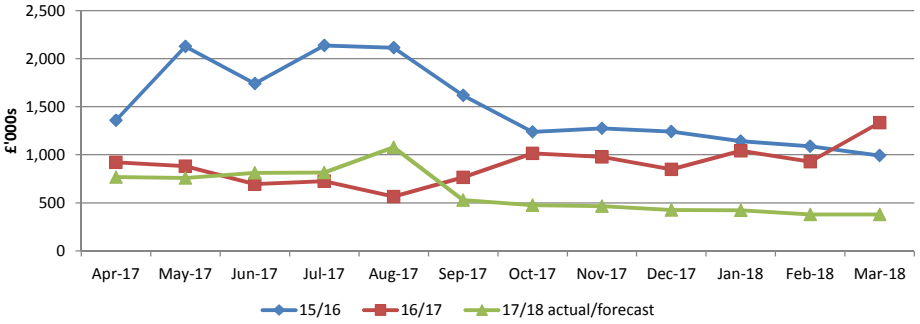
Agency costs of £4.8m represent 3.2% of the total pay bill and are well within the year-to-Month 5 agency cap of £5.3m. However, agency expenditure increased in-month and is greater than in same period in 16/17. This is due to an inablity to substantively fill posts. The total cost of agency, bank and substantive staff was well within the Month 5 pay budget.

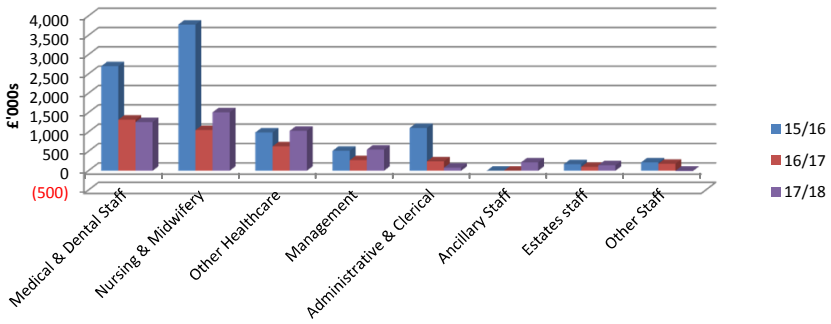
Year-to-date Agency

	15/16 £k	16/17 £k	Ceiling £k	Actual £k	Variance £k
Medical & Dental Staff	2,700	1,317	1,598	1,255	(343)
Nursing & Midwifery	3,777	1,048	2,021	1,508	(513)
Other Healthcare	989	629	722	1,031	309
Management	514	273	225	546	321
Administrative & Clerical	1,104	243	493	79	(413)
Ancillary Staff	0	0	221	218	(2)
Estates staff	171	99	41	142	101
Other Staff	217	182	12	(12)	(24)
Trust	**9,472**	**3,790**	**5,332**	**4,769**	**(564)**

Compliance with Agency Cap rates

Work is under way as to set up a system to gather this information.





Payroll

(Excludes non executive directors)

	Prior year actual £k	Plan £k	Actual £k	Variance £k
Medical & Dental Staff	41,172	44,004	43,753	(250)
Nursing & Midwifery	53,765	56,922	54,151	(2,771)
Other Healthcare	19,065	21,031	19,287	(1,744)
Management	5,368	6,990	5,977	(1,013)
Administrative & Clerical	13,138	14,510	13,599	(911)
Ancillary Staff	6,043	5,806	5,707	(99)
Maintenance Staff	994	1,293	988	(304)
Other Staff	76	(731)	260	991
Trust	**139,621**	**149,825**	**143,722**	**(6,103)**

Staff in post inc bank staff

	Prior year actual WTE**	Plan WTE	Actual WTE	Variance WTE
Medical & Dental Staff	997	1,185	1,128	(58)
Nursing & Midwifery	3,503	3,562	3,395	(168)
Other Healthcare	1,108	1,285	1,139	(146)
Management	185	244	197	(47)
Administrative & Clerical	1,107	1,288	1,178	(109)
Ancillary staff	556	613	578	(35)
Maintenance Staff	71	85	63	(23)
Other Staff	14	13	16	3
Trust	**7,540**	**8,275**	**7,693**	**(582)**

** Before 17/18 Bank staff WTEs were only reported for Nursing & Midwery

Finance Report Month 5 2017/18 — 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 updated NHSI plan submitted in June 2017.

	1 April 17	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	386,263	421,227	395,432	(25,795)	1	495,307	450,420	(44,887)	
Intangible Assets	681	666	666	0		645	645	0	
Other Assets	4,149	4,198	3,576	(622)		3,878	3,256	(622)	
Non Current Assets	**391,093**	**426,091**	**399,674**	**(26,417)**		**499,830**	**454,321**	**(45,509)**	
Inventories	8,109	8,403	8,023	(380)		8,241	7,861	(380)	
Trade and Other Receivables	50,477	44,492	46,505	2,013	2	46,065	51,078	5,013	
Cash and Cash Equivalents	7,407	3,297	9,201	5,904		3,668	3,669	1	
Non Current Assets Held for Sale	0	0	0	0		0	0	0	
Current Assets	**65,993**	**56,192**	**63,729**	**7,537**		**57,974**	**62,608**	**4,634**	
Trade and Other Payables	(69,574)	(61,605)	(69,629)	(8,024)	2	(70,103)	(72,561)	(2,458)	
Borrowings	(7,377)	(7,377)	(7,600)	(223)	3	(8,201)	(7,524)	677	
Other Financial Liabilities	0	0	0	0		0	0	0	
Provisions	(4,136)	(4,571)	(2,859)	1,712		(1,071)	(1,859)	(788)	
Other Liabilities	0	0	0	0		0	0	0	
Current Liabilities	**(81,087)**	**(73,553)**	**(80,088)**	**(6,535)**		**(79,375)**	**(81,944)**	**(2,569)**	
Borrowings	(195,264)	(224,681)	(223,288)	1,393	3	(283,915)	(257,410)	26,505	
Trade and Other Payables	0	0	(17)	(17)		(200)	(217)	(17)	
Provisions	(1,937)	(1,942)	(1,906)	36		(1,970)	(1,934)	36	
TOTAL ASSETS EMPLOYED	**178,798**	**182,107**	**158,104**	**(24,003)**		**192,344**	**175,424**	**(16,920)**	
Financed by:									
Public Dividend Capital	(294,776)	(327,061)	(301,788)	25,273	3	(389,693)	(371,605)	18,088	
Retained Earnings	167,206	167,206	167,205	(1)		167,206	167,205	(1)	
(Surplus)/Deficit for Year	0	28,976	27,707	(1,269)		81,371	80,204	(1,167)	
Revaluation Reserve	(51,228)	(51,228)	(51,228)	0		(51,228)	(51,228)	0	
TOTAL TAXPAYERS EQUITY	**(178,798)**	**(182,107)**	**(158,104)**	**24,003**		**(192,344)**	**(175,424)**	**16,920**	

1. The capital programme is behind plan. The 3Ts programme forecast is based on the revised cashflow from the main contractor and that has pushed a material amount of expenditure into 18/19. The operational programme is progressing, but many schemes are at planning rather than implementation stage so expenditure is still minimal compared to the plan.
2. Some more legacy debts have been paid and almost all the monthly SLA payments are being made on time so overall trade and other receivables has improved. The trade and payables balance is lagging behind with large intra NHS balances contributing to this variance.
3. PDC drawdown is based on the actual and forecast 3Ts expenditure which is running behind the original plan; the full year forecast is lower because of the revised 3Ts expenditure forecast, but this is offset to a certain extent by the switch in the basis of funding for the emergency capital work which is now assumed to be PDC rather than loans. This also accounts for the material variance in borrowings for the full-year forecast.

Finance Report Month 5 2017/18 — Cash — G

The plan reflects the June NHSI return and is based on achievement of the control total for the year. Capital funding for 3Ts and the Radiotherapy East scheme is in place for the year; all of the Radiotherapy East Scheme funding has been drawn down, the 3Ts funding is being drawn down to match capital expenditure, subject to utilisation of internal funding soruces first. Funding for the other strategic schemes (ED - £15m, Backlog Maintenance - £19m, and Pathology - £1m) is subject to approval from NHSI, but the associated income and expenditure cashflows are included in the full-year cashflow forecast. In the plan this was financed by loans, but on the advice of NHSI it is now assumed that it will be by PDC, and this accounts for the full-year variances in the debt drawdown and PDC. The year-to-date variances on capital and PDC reflect the changed 3Ts outturn for the year and the low expenditure on capital to date.
Revenue deficit funding is based on the control total deficit of £65.4m for the year, phased according to the monthly deficit. The drawdown is based on the actual revenue results and revised forecast for the year. The Trust has received £28.4m to date and with £5.5m payable in September. The year-to-date cash holding is above plan because of receipts paid over late in the month. The year-end level of cash holding has been 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 and is dependent on achievement of the planned control total and planned revenue funding.

Year-to-date

	Plan £k	Actual £k	Variance £k
Cash Balance	**3,297**	**9,201**	**5,905**

Year-End Forecast

	Plan £k	Forecast £k	Variance £k
Cash Balance	**3,668**	**3,669**	**1**

Year-to-Date

	Plan £k	Actual £k	Variance £k
EBITDA	(12,789)	(11,836)	954
Non Cash I&E Items	0	0	0
Movement in Working Capital	(5,459)	(5,603)	(144)
Provisions	(3,607)	(2,469)	1,138
Cashflow from Operations	**(21,855)**	**(19,908)**	**1,948**
Capital Expenditure	(42,178)	(11,773)	30,405
Cash receipt from asset sales	0	0	0
Cashflow before financing	**(64,033)**	**(31,681)**	**32,353**
PDC Received	32,285	7,012	(25,273)
PDC Repaid	0	0	0
Dividends Paid	0	0	0
Interest on Loans and leases	(1,796)	(1,796)	0
Interest received	17	12	(5)
Drawdown on debt	30,774	30,410	(364)
Repayment of debt	(1,357)	(2,163)	(806)
Cashflow from financing	**59,923**	**33,475**	**(26,448)**
Net Cash Inflow / (Outflow)	**(4,110)**	**1,794**	**5,905**
Opening Cash Balance	7,407	7,407	-
Closing Cash Balance	**3,297**	**9,201**	**5,905**

Year-End Forecast

	Plan £k	Forecast £k	Variance £k
EBITDA	(26,070)	(25,760)	310
Non Cash I&E Items	0	0	0
Movement in Working Capital	(4,726)	(10,871)	(6,145)
Provisions	(6,955)	(3,327)	3,628
Cashflow from Operations	**(37,751)**	**(39,958)**	**(2,207)**
Capital Expenditure	(134,611)	(89,513)	45,098
Cash receipt from asset sales	0	0	0
Cashflow before financing	**(172,362)**	**(129,471)**	**42,891**
PDC Received	94,917	76,829	(18,088)
PDC Repaid	0	0	0
Dividends Paid	(6,336)	(5,448)	888
Interest on Loans and leases	(9,471)	(7,974)	1,497
Interest received	38	33	(5)
Drawdown on debt	95,547	68,365	(27,182)
Repayment of debt	(6,072)	(6,072)	0
Cashflow from financing	**168,623**	**125,733**	**(42,890)**
Net Cash Inflow / (Outflow)	**(3,739)**	**(3,738)**	**0**
Opening Cash Balance	7,407	7,407	-
Closing Cash Balance	**3,668**	**3,669**	**1**

Finance Report Month 5 2017/18 — Rolling Cashflow — A

The rolling cashflow spans two financial years and starts with the current month's actual results which are forecast forward for another eleven months, to provide a full forward year cashflow forecast.

Year-to-Date	Plan £k	Actual £k	Variance £k	Year-End Forecast	Plan £k	Forecast £k	Variance £k
	3,297	9,201	5,905		3,668	3,669	1

	Aug-17 £k Act	Sep-17 £k For	Oct-17 £k For	Nov-17 £k For	Dec-17 £k For	Jan-18 £k For	Feb-18 £k For	Mar-18 £k For	Apr-18 £k For	May-18 £k For	Jun-18 £k For	Jul-18 £k For
EBITDA	(442)	(1,827)	(1,103)	(491)	(2,939)	(1,275)	(4,437)	(1,853)	(3,267)	(3,470)	(478)	(43)
Non Cash I&E Items	0	0	0	0	0	0	0	0	0	0	0	0
Movement in Working Capital	(2,814)	(2,504)	(1,765)	(2,233)	4,256	10,325	(11,326)	(2,021)	11,272	(1,321)	(3,733)	(1,082)
Provisions	175	26	(1,000)	81	35	0	0	0	(5,013)	17	(18)	(3)
Cashflow from Operations	(3,081)	(4,305)	(3,868)	(2,643)	1,352	9,050	(15,763)	(3,874)	2,992	(4,774)	(4,229)	(1,128)
Capital Expenditure	(2,701)	(5,009)	(9,098)	(10,399)	(16,677)	(23,873)	(251)	(12,433)	(13,623)	(7,115)	(7,544)	(6,868)
Cash receipt from asset sales	0	0	0	0	0	0	0	0	0	0	0	0
Cashflow before financing	(5,782)	(9,314)	(12,966)	(13,042)	(15,325)	(14,823)	(16,014)	(16,307)	(10,631)	(11,889)	(11,773)	(7,996)
PDC Received	0	3,509	10,743	10,263	9,622	10,441	10,745	14,494	6,008	7,279	7,336	7,054
PDC Repaid	0	0	0	0	0	0	0	0	0	0	0	0
Dividends Paid	0	(2,079)	0	0	0	0	0	(3,369)	0	0	0	0
Interest on Loans and leases	(215)	(1,670)	(215)	(632)	(215)	(215)	(1,362)	(1,869)	(215)	(428)	(215)	(215)
Interest received	3	3	3	3	3	3	3	3	4	4	4	4
Drawdown on debt	4,791	5,501	3,945	4,603	6,381	4,127	7,975	5,423	4,975	4,975	4,975	4,975
Repayment of debt	(1,242)	(873)	(124)	(548)	(125)	(124)	(1,242)	(873)	(124)	(548)	(125)	(124)
Cashflow from financing	3,337	4,391	14,352	13,689	15,666	14,232	16,119	13,809	10,648	11,282	11,975	11,694
Net Cash Inflow / (Outflow)	(2,445)	(4,923)	1,386	647	341	(591)	105	(2,498)	17	(607)	202	3,698
Opening Cash Balance	11,646	9,201	4,278	5,664	6,311	6,652	6,062	6,167	3,669	3,686	3,079	3,281
Closing Cash Balance	9,201	4,278	5,664	6,311	6,652	6,062	6,167	3,669	3,686	3,079	3,281	6,979

Finance Report Month 5 2017/18 — 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	**37,806**	**16,705**	**(21,101)**
Operational Capital	**6,060**	**1,853**	**(4,207)**
Total	**43,866**	**18,558**	**(25,308)**

Year-end Forecast

	Plan £k	Forecast £k	Variance £k
Strategic Capital	**128,620**	**83,850**	**(44,770)**
Operational Capital	**23,332**	**23,761**	**429**
Total	**151,952**	**107,611**	**(44,341)**

Strategic Capital The 3Ts plan for 2017/18 was based on the FBC contractual cashflows. Construction of the Clinical Admin Building continues to progress and the Main Scheme piling re-commenced following the removal of asbestos from the Eastern side of the site which has allowed excavation works to progress. Work on the helideck framework is progressing and work continues in the Hanbury building to rectify defects and enable the Radiopharmacy service to obtain a Medicines and Healthcare products Regulatory Agency (MHRA) licence. The main buildings work and installation for the Radiotherapy East scheme is complete, but there is some IT work to be completed prior to the finalisation of the scheme. The ED, Backlog Maintenance and Pathology schemes are subject to approval from NHSI and DH. The Emergency application is working its way through the approval process and is expected to be approved very shortly. On NHSI advise the funding source is assumed to be PDC. Forecasts have been updated to reflect the expected expenditure in-year, but the in-year phasing is subject to change depending on approval dates and detailed work plans. The Pathology business case is awaiting agreement to proceed to FBC so the forecast assumes minimal spend in-year and may slip into next year.

Operational Capital The plan is based on the plan approved by the Board in June. Progress with the plan implementation is still very slow with minimal expenditure having been incurred in August. Procurement are progressing the equipment schemes and IT has a prepared a detailed work plan which was approved at the Capital Committee for implementation so it is expected that expenditure will increase in the latter part of September and October. The phasing of plans for Procurement and Estates is underway and will be completed for the next Capital Expenditure Committee meeting. The approved plan includes an element of over-programming in line with previous years and will be subject to change during the year dependent on progress on schemes. The over-programming amounts to £5.3m (23%).

	Plan £k	Actual £k	Variance £k
Source of Funds - (CRL)	**(43,766)**	**(17,546)**	**(26,220)**
Expenditure			
Strategic Capital			
3Ts	35,387	15,771	19,616
ED	0	214	(214)
Backlog Maintenance	0	0	0
Pathology	0	0	0
Radiotherapy East	2,419	720	1,699
Total Strategic Capital	**37,806**	**16,705**	**21,101**
Operational Capital			
Major Projects (>£1m)			
LINAC Replacement	450	25	425
Acute Floor Reconfiguration	747	377	370
Electrical Substation - TKT Services	600	735	(135)
Replacement CT PRH	0	1	(1)
Small Projects (<£1m)			
Medical Equipment Replacement	2,050	128	1,922
IM&T Infrastructure	900	97	803
Estates Infrastructure	950	158	792
Service Development	263	203	60
Charitably Funded Schemes	100	129	(29)
Total Operational Capital	**6,060**	**1,853**	**4,207**
(Under)/Overspend against CRL	**100**	**1,012**	**(912)**

	Plan £k	Forecast £k	Variance £k
Source of Funds - (CRL)	**(147,112)**	**(102,218)**	**(44,894)**
Expenditure			
Strategic Capital			
3Ts	98,019	45,998	52,021
ED	15,000	14,966	34
Backlog Maintenance	7,500	19,467	(11,967)
Pathology	5,682	1,000	4,682
Radiotherapy East	2,419	2,419	0
Total Strategic Capital	**128,620**	**83,850**	**44,770**
Operational Capital			
Major Projects (>£1m)			
LINAC Replacement	1,038	1,038	0
Acute Floor Reconfiguration	747	749	(2)
Electrical Substation - TKT Services	929	929	0
Replacement CT PRH	1,296	1,296	0
Small Projects (<£1m)			
Medical Equipment Replacement	3,299	3,474	(175)
IM&T Infrastructure	6,382	6,382	0
Estates Infrastructure	6,153	6,207	(54)
Service Development	3,186	3,186	0
Charitably Funded Schemes	302	500	(198)
Total Operational Capital	**23,332**	**23,761**	**(429)**
(Under)/Overspend against CRL	**4,840**	**5,393**	**(553)**

Finance Report Month 5 2017/18 — Aged Debtors

The Trust debtors are a mixture of invoiced debtors, accrued income and prepayments. The level of invoiced debtors has decreased by £6.5m since the end of July and the value of overdue debts has decreased by £2.2m.

Invoiced Debtors	Within Terms 1-30 Days	1 Month Overdue 31-60 Days	2 Months Overdue 61-90 Days	3 Months Overdue Over 90 Days	Total	Current Month Over 30 Days	Prior Month Over 30 Days	Notes
	£k	£k	£k	£k		£k	£k	
CCGs	732	257	267	5,932	7,188	6,456	8,182	1
Trusts	540	745	347	3,901	5,533	4,993	4,963	2
Other NHS	78	16	64	692	850	772	1,888	3
Other Debtors	1,174	651	167	1,550	3,542	2,368	1,961	4
Private Patients	231	432	52	794	1,509	1,278	1,035	5
Overseas	20	8	12	363	403	383	379	
Total Invoiced Debtors	**2,775**	**2,109**	**909**	**13,232**	**19,025**	16,250	18,408	
Provision for Bad Debts (including RTA Provision)					(5,873)			
Accrued Income					24,023			
Prepayments					7,522			
Other Debtors					1,808			
Total Trade & Other Receivables					**46,505**			

Other Receivables	Current Month	Prior Month
		£k
Accrued Income		
Work In Progress	3,978	3,978
CCG Service Level Agreements	8,691	4,565
Injury Cost Recovery Fund	2,666	2,562
Other	8,688	7,708
Total Accrued Income	**24,023**	**18,813**
Prepayments		
Maintenance & Other Contracts	1,020	4,536
NHS Litigation	1,818	1,454
Other	4,684	1,257
Total Prepayments	**7,522**	**7,247**

1. CCGs. The CCGs overdue balance has improved by £1.7m and will improve with the settlement of some the remaining legacy balances which are: invoices for 3Ts support (£1.2m and which has been agreed to be paid), shortfalls from 16/17 SLA payments (£0.6 - of which £167k is being paid in September), resilience funding (£1m), 15/16 arbitration settlement invoices (£0.6m), final SLA settlement 16/17 (£1.7m - of which £1.4 is expected in October). The NCA debtors over 30 days have increased by £10k and the over 90 days have remained the same as July.

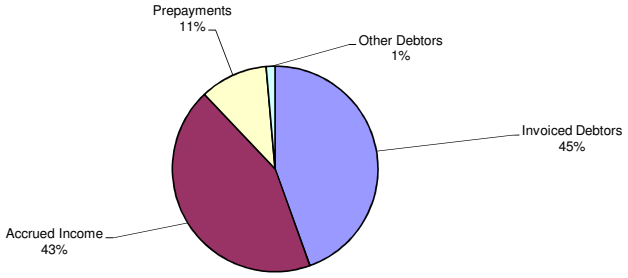
2. Trusts. Local organisations continue to account for 93% of the total debt and progress to clear these is slow. The payment on account from the largest debtor (pending resolution of the longstanding disagreement on the SLA) is now expected in September and will be part of a cashflow payment plan. Work on the other local organisation's creditor balances is nearing completion which should release payment of the Trust's outstanding debtor balances.

3. Other NHS. The over 30 days has improved with the settlement of the HEP C drugs invoice of £1.1m. The balance left includes the legacy EPR debt of £627k.

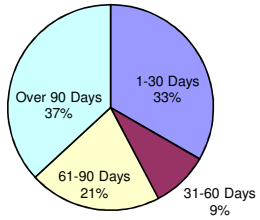
4. Other Debtors. The over 30 days balance has increased by £407k which is mainly due to a shortfall on the SMSKP contract. The other material debtor in this category is the University of Sussex account which is on hold pending resolution of SIFT payments between the two organisations; this is near resolution.

5. Private Patient overdue debts have improved by £4k.

Trade and Other Receivables



Invoiced Debtors Ageing



Finance Report Month 5 2017/18

Clinical Directorate Performance (1 of 2)

Abdominal:

Income

Income exceeds plan due to the significant increase in Hep C treatment patients resulting in higher than expected PbR excluded income. This is expected to fall back in line with plan later in the year, subject to treatment numbers currently being agreed with NHSE.

Pay

The pay variance is driven by on-going medical staffing cost pressures. The majority of these started in prior financial years and are the subject of business cases, funding for which has been earmarked in Reserves. The business cases will be informed by the capacity and demand analysis currently being undertaken.

Non-pay

The Non-Pay PBR excluded drugs expenditure is significantly higher than plan, offsetting the higher than plan income. In-tariff non-pay is marginally higher than plan with activity driving higher than plan drug costs offset by savings in outsourcing.

	PY Actual	Plan	Actual	Variance	RAG
	£k	£k	£k	£k	
Income	(17,942)	(3,477)	(3,788)	(312)	G
Pay	6,980	6,890	7,433	543	R
Non-Pay (tariff)	3,013	2,179	2,187	8	R
Non-Pay (PBR exc & CDF)	2,851	3,174	3,520	345	R
EBITDA *	(5,099)	8,766	9,351	585	R

Acute Floor:

Income: Not all CCG funded GP posts at PRH have GPs in post, with a corresponding underspend in pay. Pay: The underspend is due to consultant and junior medical vacancies in ED and Critical Care along with nursing vacancies in critical care and acute medicine. This is partly offset by nursing agency and bank usage in RSCH ED (sickness cover plus additional shifts over and above template), PRH ED (sickness cover), AMU (high usage of bank staff due to sickness & acuity) and RSCH ITU (using a non-framework agency).

Non-pay: The underspend from RSCH ITU, PRH ITU & PRH ED clinical supplies is a continuing trend but is partly offset by drugs overspend in ITU.

	PY Actual	Plan	Actual	Variance	RAG
	£k	£k	£k	£k	
Income	(20,338)	(730)	(650)	80	R
Pay	16,410	16,716	16,378	(339)	G
Non-Pay (tariff)	2,158	1,932	2,035	103	R
Non-Pay (PBR exc & CDF)	88	68	31	(37)	G
EBITDA *	(1,682)	17,986	17,794	(192)	G

Cancer:

Income: Underperformance has been driven by a changing CDF criteria; this has resulted in spend reducing by 70% on the previous year and whilst PBRX Drugs Income has shown a significant in-month surge, this is still not sufficient to offset YTD CDF variances. Non-Pay CDF & PBRX show a matching underspend. Other soucres of income (SLA's, Macmillan \ grant funding) are over-achieving.

Pay: Overspent due to Medical Staff (£75k Medical Agency/Bank/Locum in-month overspend in Haematology), Nursing (ongoing agency premium re chemotherapy nurses at the new PRH Unit) and A&C extra Pathway Co-ordinators and bank usage due to increasing activity. This is partly offset by Other Healthcare underspend which is linked to delays with the new Eastbourne Unit and difficulties in recruitment.

Non-Pay: An overall underspend YTD due to CDF criteria changes, but with an in-month spike in PBR X drugs. Investigation has clarified this as a one-off occurrence. However there are overspends on Outsourcing (staffing issues in Radiotherapy areas & in Medical staff at Preston Park Breast Centre).

	PY Actual	Plan	Actual	Variance	RAG
	£k	£k	£k	£k	
Income	(19,947)	(8,781)	(8,741)	40	R
Pay	7,152	7,530	7,652	122	R
Non-Pay (tariff)	2,119	1,238	1,345	107	R
Non-Pay (PBR exc & CDF)	6,357	7,670	7,486	(183)	G
EBITDA *	(4,320)	7,657	7,742	85	R

Cardiovascular:

Income: PbR excluded income is below plan by £229k and offset by reduced expenditure. Cardiac Private patient activity is still behind plan by £259k but the directorate is confident activity will catch up in the following months as consultants have existing waiting lists. The summer months have been cited as usually quiet for private patient activity.

Pay: The overspend of £180k is primarily Nursing in Cardiac (£159k) including the effect of continued bank and agency use for 6A day case ward for medical outliers, additional HCAs and security employed on level 10 for specialling patients (one patient needed 24 hour security for 5 weeks).

Non-pay: The favourable variance on PbR excluded non-pay expenditure is offset by PbR excluded income. Of the £771k unfavourable variance on other non pay, £696k relates to Medical & Surgical supplies across the three specialties with £197k of this variance having been recognised as needing to be transferred to PbR excluded expenditure in September 2017. The remainder of the variance can be being attributed to increased activity (contract income is £562k above plan as at the end of August 2017), which is not delegated this year.

	PY Actual	Plan	Actual	Variance	RAG
	£k	£k	£k	£k	
Income	(29,065)	(5,048)	(4,496)	552	R
Pay	11,289	12,059	12,239	180	R
Non-Pay (tariff)	6,189	5,931	6,702	771	R
Non-Pay (PBR exc & CDF)	3,080	3,296	3,072	(224)	G
EBITDA *	(8,506)	16,238	17,517	1,279	R

Central Clinical Services

Income

The income variance is due to reduced income (£308k) within Pathology (Micro and Biochem), offset by overachievement of PBRX income in Imaging and Dietetics, along with some additional SLA income in Pharmacy.

Pay

The underspend is due to vacancies in Imaging (19wte), Pathology (14wte), Physiotherapy (14wte) & Pharmacy (14wte). Although some shifts have been filled by agency and bank staff there were still significant gaps.

Non Pay

The unfavourable variance is driven by increased expenditure with Roche on patient activity and higher demand for Blood products. In addition, the outsourcing of Histology activity due to cancer targets within Pathology and continued outsourcing of Ultrasound and PET CT scans in Imaging are increasing costs. Non Pay (PBRX) underspends mainly relate to lower drugs spends in Pathology, and offsets income under-achievement.

	PY Actual	Plan	Actual	Variance	RAG
	£k	£k	£k	£k	
Income	(12,113)	(3,265)	(3,065)	201	R
Pay	17,393	18,226	17,855	(371)	G
Non-Pay (tariff)	8,462	8,642	9,039	397	R
Non-Pay (PBR exc & CDF)	587	687	567	(120)	G
EBITDA *	14,329	24,290	24,397	107	R

Children's Services:

Income: The unfavourable variance is driven by Credit memo's for CCG income for Health visitor posts. PP income is below target due to a central adjustment reversal. The plan around this may need to be reviewed.

Pay: A favourable pay variance is due to nursing vacancies. This is partly offset by a significant overspend in medical consultants due to unfunded posts and the covering of middle grade vacancies. Business cases are being drawn up to address this issue.

Non-Pay: The unfavourable variance is due to the receipt of delayed invoices and in month corrections to PbR drugs expenditure for CF drugs. Also CGM equipment has been coded as PbR which the CCG are disputing. Negotiations are ongoing to resolve this. Healthcare from Other NHS bodies also adverse due to ongoing accruals for Paediatric Outreach Services.

	PY Actual	Plan	Actual	Variance	RAG
	£k	£k	£k	£k	
Income	(18,139)	(1,041)	(971)	70	R
Pay	9,589	9,943	9,911	(32)	G
Non-Pay (tariff)	1,480	1,479	1,552	73	R
Non-Pay (PBR exc & CDF)	531	611	620	9	R
EBITDA *	(6,539)	10,992	11,112	119	R

Head and Neck:

Income: PP income in Ophthalmology is down due to long stay patients on the ward. The income from other NHS organisations is down as the number of sessions we provide has reduced. The directorate is currently reviewing and agreeing these charges with the relevant Trusts. Pay: Nursing is overspending and is driven by bank use in the Outpatients and A&E dept in Ophthalmology and in PRH Outpatients due to the additional clinics that are being run by other specialties. Also there is an overspend on healthcare scientists in medical photography from the work relating to the SI.

Non-Pay: The expenditure on drugs and corneal implants in Ophthalmology is up and is related to the additional activity that is being seen.

	PY Actual £k	Plan £k	Actual £k	Variance £k	RAG
Income	(11,212)	(1,586)	(1,552)	33	R
Pay	4,496	4,435	4,425	(10)	G
Non-Pay (tariff)	1,532	1,314	1,375	61	R
Non-Pay (PBR exc & CDF)	1,046	1,278	1,260	(18)	G
EBITDA *	(4,139)	5,441	5,508	66	R

Musculoskeletal:

Income: Rheumatology PBRX income over-achievement is the only material variance & is linked with the introduction of new treatment regimes. This Income is matched by a Non-Pay PBRX Drug overspend. However the directorate has under-achieved it's Central Income Target by £1.4m, largely T&O inpatient activity, below planned activity (elective) and earning less per case (non-elective)

Pay: Pay budgets broke-even in August. Medical pay remains overspent with Jr Dr costs for August significantly above trend and Consultant costs have increased due to both a new starter & overtime payments. Nursing vacancies continue to contribute to the underspend, but the in-month performance is worse than forecast or expected. There are on-going recruitment issues linked to the PRH site which also impacts on the ability to cover vacancies with Bank staff.

Non-Pay:

The PBRX Drug overspend is linked to the Income overachievement & unrelated to any other Non-Pay underspends. The biggest of these is for Clinical Supplies, which are at a low level due to low activity YTD. The drivers for this include dropped sessions, changes in case mix & the reduced costs due to procurement savings. Forecasts have been updated to reflect these & it is hoped that this will help contribute to the overall underspend.

	PY Actual £k	Plan £k	Actual £k	Variance £k	RAG
Income	(19,867)	(3,635)	(3,776)	(142)	G
Pay	6,728	6,896	6,645	(251)	G
Non-Pay (tariff)	3,799	3,753	3,543	(210)	G
Non-Pay (PBR exc & CDF)	3,023	3,585	3,722	137	R
EBITDA *	(6,318)	10,599	10,133	(466)	G

Neurosciences and Stroke Services:

Income: Above plan due to PBRX Homecare and Hospital Drugs income (YTD overachieved by £421k) offset by underachieved Private patients, Neuroservices and Neurophysiology activity income of £37k, £39k and £59k, respectively.

Pay: Underspent which is mainly driven by large number of Nursing vacancies (45 WTE at M5) mainly at Level 8, Nursing theatres, Ardingly and Lindfield Wards resulting in an overall YTD underspend of £169k for Nursing. Other Health care staff underspends by £43k due mainly to vacancies (2.12 WTE @ M5) offset by overspend of £44k against A&C line due to unfunded posts.

Non Pay Overspend against in tariff expenditure largely driven by MRI outsourcing to Medica(£65k) and Neuropathology activity recharges from UCLH (£38k).Overspend against PBRX (£423k) offset against the overachieved PBRX drugs income line.

	PY Actual £k	Plan £k	Actual £k	Variance £k	RAG
Income	(14,694)	(4,649)	(4,942)	(293)	G
Pay	7,913	8,273	8,107	(165)	G
Non-Pay (tariff)	2,486	1,806	1,969	162	R
Non-Pay (PBR exc & CDF)	3,489	4,151	4,575	423	R
EBITDA *	(806)	9,582	9,709	127	R

Perioperative:

Income: Over achievement against income attributed to increased Private patients income (£160k) due to accurate PP data recording system.

Pay: Additional theatre sessions run resulted in Medical staff pay costs continued to overspend (YTD £195k), the service is currently dealing with 3.8% increased activity on 2016/17. Collective underspend of £102k against Nursing and Scientific staff costs due to high levels of staff turnover/ vacancies not fully backfilled by agency and bank staff at Theatres across the two sites.

Non pay: The overspend on non-pay is also attributed to increased activity/sessions, with theatres across the two sites and Sterile services at RSCH overspending for clinical and General supplies and Anaesthetics equipment lines.

Cessation of cross charges for extra sessions to other specialties has also resulted in a cost pressure for the service.

	PY Actual £k	Plan £k	Actual £k	Variance £k	RAG
Income	(202)	(198)	(328)	(131)	G
Pay	10,742	11,328	11,395	67	R
Non-Pay (tariff)	2,454	2,437	2,694	257	R
Non-Pay (PBR exc & CDF)				0	A
EBITDA *	12,994	13,568	13,762	194	R

Speciality Medicine:

Income: PBRX income has reduced in Respiratory, Diabetes and HIV, benefitting from switches to generic drugs, and SLA income from NHS Trusts and CCGs is behind plan largely due to a lack of medical staff to fulfil the SLA requirements.

Pay: The underspend relates to high levels of Nursing vacancies, not fully covered by flexible staff, and medical vacancies. There are also some posts being left vacant to achieve CIP targets non recurrently.

Non-Pay (tariff) overspends are due to archiving costs for HIV \ GUM records, CPAP machine purchases (Respiratory) relating to RTT backlog, drugs pressures in Respiratory and HIV and additional Pathology charges relating to tests for Dermatology. Patient activity is over plan, principally in Respiratory and Elderly.

Non-pay (PBRX) is underspent because a lower value of drugs & devices have been issued, again benefitting from switches to generic drugs.

There are outstanding budget adjustments for Newhaven Downs to increase funds available but in turn there are also adjustments to be made to reduce budgets where CIP is being applied.

	PY Actual £k	Plan £k	Actual £k	Variance £k	RAG
Income	(28,788)	(6,510)	(6,109)	401	R
Pay	10,332	11,113	11,032	(80)	G
Non-Pay (tariff)	3,340	2,346	2,765	419	R
Non-Pay (PBR exc & CDF)	5,982	6,220	5,915	(305)	G
EBITDA *	(9,135)	13,168	13,603	435	R

Women's Services:

Pay: Underspend against pay lines are mainly driven by Nursing & Midwifery line (£150k) due to vacancies in wards at Bolney, Horsted Keynes and Level 11 (RSCH). This is partly offset by Medical Pay (£60k), which is overspent due to over established training grades staff providing cover for rota gaps due to Consultant and SAS Doctors vacancies. In addition, use of agency consultants and locums covering sickness and absences also contributing towards the Medical overspend.

Non Pay: High levels of Maternity pathway recharges from other trusts are driving the overspend against the non-pay lines

	PY Actual £k	Plan £k	Actual £k	Variance £k	RAG
Income	(13,708)	(191)	(204)	(12)	G
Pay	7,831	7,946	7,830	(116)	G
Non-Pay (tariff)	961	943	960	16	R
Non-Pay (PBR exc & CDF)	2	1	2	1	R
EBITDA *	(4,915)	8,699	8,588	(111)	G

Finance Report Month 5 2017/18

Departmental Performance

Facilities and Estates:

Income: YTD £101k adverse - principally due to loss of note taking facility in parking fee machines at PRH; income reduced by £24k in month and £122k ytd. The business case to purchase new machines has been approved and is awaiting action on behalf of procurement.
Pay: YTD (£285k) - Soft FM adverse against plan in month £147k the effect of the M01-05 CIP adjustment put through, YTD £26k better than plan. YTD - £117 Security services - 4wte's vacant, Estates £137k - 21 wte's vacant. EBME - £56k better than plan due to 2 wte posts left to fill.
Non pay: YTD £108k adverse, in month £161k adverse. Due in the main to a combination of adverse variances on backlog maintenance £340k in month and £382k YTD - Barry Building Boilers, Chiller – Sussex Cancer Centre and Load Bank Testing & Generator Maintenance , CIPS budgets not allocated out to services YTD (£133k) and £34k on utilities. These are offset by a rate rebate of (£117k) and under spending in Soft FM YTD (£383k).

	PY Actual	Plan	Actual	Variance	RAG
	£k	£k	£k	£k	
Income	(1,658)	(1,647)	(1,546)	101	R
Pay	7,807	7,999	7,713	(285)	G
Non-Pay	9,428	9,530	9,638	108	R
EBITDA *	**15,577**	**15,881**	**15,805**	**(77)**	G

Chief Finance Officer:

Income: The variance is due to a salary recharge for the Assistant Director of Finance on secondment to East Sussex Healthcare NHS Trust. Also, there are misc. receipts received relating to Private Patients.
Pay: There are high levels of vacancies particularly within Financial Management, Business Support and Procurement. These vacancies are actively being recruited to.
Non-Pay: This is mainly deriving from Consultancy spend which is significantly lower than the budget because of FTI Consultancy costs being recognised against PMO pay budgets.

	PY Actual	Plan	Actual	Variance	RAG
	£k	£k	£k	£k	
Income	(112)	(322)	(372)	(50)	G
Pay	2,539	2,998	2,656	(342)	G
Non-Pay	814	1,181	875	(306)	G
EBITDA *	**3,241**	**3,857**	**3,159**	**(698)**	G

Chief Executive's Office: £0.126m overspend;

Pay: overspend of £91k, predominantly due to the recharge of the Western executive board. Vacancies across the directorate mitigates some of the overspend on pay reducing it to 91k

Non-Pay £36k Adverse: Mostly driven by Redundancy payments 66k, Consultancy - Interim fees relating to Clinical and Corporate Governance review 30k, The Trust chair & NEDS costing more than budget by 15k. This is compensated by underspends in Education and training mainly in Transformation Team, BME and Communications by (52k) and lower spend in various other areas by (19k)

	PY Actual	Plan	Actual	Variance	RAG
	£k	£k	£k	£k	
Income	(40)	0	0	(0)	G
Pay	989	932	1,023	91	R
Non-Pay	374	349	385	36	R
EBITDA *	**1,323**	**1,281**	**1,408**	**126**	R

Chief Nurse's Office:

Income: Variance due to unplanned income received from Surrey & Sussex Healthcare in relation to the Mouthcare Matters, and funding for expenses pay & non-pay and agreement with B&HCCG to fund for a Care Home Liaison Discharge Coordinator FTC for one year ending September 17. Offsets with expenditure.
Pay: Mainly driven by vacancies across the Nursing Directorate some of which are in the process of being filled,
Non-Pay: Spend on recruitment agency fees and related T&S on the Nursing International recruitment has slipped, and will occur later in the year.

	PY Actual	Plan	Actual	Variance	RAG
	£k	£k	£k	£k	
Income	(5)	(5)	(45)	(40)	G
Pay	1,400	1,502	1,367	(136)	G
Non-Pay	504	595	511	(84)	G
EBITDA *	**1,900**	**2,093**	**1,833**	**(260)**	G

Chief Operating Officer

Income: No accruals done in IT for PACS, due to confirmation awaited of value and profile.
Pay: There are high vacancies within Clinical Admin Support (CAS). Whilst some have been approved through VCG, others were being managed to compliment a CAS Redesign. The Site Management team budget does not reflect the required establishment.
Non-Pay: Underspends in IT, particularly within Infrastructure, relating to contracts.

	PY Actual	Plan	Actual	Variance	RAG
	£k	£k	£k	£k	
Income	(35)	(36)	(10)	27	R
Pay	6,810	7,069	6,542	(527)	G
Non-Pay	1,651	1,220	1,192	(29)	G
EBITDA *	**8,425**	**8,253**	**7,724**	**(529)**	G

Medical Director's Office:

Income: underperformance mainly in Research and Education. Research £556k - Commercial trials income lower than expected, LCRN Div/Spec Leads income is to be confirmed and Government and EU grants income shortfalls are matched with reduced expenditure levels. Education £59k - Income generation fluctuations, funding to be confirmed and SIFT budget estimate for 1718 overstated.
Pay: Mainly due to Medical training grades budgets needing to be re-aligned, offset by vacancies.
Non-pay: underspend mainly due to Medical postgrad and undergrad expenditure lower than expected. EU Grants Euro Revaluation adjustments (gain), Research core projects underspends in line with income and other expenditure lower than expected.

	PY Actual	Plan	Actual	Variance	RAG
	£k	£k	£k	£k	
Income	(13,697)	(12,681)	(12,066)	615	R
Pay	4,477	4,557	4,396	(161)	G
Non-Pay	10,837	10,976	10,736	(240)	G
EBITDA *	**1,617**	**2,852**	**3,066**	**214**	R

Strategy and Change:

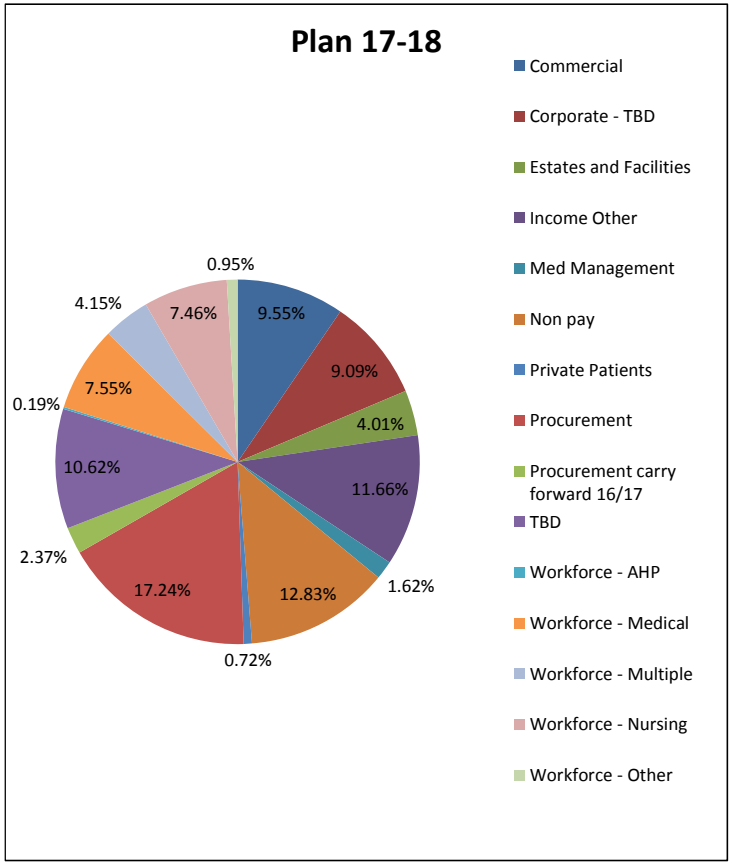
The Directorate is underspent accross the board, primarily due to vacancies and low spending on consultancy and computer licenses & hardware purchases.

	PY Actual	Plan	Actual	Variance	RAG
	£k	£k	£k	£k	
Income	(1,378)	(1,652)	(1,655)	(4)	G
Pay	2,534	3,208	3,190	(18)	G
Non-Pay	1,035	925	894	(31)	G
EBITDA *	**2,191**	**2,482**	**2,429**	**(53)**	G

Finance Report Month 5 2017/18 — Efficiency and Transformation programme — G

Whilst the majority of the efficiency plan schemes have been finalised with the Directorates, there are still some projects that need to be developed. The savings reported year-to-date are below the NHSI plan target by £0.2m, and the internal plan by £0.05m. The forecast is to achieve the £20m target after risk assessing individual forecasts down by £0.95m.

		Year to Date			Year End		
		Plan	Actual	Variance	Plan	Forecast	Variance
		£k	£k	£k	£k	£k	£k
Themes							
Commercial	Income (Patient Care Activities)	708	896	188	2,000	2,000	0
Corporate - TBD	Pay (Skill mix)	413	0	(413)	1,905	1,905	0
Estates and Facilities	Non pay	96	216	120	494	494	0
Estates and Facilities	Pay (Skill mix)	14	156	142	346	346	0
Income Other	Income (Patient Care Activities)	326	419	93	2,433	2,433	0
Income Other	Non pay	5	0	(5)	10	10	0
Med Management	Non pay	96	114	18	339	339	0
Non pay	Non pay	295	661	366	2,687	2,687	0
Private Patients	Income (Patient Care Activities)	44	0	(44)	150	150	0
Procurement	Non pay	1,321	749	(572)	3,612	3,612	0
Procurement carry forward	Non pay	257	367	110	496	496	0
Workforce - AHP	Pay (Skill mix)	12	12	0	40	40	0
Workforce - Medical	Non pay	68	0	(68)	97	97	0
Workforce - Medical	Pay (Skill mix)	400	517	117	1,485	1,485	0
Workforce - Medical	Pay (WTE reductions)	16	3	(13)	0	0	0
Workforce - Multiple	Pay (Skill mix)	337	275	(62)	870	870	0
Workforce - Nursing	Non pay	4	0	(4)	0	0	0
Workforce - Nursing	Pay (Skill mix)	405	285	(120)	1,520	1,520	0
Workforce - Nursing	Pay (WTE reductions)	118	8	(110)	42	42	0
Workforce - Other	Pay (Skill mix)	15	6	(9)	141	141	0
Workforce - Other	Pay (WTE reductions)	6	15	9	59	59	0
TBD	Pay (WTE reductions)	(204)	0	204	2,224	2,224	0
Efficiency Plan Total		**4,749**	**4,699**	**(50)**	**20,950**	**20,950**	**0**
Plan adjustment to NHSI return/Forecast Risk Adjustment		131	0	(131)	(950)	(950)	0
Efficiency Requirement in NHSI Plan		**4,880**	**4,699**	**(181)**	**20,000**	**20,000**	0



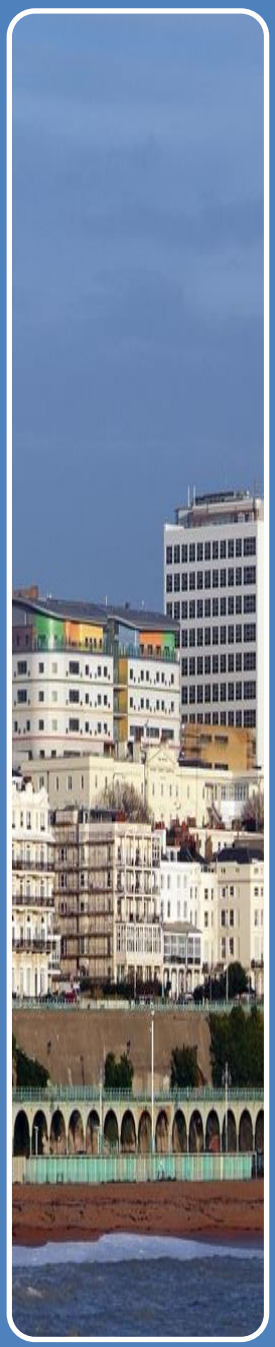
Brighton and Sussex University Hospitals NHS Trust

To: Board of Directors

Date of Meeting: 26th September 2017 Agenda Item: 10

Title
Infection Control Annual Report 2016 - 17
Responsible Executive Director
Nicola Ranger – Chief Nurse
Prepared by
Suzanne Morris, Deputy Director of Infection Control
Status
Public
Summary of Proposal
This annual report provides a summary of the Trust performance against local and national infection prevention initiatives as outlined in the Infection Prevention Programme 2015/16.
Implications for Quality of Care
The report includes that actions relation to infection prevention including the challenges of the old buildings and development of the new buildings. It also examines infection prevention practice and surveillance of infection.
Link to Strategic Objectives/Board Assurance Framework
This report incorporates key national, regional and local quality indicators relating to infection prevention and control providing assurance for the Board and highlighting issues of concern
Financial Implications
nil
Human Resource Implications
nil
Recommendation
The Board/Committee is asked to: NOTE
Communication and Consultation
nil
Appendices
Infection prevention Annual report

NHS
Brighton and Sussex University Hospitals NHS Trust



Director of Infection Prevention and Control Annual Report 2016-2017

Suzanne Morris
Deputy Director of Infection Prevention and Control

Contents

Section 1

Executive Summary

This annual infection prevention report provides a brief description as to the current activities for the prevention, control and management of infection.

The Trust recognises the obligation placed upon it by the Health Act 2008 (updated 2015) to comply with the Code of Practice for health and adult social care on the prevention and control of infections and related guidance.

A legal requirement of this Act (section 1.1 and 1.3) is for the Board of Directors to receive an annual report, to reflect the activities that have been undertaken within the Trust to prevention, control and manage infections; this report will be submitted to the Board of Directors by the Director of Infection Prevention and Control. The report will be released to the public following the Trust Board's approval.

The prevention of healthcare associated infection is a key part of the work of Brighton and Sussex University Hospital NHS Trust (Trust). The Trust supports the principle that infection should be prevented wherever possible or; where this is not possible, minimised to an irreducible level and that effective systematic arrangements for the surveillance, and that a high standard of infection prevention is fundamental to the care of patients at the Trust.

2016-17 has been a busy year for the Infection Prevention Team (IPT), who continued to maintain high visibility and engagement in the clinical areas. With a continued increasing routine workload it can be challenging provide a flexible response to incidents, however this has been maintained throughout the year. The team requires electronic infection control surveillance software, to work more effectively. Key points:

- There has been three Trust apportioned MRSA bacteraemias reported against a ceiling target of zero
- There has been 51 Trust apportioned *Clostridium difficile* toxin positive cases against a ceiling target of 46
- There has been three period of increased incidents related to *Clostridium difficile,* one has been escalated to an outbreak.
- The Trust has reported 20 Trust apportioned MSSA bacteraemias
- Hand hygiene Standard Operating Procedure for hand hygiene was implemented for hand hygiene

compliance, which involves a range of frequencies of auditing

In addition to our on-going activities there has been:

- Change the structure of infection prevention meetings
- Improvements the formatting of information presented at these meetings
- Implementation of a Standard Operational Procedure for hand hygiene auditing
- Advice and support given to 3Ts in relation to the new build at the Royal County Hospital site
- Advice and support given to Estates in relation to air handling units and ventilation
- Advice and support given to clinical areas during periods of outbreaks, incidents and periods of increased incidents
- Devolution of accountability for infection prevention to local clinical teams continued during the year through strengthening of the role of the infection prevention link practitioners

Our goal is to deliver 'harm free care' – ensuring e no patient acquires a single preventable infection.

Nicola Ranger

Chief Nursing Officer

Director of Infection Prevention and Control

Section 2

Surveillance

Surveillance of infections is one of the most important components of infection prevention practices. It is defined as the on-going, systematic collection, analysis, interpretation and dissemination of data regarding an infectious event. This information forms the bases of the infection prevention service provided to the Trust

Mandatory Healthcare Associated Infection Surveillance

Clostridium difficile infection

The incidence of *Clostridium difficile* infection (CDI) is monitored by the Trust and the Department of Health. The Trust reported 51 Trust acquired cases against an annual trajectory of <46 cases.

A Root Cause Analysis (RCA) is undertaken for all Trust acquired cases. Most of the cases were associated with appropriate antibiotics in patients with infections and are required to prevent life threatening situations. Reviews indicated that the antibiotic prescribing was appropriate and in line with the Trust antimicrobial policy, microbiological and clinical advice.

A percentage of cases had an underlying bowel disease, which made it difficult at times to determine when the patient had a change in their bowel habit.

The main learning points and actions from the RCA's were recognising diarrhoea as soon as possible, obtaining a sample early and promptly implementing source isolation. **Table 1:** The Trust set a monthly and quarter trajectory for Trust acquired *Clostridium difficile* infection the table below demonstrates these for 2016-17

Month	No. of cases	Internal trajectory	Q Breach
Apr	4	3	**T: 10 Cases: 8**
May	2	3	
Jun	2	4	
Jul	7	3	**T: 10 Cases: 19**
Aug	3	3	
Sep	9	4	
Oct	5	4	**T: 13 Cases: 13**
Nov	4	4	
Dec	4	5	
Jan	4	4	**T: 13 Cases: 11**
Feb	4	4	
Mar	3	5	
Total	**51**	**46**	

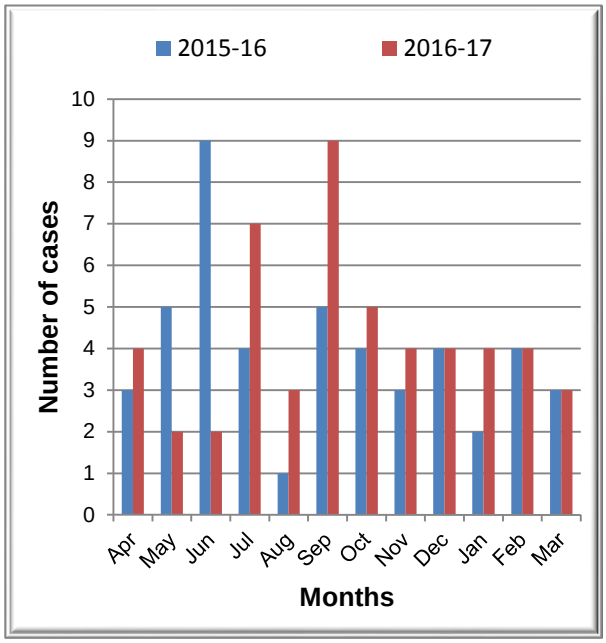
In 2015-16 the Trust saw a spike in the number of reported Trust acquired cases in June, for 2016-

17 the Trust saw two spikes, in July and September 2017 (refer to Graph 1). The IPT has reviewed these spikes; it was not possible to identify why there was a spike in cases for these months.

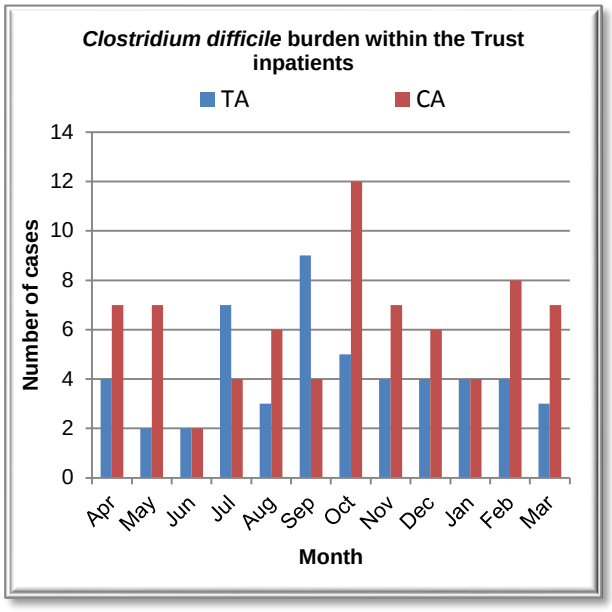
A *Clostridium difficile* infection action plan was implemented in October 2016, which included:

- Trust wide training for the use of sporcidial wipes
- Trust wide commode audit
- Implementation of a RCA review panel
- Hand hygiene awareness training for auditors
- Hand hygiene awareness workshops in the clinical areas

Graph 1: Demonstrates the number of Trust acquired during 2015-16 compared to 2016-17



Graph 2: Demonstrates the *Clostridium difficile* infection burden within the Trust inpatients, this includes hospital acquired and community acquired case 2016-17 (Key: TA – Trust acquired, CA – Community acquired)



Methicillin Resistance *Staphylococcus aureus* Bacteraemia

In accordance with the Department of Health targets for reducing the incidence of Methicillin Resistance *Staphylococcus aureus* (MRSA) bacteraemia the Trust has to report less than zero cases for 2016-17.

MRSA bacteraemias reported by the Trust includes three Trust acquired, three Community acquired and one other acquired for 2016-17.

The IPT in conjunction with the clinical teams undertook a Post Infection Review (PIR) for each of the Trust acquired cases.

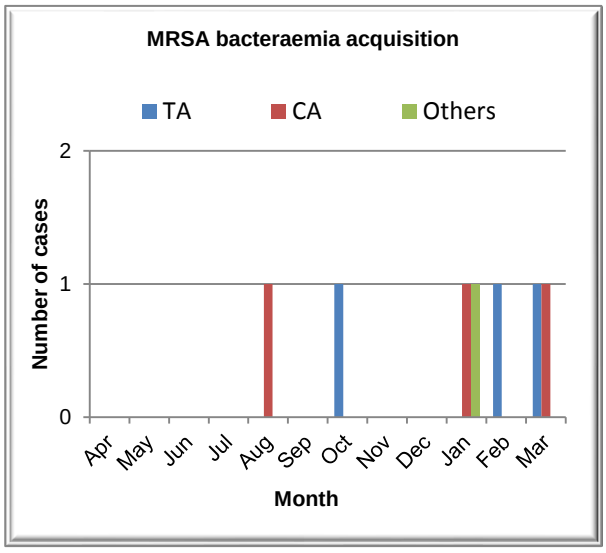
Case 1 October 2016 (Cardiology): the PIR identified that the most likely root cause for the blood stream infection was the angiogram puncture site. Actions implemented included changing the skin preparation to include shaving the skin at the time of the procedure with electrical clippers and to prepare the skin with ChlorPrep® skin prep.

Case 2 February 2017 (Respiratory Medicine): the PIR identified that the most likely root cause

for the blood stream infection was the peripheral venous catheter site. Actions implemented included reviewing patients who require multiple courses of antibiotics their suitability for another form of venous access such as a peripheral inserted central catheter (PICC).

Case 3 March 2017 (Renal): the PIR identified that the most likely root cause for the blood stream infection was the haemocath, which was inserted urgently for dialysis. Actions implemented included screening all day case patients who have a breach in their skin as part of their MRSA screening. To provide decolonisation packs to all elective planned patients who test positive and for all unplanned day cases when the department do not have any MRSA screening results.

Graph 3: Demonstrates the number of Trust, Community and Others acquired MRSA blood stream infections for 2016-17



Methicillin Sensitive *Staphylococcus aureus* Bacteraemia

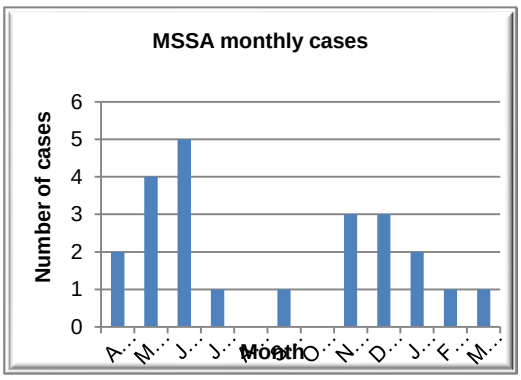
There is no national benchmark or annual threshold set for MSSA bacteraemia rates; however the Trust aims to have no more than 3 cases per month. There were 23 Trust acquired Methicillin sensitive *staphylococcus aureus* (MSSA) bacteraemias reported during 2016-17.

A RCA is undertaken for all Trust acquired cases, most of the cases were associated with inadequate on-going care of vascular venous devices (VADs). VADs are widely used across the Trust for the administration of medication, physiological monitoring and carrying out blood processing. They can be short term peripheral venous catheters (PVC), which last a few days, to long term tunnelled devices that can last for years. The Trust has a dedicated IV Therapy Service who inserts Peripheral Inserted Central Catheter (PICC). Most clinical areas will have direct contact with patients with medium to long term devices.

The care of intravenous (IV) devices remains an important issue for the Trust.

The plan for 2017-18 is to move more patients having medium term VADs such as midlines, and to undertake an audit; to determine the rate of infection, using the international definitions and to determine the compliance with the standard and an evidence based care bundle.

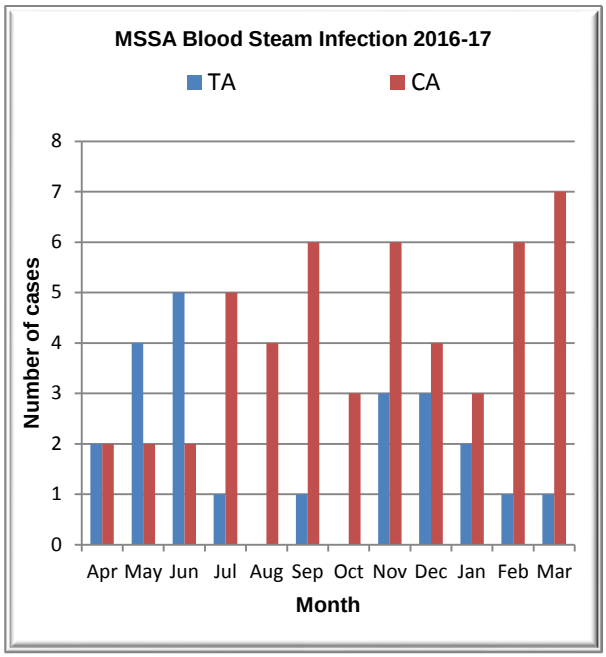
Graph 4: Demonstrates that the Trust did not achieve its internal trajectory in May and June 2016



A Root Cause Analysis (RCA) is conducted for each of these cases. There has been learning from these cases relating to peripheral vascular line management in particular and actions have been taken locally and learning shared across the Trust:

- VIP audit
- Review of Aseptic Non Touch Technique (ANTT) practices
- Development of appropriate ANTT poster
- Development of appropriate ANTT competencies

Graph 5: Demonstrates the burden within the Trust inpatients, this includes hospital acquired and community acquired case 2016-17



Escherichia coli Bacteraemia

Escherichia coli bacteria are frequently found in the intestines of humans and animals. There are many different types of *E. coli,* and while some live in the intestine quite harmlessly, others may cause a variety of disease. *E. coli* bacteria can cause a range of infections including urinary tract infection including cystitis, intestinal infections, and they can be a primary infection spreading to the blood.

The Trust has reported 262 cases of *Escherichia coli (E. coli)* bacteraemia, a steady increase over the past few years, which has also been experienced nationally. There is no national benchmark or annual threshold for *E. coli* bacteraemia or a standard for attribution of acquisition 2016-17.

As from the 1st April 2017, the Trust will be required to report all *E. coli* bacteraemia, using the same definition as that for MRSA/MSSA bacteraemia.

The Government has launched an initiative from April 2017, to reduce Gram negative infections by 50% by 2021. With the first phase for 2017-18 to reduce by 10% *E. coli* bacteraemia across the health economy, this will be led by the Clinical Commission Groups (CCG's)

Surgical Site Infection Surveillance

Surgical Site Infection Surveillance (SSIS) has been undertaken for cranial surgery for the period April – June 2016. Orthopaedic SSIS is mandatory by Public Health England (PHE) for 1 quarter per year, this was total knee replacement (TKR) surgery SSIS October – December 2016.

Cranial surgery SSIS was undertaken April-June by the IPT. 104 patients matched the criteria for inclusion in the surveillance. 1 patient acquired SSI infection, which was classified as deep incisional. The cranial surgery infection rate was 0.96%, compared to the national cranial surgery SSIS average rate of 1.9%.

Serious Incidents

The Trust reports any incident which meets the definition of a Serious Incident (SI); the following summarise the 2016-17:

- One SI related to a Period of Increased Incident of *Clostridium difficile* infection, where the majority of the cases were identified to have the same ribotyping
- There were 3 cases of MRSA bacteraemia reported
- There were zero *C. difficile* cases classified as 1a on the death certificate where *C difficile* had a significant contribution to the cause of death
- There were no reports of infected healthcare worker or patient incident necessitating a look back exercise

Serious incident *Clostridium difficile* infection

Initially two patients were identified as *Clostridium difficile* toxin positive during a 28-day period on Ardingly Ward by the IPT, at this time this did not trigger a Period of Increased Incident (PII), as the second patient first sample was positive on admission to the ward and therefore classed as a community acquired. A further case was identified within the 28-day period of the first case; this triggered the PII on the 12th August 2016.

The IPT investigated and implemented several control measures, including sending the samples from the six patients for PCR ribotyping. A full 49 element Quality Cleaning audit was conducted for the ward, and enhanced cleaning was implemented. Antimicrobial documentation was reviewed.

Care and service delivery problems identified included failure to promptly source isolate under enteric precaution those patients with diarrhoea, standards of cleanliness was below acceptable standards. Contributory factors identified included that all the patients were linked to the same, closed bay. This bay was used, temporarily, for the storage of medical and nursing equipment and was not cleaned.

Lessons learned included; promptly identification of risk and source isolate under enteric precautions, appropriate cleaning of medical and nursing equipment.

Cluster

Cluster is defined as two or more cases that initially appear to be linked by space and which have sufficient proximity in dates of onset of illness to warrant further investigation

Stenotrophomonas maltophilia

Stenotrophomonas maltophilia is a Gram-negative bacterium that is a cause of nosocomial infection primarily in immunosuppressed patients. There is also concern about antimicrobial resistance. The route of transmission is not clear and the bacterium has numerous reservoirs including water, soil and food.

In the event of increased incidence above baseline of any organism an investigation is initiated by the IPT to ensure compliance with infection prevention policy and procedures.

Three cases of *Stenotrophomonas maltophilia* was identified in June, July and August 2016 (there were four cases reported between April 2015 and May 2016). Actions implemented, hand hygiene awareness and auditing, Practice

Educator to implement competency checks and review QC cleaning scores.

Incident

An incident is defined as a single case of any serious illness which has major implications for others, the Trust or the wider public health.

Invasive Group A *Streptococcal* infection

Group A *Streptococcal* (GAS) infection is a bacterium, which is often found in the throat and on the skin. Most GAS infections are relatively mild illness, on rare occasions they can cause other severe and even life-threatening disease. Where the bacteria enters parts of the body where it is not usually found, these are termed invasive GAS (iGAS), two of the most severe, but rare forms of iGAS are necrotising fasciitis and Streptococcal toxic shock syndrome.

The patient at RSCH, was an emergency admission with a two week history, of severe abdominal pain, which had become worse in the previous 24 hours; the patient journey involved six ward transfers during their admission. At the time of the positive sample in January 2017, the patient was in contact with six other patients, which the IPT reviewed and monitored for a month, no further cases were reported.

Escherichia coli 0157

During July 2016 Public Health England (PHE) reported on a national outbreak of *E. coli* 0157. Brighton and Sussex University Hospitals NHS Trust provided acute care to nine patients from a home that was part of the national outbreak. Seven of the nine cases required in-patient admission. The in-patients were source isolated in single rooms and managed with enteric precautions in-line with Trust policy. . There was good communication between the clinical site team, infection prevention team, ward staff, PHE and microbiology. The outbreak was declared over by PHE in August 2016.

Outbreak

An outbreak is defined as two or more cases where the onset of illness is closely linked in time and in space, where there is suspicion of, or evidence of, a common source of infection with or without microbiological support.

MRSA colonisation

MRSA lives harmlessly on the skin and inside the nose and throat, and is referred to as colonisation. The bacterium can cause significant infections when it enters the body through a break in the skin.

The IPT identified that there was in increase in the number of positive MRSA screens on the Special Care Baby Unit (SCBU) at PRH during September 2016. Four babies were positive for MRSA colonisation, two of these were twins. The IPT undertook an investigation in conjunction with the clinical team. Control measures were implemented, and the samples were sent to Colindale Reference Laboratory for further investigation, the ribotyping were the same for all four babies, indicating cross infection occurred within the unit.

Control measures included hand hygiene awareness for both staff and parents, cleaning of nursing and medical equipment. The IPT continue to undertake surveillance for a further 8

weeks, no further cases were identified, and therefore the outbreak was declared over.

Norovirus

Outbreaks of norovirus are essentially difficult to predict, and have a significant impact on the operational services of the Trust; it impacts upon elective activity and the correct placement of patients on wards..

Our outbreaks were sporadic and the operational impact of norovirus was well managed. The IPT worked with clinical staff to resolve the sporadic outbreaks of diarrhoea and vomiting, which was greatly facilitated by the use of rapid diagnostic technology, which enabled the team to determine on the same day whether norovirus was implicated or not.

Between April 2016 and March 2017, there were 20 reported outbreaks of norovirus, and affecting the wards, which were either partially or completely closed. Although the initial control measure is to close bays rather than wards, the management principle is to discuss the management with the Clinical Staff, Deputy DPIC, IPN's and Consultant Microbiologist daily. As these were individual wards, meetings were held with the clinical staff daily.

The management strategy for norovirus outbreak was generally done by closing the bay/ward to transfers and admission, with cleaning of the ward before re-opening; 48 hours after the last affected patient had become asymptomatic. During 2016-17 the management strategy used evolved around containment and compartmentalisation of the ward, enabling patients to be cohort nursed i.e. symptomatic patients and contact patients. This involved initially closure of the bays to transfer and admission, if the outbreak should spread and affect 50% of the ward, the ward status was upgraded to complete ward closure for admission and transfer.

Once the ward had been closed, it was important to aim to have this ward back in circulation as soon as possible; therefore as beds became available through discharges; patients were moved into single rooms or cohorted into a bay. This allowed affected areas of the ward to be cleaned and opened sooner.

By using good sound infection prevention and control practices, it was possible to contain the outbreak.

The epidemiology of the outbreak is highly suggestive of multi-focal outbreaks with the virus being brought into the hospital on numerous occasions. Similar outbreaks were observed over the same period in other local Trusts and also within the community. During the year, there continued to be effective collaboration between the Operational Team and the IPT, which lead to prompt and successful containment. All wards which were closed or restricted were closed to discharge and/or admission as recommended by the IPT.

The following tables outline the wards where a norovirus outbreak was either confirmed or suspected, numbers of symptomatic patients and staff, and the total number of bed lost days for each area affected. The number of staff relates to the number of symptomatic staff, which worked directly in that particular clinical area. It does not take into account symptomatic staff in other areas of the Trust.

Key: C = Confirmed case, S = Suspected case, Pt = Patients number, St = Staff Numbers

Table 2: Demonstrates the wards affected by norovirus, which were closed for admission and transfer by the IPT

	Ward	Pt	St	C/S	Bed days lost
Jul	Egremont	5	1	S	3
Aug	Level 8 A West	6	1	S	0
Nov	Ardingly	10	7	C	21
Nov	Hurstpierpoint	10	6	C	43
Nov	Level 8 A West	3	0	S	1
Nov	Pyecombe	4	0	S	4
Nov	Trafford	18	13	C	43
Dec	Balcombe	15	5	C	50
Dec	Pyecombe	6	2	C	24
Dec	Twineham	22	5	C	42
Dec	Pyecombe	2	0	S	2
Dec	Albourne	6	0	S	4
Mar	Emerald	11	4	C	3

Laboratory acquired infection - *Shigella spp*

During February 2017, there were two confirmed cases of *Shigella flexneria* and one confirmed case of *Shigella sonnei,* which match positive patient sample isolates that were being handled within the laboratory during the theoretical incubation period of this incident. A further case was identified to be *Shigella* spp. DNA positive but failed to be confirmed by culture and two further cases were both negative for *Shigella* spp. DNA.

A laboratory inspection was undertaken during February and subsequent review meetings were held in March and April 2017. An Health and Safety Executive inspection is due to be taken during May 2017.

It was identified during the investigation that the root cause of the contamination of the environment, which lead to the infections was due to agglutinations being carried out on an open bench, non-compliance with existing policies and procedures. It was also identified that there was poor hand hygiene practice, and lack of suitable hand washing facilities within the department, and the general department environment was not cleaned to the required standards. Actions were implemented to correct these and monitored for 6 months post outbreak. There has not been any further cases reported, and the outbreak was declared over in April 2017.

Influenza

Influenza epidemics happen annually affecting a large number of people and influenza planning requires a multi-agency approach. Preventive measures include vaccination of ‘at risk’ groups and standard infection prevention principles. Some people with underlying health condition and influenza will require acute hospital admission and treatment. Recent developments in molecular technology have resulted in diagnostic tests for a range of respiratory viral pathogens that include influenza. However the results are not available immediately and may be some days after development of symptoms.

Infection prevention and control guidance (PHE 2016b) advises on precautions to be taken with patients that develop respiratory infections that include standard, droplet and aerosol (the latter two may involve source isolation).

The IPT were notified on 14th November 2016, that there were three cases of confirmed Influenza A; on Pyecombe Ward. There were three contact cases; two of these had already received their influenza vaccination. The IPT advised to cohort the bay,. And the bay was closed to admission and transfer

The IPT were notified on the 18th January 2017, that there were six patients and 1 member of staff on the Haematology – Oncology Ward displaying symptoms of influenza. Four of the symptomatic patients were confirmed Influenza A RNA+. The Bay was closed to admission and transfer, appropriate control measures and cleaning frequencies were implemented, and the Bay was reopened on the 19th January 2017.

Period of Increased Incidents

The definition for a period of increased incident for *Clostridium difficile* infection, is two or more new cases (occurring >48 hours post admission, not relapses) in a 28-day period on a ward. An outbreak of *Clostridium difficile* infection is declared if the ribotyping of the isolates are the same.

There were three suspected or confirmed Periods of Increased Incident (PII) during the first 6 months of 2016-17. The majority of these cases were clinically mild, although they frequently occurred in patients who were seriously ill from other causes. During a PII the team will conduct several audits, including CDI snap shot audit, hand hygiene audit, environmental audits.

These incidents were reported internally via the Trust Datix system, and as required to the PHE, CCG as part of the internal mandatory surveillance of HCAI i.e. PII related to *C difficile*. Reports on these incidents are available from the IPT. A summary of the reports is available below.

Table 4: Highlights which wards which were reported as having a PII.

Ward	Date	Number of cases	Ribotype
Egremont	July	2	Unknown 002
Ardingly	May	4	005
Level 8 Tower	July	3	Sporadic

* PII – Period of Increased Incident, two (2) or more cases occurring >48hrs post admission (not relapses) in a 28 days period on one clinical area

When a ward has PII, the following actions are implemented by the IPT:

- Isolating appropriately according to the Trust Isolation Policy
- Implement control measures i.e. correct use of PPE, cleaning of the environment and equipment, in the case of *C. difficile* the removal of the alcohol based hand rub from the point of care
- Complete DATIX
- Communication email is circulated to Clinical Staff, Senior Management Team, DIPC, IPT, Consultant Microbiologist, Operational Team, Bed Managers on a daily basis following patients review
- Patients, and where necessary carers/relatives, are informed and kept up to date with the situation
- Sample is forwarded to the Reference Laboratory for ribotyping
- RCA investigation is commenced
- Hot spot / CDI audits are undertaken by the IPT
- Communication with external stakeholders i.e. CCG, PHE

Ardingly Ward: 4 cases of *Clostridium difficile* infection was reported, as described previously,

This PII has been escalated to an 'Outbreak' and a Serious Incident investigation is in progress.

Egremont Ward: 2 cases of *Clostridium difficile* infection were reported. The first case was reported on the 7th July, due to the acuity of the patient and an inability to 'special' the patient if moved to a side room, the patient was not sourced isolated immediately when they became symptomatic. Unfortunately, ribotyping was not undertaken; an investigation by the microbiology laboratory is in progress. The 2nd case was transferred to the ward on the 14th July, during the RCA again due to the acuity of the patient and an inability to 'special' the patient if moved to a side room, the patient was not sourced isolated immediately when they became symptomatic. Ribotying indicated 002 strain. The *Clostridium difficile* infection spot check audits score were 95%, the deficits were action upon immediately. Although both patients were on the same ward at the same time, they were not next to one another; however it is not possible to say with certainty that the PII on Egremont Ward was not an outbreak situation, as it was not possible to identify the ribotyping of the first case.

Level 8 Tower: 3 cases of *Clostridium difficile* infection were reported. The first case was reported on the 29th July, 2nd case on the 2nd August, and the 3rd case on the 5th August. All three patients were source isolated immediately the patient became symptomatic.

The *Clostridium difficile* infection spot check audits score were below 95%, 1st case 55%, 2nd case 55% and the 3rd case 81%. The non-compliance identified included; incorrect isolation door signage displayed, documentation not completed (Bristol stool chart), issues with antibiotic prescribing, storage of linen, and incorrect waste stream implemented. Feedback was provided to the clinical staff. Action plan was implemented with support from the IPT, subsequent *Clostridium difficile* snap short audits, and the ward obtained 100%.

Although these patients were on the same ward at the same time, they were not in direct proximity to one another during their admission, and they had not used the same bed space. Ribotyping of specimens from 2 patients were identified as sporadic, though classed as sporadic they were different ribotypes, the 3rd case was recorded as colonisation. This incident is reported as a PII.

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Section 3

IV Therapy Service

The aim of the Intravenous Therapy Service is to provide high quality; evidence based intravenous therapy nursing to patients within the Trust. The service aims to be comprehensive, flexible and easily accessible. The service also incorporates Outpatient Parenteral Antimicrobial Therapy.

The Intravenous (IV) Therapy service is a team of specially trained nurses that visit patients within the Trust, to identify they suitability of the insertion of a Peripheral inserted central catheter (PICC), receiving Out Patient Parenteral Antimicrobial Therapy (OPAT) and insertion of difficult venous peripheral cannulas.

3. 1 IV Therapy Team comprising of the following individuals

A comprehensive IV therapy service is provided Trust wide. The IV Therapy Team provides a liaison and telephone consultation service for all inpatient and outpatient services. IV therapy expertise is provided across the Trust by a team consisting of specialist IV Clinical Nurses, Consultant Microbiologist, Antimicrobial Pharmacist and Healthcare Assistant.

3.2 Budget allocation to the IV Therapy Team

The IV Therapy Team provides an infection prevention service for the Trust (900 beds) across the Trust, The budget is broken down to Pay and Non-pay.

Table 6: Demonstrates the pay and non-pay budget allocated to the IV Therapy Service for 2016-17.

	Base Plan	Actual	Var: Act v Bud
Total pay	341,497	357,523	16,026
Total non-pay	0	8,513	8,513

The annual non-pay budget was zero. This was based on the IV Team cross charging for 2015 – 2016, which generated £20k. In conjunction with the Procurement Team the prices of items used that are cross charged to the clinical areas was reviewed. The non-pay budget covers course fees, travelling expenses, printing and stationary plus the licence fee for OPAT data-base.

3.3 Training

Cannulation and venepuncture training for Registered Nurses has been completed via a workbook with an assessment, which is signed off by a mentor. For HCA's training is offered via a face to face training session, which is followed by

a practical assessment, which is signed off by a mentor.

A two day IV study day course is provided for all staff, required to be competent in the administration of IV drugs/therapy. The IV Team has provided 12 sessions, a total of 271 attendees.

A one day IV Update course for all staff who administer IV therapy, which is required every three years. The IV Team has provided 18 sessions, a total of 555 attendees.

Cannulation and venepuncture training sessions for the HCA's; the IV Team has provided 11 sessions, a total of 174 attendees. Unfortunately due to reduce resources two sessions were cancelled.

The IV Team have also provided 33 individual departmental IV update, including Renal, ITU and Midwifery,

- One ad-hoc IV Update was arranged for the Imaging Department; which was undertaken in May, a total of 15 attendees
- Two ad-hoc IV study days arranged for Radiographers
- Two ad-hoc study days arranged for the International Nurses
- One ad-hoc study day arranged for Maternity
- One ad-hoc study day arranged for Outreach Nurses on accessing Portacaths, a total of 7 attendees
- Four administrations of IV drugs/therapy days were arranged for the International Nurses, a total of 25 attendees

3.4 Peripherally inserted central catheter line insertion

Table 7: During 2016-2017 the IV Team has:

Activities	Number of patients
Insertion of PICC	1039
Patient assessment for PICC, maintenance, USS cannulas and venepuncture	2206
Difficult cannulations	1257
Difficult cannulation requiring USS	220
OPAT	300

Patients who have chronic diseases such as; Bronchiectasis, Discitis and Cellulitis, frequently require hospitalisation for IV therapy; to manage their long term, acute infections. There is an opportunity to improve the current pathways for these patients. The plan is to concentrate our services, and provide ambulatory clinics on site. This will be more convenient for our patients, their families as they can go to 'one-stop shops' for all their IV care and treatment needs. It will mean that how we configure some of our services will change but it also means we can start to offer appointments at convenient times for the patient and their family.

3.5 Outpatient Parenteral Antimicrobial Therapy Service

Outpatient Parenteral Antimicrobial Therapy Service (OPAT) allows patients to be given intravenous antibiotics in the community, rather than as an inpatient. The service is driven by a focus on, improving patient experience, by providing of care to the patient at home and efficiency saving. The service can be used for patients with severe or deep seated infections

which require parenteral treatment, but are otherwise stable and well enough not to be in hospital. These patients may be discharged early to an OPAT service or may avoid hospital admission altogether.

All OPAT patients continue to have their medical condition and therapy closely supervised by a multidisciplinary team. The service has contributed to reducing a patient's length of staff in the Trust, has promoted early discharge and has improved patient experiences.

Receiving IV antibiotics at home, rather than as an inpatient, improves the quality of life for our patients, and reduces the risk of them acquiring a hospital acquired infection. Feedback from OPAT patients is overwhelmingly positive, citing the benefits of receiving treatment at home, the ability to return to work, and the care, support and expertise of the IV Team.

Table 8: Who administered OPAT

Provider	Year	
	2015-16	2016-17
Brighton and Hove	94	111
West Sussex	74	50
East Sussex	62	27
Trust	22	21
Self-administration	11	18
Carer/Family	1	2
Newhaven Rehab Unit	2	4
Surrey		1
Isle of Wight		1
Total	**266**	**235**
Bed days	**6720**	**5871**

Table 9: Demonstrates the types of infections the OPAT has treated during 2016-17 and the number of cases per infection

Infections	No of cases
Joint	39
Cellulitis	35
Bronchitis	28
Osteomyelitis	24
Septic arthritis	13
Osteomyelitis / Diabetic foot	13
Wound infection	13
Discitis	12
Liver abscess	10
Bacteraemia	9
Brain abscess	6
Urine track infection	5
Endocarditis	5
Thigh abscess	3
Epidural/Spinal abscess	3
Empyema	3
Abdominal abscess	2
Meningitis	2
Psoas abscess	1
Diabetic Ft no Osteomyelitis	1
Lung abscess	1
Candida	1
Perinephric abscess	1
Infected Port-a-cath	1
Chest infection	1
Typhoid	1
Community acquired pneumonia	1
Tuberculosis	1

Table 10: Demonstrates the number of cases treated by OPAT per speciality during 2016-17.

Speciality	No of cases
Orthopaedic	80
Infectious Diseases	35
Respiratory	32
Medicine	26
Gastrointesting	15
Neurosurgical	11
Diabetes/Endoscopy	10
Cardiac surgery	6
Emergency Department	4
Cardiology	4
Cardiology	4
Vascular surgery	2
General surgery	2
Urology	2
HIV	1
Renal	1
Obstetrics / Gynaecology	1
General surgery	1
Care of the Elderly	1
Ear, nose and throat	1

3.6 HSJ Awards

The IV Team was short listed for the Patient Safety category in the 2016 HSJ awards. The short list was based on evidence they submitted in relation to the change of practice within the Trust to the remove of Peripheral venous cannulas (PVC's). Unfortunately the IV Team were unsuccessful on this occasion, however the IV Team has received recognition for the service they provided from both patients and staff, and have been nomination for the star of the month.

3.7 Cannula Audit

PVC is the most common procedure in the hospitalised patients; the complications associated with PVC's can have potentially damaging or even fatal consequences for the patient. Infection and phlebitis are avoidable if simple hygiene and safety principles are adhere to for each patient at the point of contact.

The IV Team conducted a peripheral venous catheterisation management audit in July 2016 and March 2017, the audits took place across the Trust. Feedback was given immediately to the clinical staffs, which was confirmed with a follow up email to the Ward Leader.

It is important to note, clinical areas not recorded on this table, or those on the table which have no score recorded against them; were audited. There were no indwelling venous devices on the day of the audit.

Table 12: A summary of both audits scores demonstrates compliance with the set standard. The Red / Amber / Green approach has been used to highlight 'improvement / no movement / deterioration' with compliance –

Indicates that there has been improvement with compliance since the audit in July 2016

Indicates that there has been no improvement or deterioration with compliance since the audit in July 2016

Indicates that there has been a deterioration with compliance since the audit in July 2016

Clinical area	Score	
	July 2016	March 2017
ACU	75%	
Albion		87.2%
Albourne	54%	100%
AMU	50%	94.3%
Ansty	66%	95.2%
Ardingly	50%	85.7%
Balcombe	53%	92.5%
Baily	37%	66.7%
Bolney		70%
Bristol	43%	93.3%
Catherine James	46%	93.8%
Chichester	51%	52%
Clayton	85%	100%
Clinical decision unit / SSW		36.0%
CT Hurstwood Park		100%
Day case		62.5%
Day Surgery Unit		83.3%
Donald Hall	100%	54.5%
ED/CDU PRH	48%	70.5%
ED RSCH	75%	42.1%
Egremont	23%	100%
Endoscopy Unit RSCH		57.1%
Grant/Courtyard Building Level 7	54%	
Haematology/Oncology	52%	96.7%
Haematology Day Unit		100%
Hosted Keynes	37.50%	72%
Howard 1/Courtyard Building Level 8	43%	60%
Howard 2/Courtyard Building Level 6	86%	80%
Hurstpierpoint	71%	91.7%
Jowers	53%	80.8%
ITU - PRH		92.9%
Level 5 HDU	77%	
Level 6A + CCU	47%	96%
Level 7A	35%	68.2%
Level 7 ITU		90%
Level 8 Tower	69%	69%
Level 8A East	57%	80%
Level 8A West	42%	64%
Level 9A East, West and South	75%	
Level 9A East		100%
Level 9A South		98.9%
Level 11	44%	41.7%
Level 12		33.3%
Level 13		50.%
Level 14		100%
Lewes		65.9%
Lindfield	82%	75%
Newtimber	10%	80%
Overton		100%
Pycombe	66%	99.3%
RACH Level 8		51.4%
RACH Level 9		55%
RAMU	88%	55.6%
Renal	59%	
SAU	87%	100%
Solomon	76%	80%
Sussex Cancer Centre		85.3%
Trafford		84%
Twineham	74%	77.6%
Vallance	57%	81.8%
Trust average:	**59%**	**78.8%**

Although the Trust overall compliance score of 78.8% shows a significant improvement the insertion and management of IV devices. I 7 clinical areas, no improvements had been made, in fact 6 of these there were deterioration in their compliance score.

The audits identified some common themes, which included:

- Inconsistence with the IV insertion and management documentation. This included the date and time of insertion, name of who inserted the device not being recorded,
- The PVC should be reviewed at least 3 times per day and the VIP documented
- PVC dressing was not clean and/or intact
- Documentations for when a PVC is inserted off the ward is not completed i.e. Emergency Department (ED), Theatres
- If the PVC was insitu for >72hrs, the rational was not documented in the nursing / medical notes

This can significantly influence the quality of care provided and the outcome for the patient, therefore it is imperative that staff adopt the principles associated with the management and care of patient who have these devices in situ.

There is still significant improvement required to the insertion and management of venous devices. Individual Ward Leaders have been requested to produce and implement an individual local action plan.

During 2017-2018, the IV Team will:

- Facilitation and support clinical areas in the insertion and management of venous devices
- Conduct weekly audits for areas where their compliance score is low
- Continue to reinforce training in the management of IV access devises using internal and external resources
- Continue to drive the use of cannulation packs and blood culture pack through the Trust
- Change in the IV Team working hours, thereby increasing the frequencies they are working on the clinical floor, improving the fluidity of the IV Team
- Conduct the Trust wide audit on IV insertion and management every 6 months
- Order code has been issued to Ward Leaders and is available via the IV infonet page to enable easy ordering
- The IV Team and BBraun, to conduct a Trust wide awareness of peripheral cannula VIP during 2017-2018
- Review and update the VIP poster during 2017-2018

3.8 Patient information

The IV Team has developed a patient information leaflet in relation to PICC insertion and management of the line, which is appropriate for both patients and carers. The information leaflet will be implemented in June 2017, and will be issued to every patient that the IV Team inserter a PICC, and will be available on the Trust IV Therapy info page.

3.9 Patient self-administration

The IV Team during 2016-2017 taught 22 patients to self-administer their antibiotic. This has been beneficial to the, patient, as it enable self-care carers and Trust. Especially when there has been reduced community capacity, as this has enabled the patient to be discharged promptly. Rather than remain an inpatient for the course of their treatment.

3.10 Jowers Ward Treatment Room

The Treatment Room on Jowers Ward is used by the IV Therapy, procedures undertaken here include, PICC or Mid-Line placement, USS cannulation, PICC dressing changes, administration of antibiotics, bloodletting for

relevant blood tests related to OPAT, managing occlusion in PICC's and the removal of the PICC. During 2016-2017, a total of 390 patients have been seen in the Treatment Room.

3.11 Securacath®

SecurAcath® is a new standard of care for PICC securement, it provides improved stability, which could prevent therapy interruption, improve vessel health and preservation, and lower the overall cost of patient care. The trial was undertaken and was successful. The outcome of the trail will be presented to the Product Selection Group in May 2017; it is proposed that these will be in use by the end of June 2017.

3.12 Nautilus®

Traditionally the PICC tip location is confirmed by X-ray prior to the commencement of treatment. Nautilus is an innovative new ECG product which has been designed to help reduce both the patient and the clinical staff exposure to X-ray radiation and enhance therapy. This will aid the IV Team during insertion of PICC's to find their way by providing accurate, real time tip location confirmation, meaning treatment can commence without delay following the insertion of the PICC.

There are 2 machines available to the IV Team, who are in the process of developing their competences. During this time the traditional method of PICC tip placement confirmation will continue.

3.13 Gripper Plus® Power P.A.C Safety Huber Needle

During 2016-2017 the IV Team reviewed the Gripper Plus® Power P.A.C needle. The system provides the flexibility of use including power injection of contrast media, it allows for higher pressure and flow rates for power injections with PORT-A-CATH® Power P.A.C systems and other power injectable port systems. The IV Team has had discussion with the Trust Procurement team and a trail is planned to commence in May 2017.

Section 4

Infection Prevention Service

Healthcare associated infection is every present risk for patients and staff, requiring constant application of best practice to reduce to a truly unavoidable minimum. The Infection Prevention Service aims to be comprehensive, flexible and easily accessible.

To be effective, infection prevention must be integrated into the complex and multiple interlinking systems within the Trust. Infection prevention cannot be the role and responsibility of a single individual or a small dedicated team, it must be a priority at all levels and integrated within the varies systems within the Trust, including management and education

The Chief Executive Officer (CEO) has overall responsibility for the control of infection within the Trust. The Chief Nurse, is the Trust designated Director of Infection Prevention and Control (DIPC). The consultant Nurse for Infection Prevention is the Trust designated Deputy Director of Infection Prevention and Control (DDIPC). .

4.1 Infection prevention meetings

The meeting structure was reviewed with the Director of Infection Prevention and Control, Deputy Director of Infection Prevention and Control, Director of Clinical Governance and the NHS Improvement Lead for Infection Prevention.

The infection prevention meetings used to comprise of the Infection Prevention Action Group (IPAG), which were held on three Fridays per month, and the Hospital Infection Prevention and Control Committee (HIPCC), which was held once a month on a Friday.

The new meeting structure was implemented in September 2016, and comprises of the following:

- Root Cause Analysis (RCA) Review Group; meets on the 1st Friday of the month, and is chaired by the Deputy Chief Nurse. The group consists of the Deputy Chief Nurse (Chair), DDIPC, Consultant Microbiologist, Antimicrobial Pharmacist, and a Directorate Lead Nurse (DLN) as per the allocation matrix.

  The purpose of the meeting is to review and sign off the RCA and/or Post Infection Review (PIR) investigations pertaining to HCAI's for approval and sharing, to determine if the investigation report meets the requirements for quality and

effectiveness and to ascertain learning from these incidents.

- RCA Lapse in Care Review, , is chaired by the Deputy Chief Nurse). The group consists of two representatives of the Trust and two representatives from the Clinical Commissioning Group (CCG)

- The purpose of the meeting is to review the RCA in relation to CDI for lapses in care, which are discussed and agreed

  The agreed lapses in care / no lapses in care are disseminated to the clinical staff via the Infection Prevention Operational Meeting (IPO), the Infection Prevention Committee (IPC), the Nursing and Midwifery Management Board (NMMB) and the Practice Improvement Meeting (PIM).

- Infection Prevention Operational (IPO), and is chaired by the(Deputy Chief Nurse. The group consists of senior clinical nursing staff, Pharmacy, Soft Facilities and 3T's.

  The purpose of the meeting is to promote and protect the health and wellbeing of patients, visitors and staff. To provide a collective specialist and operational resource that supports and drives improvement in the prevention and management of infection.

- Infection Prevention Committee; is chaired by the Chief Nurse). The group consists of senior clinical staff, Estates and Soft Facilities, Decontamination, Pharmacy and external stakeholders.

  The purpose of the meeting is to advise the Board of all aspects of infection prevention, to provide assurance that the environment within the Trust is clean and safe.

Table 13: Reporting to this Committee are operational groups namely:

Infection Prevention Operational Meeting (IPOM)	Chaired by Deputy Chief Nurse
RCA Review Group	Chaired by Deputy Chief Nurse
Water Safety Group	Chaired by Deputy Director of Estates
Ventilation Group	Chaired by Deputy Director of Estates
Antimicrobial Stewardship Group	Chaired by a Microbiologist
Decontamination Group	Chaired by the Decontamination lead

4.2 Assurance framework

The Health and Social Care Act 2008 – Code of Practice for health and adult social care on the prevention and control of infection; guides organisations towards an assurance framework. This framework is designed to build upon the systems and structures that already exist to maintain best practice and ensure high standards of infection prevention. The framework provides

the Trust with the necessary monitoring and reporting systems to enable the standards to be maintained.

- Internal assurance framework
    - Root cause analysis
    - Surveillance
    - Audit programme
    - Published annual report

- External assurance framework
    - Reporting of clusters/outbreaks infections to Public Health England (PHE)
    - Reporting of serious incidents of HCAI's to PHE and CCG

4.3 RCA process

The Trust continues to build on information and experience to increase the overall understanding of what is required to achieve sustainable reductions in the HCAI;s. RCA's investigation is a well-recognised way of doing this, offering a framework for reviewing patient safety incidents.

All Trust apportioned CDI cases and MSSA bacteraemia are investigated using the Root Cause Analysis (RCA) process. The expectation is that the RCAs are completed within 30 days of the notification. Currently this is not always being achieved in the divisions due to various clinical commitments.

The RCAs process involves the IPT, Consultant Microbiologist and Antimicrobial Pharmacist, the Clinical Team looking after the patient, Ward Leader/Matron, and the patient Consultant. The responsibility for completion of the RCA rests with the relevant division and must be completed collectively by the relevant teams. The RCA is discussed and an action plan created.

Each RCA, including the associated action plan will be presented and monitored at the Infection Prevention Review Group, and at the Divisional Governance meetings, facilitating the sharing and learning across the Trust. Infection prevention is a standing item on the agenda of these meetings, this is where the progress of the action plan from the RCA will be monitored and progressed.

Plan for 2017 – 2018, the RCA tool was reviewed and updated in March 2017; it was ratified at the IPC, and will be implemented as from the 1st April 2017. The process will apply to all Trust staff involved in the care of patients with any of the following:

- MSSA bacteraemia
- *Clostridium difficile* infection
- *Escherichia coli* bacteraemia
- Any infection related incidents where advised by the IPT
- Directorates may initiate a RCA at their own discretion.

The process will be trigger when a positive result is received by the IPT, and the process will be completed within 45 working days.

4.4 Reporting mechanisms

The reporting mechanism demonstrates that infection prevention is an integral part of quality and performance activities within the Trust.

- The DPIC is accountable to the CEO and reports to the Trust Board. These reports are exception reports and risk incident summaries. Data surveillance for the previous month is also reported on

- Data surveillance of all suspected or confirmed infections are emailed through

the IPT from all services and this is monitored through the IPC

- The day to day issues are dealt with in the first instance by the Infection Prevention Nurses (Band 7), with support and advice from the DDIPC

- The IPT provide infection prevention expertise including results of surveillance, audit and alert organisms reporting to a variety of groups across the Trust

- The DDPIC meets weekly with the Consultant Microbiologist and Infection Prevention Doctor

- The DPIC and the DDPIC meets bi-weekly

4.5 Description of Infection Prevention arrangements

It has been a full year for the Infection Prevention Team (IPT), they have faced a challenging year, and staffs have worked exceptionally hard to embed underpinning processes, policies and organisational principles. The focus was to ensure the establishment of solid foundations whilst at the same time, ensuring the service delivery was maintained.

The day to day business of infection prevention is carried out by the IPT. They provide a comprehensive infection prevention service Trust wide. They provide a liaison and telephone consultation service for all inpatient and outpatient services, with arrangements for service cover during declared outbreak via the 'on-call' Consultant Microbiologist.

In April 2016 an Infection Prevention Nurse (Band 7) retired, and an Infection Prevention Trainee (Band 6) left the service. This gave the opportunity to review the structure of the team and the job descriptions for the roles within the team.

The IPT continues to embed infection prevention responsibilities across the whole Trust. Trust staffs have shown they remain committed to working towards the infection prevention agenda by fulfilling their responsibilities, implementing action plans, reporting patients with infections, monitoring their progress and undertaking robust training.

Plan for 2017 – 2018

- Appoint an Infection Prevention and IV Resource Team Lead (Band 8a) to be advertise In April 2017

- Appoint an Infection Prevention Data Analysis (Band 5) to be advertise in April 2017

- Appoint a Clinical Educational role, which world cover both infection prevention and the IV Therapy Resource Team, advertised in September 2017

- Appoint 1.6 WTE Infection Prevention Support Assistance, role to support the Infection Prevention Nurses in the delivery of the Infection Prevention Service

4.6 Annual program of work

An annual program of work is written in conjunction with the Infection Prevention Annual Report for 2017-18.

The programme aims to continuously review and build on existing activity, driven by local needs, while incorporating and complying with the latest Department of Health (DH), Public Health England (PHE) or other relevant strategy and regulations as laid out in such documents.

The program is a Trust wide infection prevention programme of work has been developed. This will be supported by the infection prevention links (IPL's). IPL's play a critical role in clinical practice, providing the opportunity to develop knowledge and play a key role in clinical practice to influence, and where necessary, change practice.

4.7 Budget allocation

The IPT provides an infection prevention service for the Trust (900 beds) across the Trust. The annual non-pay budget covers course fees, travelling expenses, printing and stationary plus computers.

During 2016-17 the IPT was not functioning at full establishment, it is planned during 2017-18, that these vacant positions will be appointed to, therefore the funding will remain in the 2017-18 pay budget.

Table 15: Demonstrates the pay and non-pay budget allocated to the IPT for 2016-17.

	Base Plan	Actual	Var: Act v Bud
Total pay	332,042	191,642	(140,401)
Total non-pay	32,483	8,651	(23,832)

The infection prevention activities of the Consultant Microbiologist is not differentiated from their general microbiology work in terms of pay costs, and as such it forms part of the Pathology SLA with Frontier, and is not related to the Infection Prevention budget.

4.7 Infection Prevention Link Practitioner

Infection Professional Link Practitioners (IPLP's) are nurses or multi-disciplinary team (MDT) members who have an interest in infection prevention and are prepared to work as a link between the infection prevention specialist service and their clinical area of work. They are nominated by each clinical area. Many areas have chosen to have more than one staff member sharing the role. The IPL's come from a range of different clinical disciplines, and are the lynch pin in successfully reinforcing the message that infection prevention is everyone's responsibility. They place a key role in informing, educating and supporting their colleagues in the clinical area. They also undertake frequent audits of key aspects of clinical practice.

During 2016 - 2017 the IPLP's attended 3 Infection Prevention Professional Study Days. These days served both an educational purpose, networking with colleagues, and as a means to keep the IPLP's updated with relevant issues internally, local and nationally. They also provide a forum for exchanging ideas and for discussion around key issues. The agenda for the days will be based on local intelligence and national guidance.

Previous meeting evaluation have identified that the IPLP's have found this format to be very informative and the feedback has been very positive. IPLP's preferred the whole day approach as it provided them the opportunity to

share ideas and discuss with other links from across the hospital site.

During 2016 – 2017, a specific IPLP meeting was incorporated into the day, this is held for an hour at the beginning of the day. This approach has enabled the IPT to share information specifically with the IPLP, and enable them to share with colleagues within their clinical areas.

Role and responsibilities of the IPL's:

- Act as a role model and resource in relation to IP and promote best practice
- Attend quarterly meetings and feedback to clinical area and team
- Being visible in workplace
- Being accessible to all staff, MDT members, patients, staff and visitors
- Challenge poor practices and support staff in reviewing and changing these behaviour patterns
- Assist with undertaking of audits, education and training, outbreaks, RCA's and keep information board up to date
- Seek advice and guidance from the IPAC team when presented with new or complex situations
- Promote the use of appropriate documentation
- Assist and ensure that patients are isolated appropriately

4.8 Infection Prevention Nurse Ward Rounds

All new patients with an alert organism i.e. *Clostridium difficile* are reviewed individually by an Infection Prevention Nurse within 24 hours of the team being aware of the result. This is viewed nationally as good practice.

During a norovirus outbreak the ward was visited daily by an Infection Prevention Nurse, irrespective of which Hospital site the outbreak was occurring in. This approach has improved the management of these patients as well as compliance with infection prevention and control practices. In addition, the enhanced presence of the IPT in clinical areas greatly increased their availability for advice and guidance and improved communication with staff, patients and relatives.

From February 2016, the Band 7 Infection Prevention Nurses has accompanied the Consultant Microbiologist on his ITU and HDU ward rounds. This will continue, once the team are up to establishment this will be extended to incorporate Haematology and Cardiac, as well the Director of Infection Prevention and Control to also participate in these weekly ward rounds.

4.9 NHS Improvement visits

Following the Trust April 2016 CQC visit, the NHS Improvement Lead for Infection Prevention worked closely with the IPT and Trust, to enable the Trust to be fully compliant with the Health and Social Care Act 2008, to deliver improvements in targeted infection prevention risk areas, to bring about rapid improvement in the delivery of infection prevention practices. This support has enable the team to bring together the values and ambitions of the Trust, review the teams capacity and capability to improve the way the infection prevention service is delivered.

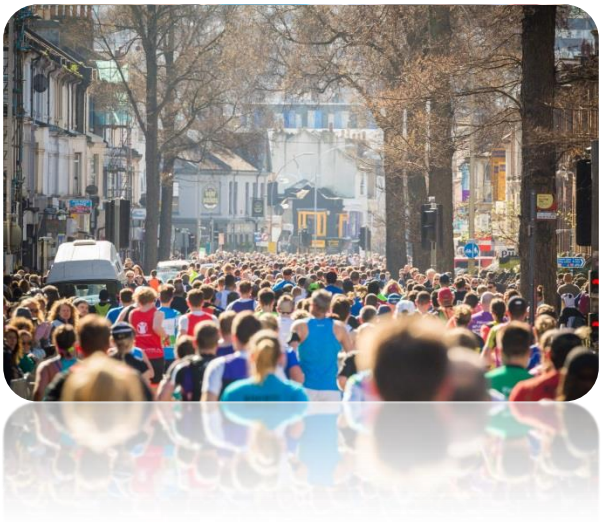
NHS Improvement Lead for Infection Prevention has made several visits to the Trust focusing on environmental and equipment cleanliness.

4.10 Brighton Marathon

Brighton Marathon took place on the 17th April 2016, although there are enormous health benefits in participating in a marathon, it also places a huge physical challenge on the body.

On the day a large team of doctors, paramedics and nurses (including the IPT) working in conjunction with the St John Ambulance Team, along with physiotherapists and podiatrists, provided first aid and medical treatment as required.

Picture 1: Runners on route through Brighton



The medical provision went extremely well, the strong relationship and understanding, which had developed between the different organisations was key to how well the event went.

There were 433 individuals who required medical treatment, 2,137 social contacts (provision of plasters Vaseline etc), this was a rise of 85% compared to 2015. 6 individuals were transfer to the Trust (1 individual was not related to marathon).

The main objective of the IPT was to assess current practices and opportunities for improvement in relation to infection prevention practices in a 'field' situation. Infection prevention strategies are designed to protect patients, public and staff. Routine practices that are critical to the prevention of infection included hand hygiene using of alcohol based hand rub, use of personal protective equipment, cleaning and disinfection and management of waste. An observation report and recommendations was submitted, and was discussed at the debrief meeting, which will be incorporated into next year event.

Picture 2: Clinical staff making up electrolyte oral fluids

4.11 World Health Organization 'Clean Hands Saves Lives'

The Trust took part in the World Health Organization (WHO) 'Clean Hands Saves Lives Campaign on the 5th May 2016. The campaign focussed on raising awareness in practising effective hand hygiene to reduce risk of infections in surgical patients. The IPT led the campaign with Mildred Ruwona Infection Prevention Nurse Trainee; coordinating the campaign.

- The campaign was launched on by sending emails to the Infection Prevention Link Practitioners and Surgeons and Surgical Directorates informing them about the campaign

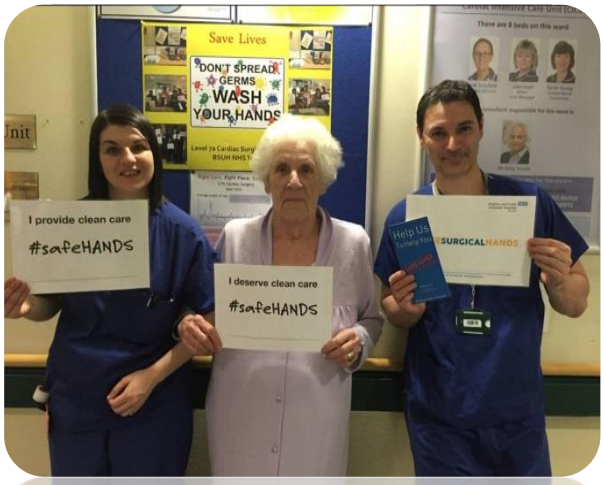
- Information about the campaign was also communicated through Trust intranet and at PIMs

- A Clean Hands Saves Lives Newsletter was sent out on during March 2016
- Hand hygiene leaflets and booklets were distributed within the Trust

- A Twitter campaign gave healthcare workers the opportunity to show their commitment by sharing photos with hashtag ***#safesurgical hands*** on the social media site.

Picture 3: Clinical staff twittering!

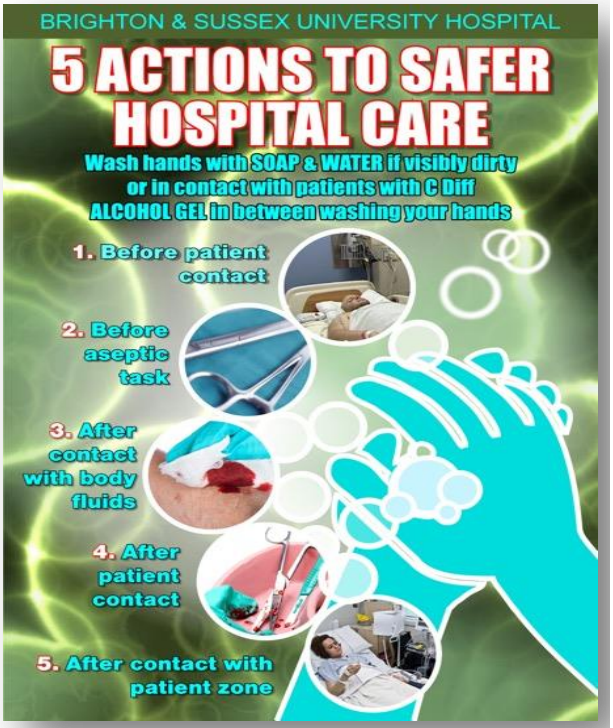
Picture 4: Clinical staff and patients twittering!



Seven departments participated in the competition, and the standards were high, there were two joint winners;

Poster Winner 1: Cardiac Level 7A

Poster Winner 2: Main Theatres



On 20th June 2016, Suzanne Morris Deputy Director of Infection Prevention and Control, Caroline Davies Deputy Chief Nurse and Mildred Ruwona Infection Prevention Nurse Trainee presented the prizes to the winners.

This was a very positive day, with many clinical areas across the Trust participating. The posters have been presented to the Trust Communication Team, requesting them to be reviewed as potential Trust wide hand hygiene posters.

4.8 Semelweiss Hand Scanner Trial

The Semelweiss scanner is an innovative device for providing immediate quality assured feedback regarding hand hygiene technique. It is designed to help learn the technique for proper hand hygiene and can be used by staff, patients and the public.

The Trust trialled the Semelweiss Scanner for several months during 2016, the objectives of the trial was to provide instant highlights of any defects in the hand hygiene technique, and to raises awareness of potential hand hygiene technique issues.

The Semelweiss Scanner has been used to raise hand hygiene awareness, as it provides real-time feedback on hand hygiene technique to individuals in the clinical setting (including Wards, Departments and Theatres), public awareness sessions, training sessions for nursing staff, medical staff and hotel service staff as well as the Contractors working on the 3T's project.

The information the trial provided helped the company to make alterations to enable the scanner to be fit for purpose in an acute healthcare setting, as well has having a unique database of hand images. However the system frequently 'crashed' and clinical staff were unable to reboot the system, therefore at this time, the decision has been made not to purchase the system at this time, but will review once the 'crashing' has been addressed by the company.

4.9 Fit mask testing

To ensure compliance regarding fit testing (face mask FFP 3) across the Trust, a programme has been developed. This program will ensure appropriate training is provided to the nominated members of staff from each clinic staff (2-3 members of staff). The first training for 'train the tester' was undertaken in March 2017, further sessions will be provided during 2017 – 2018. All records of fit testing completed will be stored at local level as well as a copy being held within the Infection Prevention Department and Health and Safety.

Plan for 2017 – 2018, to undertake an audit during the first quarter of 2017 – 2018, which will

influence the number of 'fit tester' required. Training will be provided during 2017 – 2018.

4.9 Surveillance

The IPT currently has an inadequate solution in place for surveillance of HCAI's. This results in the following:

- Delays to identification and treatment of infections
- Unknown and missed infection episodes
- Risks to patient safety
- Risks of avoidable mortality to patients not mitigated
- High band Infection Prevention Nurses spending 40% of their time on clerical work is inefficient
- No ability to widen surveillance

The current system has failed on several occasions, and as a result:

- Patients were at risk of delays in affective management from an infection control perspective, with the increased risk of exposure of infections to other patients
- Data is not being uploaded to the Public Health England Healthcare Data Capture System in a time manner, validation of the data highlights approximately 20-30 cases per month are missed being captured

The Infection Prevention Nurses (IPN's) have spent a large amount of their time in the office searching databases, approximately 40% of their time, rather than being out on the wards helping to prevent and reduce the impact of HCAI's, which is particularly significant under the Trust current building plans, which will have an impact on the Trust for the following 10 years.

This issue has been raised via reports to the Infection Prevention Committee, Quality and Performance Committee, Information Communication Technology Team and the Board via the DDIPC and DIPC.

Section 5

Antimicrobial Stewardship

Antimicrobial stewardship optimises the treatment of infection and minimises the associated collateral damage such as the emergence of resistant organisms and *Clostridium difficile* infection.

Antimicrobial Stewardship is an overarching system of strategies to improve the use of antibiotics to benefit patient outcomes from infection, and it remains an integral part in the Trust achieving its *Clostridium difficile* infections. Continued reduction in overall antimicrobial consumption and particularly penicillin and carbapenem prescribing is a priority in slowing the emergence of antimicrobial resistance.

The approach within in the Trust is proactive i.e. antimicrobial policy, formulary and restriction, guidelines or pathways for treatment and prophylaxis, and reactive i.e. antimicrobial prescription review, audit and feedback. The National Antimicrobial Resistance CQUIN for 2016-17 is an opportunity to further the Antimicrobial Stewardship agenda.

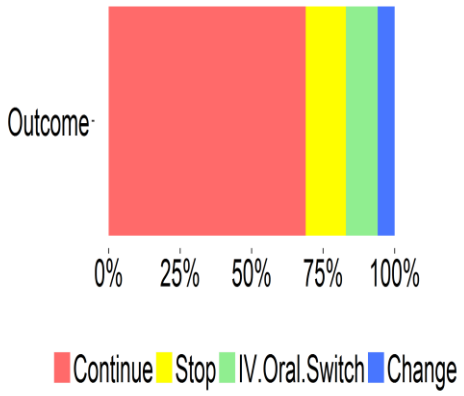
5.1 Antimicrobial CQUIN

Provisional analysis from July – August 2016 of the Trust antimicrobial prescribing; the sample size was 202 antimicrobial prescriptions, 19 from PRH; 177 from RSCH; 6 were not documented

- Administration route: 115 (57%) were IV; 85 (42%) were PO; 2 (1%) were topical
- Indication was documented in 182/202 (90.1%, 95% Binomial Confidence Interval (CI) 85.1% – 93.8%) prescriptions (no missing data)
- Indication was consistent with the Trust guidelines in 165/184 (89.7%, 95%CI 84.3% – 93.7%) prescriptions (data missing in 18/202 (9%))
- Duration was documented in 171/200 (85.5%, 95%CI 79.8% – 90.1%) prescriptions (data missing in 2/202 (1%))
- Duration was consistent with the Trust guidelines in 144/176 (81.8%, 95%CI 75.3% – 87.2%) prescriptions (data missing in 15/202 (7%))
- 72-hour review was documented in 126/151 (83.4%, 95%CI 76.5% – 89.0%) prescriptions (data missing in 51/202 (25%))

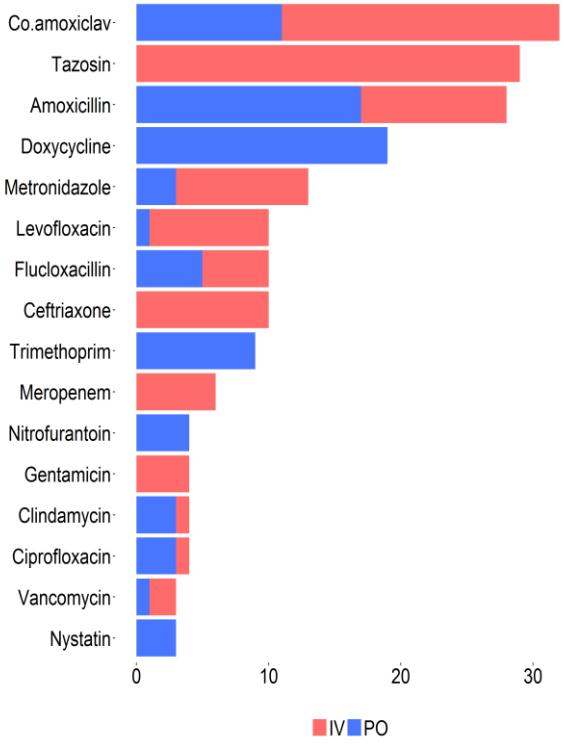
Table 16: Outcome of antimicrobial reviews (data missing in 67/202 (33%)):

Continue	93	69%
Change	8	6%
IV to oral switch	15	11%
Stop	19	14%
Total	135	100%



5.2 Choice of antimicrobial

Chart 6: The following shows all antimicrobials with ≥3 prescriptions ranked by frequency:



Co-amoxiclav, Tazosin, Amoxicillin and Doxycycline cover half of all antimicrobial prescriptions (total n = 108).

Table 17: Adherence to indication guidelines for these antibiotics is shown below:

Antibiotic	**N**	**Indication complies with guidelines**	**Indication complies with guidelines (%)**	***P*-value***
Co-amoxiclav	32	22/29	76%	-
Tazosin	29	26/26	100%	0.01093
Amoxicillin	28	25/26	96%	0.0538
Doxycycline	19	16/19	84%	0.7185

* *P*-values from Fisher exact test in 2x2 contingency tables comparing Co-amoxiclav with Tazosin, Amoxicillin and Doxycycline. The Co-amoxiclav vs Tazosin comparison was statistically significant i.e. Co-amoxiclav prescriptions were less likely to comply with the Trust guidelines than Tazosin prescriptions.

Focusing on the co-amoxiclav prescriptions, 14/20 (70%) IV prescriptions complied with the Trust guidelines compared with 8/9 (89%) oral prescriptions. Sample size was too small to reach statistical significance (*P*=0.3816, Fisher exact test), though the trend is suggestive.

Overall, 95/105 (90%) IV prescriptions complied with trust guidelines for indication, compared with 68/77 (88%) for oral prescriptions. This difference was not significant (*P*=0.8208, Pearson's χ^2 test).

5.3 Conclusions

- Indication is documented in 90% (85% - 94%) of antimicrobial prescriptions

(binomial 95% confidence intervals in parenthesis)

- Indication is consistent with trust guidelines in 90% (84% - 94%) of prescriptions
- Duration is documented in 86% (80% - 90%) of antimicrobial prescriptions
- Duration is consistent with the Trust guidelines in 82% (75% - 87%) of prescriptions
- There is ~10% data missing for both indication and duration consistency with the Trust guidelines. This could bias the results (maybe pharmacists are more likely to leave this question blank if they aren't sure, and are more likely to be uncertain if the prescription differs from guideline).
- 72-hour reviews are documented in 83% (77% - 89%) prescriptions, though there is 25% data missing
- Outcome of antimicrobial review has 33% data missing. Of those documented, the most common outcome (two-thirds) is to continue with the present treatment.
- The most common antimicrobials used are co-amoxiclav, tazosin, amoxicillin and doxycycline, which together represent half of all prescriptions.
- Of the most commonly used antimicrobials, the indication for co-amoxiclav was the least consistent with the Trust guidelines. IV prescriptions of co-amoxiclav were less consistent than oral, though the difference did not reach statistical significance due to small sample size.
- Overall for all antibiotics, there was little difference in indication consistency with trust guidelines for oral vs IV prescriptions.

5.4 Recommendations and discussion points

- Add "antimicrobial indication" to the form
- Modify "72-hour review" question to include prescriptions <72 hours duration, as this is causing confusion
- Consider including "discussed with micro" along with adherent to trust guidelines. Presumably if micro have agreed then it's not a "bad" prescription from an antimicrobial stewardship perspective
- Encourage complete data entry!

Section 6

Decontamination

The purpose of decontamination is to prevent the spread of microorganisms and other noxious contaminants that may threaten the health of human or animals, or damage the environment.

6.1 Internal local audits completed

- ENT OPD – This service provision was centralised on Monday 25th July 2016 into the Endoscope Decontamination Unit (SSD)

- RACH Level 7 Theatres – a JAG audit has been undertaken and an action plan developed, re-audit will commence in March 2018

- Clinical Media Centre – This service provision will be centralised into SSD by the end of November 2016

- TMBU – the audit in September 2015 found that the decontamination of linen was noncompliant with the requirements of HTM 01-04; there is an action to transfer the reprocessing of linen to the Trust's external linen provider, once the contract has been awarded

6.2 Forthcoming audits

- Research Lab – It has recently been bought to the Head of Decontamination attention that the lab were reprocessing equipment using a bench-top steriliser, an audit was undertaken, which resulted in the bench-top steriliser being removed

- Mortuary; there is no evidence that an audit has been undertaken for several years, arrangements are being made to conduct an audit as soon as possible

6.3 Capital Projects

- R.O. Loop – The replacement of the contaminated loop went out to tender, but unfortunately there was only one bidder and this bid was non-compliant. The contamination is being managed at source and is regularly sampled, analysed and audited by the Decontamination Committee, the Water Safety Group and the Infection Prevention Committee

- Replacement Washer Disinfectors at PRH, installation has been slower than expected, there has been 3 new washer disinfectors installed and commissioned,

with a further 2 being installed in May 2017

- Third Steriliser at PRH has been installed and commissioning will commence in May 2017

6.4 On-going Projects

- Cardiac Theatre – Centralisation of the decontamination of the Sorin Heater/Cooler units has been completed

- SSD – implementation of the new HTM's for decontamination this has already commenced but additional testing is required for the storage cabinets of flexible Endoscopes

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Section 7

Education

Our vision is to provide consistently excellent and safe patient-centred care, through staff having the required knowledge to reduce the risk of infections.

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, are required to receive a Trust induction and update that reflects national competencies as outlined by Skills for Health (2011). The General Medical Council (2009) has also published outcomes and standards that include infection prevention for undergraduate medical 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).

For the year 2016-17 the IPT delivered 219 hours of education and training via 219 sessions. 1249 members of staff, students (multi-disciplinary including medical and nursing) and other groups including volunteers, have received education related activities related to infection prevention education and other related activities. .

This figure currently excludes the number that attended Trust induction and clinical/non-clinical mandatory updates. Number of staff attending Trust Induction and subsequent updates are captured on the Trust IRIS system, which in turn informs statutory and mandatory training key performance indicators.

As of April 2017, 84% clinical staff and 92% non-clinical staff are compliant with their infection prevention update. In order to ensure consistency for the Trust Induction, the learning outcomes, as specified by Skills for Health (2011) were covered for all staff. For the update the expectation is that staff will be familiar with the content of the infection prevention workbook (clinical/non-clinical). The sessions are an opportunity to update on the position of the organisation in relation to infection prevention and negotiate learning outcomes so as to suit those in attendance. For example, when delivering an update specifically to phlebotomy teams there could be an emphasis on personal protective equipment that focuses on exposure to body fluids such as blood and sharps management.

An external audit was undertaken of the anatomy facility at Brighton and Sussex Medical School in July 2016. In their report they highlighted that the IPT provides hand hygiene awareness, and utilising the glow box to highlight hand washing technique. The auditor reported that this approach was an excellent idea. The IPT has

already arranged to undertake this as an on-going training session for the department.

The IPT has managed to sustain educational activity throughout the year even when challenged by staff resources issues, The team delivered more teaching hours and sessions for 2016/17 than it did in the whole of 2015/16 (219 verses 109 hours and 219 verses 59 sessions). New educational activities including hand hygiene auditor training to support the audit process and address highlighted by the CQC inspection report. The focus on hand hygiene continued with a trail of the Semmelweis hand hygiene scanner. There has been improvement in mandatory training compliance, from 44% to 84-92%.

Other options are being explored with Learning and Development, to increase the Trust compliance rate. Including the development of a specific practice educator role covering both infection prevention and venous access, this will enable greater focus on education at the point of care as well as other initiatives.

The need for a Clinical Practice Educator role, across the infection prevention and the IV therapy services, has been identified to maintain the current educational activity, and to analyse all educational activity along with evaluation. Looking forward, the role would take forward an educational strategy that aligns with the nursing and midwifery agenda, focusing on patient outcomes and interfacing with the sustainability and transformation partnerships.

Table 18: Infection prevention is an integral part of induction and Core Module (mandatory) update training, as well as several bespoke training sessions. The table below demonstrates infection prevention training undertaken in the first 6 months of 2016-2017.

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 the Trust Excludes volunteers		Face to face	Satisfy skills (2011) 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 (6000)		Face to face (lecture style), 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 the Trust is performing and to clarify any specific outcomes	Several times a month	36	18
Three yearly update	Learning and Development Department	Non-clinical staff (1382)		Face to face (lecture style) IRIS e-learning 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 the Trust is performing and to clarify any specific outcomes	Monthly	12	6

Hand Hygiene auditor sessions	Infection Prevention Team	Healthcare staff that undertake audits	65	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	27/06/2016 04/07/2016 11/07/2016 12/07/2016 13/07/2016 15/07/2016 19/07/2016 22/07/2016 25/07/2016 29/07/2016 01/08/2016 05/08/2016 08/08/2016 05/09/2016 23/09/2016 26/09/2016 18/10/2016 20/10/2016 12/01/2017 16/01/2017 30/01/2017 16/02/2017 28/02/2017 27/03/2017 30/03/2017	75	99

Training and evaluation of the Semmelweis hand scanner	Infection Prevention Team	Staff across the Trust including: Cath Labs, ED, Hotel Services, Maternity, L8A West, Medical Students	278	Face to face and some self-administered	The machine assesses application of alcohol rub against a 7 stage technique. Staff are given a percentage compliance and pass/fail	April to September 2016	17	9.5
HCA induction	Practice Development Team	Healthcare Assistants	300	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	12	9
Volunteers	Voluntary Services Department				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**		
			13			May 2016	1	0.5
			39			September 2016	1	0.5
			38			November 2016	1	0.5
			42			February	1	0.5
						PRH		
			11			April 2016	1	0.5
			18			July 2016	1	0.5
			13			November 2016	1	0.5
			16			January 2016	1	0.5

			14			March 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)	12/09/2016 3 hours x 2 13/02/2017 3 hours x 2	4	12
Medical Students	Brighton and Sussex Medical School	BSMS Module 301: Clinical Foundation Course Year 3	146	Face to face lecture theatre	Satisfy skills (2011) for health competency framework and outcomes for General Medical Council (2009)	21/09/2016	1	2
Sanitising and sporicidal wipe training	GAMA Healthcare	BSUH staff across 86 areas	86	Face to face by a company representative from Clinell	A company representative visited clinical areas. • Training: o Reiteration of correct usage of wipe demonstrated and issues identified discussed with contact staff when and as appropriate o The 5 Principles of effective decontamination demonstrated where appropriate Small group training session/discussions also undertaken during audit as necessary ranging from 1:1 staff sessions or groups of	**RSCH** 27/4/2016 06/09/2016 16/09/2016 19/09/2016 20/09/2016 03/10/2016 04/10/2016 **PRH** 20/04/2016 22/04/2016	9	41

					1-4 staff.			
Total			**1239**				**199**	**219**

Section 8

Occupational Health

Our staff health is important to us. Occupational Health Team works closely with the Infection Prevention Team to ensure that staffs are protected against infection.

8.1 Sharp injuries

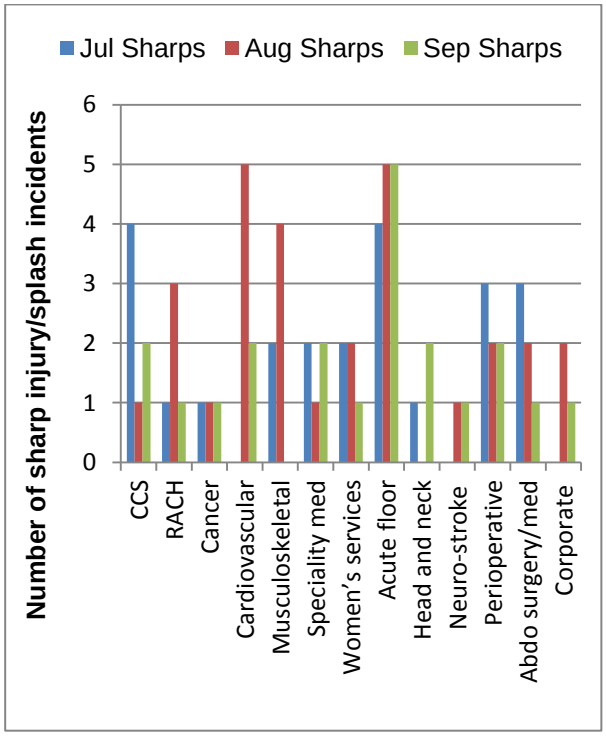
There were a total of 73 splashes sharps injuries reported to Occupational Health since July 2016.

Occupational Health continues to provide information for new staff to the Trust via the Trust induction on the prevention and management of sharps and splash injuries. This information is reinforced with mandatory training, which is available through IRIS.

Table 19: Demonstrates the type of sharp injury involved.

Causative sharp	Total
Occurred during procedure (various)	10
Splash	19
Patient moved	2
Re-sheathed needle	3
Delayed disposal	10
Upon removal of sharp	4
Caused by 2nd party (colleague)	5
Incorrectly disposed of needle	8
Overfilled sharps bin	1
Bitten by patient	1

Chart 7: Demonstrates the number of incidents reported by division, which sustained a sharp or splash incident.



8.2 Influenza immunisation program

Criterion 10 of the Health and Social Care Act 2008, Code of Practice on the prevention and control of infections and related guidance (2015), states '*arrangements for provision of influenza vaccination for healthcare workers where*

appropriate'. Under the Health and Safety at Work Act (1974), the Trust has specific duties to protect, so far as reasonably practicable those at work and others who may be affected by their work activity. The Control of Substances Hazardous to Health (COSHH) Regulations (2002) requires the Trust to assess the risk from exposure to hazardous substances including pathogens, and to bring into effect the measures necessary to protect staff and others from those risks as far as is reasonably practicable.

Any vaccine preventable disease that is transmissible i.e. person to person, will pose a risk to healthcare workers, patients, and others. Healthcare works have a duty of care towards their patients, which include taking reasonable precautions to protect themselves from communicable diseases (Green Book, Chapter 12).

Department of Health (May 2016) stated that more people than ever received the vaccination against influenza; this was not reflected in the Trust uptake, which was 46.5% (PHE 2016).

Influenza immunisation helps to prevent influenza in healthcare workers, and may also reduce the transmission of influenza to vulnerable patients (Green Book Chapter 12). Healthcare workers are more likely to be exposed to the influenza virus, every year a number of healthcare workers will acquire influenza, particularly where there are influenza outbreaks.

The Trust is committed to providing a robust influenza immunisation program; this has been based on a local risk assessment as described in '*Immunisation against Infectious Disease'* (Green Book). The vaccine will be available to all staff free of charge (COSHH Regulations 2002). The first batch of vaccination was delivered to the Trust on Monday 10th October and the immunisation program commenced. The Trust aim is to offer the influenza vaccine to all staff, if any member of staff declines the vaccine, they will be requested to complete a form stating that they have been offer the vaccine and have chosen to decline the opportunity to be vaccinated.

As well as the vaccination being offered by the Occupational Health Service, there is a team of Nominated Nurse Vaccinator, who are offering vaccination to staff on the clinical wards and at drop in clinics. The dates of these will be advertised on the Trust info net. There is a link on the staff info net for staff to make contact with a nominated vaccinator.

The aim of the programme is that the majority of vaccination will have been administered by the end of December 2016. A judgement will be made at this time, to whether it is appropriate to continue to offer the influenza vaccination from January to March 2017.

Influenza immunisation is one of the most effective interventions the Trust can provide to protect staff, patients and the services the Trust provides.

Section 9

Infection Prevention Audits

Healthcare workers compliance with infection prevention practices and principles is vital in preventing the spread of infection. One tool to assess infection prevention practice in clinical areas is audits. This section provides a summary of the audits undertaken April 2016 – March 2017

9.1 *Clostridium difficile* infection snap shot audits

The NHS Outcomes Framework 2016-17 (DH April 2016) stipulates within Domain 5 that NHS organisations reduce the incidence of HCAI's including *Clostridium difficile* infections (Domain 5.2). The Trust trajectory for 2016-17 is ≤46 Trust acquired cases.

Since April 2016; *Clostridium difficile* infection snap shot audits have been undertaken by the IPT; these have been conducted for all positive inpatient cases, irrespective of their acquisition (hospital and community) of *Clostridium difficile* infection. The IPT has conducted 69 audits, which has provided a compliance percentage rate of 89%. The expectation is that all clinical areas audited are 100% compliant. Feedback was given immediately to the clinical staffs, which was confirmed with a follow up email to the Ward Leader and Matron. The audit process is on-going and is part of the IPT annual programme of work. The IPT undertook a total of 208 *Clostridium difficile* infection snap shot audits during 2016-17, with the Trust overall for compliance ranging between 82% and 95%.

Chart 8: Demonstrates the Trust overall *Clostridium difficile* infection spot check scores for 2016-17

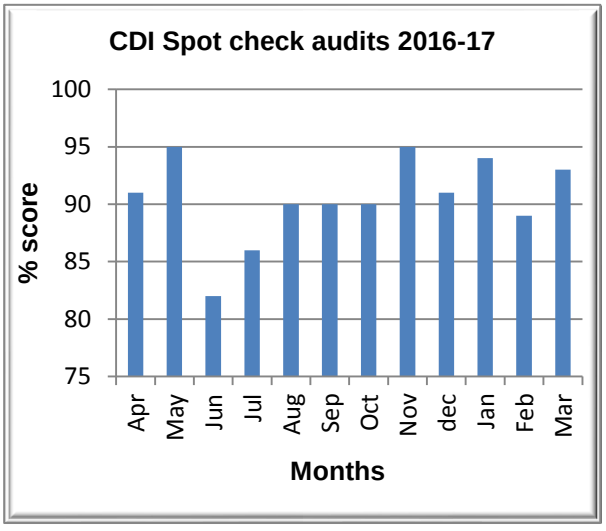


Chart 9: Demonstrates the number of audits undertaken by the IPT per month during 2016-17

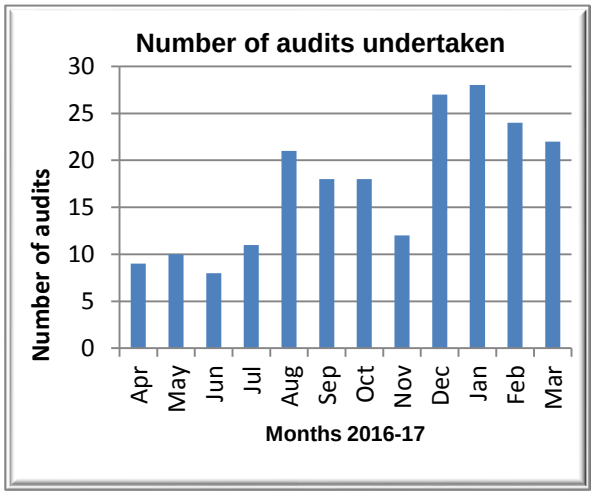


Table 18: Demonstrates the number of *Clostridium difficile* infection hot spot audits and the average compliance percentage for that month.

Month	No. of audits undertaken	Compliance
Apr	9	91%
May	10	95%
Jun	8	82%
Jul	11	86%
Aug	21	90%
Sep	18	90%
Oct	18	90%
Nov	12	95%
Dec	27	91%
Jan	28	94%
Feb	24	89%
Mar	22	93%
Total	208	90.5%

Current themes for non-compliance; incorrect waste stream used, isolation door signage not displayed, source isolation not implemented until the sample result was known, sporicidal wipes available, incorrect waste stream, Bristol Stool chart not implemented,

At the time of the audits the ward staffs are informed of any deficits, and these are corrected immediately. A report is presented at the Infection Prevention Committee. These spot check audits will continue through 2017-18

9.2 MRSA suppression therapy – May 2016

Although the prevalence of Methicillin Resistant *Staphylococcus aureus* (MRSA) has diminished, MRSA transmission continues to occur.

The purpose of this audit was to check compliance to IC 007 MRSA policy. All MRSA positive patients, and/or patients' known to be MRSA positive and/or with less than three negative consecutive screens since a positive MRSA screen receive MRSA suppression therapy.

The IPT undertook an audit of MRSA suppression is April and May 2016. The IP team visited all the wards with MRSA positive patients.

Criterion 5 states that healthcare providers will need to demonstrate "*prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.*

Criterion 9 states; healthcare providers "*Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.'*

Audits were undertaken by Infection Prevention Team over three days in April / May 2016 using the audit tool in Appendix 1.

Case finding involved extracting from OASIS, all inpatients with a previous history of MRSA and checking WinPath® for MRSA screen results. The

MRSA databases were also reviewed and an audit form completed for each patient that fulfilled inclusion criterion.

The wards were visited. Each MRSA positive patient's nurse was asked if they were aware of their patients' MRSA status. Drug cards were reviewed for MRSA suppression prescriptions and administration. Patients were asked if they are aware of their MRSA status.

60% of the clinical staff providing direct care for MRSA positive patients was aware of the patients MRSA status. MRSA suppression therapy was prescribed for 45% of cases, 15% did not have it prescribed but clinical staff had administered the MRSA suppression therapy. However there was no evidence that the patient's hair had been washed as per policy. 15% of patients were not aware of their MRSA status.

Key issues identified include:

- Audit results have indicated that clinical staffs are not acting upon the results communicated to them from the IPT. The MRSA status is always documented on the hand over sheet or verbalised to colleagues and medical staff so the message is lost

- Ward clerks no longer check OASIS for patient alerts, and clinical staff do not routinely check OASIS

- Full suppression therapy not given to all patients

- Patients were generally aware of their MRSA colonisation status, 2 patients cited that they had acquired their colonization from the Trust

The IPT has made several recommendations to enable the clinical areas to be compliant with IC 007 MRSA Policy:

- Results of the audit to be shared with all relevant staff at ward meetings, hand overs. Raising the profile of identifying MRSA position patients and acting accordingly on their results

- Ward Clerk checks all inpatient admissions on OASIS for the 'red diamond' MRSA alert, and check the inside cover of the patients health records for a MRSA positive sticker

- If OASIS indicate the patient is MRSA position, but there is no MRSA positive sticker in the health records, to insert a MRSA positive sticker

- OSASIS PAS should be reviewed daily to identify all patients in their clinical are who are MRSA positive, and inform the Ward Leader or Nurse-in-Charge

- Ensure hand-over sheets are updated with patients MRSA status according to local ward policy

- Not all MRSA positive patients receive MRSA suppression therapy (in accordance to the IC 007 MRSA policy). This increases the risk of MRSA infection / transmission to other patients.

9.3 Commodes – September 2016

14th-16th September 2016, the IPT conducted a commode audit across the whole Trust, a total of

44 areas were visited, and a total of 121 commodes audited for structural integrity, cleanliness and presence of the 'I am clean' sticker.

To comply with the Health and Safety at work Act 1974 and the Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance, the commode must be in a good state of repair and be clean. This is to ensure no harm could come to the patient physically or by risk of cross infection.

It is Trust policy that all commodes are disinfected after use with a sporicidal wipe and an 'I am clean' label placed on the commode to indicate it has been disinfected.

Up to 3% of commodes had visual soiling on either the wheels, frame or hard seat compared to 9% when last audited in December 2015. 3% of the frames had some coating missing, 2% of hard seats had some cracks and 4% soft seats had some damage.

This was an improvement since December 2015 when 10% had frame damage and 21% soft seat damage.

50% of commodes had the 'I am clean' sticker present compared to the last audit when it was 36%.

An action plan will be sent to the directorates and monitored at the monthly infection prevention operating meeting. The next audit is planned for December 2016.

9.4 Cleaning wipe dispenser – September 2016

Audit was undertaken of the GAMA cleaning wipe dispensers across the Trust. A total of 86 areas were visited (the audit is still on-going). In each ward/department the bays, side rooms, toilets, clean and dirty utility, treatment room etc. were reviewed. Initial findings; many of the red dispensers are broken and require replacement, many areas do not have the green dispensers due to refurbishment, and some are damaged and require replacement, others require relocation.

9.5 Hand hygiene audit 2016-17

Effective hand hygiene plays an important role in reducing HCAIs, and for this reason it must be practised by everyone; to protect our patients, staff and the public.

A Standard Operational Procedure (SOP) was implemented in June 2016. Data from the May monthly hand hygiene audits was used as a baseline; this dictated where wards started on the SOP audit criteria implemented; which were:

- Daily audits clinical areas scored <85%
    - Daily monitoring until scores are >86% for 7 consecutive days, then move to weekly audits
- Weekly audits clinical areas scored 86-95%
    - Weekly monitoring until scores reach >95% for at least 4 consecutive weeks, then monthly, if at any time one of the weekly scores falls below 96%, move to daily
- Monthly audits clinical area scored 96-100%
    - Monthly audit score 96-100%, continue with monthly monitoring
- Non-return in the monthly monitoring, weekly audits were required

Initially there were 46 clinical areas on monthly, 30 clinical areas on weekly and 25 clinical areas

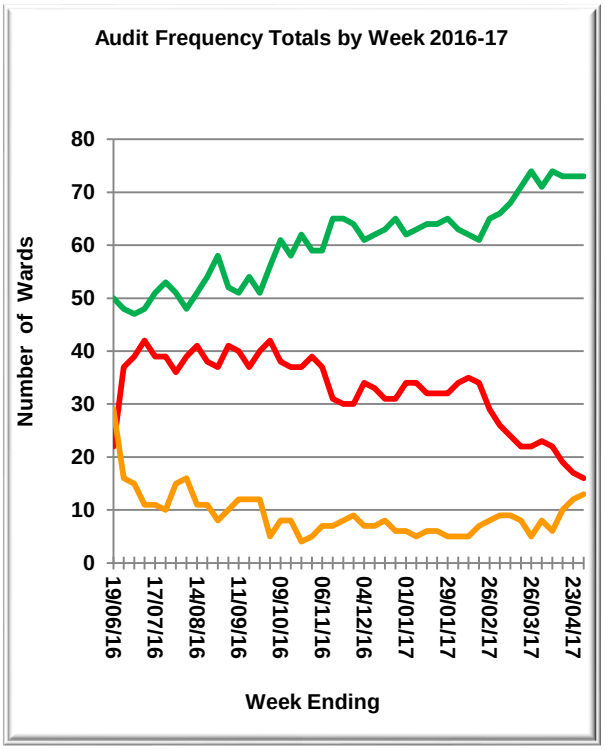
on daily audits. It was anticipated, that the weekly audits would probably stay static, with an increase in daily and a decrease in monthly audits.

Daily audits: there was a significant increase in the daily audits from 25 clinical areas to 50 clinical areas, this trend decreased, with a second wave of increased activity seen and there is at present 40 clinical areas on daily audits

Weekly audits: the weekly audits remained static for a short while following the introduction of the SOP. This was followed with a steady decrease in the number of clinical areas on weekly audit. A second wave was seen, which peaked with 19 clinical areas on weekly audits, since then there has been a stead downward trend, with 8 clinical areas at present on weekly audits

Monthly audits: the monthly audits remained static for a short while following the introduction of the SOP. This was followed with a steady decrease which bottom out at 39 clinical areas. A steady increase was then seen, peaking at 60 clinical areas on monthly. A second shallow decrease wave was seen, this has turned upwards and there are at present 55 clinical areas on monthly audits.

Chart 10: Hand hygiene audit movement across the Trust from April 2016 – March 2017 (Green line monthly audit, amber weekly audit and red daily audits)



As there was considerable confusion and it was agreed that daily audits were not helpful it has been agreed for 2017-18 the hand hygiene audit schedule will change and from 1st May 2017 all wards and departments will undertake weekly hand hygiene.

9.6 IPT spot check hand hygiene audits

During the Trust recent Clinical Quality Commission (CQC) visit it was identified that hand hygiene compliance within the Emergency Department was below an acceptable level.

The IPT visited the department in May and conducted a spot check hand hygiene audit, the score was 7%. This audit identified that there was a lack of suitable hand decontamination facilities within the department. Additional hand hygiene based alcohol rub dispensers were installed at the point of care, including additional hand washing sinks. Hand hygiene awareness sessions were provided by the IPT, which included medical

teams, nursing teams, paramedic team and hotel Service teams.

Six ad-hoc training session were delivered by the IPT team for ED staff. Training included the use of the 'glow box', WHO '5 Moments', hand hygiene technique, and how to apply the hand hygiene products.

There was a significant lack of staff awareness of WHO '5Moments', hence this was a key part of the training, as the audit is focus around the '5 Moment'. Posters were issued and displayed within the department, to reinforce the message in relation to the WHO '5 Moments'. Subsequent audits were undertaken by the IPT, which showed a steady improvement with compliance to hand hygiene

Table 20: Hand hygiene audit carried out by the IPT, results

DATE	AREA	Audit Score
17th May	ED, Majors and Resus	7%
9th June	ED, Majors 2B	18%
9th June	ED, Majors A and Resus	55%
14th June	ED, Majors 2B	80%
15th June	ED, Majors 2A	70%
21st June	ED, Resus	60%
30th June	ED	80%

Issues raised by some of the ED staff:

- Hand washing soap made hands dry
- Staff in Majors 2A informed that often hand wash soap dispenser was empty
- Paper towels sometimes unavailable in changing rooms

Staff engagement was very good, and work every hard to address these issues and improve the department hand hygiene score. The audit score on the 5th October for the department was 94%.

9.7 Maternity L12 and L13

The SOP was implemented in June 2016, and this identified Maternity L12 and L13 compliance score was well below an acceptable level. The IPT undertook an initial audit on 21st June for L12, their score was 40%, and an audit on the 22nd June for L13 was their score was 25%. The auditing on L13 was challenging as it was not possible for the team to enter the room when mothers were in labour. During the audit an assessment was also conducted for the availability of hand hygiene alcohol based rubs and hand washing sinks within the departments, there was a lack of available alcohol based hand rub at the point of care i.e. patients rooms.

The clinical leads took ownership at a local level; they developed an action plan and implemented it to improve clinical practice. As part of this action plan; each morning staff reminded each other about their latest hand hygiene scores during handover period, this had a significant impact and within a short period of time their hand hygiene score was 94%. Staff also discussed the issues identified during the audits. Subsequent hand hygiene audits were done by the IPT, results were fed back to the Ward Leader. Two ad-hoc training session were delivered by the IPT team for Maternity. Training included the use of the 'glow box', WHO '5 Moments', hand hygiene technique, and how to apply the hand hygiene products.

Table 21: Hand hygiene audit carried out by the IPT, results

Date	Area	Audit score
21st June	L12	40%
22nd June	L13	25%
1st July	L12	94%

There were significant improvements in hand hygiene practices in the department resulting in increased hand hygiene scores within a short period, the department is currently on monthly hand hygiene audits.

Section 10

Facilities and Estates

Continuous measurement and management of performance of Facility and Estates Management Service is also vital in the prevention and control of hospital acquired infection.

10.1 Soft Facility Management Service

Although often underestimated, efficient Soft Facilities Management (Soft FM) service plays a critical role within the Trust, directly impacting the patient experience and enabling the efficient provision of clinical care. Soft FM include cleaning, catering, grounds maintenance, waste management, pest control, car park management, internal logistics, security, reception staff and helpdesk.

Following the mobilisation of the Soft FM services and the introduction of a number of temporary measures, the Trust moved forward with the implementation of new equipment to the in-house service. Workshops were held for Housekeeping in November 2016, were they were updated on the new processes, and equipment that Soft FM were planning to implement during 2016-17. The workshops included microfiber clots and mops, voleopro vileda trolley, chemicals/COSHH and laundry process.

10.2 Microfiber system

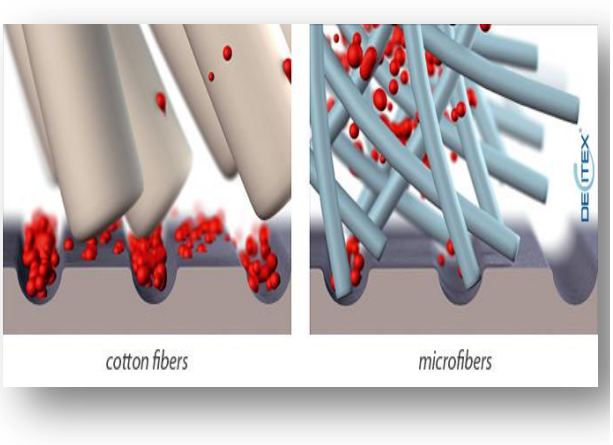
Decitex microfiber: microfiber mops and cloths have a different structure to classical woven cloths. There made of composite synthetic fibres, which are naturally statically charged, the fineness of microfiber threads makes it possible to increase the density of cleaning textiles in an extraordinary way. Due to their thinness and density, the microfiber can easily cope with soiling just be rubbing (mechanical force) and then absorbing it deeply into the spaces created between the fibres (capillary action).

The Sinner circle defines that four factors that are indispensable to good cleaning, these being chemical action, mechanical action, temperature and time of action. Reduction of one of these implies the need to compensate by one or several of the others.

The target aim of microfiber is to follow this principle, increasing the mechanical factor implies reducing the chemical factor and the contact time and related temperature

Picture 5: Moving from ordinary fibre cloth and mop to a microfiber, the textile has increased significantly, thereby increasing its mechanical

ability to up surface dirt. This also has a direct impact on the need for chemicals



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A trail in the use of the microfiber was held, involving four different manufactures, namely Diversey, Vileda, Decitex and Vikan. The trail was held at Princess Royal Hospital.

The preferred supplier emerged as Decitex. The Trust purchased Dx1 mops and T200 cloths, and during December 2016, the Trust started to withdrawn the use of disposable cloths and mops and replace with the microfiber cloths and mops. Training was provided to Housekeeping staff, and the company representative visits the Trust monthly and link with the clinical teams.

The microfiber cloths and mops are designed to be used dry or dampened with water only. The mops can remove 99.999% of surface dirt compared with traditional cleaning with a mop and bucket which only removes 30%. There are not recommended for use in situation where chemicals would normally be considered essential. From an infection prevention perspective, Tristel Fuse® in the event of an infectious outbreak or for isolation cleans. The rollout was well received and improvements in the condition of the flooring across the Trust were noticed immediately.

Vileda Voleo Pro trollies: The Trust has an assortment of cleaning trollies, it was important to standardise these for the clinical areas. Soft FM reviewed several models on the market and selected the Vileda Voleo Pro trollies. There were several advantages, including it being quick and easy to assemble, and it has the ability to store large cleaning tools and accessories within the trolley's outer limits without anything sticking out. The trolley is also easy for staff to manoeuvre, to store and to clean.

The Trust has purchased a total of 70 Vileda Voleo pro trollies to replace the mixture of Vermop shopsters and wet dry systems in use at ward level. The withdrawn Vermop trollies have been assessed and where appropriate redistributed within other department areas. The system was rolled out via housekeeping workshop during January 2017.

Picture 6: The Vileda Voleo Pro trolley

In-house laundry: It is vital that the microfiber cloths and mops are decontaminated promptly

and appropriately. It is estimated that the Trust will use in access of 10,000 re-usable microfiber cloths and mops every day to clean all areas of the Trust. Soft FM has worked in partnership with infection prevention installed new Miele® commercial laundry machines (washing machines) and tumbler driers; these are sited both at RSCH and PRH. Processes are in place to distribute and collect the used mops and cloths, and for processing them through the laundry facilities. The facilities will be audited by the IPT annually.

Cleaning chemicals: In conjunction with the implementation of the microfiber cloths and mops, the cleaning chemicals were reviewed. This review stream-lined the chemicals used within the Trust, for specific tasks. Training in relation to the specific chemical used was provided for Housekeeping staff and Domestic staff. New COSHH folders containing the Data Sheets and risk assessments for the chemical used have been issued to all areas that use the specific chemical.

10.3 Quality checks

Scheduled visits: these have not yet commenced as all QC's are conducted with a member of the nursing team present. The Monitoring Officers are currently in the process of scheduling the visits through the shared calendar. From March 2017, a programme of quarterly managerial audits, which will be undertaken randomly, and unannounced, they will be undertaken with a senior member of the management team.

Revised checklist: the checklist has been simplified to highlight the functional area and is coloured coded, the responsibility for cleaning element, pictorial of cleaning element and description of the frequency of the clean (Appendix 2). These were rolled out from January 2017.

Cleaning frequencies: The National Patient Safety Agency (NPSA) published the national specifications for cleanliness for the NHS (2007). In the healthcare environment lack of cleanliness can cause a risk of infection and a risk to patient confidence. Different rooms and functional areas within the Trust represent different degrees of infection and confidence risk to patients, staff and visitors. The risk category of each area determines, minimum cleaning frequency, auditing frequency, timeframe for problem rectification, target cleaning score, staff allocation, and the equipment used. All functional areas are assigned to one of four risk categories; very high, high, significant, low. The minimum cleaning frequencies for healthcare elements in each risk category determine the work schedule for Housekeepers (Appendix 3). The current cleanliness score for each area is displayed on the cleaning board, which is located near the entrance of the ward or department,

10.4 PLACE

During 2016 the Patient Led Assessments of the Care Environment (PLACE) is a self-assessment of non-clinical services which contribute to healthcare delivered in the NHS and was introduced in 2013 to replace the form Patient Environment Action Team (PEAT). The programme encourages the involvement of patients, the public and bodies, both national and local, with an interest in healthcare in assessing the Trust. This is done in equal partnership with NHS staff to both identify how they are currently performing and to identify which services can be improved for the future.

PLACE took place across the Trust from March through to June.

This was led by Healthwatch, Brighton and Hove and Mid Sussex who joined clinical teams, ex patients and visitors in looking at the way in which our environment supports patient care.

Below are the scores that relate to infection prevention for the Trust 2016 with comparison to the national average scores,

	RSCH	RACH	PRH	SOTC	Nat Av
Cleanliness – housekeeping nursing	98.65	98.10	95.7	98.45	98.1
Condition, appearance, maintenance	83.8	88.67	86.47	94.68	93.4

Since the formal assessments earlier on this year, the Trust has met with Healthwatch assessors from both Mid Sussex and Brighton and Hove to discuss progress and action from the visit.

A number of issues highlighted have already been actioned or are in the process. It has been agreed that both Healthwatch teams will visit both sites on a regular monthly basis joining clinical teams to undertake environmental walks. This will enable us to jointly identify how we can improve the environment for our patients.

10.5 Estates Management Service

Estates are responsible for the infrastructure that the Trust relies on. They are not only involved with the building themselves and the systems that keep them running, but are also involved in the planning and commissioning of new buildings and facilities, redeveloping existing premises or the disposal and demolition of redundant resources.

The Estate team continue to work closely with the IPT in improving the practices of maintenance and monitoring on both the ventilation and water systems.

- There is a programme now in place for annual verification of all critical ventilation areas, with specialist ventilation. The programme is overseen by the Ventilation Group
- Water safety is managed through the Water Safety Group. All systems continue to be tested, monitored and reported on in liaison with the IPT. The remedial works have been acted on quickly from notification, with excellent communication and cooperation with the end users

10.6 Water Management

The Trust uses in excess of 250,000m^3 of water during the course of a normal year, which is provided by the local water authority. The water systems and functions on site range from the provision of potable water supplies, tank water supplies and specialist 'treated' water supplies providing for process plant and medical equipment.

Water Audit:

Waterborne pathogen risk management audit was undertaken to appraise the monitoring arrangements in place to check the efficacy of waterborne pathogen risk control measures, in November 2016.

The Trust monitoring arrangements are contracted out to a 3rd Party and are conducted at frequencies prescribed in the terms agreed and recorded for auditing purposes. The report gave 33 recommendations for improvement, and 29 of

those were considered to be of high priority, requiring urgent attention from the Water Safety Group (WSG). During 2016-17 the WSG has meet many of the recommendations, and will continue during 2017-18 to implement the required steps to meet the outstanding recommendations.

Water management research:

Since April 2016 Omnia-Klenz Ltd has been working in conjunction with the Trust with various water research projects. Omnia-Klenz Ltd is a small company based in the North West of England that was created to develop new technologies for water outlet treatment and control within various sectors including Healthcare. Over 7 years of development Omnia-Klenz Ltd now has a range of products, which have been developed and patented. They have a significant number of advantages ranging from excellent cost and resource savings to CO_2 reductions and other environmental benefits.

Several projects have been either implemented and completed or are currently underway on several aspects of the water system at the Royal Sussex County Hospital; these include:

Project 1: Evaluation and trial of in-situ disinfection using showers with point of use (POU's) water filters fitted as the test subjects. This trial was evaluation Omnia-Klenz's patented Shower-Klenz Professional System using their post mixer in-situ disinfection device.

This evaluation was based on approx. 90 showers that had POU's fitted to them, at the start of the process the 90 was split in to two separate groups. The first group were to be used as the control i.e. no change in process or procedure and the POU programme would be kept the same as would all shower head cleaning/treatment. For the second group the in-situ disinfection device (post mixer) was fitted and a schedule for disinfection was created, with regards to testing the existing water testing by Suez was maintained and Omnia-Klenz did on-going tests including ATP's and *Pseudomonas* testing using the latest onsite rapid test product from IDEXX (Pseudalert).

The evaluation was successful due to the following points: -

- Initial ATP levels pre-trial testing ranged from very high to maximum readings on the on hygiene ATP scale (9999 reading)

- Clear evidence of biofilm removal after one treatment due to reduction in test results

- Typically re-established within one week of treatment partly due to aged hoses and the use of POU's on the showers which by design traps the growths and as shown from tests and results feeds back into the hose and wider water system. Due to this the system is essentially increasing system contamination in existing contaminated areas and creating new areas of contamination within the system

- Due to the length of time that some outlets had been involved in the POU programme several treatments were required to essentially eradicate biofilm growth due to tenacity of the aged biofilm, this highlighted Omnia-Klenz belief that an initial intense programme of disinfection over the first week – 4 weeks would be required for areas involving aged outlets

- Re-establishment will always occur due to the very nature of water, biofilm growth and the environmental aspects these outlets generally operate within. Due to these reasons the Shower-Klenz Professional system is to be used on a scheduled basis, this scheduled would be based upon the risk assessment of with individual outlet, area, building or even site. The scheduling ability means that the trust can amend the schedule if required due to short, medium or long-term risk changes

- The time taken to disinfect the outlets is far quicker, easier and more cost and resource efficient that current methods

Project 2: Evaluation and comparison trial of Shower-Klenz using two different types of in-situ disinfection device (post mixer disinfection and pre-mixer disinfection) based in Sussex House on the accommodation floor and the 2nd floor offices. Also, evaluation Omnia-Klenz patent pending development for eradicating back contamination from a contaminated outlet into the wider water system.

Following on from the previous evaluation it was decided to review the two different fitting types plus following on from the realisation of:

a) The quality of the POU's before the changeover to Pall POU's and

b) The serious issue with back contamination due to the design of POU's.

The low risk area of Sussex House was used to gauge the success of treatment from removing the POU's as part of the process working in conjunction with the in-situ disinfection

Showers were chosen for pre mixer and post mixer in-situ disinfection based upon the location of pipes and the ease of install of the equipment, before install as with the previous project pre-install testing was completed as well as on-going testing.

The showers with the pre-mixer devices and following POU removal saw an immediate drop to 0 mpn (1 cfu = 1 mpn) from 25,000+mpn using IDEXX's Pseudalert onsite rapid test, ATP levels also dropped to zero or close to. A further observation was that the re-establishment of biofilm was far lower due to the lack of back contamination from a POU being fitted and any increase you could say was from natural rates of growth that you would expect to see.

The evaluation was successful due to the following points: -

- Both types of Shower-Klenz disinfection device were successful and the rate of success was higher upon the removal of the POU

- The pre-mixer however does offer the significant benefit of disinfecting the mixer & TMV (where fitted) rather than just the hose and head. This is particular important where you have had long-term contamination of the outlet or the system, long-term use of a POU programme plus if you have a water source that is seen to be passing through or creating contamination

- The Omnia-Klenz back contamination prevention device works by blocking any contamination that may be in the outlet from heading back into the water system to contaminate another outlet or outlet's

- All POU's were removed with no evidence or positive tests by Suez that we are currently aware of

- The time taken to disinfect the outlets is far quicker, easier and more cost and resource efficient that current methods

Plan for 2017-18, Project 3: A trial of Omnia-Klenz's self-developed and patent pending Water Outlet Monitoring system with Trevor Mann Baby Unit (TMBU), this system has been created to reduce the amount of flushing required by highlighting under used outlets by using real world up to date data on an individual outlet basis, will be implemented.

Section 11

Procurement

Collaborative approach helps reduce the risk for patients and staff while generating saving for the Trust. The important this for procurement and infection prevention projects was a smooth journey, especially for the patient. These projects are about doing things better, they need to deliver patient and safe safety first above anything else.

While the provision of highly quality, responsive and well led care is at the heart of the ethos for the Trust, it needs to be achieved in a financially sustainable way. The objectives were:

- Improvement in value for money, with better technology and lower cost products
- Safer products for staff and patients
- Reduce risk for nurses, through less variation in clinical supplies used.

11.1 Hand hygiene decontamination products

Following the change in Soft Facilities Management, Procurement and Infection Prevention were approached by the incumbent supplier to review products and upgrade the dispensers within the Trust.

There were a variety of dispensers used throughout the Trust, some were broken and some were very old. . The aim was to replace all the dispensers in the Trust and also make an efficiency saving.

There was no contract or pricing agreement in place with the incumbent supplier, this presented an opportunity for the Procurement and Infection Prevention Team to review the products and review the present market.

The process was commenced by inviting hand hygiene suppliers to 'open days', where were held at the Royal Sussex County Hospital and the Princess Royal Hospital. This enabled the staff and public to see and evaluate the various hand hygiene products, they were requested to complete an evaluation of the products.

Following the 'open days', seven companies were invited to present their products, what they could do for the Trust in January 2016 to the review group. Based on the results of the 'open day' and

the presentation, the contract was awarded to Deb (Cutan®).

During 2016-2017, a programme for installation was agreed, which was completed in September 2016, with a follow up review to complete any snagging issues, and to install in clinical areas that they could not access during the initial installation. The supplier has been delivering training and undertaking hand hygiene audits while working with materials management to agree stock levels and timings to ensure a smooth transition across the Trust.

11.2 Disposable paper products

Disposable paper products, which included hand paper towels, toilet roll, face tissues and couch roll. This review was completed in conjunction with the hand hygiene decontamination products, and followed the same process.

- Hand paper towels; the Tork Matic® hand towel roll dispenser was implemented across the Trust, which is easy to maintain, and reduces consumption with the one-at-a-time sheet dispensing

- Toilet paper tissue; the Tork SmartOne® toilet roll dispenser. Dispensing single sheet toilet paper in a hygienic method, as the individual only touches the paper that they are going to use. It ensures high efficiency in the delivery of single sheet paper, which helps to reduce consumptions by 40%

The supplier ran a series of activities to support Housekeeping staff in adopting the new products, to ensure the products were used safely. Training and support to clinical staff, and material management to ensure there were the appropriate stock levels of the new products and no negative impacts on hand hygiene compliance.

11.3 Commodes

It is well established within the literature that many healthcare associated infections are prevented by infection prevention procedures designed to interrupt the transmission of microorganisms from a source. Commodes are in use constantly throughout healthcare facilities, with the surfaces being constantly handled, and any pathogen present has the potential to be transferred to not only other surfaces but more importantly to patients, thus compromising patient safety.

In order to examine the effectiveness and thoroughness of cleaning commodes an audit was undertaken to assess compliance with evidence based practice, which demonstrated that commodes allocated to individual patients were not always being cleaned after every use. There were several design of commodes used throughout the Trust, which were not designed to aid cleaning.

One of the actions following this audit for the IPT was to standardise the style of commode used within the Trust. Commodes are notoriously difficult to clean, with many having poor quality frames that rust in a short period of time. The design for commodes has remained unchanged for several years; the first part was for the IPT to review the commodes available on the market.

The GAMA® commode was selected by the IPT, as its design was revolutionary, it was easy to clean, with smooth rounded surfaces, contained

no screws, bolts or nuts, and had no hard to reach areas therefore reducing the ability for dirt to accumulate. The commode dismantles very easily to allow for complete cleaning, the plastic seat also had no stitching or foam. The hinged arms also allow for easy patient transferring to and from the commode and the commode had weight capacity for a weight of 190kg.

In conjunction with the Procurement Team the IPT trialled this commode at RSCH, which was successful. It was agreed that the Trust would standardise its commode purchase to the GAMA® commode.

The supplier has run a series of activities during 2016-2017 to support Clinical and Housekeeping staff in adopting the new commode, to ensure the it was used safely, by improve staff knowledge through education, standardise cleaning procedures and ultimately to improve patient safety.

GAMA® also supplies the Trust with patient wipes and hard surface wipes, the commode was included within the current pricing agreement at a reduced price.

11.4 IV products

Several items have been reviewed, trialled and/or evaluated by the IV Team, including (more details can be reviewed in Section 3 of this report):

- IV film dressings
- Neonatal cannulation pack
- Paediatric cannulation packs
- Paediatric blood culture packs (to be implemented in 2017)
- Griplock securement device
- Securacath

11.5 Procedure packs

The IPT and the IV Team are key stakeholders in the evaluation of the various procedure pack used across the Trust. At present there are 58 packs out for tender including specific packs related to the IV Team:

- Central insertion catheter packs (due to be awarded May 2017)
- Peripheral inserted central catheter insertion packs (due to be awarded in May 17)

Acknowledgements

I would like to thank staff for their efforts and hard work to deliver our goal. I would also like to thank the following individuals who have contributed to this report:

- Suzanne Morris; Deputy Director of Infection Prevention and Control
- Martin Still, Infection Prevention Nurse
- Andrew Davies, Infection Prevention Nurse
- Vikesh Gudka, Lead Pharmacist Infectious Diseases
- Sarah Zahoppoulos, Occupational Health Advisor
- Peter Brown, Decontamination Operational Lead
- William Haynes, Deputy Director of Facilities and Estates

Who have helped in compiling this annual report.

Appendix 1: Example of cleaning check list

Brighton and Sussex University Hospitals NHS Trust

Housekeeping Daily Cleaning Checklist - VERY HIGH RISK

Ward/Dept:…… w/c……

	Signature ADM		
M		F	
T		S	
W		S	

Element	Frequency	M	T	W	T	F	S	S
14. Switches/Sockets	Daily							
15. Walls	Check daily/dust weekly							
17 All doors	Daily							
18 .Internal glazing inc; partitions	Daily							
20. Mirrors	Daily							
21. Patient TV	Daily							
22. Radiators	Daily							
23. Ventilation grilles/inlets	Vacuum external weekly							
24. Floors Polished	Vacuum & wet mop twice daily/Machine weekly.							
25. Non Slip Floors	Vacuum & wet mop twice daily/Machine weekly.							
26. Soft Floors	Daily/Shampoo 6 monthly.							
29. Cleaning Equipment	After use							
30. Low surfaces	Twice Daily							
31. High Surfaces	Twice Weekly							
32. Chairs	Daily & 1 check clean							
33. Beds	Frame Daily/Underframe weekly.							
34. Lockers	External twice daily							
35. Tables	Twice daily							
36/37. Handwash/Sanitiser dispensers	Daily internal/external.							
38. Waste bins	Daily check and clean. Deep clean weekly							
39. Curtains/Blinds	Privacy curtains x three monthly. Windows annually.							
45. Showers	Daily & 1 check clean							
46. WC & Bidets	Three times daily							
47. Replenishments	Three times daily							
48. Sinks	Three times daily							
49. Baths	Daily & 1 check clean							

If you have an issue with the cleaning in your area please call the Helpdesk on **Ext 3250**

BSUH National Standards of Cleanliness Cleaning Checklist **VERY HIGH RISK**

Appendix 2: Example of cleaning poster

VERY HIGH RISK AREA
Cleaning frequency and schedule
Items 1 – 13 Nursing Team
6,19,27,28 - Estates Team
40-44 - Catering Team

Brighton and Sussex University Hospitals NHS Trust

14. Switches, sockets and data points All wall fixtures e.g. switches, sockets and data points should be visibly clean with no blood and body substances, dust, dirt, debris, adhesive tape or spillages	 **Frequency :** **1 Full Clean Daily**	**15. Walls** All wall surfaces including skirting should be visibly clean with no blood and body substances, dust, dirt, debris, adhesive tape or spillages.	 **Frequency :** **1 check clean daily, dust weekly, wash yearly**
17. Doors All parts of the door structure should be visibly clean so that all door surfaces, vents, frames and jambs have no blood or body substances, dust, dirt, debris, adhesive tape and spillages.	 **Frequency :** **1 Full Clean Daily**	**18. All internal glazing including partitions** All internal glazed surfaces should be visibly clean and smear free with no blood or body substances, dust, dirt, debris, adhesive tape and spillages. They should have a uniform shine appearance.	 **Frequency :** **1 Full Clean Daily**
20. Mirrors Mirrors should be visibly clean and smear free with no body substances, dust, dirt, debris, adhesive tape and spillages.	 **Frequency :** **1 Full Clean Daily**	**21. Beside patient TV** All parts of the bedside patient TV should be visibly clean with no blood or body substances, dust, dirt, debris, adhesive tape or stains.	 **Frequency :** **1 Full Clean Daily**
22. Radiators All parts of the radiator (including between panels) should be visibly clean with no blood or body substances, dust, dirt, debris, adhesive tape and spillages.	 **Frequency:** **1 Full Clean Daily**	**23. Ventilation grilles extract and inlets (External)** The external part of the ventilation grille should be visibly clean with no blood and body substances, dust, dirt, debris, or cobwebs.	 **Frequency:** **1 External vacuum weekly**
24. Floor – Polished The complete floor including all edges, corners and main floor spaces should have a uniform shine and be visibly clean with no blood or body substances, dust, dirt, debris, spillages or scuff marks.	 **Frequency:** **2x Dust removal daily** **2 x Damp mop full clean daily** **1 x Machine clean weekly** **Yearly – Strip and reseal**	**25. Floor – Non slip** The complete floor including all edges, corners and main floor spaces should have a uniform finish and be visibly clean with no blood or body substances, dust, dirt, debris, spillages.	 **Frequency:** **2x Dust removal daily** **2 x Damp mop full clean daily** **1 x Machine clean weekly**
26. Floor – Soft The complete floor including all edges, corners should be visibly clean with no blood or body substances, dust, dirt, debris or spillages. The floor should have a uniform appearance and an even colour with no stains or watermarks	 **Frequency:** **1 x Vacuum daily** **1 x 6 months Shampoo**	**29. Cleaning Equipment** Should be visibly clean with no blood or body substances, dust dirt or debris and clean after use. Allow to air dry where possible.	 **Frequency:** **1x Full clean daily** **& After each use.**

Appendix 3: Minimum cleaning frequencies for healthcare elements in each risk category

Category	Example area	Required service level	Target cleanliness score	Audit frequency	Rectification time
Very high risk	Theatre, ,ICU,TMBU A&E, Haematology Invasive procedures Augmented Care areas	**Intensive and frequent cleaning**	98%	**Weekly**	Immediate
High Risk	Wards Public Areas Sterile supplies	**Regular and frequent, with spot cleaning**	95%	**Monthly**	Immediate
Significant	Laboratories Out Patients	**Regular and frequent with spot cleaning**	85%	**Quarterly 4 per year**	3 hours – patient areas 24hours –non patient areas
Low risk	Administration Office	**Regular and frequent, with spot cleaning**	75%	**Twice a year**	2 days

Appendix 4: Waterborne pathogen risk management audit recommendations

	Recommendation	Priority/Risk Level
1	To ensure that the frequency of all routine microbiological sampling is defined clearly in the SLA.	High
2	To ensure that water samples taken for the purpose of *P. aeruginosa* monitoring are taken only form those areas that are specified by the Trust and designated as augmented care areas, or where clinical intelligence dictates otherwise.	High
3	To ensure that water samples taken routinely for *Legionella* analysis are taken from areas where the risk assessment has shown an elevated vulnerability of patients to Legionnaires' disease.	High
4	Suez to ensure that water samples taken for the purpose of *P. aeruginosa* analysis are transferred to a thermally insulated cooled container prior to transfer to the refrigerator refrigerated within two hours, as defined in national standards, e.g., cool boxes or cool bags.	High
5	Suez to ensure that when samples are taken for *P. aeruginosa* analysis, that they are transferred to a refrigerator prior to collection by the courier.	High
6	The Trust to provide refrigeration facilities for the storage of *P. aeruginosa* samples prior to collection for analysis.	High
7	To ensure that transport conditions of water samples taken for microbiological analysis are appropriate to meet those recommended in national guidance.	High
8	To ensure better coordination of cleaning and sampling activities in augmented care areas in order to facilitate the taking of pre-flush water samples for *P. aeruginosa* analysis.	High
9	To ensure that, when it is clear that pre-flush samples cannot be taken,	High

	e.g., when cleaning activities are being conducted, or have recently been performed in the sampling area, necessitating that a post-flush sample can only be taken, that this is documented in the sampling record.	
10	To ensure that when water temperatures are measured for the purpose of monitoring control measures, this is done in line with national standards, i.e., that the time elapsed during the measuring period is noted using a timing device by Suez operatives.	Medium
11	To ensure that sampling and monitoring activities conducted by Suez are performed in a manner that minimises the potential for cross-contamination between areas visited.	High
12	To ensure that reagents used to measure chlorine levels in water samples are not disposed of in clinical WHBs.	Medium
13	To include information relating to soft FM services in the WSP that reflects current management arrangements.	High
14	To develop clear procedures for cleaning staff when cleaning items relevant to water safety, taking into account of the relative risks associated with waterborne pathogens in the various hospital areas, e.g., augmented care.	High
15	To ensure that cleaning staff are adequately trained in cleaning procedures.	High
16	To ensure that visual checks and monitoring activities include both checks on adherence to cleaning procedures in addition to the outcome of the cleaning procedure and to record these checks for management and auditing purposes.	High
17	The WSG to decide on the frequency of use of outlets required to maintain effective control of waterborne pathogens across different areas of the Trust.	High
18	To ensure that infrequently used outlets are flushed at a rate that is commensurate with the risks across different areas of the Trust.	High

24	To ensure that works generated via ZetaSafe are closed off on the system.	High
25	To devise and implement a programme of regular checks to ensure that maintenance and repair activities that have a bearing on water safety are carried out to the required standard.	High
26	To ensure that a programme of safety checks, servicing, cleaning and disinfection of TMVs is in place and that these activities are conducted at a frequency agreed by the WSG and defined in the WSP.	High
27	Based on an assessment of scalding risk, consider the need for TMVs at outlets to ensure that risks from waterborne pathogens are controlled effectively and to preserve Trust resources.	High
28	To ensure that future SLAs include an element of on-site monitoring performed by the third party company to ensure the quality of sampling and other monitoring activities undertaken by its operatives.	High
29	To ensure that the Trust conducts periodic checks on the activities of third party operatives whilst undertaking these activities and to record any findings to be fed back to the contractor at monthly meetings and to the WSG.	High
30	To ensure that the Trust's Water Safety Policy and WSP reflect current staffing arrangements.	High
31	To ensure that roles and responsibilities of WSG members are clearly defined in the WSP.	High
32	To ensure that regular internal audits and checks are performed as detailed in the WSP.	High
33	To ensure that an annual audit of these internal checks is performed and recorded.	High

High	Medium	Low

Appendix

Senior Nurse Infection Prevention and Control Ward Review

Ward name	Senior Nurse	Date

Take five steps into ward and document your first impression

Key: Y = YES / N = NO

Infection Prevention / Hand Hygiene

To check	Circle	Circle	Number of observations	Number of non-compliances
Are all staff Bare Below the Elbow	Y	N		
Are all staff undertaking HH as per the 5 moments	Y	N		
Is alcohol hand rub visible on every bed	Y	N		
Has the ward completed the weekly HH audit	Y	N		
Are the wash hand basins accessible	Y	N		
Are the wash hand basins used solely for this purpose	Y	N		

Personal Protective Equipment

To check	Circle	Circle	Number of observations	Number of non-compliances
Is PPE worn appropriately	Y	N		
Is PPE removed at the right time	Y	N		
Are hands decontaminated prior to donning and removing	Y	N		

Patient Environment

To check	Circle	Circle	Number of observations	Number of non-compliances
Check 10 items (e.g. bed frames, lockers bed tables)	Y	N		
Are raised toilet seats clean	Y	N		
Has last planned periodic curtain change been undertaken and recorded on shared drive	Y	N		

MRSA Pathway

To check	Circle	Circle	Number of observations	Number of non-compliances
Have all patients been MRSA screened on admission	Y	N		
Have all patients been MRSA screened weekly	Y	N		
Do known MRSA patients have correct pathway	Y	N		
Has the patient been informed of MRSA status	Y	N		

Isolation

To check	Circle	Circle	Number of observations/reviews	Number/type of non-compliances
Are all patients requiring isolation isolated	Y	N		
Are isolation room doors closed	Y	N		
Have patients with type 5-7 stool been risk assessed	Y	N		
Do patients in isolation know why they are isolated	Y	N		

Equipment Cleaning

To check	Circle	Circle	Number of observations/items if applicable	Number/type of non-compliances
Are daily cleaning records up to date	Y	N		
Are weekly cleaning records up to date	Y	N		
Are individual wash bowls stored in patients locker (or disposable)	Y	N		
Check 10 items of near patient equipment	Y	N		

Linen

To check	Circle	Circle	Number of observations if applicable	Number/type of non-compliances
Is clean linen stored in a designated area	Y	N		
Is clean linen not adjacent to used/dirty linen	Y	N		
Are linen skips managed correctly	Y	N		

Waste

To check	Circle	Circle	Number of observations if applicable	Number/type of non-compliances
Is the waste cupboard secure	Y	N		
Is the waste stored correctly – off the floor	Y	N		
Is the waste segregated	Y	N		
Are the waste bins within the clinical area appropriate	Y	N		
Are the bins clean	Y	N		
Are the bins fit for purpose silent closing within the clinical area	Y	N		

Mattresses

To check	Circle	Circle	Number of observations if applicable	Number/type of non-compliances
Do mattresses not in use have a decontamination certificate	Y	N		
Mattresses are not stored on the floor	Y	N		
Has a monthly mattress audit been undertaken	Y	N		
Does every mattress on a bed have a SKI sheet	Y	N		

Sluice

To check	Circle	Circle	Number of observations if applicable	Number/type of non-compliances
Is the sluice clean and tidy	Y	N		
Is the sluice free from clean items	Y	N		
Are commodes , bedpan shells raised toilet seats clean	Y	N		
Are chemicals stored as per COSSH recommendations	Y	N		

Communication

To check	Circle	Circle	Number of observations if applicable	Number/type of non-compliances
Are the Cleaning schedules displayed	Y	N		
Is the last months Quality Check Score displayed	Y	N		
Is the welcome board up to date – correct staff members	Y	N		
Is the patient to staff ratio for today displayed	Y	N		
Is the information in relation to PALS and complaints clearly displayed	Y	N		
Is information in relation to Fire Alarm	Y	N		

testing clearly displayed				

Comments
Feed back

Brighton and Sussex Hospitals NHS Trust
Trust Headquarters
St Mary's House
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East Sussex
BN2 5BE

(01273) 5696955

Brighton and Sussex University Hospitals NHS Trust

To: Trust Board

Date of Meeting: [27th September 2017] Agenda Item: 11

Title
Emergency Planning, Resilience and Response
Responsible Executive Director
Evelyn Barker
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. Note the issues and required improvements and actions in relation to Lockdown.
Implications for Quality of Care
The inability 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
[state the strategic objectives which the paper/proposals support or link to, and the reference to the Board Assurance Framework]
Financial Implications
No current financial implications but there may be a cost if we need ti upgrade the facilities in the current HICC location
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 Substantial compliance • Note the improvements and actions still required and support the Resilience Team in ensuring the actions are delivered to continue to improve our major incident preparedness. • Note the issues regarding the ability to ensure lockdown in the event of a major incident • Note the improvements and actions proposed including the requirement for capital funding to deliver the necessary physical and technical security enhancements for lockdown • Note the risk that additional security staff cannot easily be mobilised in response to a major incident owing to the limited pool of in-house staff and the revised security support contract being restricted to a single local company. • Note the approach whereby upon completion of the upcoming refurbishment access to the RSCH L5 ED will not enable unescorted access into the wider BSUH site for public/patients & visitors

Communication and Consultation
Appendices
EPRR Report and Assurance Action Plan 2017-2018

Brighton and Sussex University Hospitals NHS Trust

To: Trust Board **[27.09.17]**

From: Managing Director **Agenda Item: 11**

To note and agree necessary actions

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 TEC on our current preparedness for Major incident and Mass Casualty Incidents and the further work that is required.

2 NHSE EPPR Assurance

2.1 Every year Trusts have to complete the NHSE EPRR assurance self-assessment. Following a long period of under resourcing within the Resilience Team and an increase in workload, last year, for the first time, BSUH were rated as non-compliant.

2.2 Subsequent to our non-compliant rating BSUH had to provide quarterly updates on our progress to B&H CCG. The Head of Resilience developed an action plan and the Executive Team committed to appropriately resourcing the Resilience Team by financing a Resilience Manager post to work with the Head of Resilience.

2.3 With the increased staffing resources and detailed action plan BSUH were able to achieve substantial compliance ahead of schedule in May this year.

2.4 It is now time for us to undertake our self-assessment for July 2017-2018 and the Resilience team are pleased to be able to report that we remain substantially compliant with 1 red and 4 amber ratings. The amber ratings are for business continuity (2 ambers), mass countermeasures and evacuation with lockdown being our one red rating.

2.5 The Resilience Team have now produced and updated the action plan for these amber and red ratings which can be found in Appendix 1.

2.6 The Head of Security has written a separate paper on the Development of Lockdown Plan & Capability in the Trust which is attached in appendix 2.

3 **Major incident/Mass Casualty Incident Update:**

3.1 BSUH currently has an up to date and exercised Major Incident Plan that also covers mass causality incidents. Following the learning from the recent terrorist incidents in London and Manchester, the regional mass casualty exercises that we took part in and our internal major incident table top exercise we have highlighted a number of areas where we would like to improve our current plans and processes.

3.2 The following outlines the actions and projects that have been undertaken already and this will be followed by the further work that is required.

Actions and projects that have been undertaken:

- The Resilience Team worked with the Communication Team to run a major incident and business continuity awareness campaign during National Business Continuity Week. This was supported by a new and updated Resilience page on the Infonet, daily tweets from our Resilience Twitter retweeted by the BSUH Twitter account. A link to the Resilience page on the front page of the infonet, information in the all staff communications emails and a walk round of clinical areas and non-clinical areas of PRH and RSCH by the Resilience team who handed out action cards, leaflets and signposted staff to where they could find more information.

- We covered the 'Move to Critical' phase when the National Security Level was raised to its highest level. We briefed all relevant parties and contributed to the regional debrief. The move to critical highlighted the current issues that the Security team are faced with in relation to completing the Lockdown policy.

- We facilitated an internal Major Incident table top exercise on the 11th July 2017. This was very well received. The report is currently being finalised but the debrief highlighted a number of things we can do to improve our current preparedness which are noted below.

- The Resilience Manager has undertaken the Loggist 'Train the Trainer' course and is currently planning to deliver the training internally to staff who volunteer as loggists.

- Our HELP Service has devised training for staff to be able to deliver departmental 'hot debriefs' after an incident and are working on a plan to be able to provide staff support after an incident.

- RSCH ED staff have recently undertaken two live triage exercises, and BSUH were also represented at the two regional mass casualty exercises.

- We have supported the Major Trauma Network and contributed to the production of the new Network Mass Casualty Plan. This plan includes information on the setting up of a Network Clinical Coordination Team at BSUH to help coordinate the trauma patients across the network.

- We have delivered awareness training to teams as required, most recently to RSCH Theatres and Critical Care. We have also delivered refresher training to the on call managers and continue to deliver training to all new starters at induction.

- On call Managers and Directors have been offered further external training at no cost to the Trust and many on call staff have booked on to these.

- We have delivered executive training on EPRR in BSUH, on 25th July and 1st August.

- We produced a template for wards to complete during a major incident to help identify which patients could be discharged quickly in an incident. This is now available in the on call managers Team Drive.

- We have disseminated learning from Westminster and Manchester terror attacks.

- We have updated and published the new Hazmat/CBRN Plan and produced a training video for on call managers and directors for Hazmat/CBRN incidents.

- We have produced a new Business Continuity Strategy for sign off at the August Resilience Forum meeting and then for subsequent approval at TEC.

- We have produced a Business Impact Analysis and Action Card Template for directorates to complete for their business continuity plans and we are working on a schedule to ensure all directorates have completed this over the next 12 months.

- We have attended multi-agency briefings and disseminated information and learning as necessary.

- We have collated departmental plans for Pride.

- We have been well supported by the Interim Chief Operating Officer for Emergency Care who has chaired Resilience Group.

3.3 **The following outlines the further work that is required to ensure we are fully prepared:**

- HICC: our Hospital Incident Coordination Centre (often called the Control Room) is co-located with the Clinical Operations Room on the 4th floor of the Barry Building. Both are due to move into the new CAB building and we have designed a room that will offer us the facilities needed for a Clinical Operations and HICC as well as office space for the Resilience Team.

- The Major Incident Table Top report will be completed and an action plan will be produced.

- An early review of the current Major Incident Plan to include actions that will come out of the table top report and the new processes that have been developed as part of the Mass Casualty Trauma Network Plan including working the Network Clinical Coordination Team.

- A Live Major Incident exercise to be planned for next year.

- Our current pool of trained loggists is very small and we need to encourage departments to enrol their staff on the training.

3.4 **The Board is asked to:**

- Note our current EPRR Assurance rating of Substantial compliance.
- Note the improvements and actions still required and support the Resilience Team in ensuring the actions are delivered to continue to improve our Major Incident preparedness.
- Note the issues regarding the ability to ensure lockdown in the event of a major incident.
- Note the improvements and actions proposed including the requirement for capital funding to deliver the necessary physical and technical security enhancements for lockdown.
- Note the risk that additional security staff cannot easily be mobilised in response to a major incident owing to the limited pool of in-house staff and the revised security support contract being restricted to a single local company.
- Note the approach whereby upon completion of the upcoming refurbishment access to the RSCH L5 ED will not enable unescorted access into the wider BSUH site for public/patients & visitors

Natasza Lentner
Head of Resilience
[27.09.17]

Appendix 1 EPRR Action Plan July 2017- July 2018

Core Standards	RAG Rating	Evidence	Action to be taken	Lead	Timescale
Corporate and service level Business Continuity (aligned to current nationally recognised BC standards)	**Amber**	Trustwide Business Continuity Plan in place and aligned to the BS25999 but needs to be reviewed and updated to align with the ISO 22301	Our new Business Continuity Strategy has been completed and is due for sign off at Resilience forum meeting on the 9th of August and for approval by our Trust Exec Committee following that. We have produced a Business Impact Analysis and action card Template for directorates to complete for their business continuity plans and we are working on a schedule to ensure all directorates have completed this over the next 12 months	**Head of Resilience**	June 2018
Utilities, IT and Telecommunications Failure	**Amber**	As above	As above	**Head of Resilience**	June 2018
Mass Countermeasures (e.g. mass prophylaxis, or mass vaccination)	**Amber**	We have not had to have this in place before.	As a result of recent discussions with the NHS E Heads Of EPRR, their regional colleagues are going to ask for this be on the national work programme to refresh/update this guidance as needed	**Head of Resilience**	June 2018
Whole Hospital Evacuation	**Amber**	Draft in place but work still needed on patient tracking, transport and triage	Draft in place but work still needed on patient tracking, transport and triage. Next plan to be reviewed and finalised.	**Head of Resilience**	June 2018

Core Standards	RAG Rating	Evidence	Action to be taken	Lead	Timescale
Lockdown	**Red**	The Trust has Lockdown policy in place .The ability to lockdown a building using the AACS is in place but more developed in certain areas. Existing estate mitigates against Trust wide lockdown	We are making progress towards lockdown & hope that by the end of the year we could lockdown A&E. Achieving full site lockdown is likely to take longer than 12 months and may first include perimeter lockdown and lockdown of the most critical areas. Lockdown is being raised through the Trust Exec Committee separate to EPRR Assurance	**Head of Security**	June 2018

	Compliance Level Evaluation and Testing Conclusion Full	
full compliance	Green	0
substantial compliance	Green	1-5
partial compliance	Amber	6-10
non-compliant	Red	11+

Deep Dive standards on Governance (not counted towards overall ratings)				
The organisation has published the results of the 2016/17 NHS EPRR assurance process in their annual report.	**Red**	Annual report for this year has already been completed so we are unable to complete for this year but this will be added into our annual report going forward	**Head of Resilience**	**Jun-18**
The organisation's Accountable Emergency Officer regularly attends the organisations internal EPRR oversight/ delivery group	**Amber**	Going forward the new Accountable Emergency Officer (Managing Director) will attend and chair future Resilience forum meetings	**Head of Resilience**	**Aug-17**

Appendix 2 Development of Lockdown Plan & Capability

Introduction

Lockdown is the process of controlling the movement and access - both entry and exit - of people (NHS staff, patients and visitors) around a Trust site or other specific Trust building/area in response to an identified risk, threat or hazard that might impact upon the security of patients, staff and assets or indeed the capacity of that facility to continue to operate. A lockdown is achieved through a combination of physical security measures and the deployment of security personnel.

During a wide range of incidents, health services are vulnerable. Contamination, infection or pressure of the ensuing numbers of people seeking care can threaten services to the point of collapse. In addition, it may be necessary to lockdown a site or areas within it in the event of a terrorist attack either targeted at the hospital or in the vicinity. Therefore locking down an NHS site or NHS building may be a proportionate response from a variety of threats and hazards to safeguard patients, staff, visitors and protect NHS assets.

In locking down a Trust there are three key elements: preventing the entry, exit and movement of people on a Trust site or in a building or part of a building. In preventing the entry, exit or movement of people, or a mixture of the three, the overarching aim of implementing a lockdown is to either exclude or contain staff, patients and visitors. Supporting the overarching objective of excluding or containing staff, patients or visitors, a lockdown may be characterised as a partial, progressive or full lockdown.

The physical process of preventing access or egress from any Healthcare site or building is extremely challenging. This is owing to the significant number of potential entrance/exits, the requirement that fire alarm activations deactivate electronic locking systems and the shortage of staff to be physically present at entrance and exits.

EPPR assurance requirement

The Trust is required to assure its commissioners that it has necessary plans in place to respond to a variety of risks relating to Emergency Preparedness and Resilience. The Trust is currently assessed as being substantially compliant with this requirement with Lockdown being the only element currently RAG rated as Red.

Likely scenarios requiring lockdown

The following incidents may require some degree of restriction to access/egress to or from site:

- Marauding weapon attack on BSUH as the primary target or as a follow up to an attack in Brighton/Sussex where those injured at the scene are conveyed to BSUH.
- Declared Major Incident off site placing pressure on services.
- CBRN Incident.
- Serious utility failure affecting the site.
- Child/Baby Safety Incident.
- VIP visit.

Technical capability

The Trust has a combination of electronic access controls and physical locks on doors across its estate. The electronic access control systems are installed in accordance with Fire Safety Regulations. In most cases this requires the installation of a “Press to Exit” button allowing anyone to exit the secured area. Some areas are fitted with a card reader requiring users to present their ID card to allow exit. This facility is in place in a limited number of areas requiring a higher level of security.

Most access control doors are secured by means of magnetic locks, the door unlocks by the magnet releasing on presentation of a valid card to the reader or the press to exit button being used. The door controls are also linked to the fire alarm for the building meaning that should the fire alarm activate the magnet will be deactivated and the door unlock.

Each exit door is also fitted with an emergency break glass which when used interrupts the power to the magnetic lock releasing the door. The emergency break glass should be a failsafe in case all other methods of opening the door in an emergency have failed. Once activated in order to secure the door the break glass has to be physically reset to reactivate the magnetic lock.

The access control system is monitored in the Security Control Room at RSCH and individual doors can be remotely released or locked via the software. However, as stated above, where a break glass has been used that must be physically reset at the door before the door can be secured.

The use of a magnetic lock to secure a door whilst a reasonable and widely used approach leaves the door open to being physically forced open. Because most maglocks are fitted at the head of a door it is possible if sufficient force is exerted at the bottom of the door to overcome the magnet and open the door, this is particularly true of double doors as used on most hospital corridors/ward entrances etc. Where these doors are part of a lockdown this risk needs to be acknowledged and the locking mechanism replaced to reduce the risk of doors being forced open..

Trust specific challenges for BSUH

While there is clearly a requirement for us to be able to secure all the buildings that BSUH operate from it is most likely that the RSCH site will be the site required to initiate a lockdown owing to its role as the Major Trauma Centre and its proximity to Brighton City Centre.

Site Perimeter

Lockdown guidance identifies that securing the perimeter of a site by means of a robust perimeter treatment such as fences/walls etc. reduces the potential entrances and maybe beneficial in achieving a more secure site and in facilitating Lockdown.

RSCH

RSCH does not have a defined perimeter with a variety of buildings being directly accessed from the public highway. Certain buildings such as St Mary’s benefit from a physically delineated perimeter but identified entrances cannot be secured using gates/barriers as in many cases they are not in place.

The main clinical “island” situated to the North of Eastern road in some places has a defined physical perimeter, which if adequately secured could limit the number of entrances to the site. While in the event of a whole site lockdown each building within the site would still require a lockdown plan, reducing the number of individuals gaining access to the entire site would aid the ability to successfully manage a lockdown scenario. The clinical “island” could be restricted to 6 entrances currently.

In order to make effective use of the perimeter there would need to be installation of vehicle and pedestrian gates at each of the entrances.

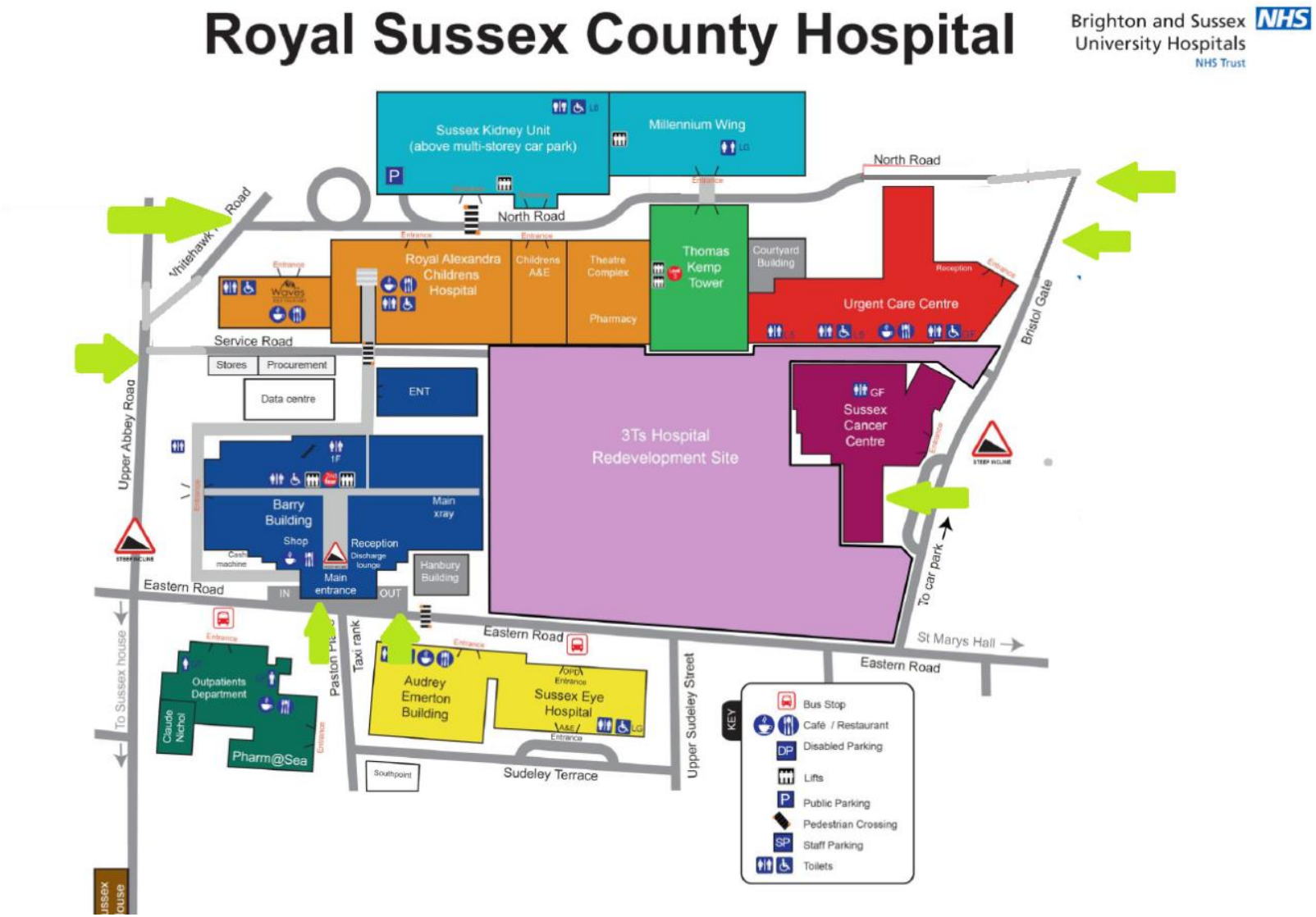
PRH

PRH does have a defined perimeter with a variety of boundary treatments in place in terms of low level fencing and hedging, none of which have any value in terms of security. There is a public right of way serving the new housing development to the south of the site which traverses the site at its western edge alongside the existing perimeter road and an access controlled gate giving access to Old Farm Close to the south eastern corner of the site.

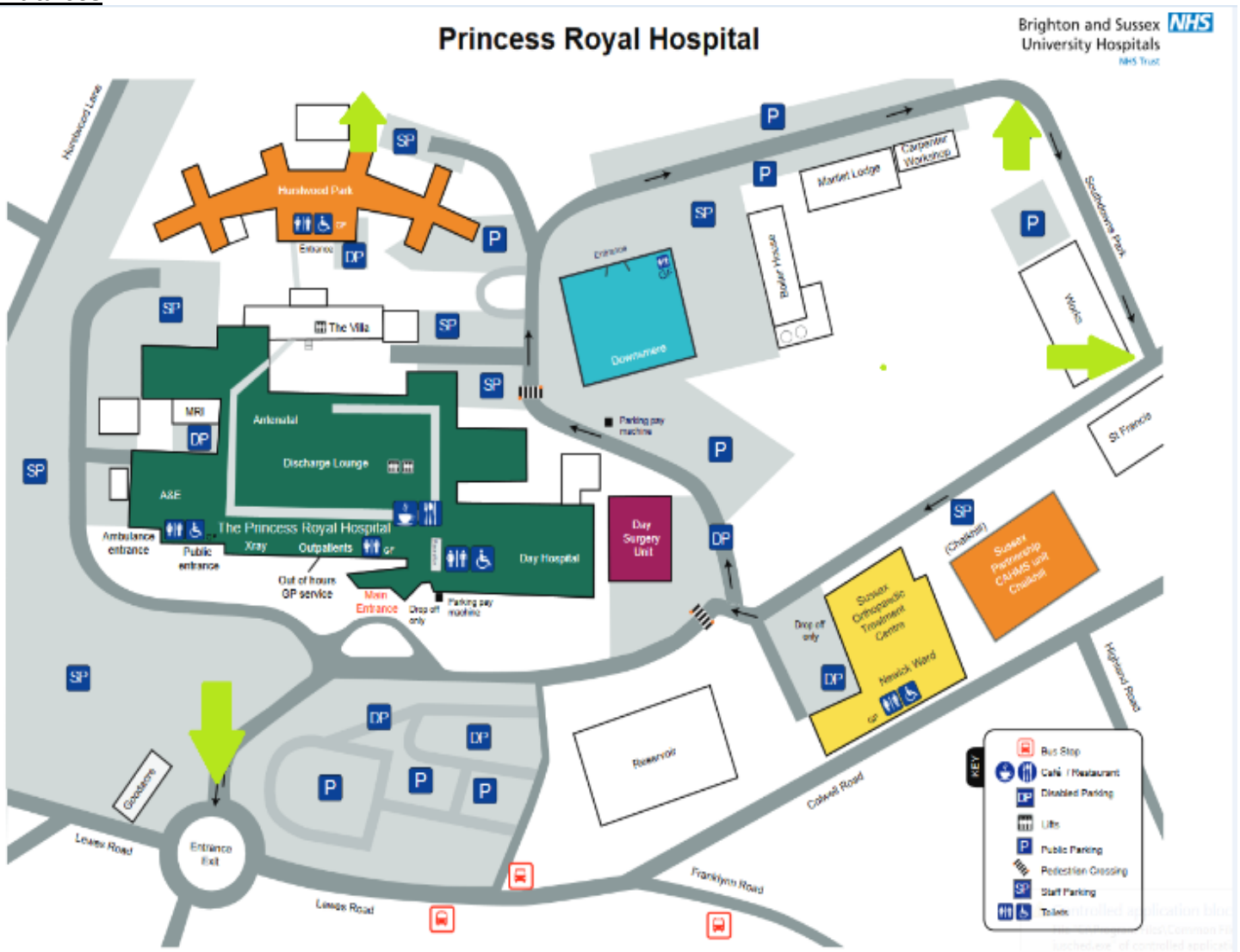
There are only 2 routine vehicle access points onto the site, one from Lewes Road and one from the private housing development to the west of the site. A third emergency access gate is also accessible from Lewes Road.

PRH also hosts an inpatient facility operated by Sussex Community Trust, a privately operated Social Club and a Southern Water facility making effective lockdown at the perimeter challenging.

Perimeter entrances to RSCH Clinical “island” Site



PRH Perimeter Entrances



Buildings

At RSCH there are currently 25 publically accessible entrances that give access to areas where patient care is delivered. This number does not include non-public areas such as St Mary's, fire exits or staff only entrance/exits.

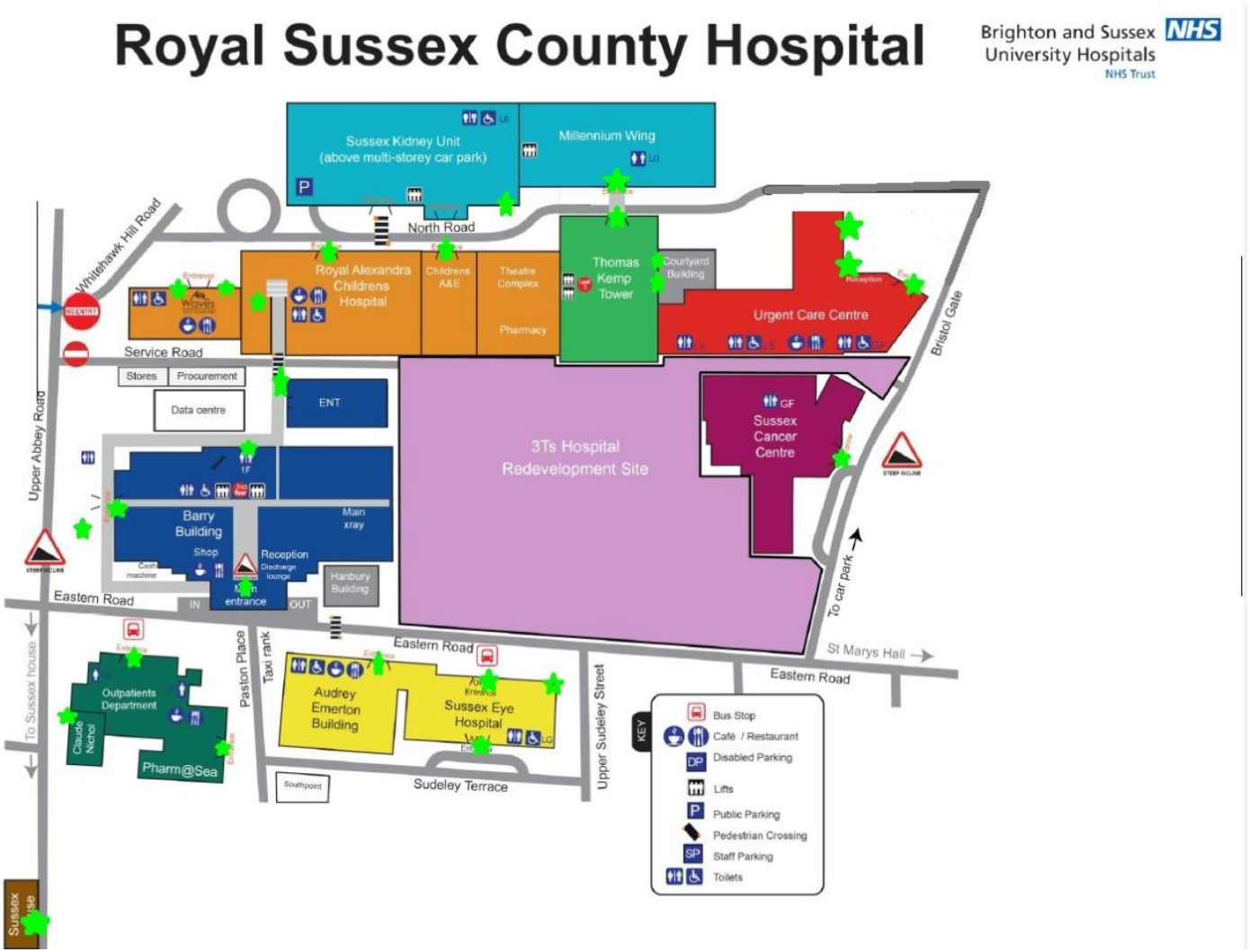
At PRH there are 9 publically accessible entrances that give access to areas where patient care is delivered. This number does not include non-public areas such as Downsmere, fire exits or staff only entrance/exits.

Other buildings where patient care is delivered include, Newhaven Downs, Hove Polyclinic, Preston Park Road, Hove Midwifery Hub, Bexhill and Eastbourne Radiotherapy Centre. None of these facilities is wholly operated by BSUH and while the necessity to lockdown these sites may be reduced the ability to do so may be dependent on coordination with and cooperation from landlord and other tenants.

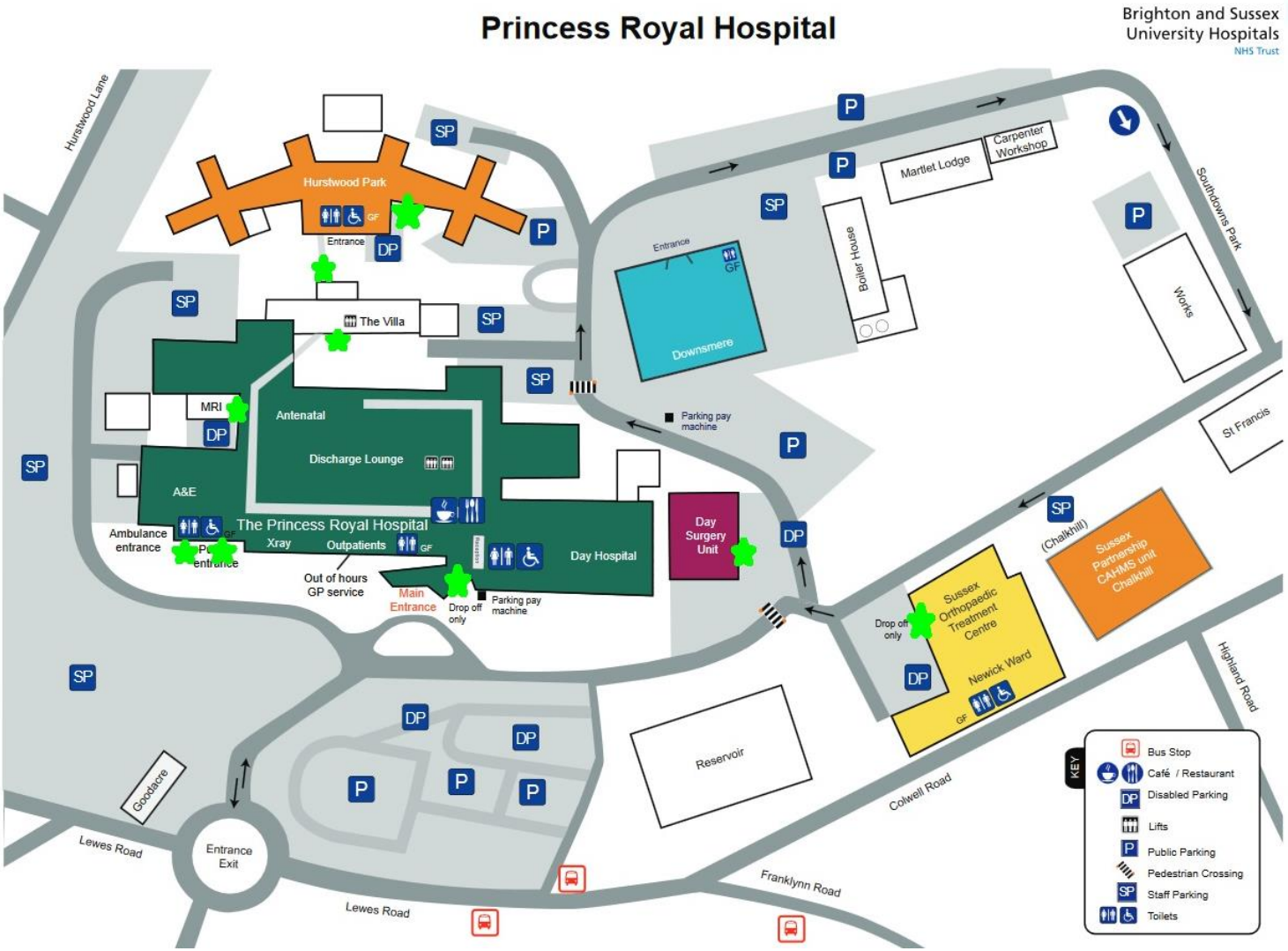
While most inpatient areas have automated access control systems (AACS) enabled 24/7 outpatient areas are either secured physically by a traditional lock out of hours or have electronic access control fitted and a timer initiated leaving the doors unlocked during the normal working day and securing at a predetermined time.

On both primary sites but particularly at RSCH the Emergency Dept is used as a routine entrance/exit into the hospital by both staff and visitors. While the geography and layout of the site may explain that, this position is not ideal clinically or operationally. The redesign of RSCH Level 5 Emergency Department area is certain to require this to be constrained during construction works and any such constraints should be considered a permanent change in terms of restricting routine access to a high profile clinical area.

Publically accessible entrances at RSCH



Publically accessible entrances at PRH



Staffing levels

At RSCH routinely there are operational security staff and Control Room Operators on duty at all times. At PRH there are routinely security staff on duty 24/7. Newhaven inpatient facility has 1 x security officer present at specific hours Monday to Friday and 24/7 cover at weekends and on public holidays. No other site from which BSUH operates has on site security cover.

As set out above the fire safety requirements of using an AACS means that in order to lockdown an area a physical presence is required at the door to prevent the use of the emergency break glass to deactivate the lock or the use of physical force to defeat the maglock.

For those fire doors not fitted with magnetic locks this is equally the case as the fire door, door furniture when activated manually, will leave the door insecure and a potential route for unauthorised access/egress.

Practical challenges and risks

The practical and operational challenges of achieving Lockdown at RSCH have been set out above and it is for this reason that the Trust has declared itself non-compliant with the lockdown requirement of EPRR Assurance. Brighton & Hove CCG have recently written to the Trust confirming that the Trust is substantially compliant in respect of EPRR Assurance but seeking further assurance on progress towards compliance including in respect of Lockdown.

The provider of the Trust's primary access control system has confirmed that it is possible to override the fire safety feature set out above for a pre-determined group of doors. This will result in those doors only being accessible to staff who have specific access control permissions on their ID card profile. This approach will require derogation from fire regulations as it may result in doors which would otherwise be fire evacuation routes remaining locked.

The scale of the requirement to achieve even a partial lockdown is such that while Lockdown is seen as a purely a security issue, it will not be possible to achieve compliance.
Consideration should be given to installing physical controls (gates) at the entrance to the RSCH clinical "island" site from the public highway as a means of mitigating the number of entrances.

While PRH only has 3 vehicle entrances its extended perimeter mitigates against a robust boundary treatment and control of entry at the perimeter.

Even where lockdown can be initiated electronically there will remain a staffing requirement to support the identification of those individuals with a legitimate need to enter/leave a specific area/building. During the normal working week it may be possible to supplement the Security Officers on duty with other colleagues from Facilities & Estates Dept and other areas. However, this will impact on the delivery of Soft FM services in

particular (portering/housekeeping) to patients and may require engagement with staff side in respect of the expectation on those staff groups. Out of “normal” hours the ability to physically support electronic lockdown is severely constrained.

Current Position

Should there be a requirement to lockdown the site today the Security staff on site will commence by staffing the main entrances to L5 A&E entrances utilising any unallocated Portering Department staff. In order to support Non Security Dept staffing entrances a Lockdown Major Incident card is being developed.

In normal hours (Monday to Friday 0700-1900) the availability of staff should enable a physical presence at L5 A&E entrances which will then be expanded to other entrances as required dependent on the scenario requiring lockdown.

Outside of normal hours the Security staff on site will commence by staffing the main entrances to L5 A&E utilising any unallocated Portering Dept staff. The security Team Leader on duty will make contact with the security contractor and request they make available additional staff. This will result in one additional security officer being available within agreed timescales. The security Team Leader will contact the Security Supervisors and Managers and will discuss on-going staffing requirements.

Historically the Security Dept maintained contracts with multiple security contractors; however, in 2015 this approach was changed by Procurement Dept insisting on a single contractor. This position has reduced our resilience and should be reversed as soon as is practicable.

Priority Areas for Lockdown

In order to develop the ability to Lockdown the sites it is proposed to prioritise the following areas:

- L5
- RACH ED
- Barry Building
- Hard Perimeter
- PRH
- Thomas Kemp Tower
- Millennium
- OPD
- Sussex Eye Hospital
- Sussex House
- St Mary’s Hall
- Freshfields

Action Plan

It is recommended that a Task & Finish Group be established as a sub group of the Resilience Group with the following departments/specialist advisors represented: Security, Estates, Fire, Resilience, with other individuals/departments co-opted as required. It is proposed that the Head of Capacity & Flow chair this group.

Suggested Tasks:

1. Consolidate lockdown into Major Incident Plan with Lockdown specific action cards.
2. Security Dept to complete a risk assessment of all areas of the Trust to identify every publically accessible entrance/exit, the details of the door, the door furniture installed and how that door can be secured in the event of Lockdown ***(underway);***
3. Confirm approach of lockdown at door level as opposed to lockdown at perimeter;
4. On completion of 2 above identify which doors must be able to be locked down in response to each of the six scenarios set out above;
5. On completion of 4 above identify whether the door can be electronically locked down, whether it requires staffing to maintain lockdown and how many staff will be required;
6. Complete a schedule of works for the necessary physical/technical works;
7. Obtain capital funding to deliver necessary works;
8. Deliver necessary works;
9. Identify & brief/train staff available to support lockdown;
10. e table-top/practical lockdown exercise.
11. Report compliance with EPRR assurance requirement
12. Revise Security support contract with Procurement Dept to seek availability of a second security contractor.

S C Whitehorn
Head of Security
11 July 2017