Brighton and Sussex University Hospitals NHS Trust

Meeting of the Board of Directors

10:00am to 12:30pm on Wednesday 25 July 2018
Lecture Theatre 1, Euan Keat Education Centre, Princess Royal Hospital,
Lewes Road, Haywards Heath RH16 4EX

AGENDA – MEETING IN PUBLIC

1.	10.00	**Welcome and Apologies for Absence**		Chair
2.	10.00	**Declarations of Interests**		All
3.	10.00	**Minutes of Board Meeting held on 30th May 2018** To approve	Enclosure	Chair
4.	10.05	**Matters Arising from the Minutes** To note	Enclosure	Chair
5.	10.05	**Chief Executive's Report** To receive and agree any necessary actions	Enclosure	MG
		PERFORMANCE		
6.	10.15	**Quality Report** To note and agree any necessary actions	Enclosure	GF/NR
7.	10.25	**Organisational Development and Workforce** To note and agree any necessary actions	Enclosure	DF
8.	10.35	**Performance Report** To note and agree any necessary actions	Enclosure	PL
9.	10.45	**Financial Performance Report** To note and agree any necessary actions	Enclosure	KG
		PATIENT SAFETY/EXPERIENCE ITEMS		
10.	10.55	**Learning from Deaths** To note and agree any necessary actions	Enclosure	GF
11.	11.05	**Overview of Patient Experience, PALS and Complaints** To note and agree any necessary actions	Enclosure	NR
		OPERATIONAL ITEMS		
12.	11.15	**WRES Action Plan** To note and agree any necessary actions	Presentation	DF
13.	11.30	**Annual Report for Medical Appraisal and Revalidation** To note and agree any necessary actions	Enclosure	GF
14.	11.45	**Annual Report on Organ Donation** To note and agree any necessary actions	Enclosure	GF

Brighton and Sussex University Hospitals NHS Trust

OTHER ITEMS

15.	12.00	**Use of Trust Seal** To note	Enclosure	DH
16.	12.10	**Other Business**	Verbal	Chair
17.	12.15	**Resolution into Board in Private:** To pass the following resolution "that the Board now meets in private due to the confidential nature of the business to be transacted"	Verbal	Chair
18.	12.15	**Date of Next Meeting** The next meeting in public of the Board of Directors is scheduled to take place on Wednesday 24th October 2018 at 9.30am in the Meeting Room, BSUH Trust Headquarters, Royal Sussex County Hospital, Eastern Road, Brighton.	Verbal	Chair
19.	12.15	**Close of Meeting**	Verbal	Chair
20.	12.15	**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

David Haycox
Interim Group Company Secretary

Brighton and Sussex University Hospitals NHS Trust

Minutes

Minutes of the Board of Directors (Public) meeting held on 30th May 2018 at 9.30am in the Meeting Room, Trust Headquarters, Royal Sussex County Hospital, Eastern Road, Brighton

Present:	Mike Viggers	Chair and Non-Executive Director
	Joanna Crane	Non-Executive Director
	Malcolm Reed	Non-Executive Director
	Mike Rymer	Non-Executive Director
	Martin Sinclair	Non-Executive Director
	Marianne Griffiths	Chief Executive
	George Findlay	Chief Medical Officer
	Denise Farmer	Chief Organisational Development and Workforce Officer
	Karen Geoghegan	Chief Finance Officer
	Nicola Ranger	Chief Nursing and Patient Safety Officer
In attendance:	Patrick Boyle	Non-Executive Director Advisor
	Jon Furmston	Non-Executive Director Advisor
	Lizzie Peers	Non-Executive Director Advisor
	Chipo Kazoka	Interim Company Secretary
	Sally Reeves	Assistant Board Secretary
	Clare Williams	Nurse Director for Workforce and Education

GENERAL BUSINESS **ACTION**

PB05/18/1 Welcome and Apologies

1.1 The Chair welcomed those present to the meeting.

1.2 Apologies were received from Kirstin Baker and Pete Landstrom.

PB05/18/2 Declarations of interest

2.1 There were no declarations of interest.

PB05/18/3 Minutes of Previous Meeting

3.1 The minutes of the meeting held on 28th March 2018 were approved as a correct record, subject to correction of a typographical error on page 6 which should read “protected” rather than “protective”. **SR**

PB05/18/4 Matters Arising

4.1 The matters arising were noted.

4.2 **PB01/18/7.8:**
Denise Farmer reported that housing options for essential workers had not been progressed to date, but that she would report back at a future meeting.

4.3 **PB01/18/10.4:**
Nicola Ranger advised that a pictorial booklet had been introduced on all wards to aid communication for those who have difficulties.

PB05/18/5 Chief Executive's Report

5.1 Marianne Griffiths presented the report, which was previously circulated, and highlighted a number of key points.

5.2 The new Emergency Ambulatory Care Unit (EACU) was officially opened at the Royal Sussex County Hospital (RSCH) in April and is the first of a number of improvements planned for the Trust's Emergency Department. The new unit is one of the first in the country where medical and surgical teams work alongside each other to treat emergency patients who do not need to stay in overnight. It is hoped that the number of patients seen in a day will increase from 40 to 70 as pathways are implemented.

5.3 The Trust's Stroke Unit achieved an "A" rating in the Royal College of Physicians SSNAP (Sentinel Stroke National Audit Programme) survey, which is great news. This is the first time that BSUH has been rated so highly in the SSNAP survey and is a direct result of the investment in the service by centralising stroke services on the RSCH site. The unit is now in the top 20% of Trusts in the country for stroke services. Marianne extended the Board's congratulations on this achievement.

5.4 Marianne reported that the Care Quality Commission (CQC) has altered its approach in assessing quality by way of regular engagement events to provide a continuous assessment of progress made. There have been two events over the last few weeks: the first in Critical Care, who were rated 'Inadequate' at the last inspection. Since then, Critical Care teams at RSCH and the Princess Royal Hospital (PRH) have both engaged with Patient First. The CQC visit went extremely well with improvements in morale being particularly noteworthy. The second engagement event was last week in the Emergency Department, which was just as positive. Both sites were visited and the CQC reported that the changes and differences were outstanding; they felt the services were safe and the staff were compassionate. Marianne said she was extremely proud of the staff who have done a fantastic job.

5.5 Another piece of positive news was the Workplace Race Equality Standard (WRES) conference which was held the previous day. The Trust has been focusing this year on improving engagement around race equality. The WRES conference was held in conjunction with the National WRES team, who gave a strong presentation to over 200 staff in attendance. It was agreed that all the information gathered at the conference would be collated and a de-brief would be arranged with the national WRES team to see how best to use the information. Staff were asked to vote on their priorities and a staff-owned action plan will be brought to Board following the next phase. The Chair added that the conference felt like a constructive and positive experience and conveyed his thanks to the National WRES team, who had added a great deal to the day.
ACTION: WRES action plan to be brought to Board in July. **DF**

5.6 As a final point, Marianne acknowledged that this meeting was to be Mike Viggers' last as Chairman of the Trust. Marianne spoke of her pride in the Trust's achievements during what has been an extraordinary year at BSUH. She added that this would not have been possible without Mike and conveyed her own and the Board's thanks to the Chair.

5.7 The Chair thanked Marianne for her comments and reflected on the last 12 months with BSUH. He said his overriding memory is of the warmth received from the staff who were understandably feeling quite unsettled by the constant change in the leadership. He believes the staff are now feeling reassured with Marianne and the team at the helm and it was good to hear their positive

comments via the WRES team at the previous day's conference. The Chair added that the Trust is starting to see improvements from the investments in A&E and the £19m additional costs to improve the fabric of the RSCH building, which is amazing. Among the Trust's many successes this year was achieving the Control Total and an additional £8m funding. There is a strong financial team in place and the work on clinical governance has put the Trust in a good place to move forward. The rollout of Patient First is yielding results and the Trust has received great feedback from the CQC, which sends out such a positive message across the organisation.

5.8 As a final point the Chair added that it is good to see the 3Ts development above ground and he is very much looking forward to seeing a brand new hospital in a few years' time. He thanked the Clinical Commissioning Groups (CCGs) who have been very supportive, as well as the fantastic staff at BSUH and an amazing leadership team in place. The Chair ended by saying that he would be very happy to be a patient at BSUH, although with the hope that the need never arises.

5.9 The Board **NOTED** the Chief Executive's Report and conveyed their thanks and good wishes to the Chair.

PERFORMANCE

PB05/18/6 Quality Report

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

6.2 George referenced the table in the report detailing Key Performance Indicators (KPIs). For April, the Crude Mortality rate is back down to a figure of 3.18% which is as expected. The Safety Thermometer is now at 97% which is the highest it has been at the Trust. There were no falls resulting in harm and no MRSA or C-diff cases, which is a big achievement for a hospital of this type. However, there is some work to do on mixed sex accommodation breaches, which is still high at 67.

6.3 With regard to mortality, the graph included in the report shows that the Trust experienced an increase in figures for this over the winter period, as did most Trusts nationally. George advised that no update was currently available for Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-Level Mortality Indicator (SHMI) this month due to issues with NHS Digital's external supplier. However, SHMI remains below 100. Out of Hospital SHMI has been raised at previous Board meetings and there are ongoing discussions with partners and CCGs as well as GP providers as to how to develop an integrated plan.

6.4 With regard to infection prevention, Nicola Ranger advised that although there were no MRSA or C-diff cases in April, there were some cases of measles reported and some contact tracing required among staff. Advice was sought from Public Health England around vaccination, although it is accepted that it is down to personal choice, and the Trust is encouraging people to have their children vaccinated.

6.5 Pressure ulcers have been discussed previously and Nicola acknowledged that there is further work required with people caring for loved ones at home due to the number of patients being admitted from home or care homes with pressure damage. It is hoped that with the work that is currently being done, grade 4 or 3 pressure ulcers will be eliminated by next year.

6.6 The Friends and Family Test (FFT) response rate increased in April to 30% of the inpatient population, which is positive, although as expected this has affected the overall percentage of patients recommending the Trust. That indicator has dropped to 92% from 98%. The next piece of work will be to analyse those wards and departments which have not scored highly on the FFT.

6.7 George advised that a report on Fractured Neck of Femur (NOF) patients would be released at the end of May and will be brought to the next Board meeting. The report provides a more integrated approach, which will give more benchmark data and should, hopefully, give the Board some confidence. The Trust (BSUH) was third in the country for outcomes regarding Fractured Neck of Femur.

6.8 Mike Rymer commented on the fantastic progress that has been made with infection control. Nicola agreed with Mike's suggestion that a regular update be provided to the Board on Gram-negative bacteria due to the national focus.
ACTION: A regular update on gram-negative bacteria to be provided to Board. **NR**

6.9 It was noted from the Quality Scorecard that the number of patients being admitted to the Stroke Unit, within four hours, did not appear to be improving. George responded that he is concerned about the numbers and this is a point of focus, although it is difficult to improve the situation until the bed capacity is increased. However, on looking at the figures alongside the performance report, the quality measure shows that the patients spending time on the Stroke Unit is minimal. George commented that it would be felt as a cause for concern if both metrics were poor.

6.10 Jon Furmston made a request to revert to 13 months reporting with SHMI to enable seasonal issues to be seen straight away. He also asked whether the Fractured Neck of Femur data could be transferred from the Performance Report to the Quality Report in order to give more clarity to the outcomes.
ACTION: SHMI reporting to show 13 months to highlight seasonal issues. **GF**
ACTION: Fractured Neck of Femur data to be moved to the Quality Report. **GF**

6.11 Lizzie Peers highlighted the increase in study leave cancellations, querying the impact on patients and whether this is an indicator of the robustness of the rostering system. George responded that this is partly due to the outpatient booking system, where there is less 'churn', and that Easter had some impact. George will follow up with Pete Landstrom to try to provide further detail.
ACTION: Discussion needed around the increase in study leave cancellations. **GF/PL**

6.12 On the subject of pressure ulcers, Patrick Boyle asked Nicola for her assessment of the contributing factors to this. Nicola advised that there are a number of frail patients being looked after at home and she had asked Alison Cannon, Chief Nurse for Sussex CCGs, if there was any additional learning available to raise awareness for patients. Another factor is the length of time that patients are spending sitting rather than lying down, which is preferable. The Chair suggested running a session on tissue viability between WSHT and BSUH as this is a big problem across the two trusts. The session could be run in a similar format to the recent infection control session which proved successful.
ACTION: Joint WSHT/BSUH session to be arranged on tissue viability. **NR**

6.13 Joanna Crane asked whether there is a plan to change any of the ceilings around metrics and targets or whether any had been substantially revised. George responded that there is some ongoing work to align the scorecard with

True North and Breakthrough objectives, but that the targets for the year are likely to be the same as new processes are embedded. He added that the following year would be more focused on delivery. Updates will be taken to the Quality Assurance Committee and any revised targets brought back to Board.

6.14 The Chair commented on the positive news regarding the increased FFT response rate. He added that having zero cases of C-diff and MRSA this month is a reflection on the cleanliness of the hospital which should be recognised.

6.15 The Board **NOTED** the content of the Quality Report.

PB05/18/7 Organisational Development and Workforce

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

- **Recruitment and retention:** Work is ongoing in Facilities & Estates around Soft FM and improvements in recruitment and retention is demonstrable in their figures. There has been more success in nursing and the first cohorts of Filipino nurses met the team at the WRES conference the previous day.
- **Appraisal:** The numbers are not increasing as quickly as they should. Each Division is focused on appraisal as part of their governance and performance arrangements and aiming to move forward.
- **WRES:** In addition to the conference, the national team held a session with the Trust Board and directors to ensure awareness and interpretation of the data. The report will be signed-off in July.
- **Leadership development:** The formal course commissioned from the Kings Fund started on Friday 25th May and was positively received.
- **Staff survey:** The information has now been circulated publicly. Denise highlighted the improved response rate and the comparative data around WRES. Key issues from the survey are care, health and wellbeing across the organisation.

7.2 Joanna raised a query regarding workforce absence due to stress and depression and asked whether there is a particular area with a higher incidence of this. Denise will follow up and supply any additional information to the Quality Assurance Committee (QAC).
ACTION: Further information to be provided and reported back to QAC. **DF**

7.3 The Board **NOTED** the report.

PB05/18/8 Performance Report

8.1 In Pete Landstrom's absence, Marianne presented the Performance Report and summarised key points.

8.2 **Activity**
Emergency activity eased slightly in April, although the number of A&E attendances increased. However, the conversion to admissions rate is down marginally compared to last year, which suggests the Emergency Ambulatory Care Unit (EACU) is working.

8.3 **Delayed Transfers of Care (DTOCs)**
DTOCs were more challenging in April with numbers up to 5.7%. The Trust is aiming to reduce this to the national average of around 3.5% so the pressure continues this quarter. Occupancy levels are overall 97%, but traditionally at the RSCH site the number is 99% which puts an unhealthy stress on the organisation. The Trust has made an important investment in A&E, partly to

add 70 extra beds by the end of next year with an interim strategy to add 35 extra beds by Winter. This should help to ease the occupancy issue.

8.4 **A&E**
The Trust achieved 85.4% performance in April. A recovery trajectory has been set out for the year and is on track, though there is a way to go to achieve 90% by October. This month is currently at 86%.

8.5 **Cancer**
The Trust was compliant in 7 of the 9 cancer metrics. However, there are stresses which are recognised and some additional governance was put in place in March to address these. The Trust has stated to the Department of Health (DoH) and NHS Improvement (NHSi) that by the end of July all cancer targets should be reached and Marianne is hopeful that this is achievable.

8.6 **Referral to Treatment (RTT**)
52 week waits are down to 5, the majority of which are patient choice issues. The aim is to have zero waits by the end of June. 42 week waits are now being targeted. The Trust's reported position in April is 83.02% against the target of 92%. There is an improvement plan, but the Trust is unlikely to hit the RTT target this year due to capacity issues.

8.7 **Diagnostic Waiting Times**
April was a challenging month at 7.28%, which is non-compliant against the <1% national target. There has been an issue around CT breaches and a new scanner is now in place. A recovery and capacity plan for CT has been finalised with a capacity and demand balance being achieved by July 2018. Sleep studies have improved with 4 breaches recorded at the end of April. One issue to note is around non obstetric ultrasound which is a big outlier. The main problem is recruitment to the vacant stenography roles, which is a very difficult role to fill and a national issue. Pete is working on this with the CCG to try and stem the increase in demand, which has been 10%.

8.8 Mike Rymer referred to the Cancer 62 day RTT from screening and asked whether this was concentrated in a particular area. George responded that this is predominantly in breast screening. George and Pete had a discussion with the screening team recently and produced an action plan. There is also the issue of the national breast screening recall which has affected the figures. There is an agreed plan to deliver the required 2,200 slots. The service was performing really well, but performance has dipped recently. There have been some recruitment successes following the retirement of three oncologists and lots of ongoing work in this area. Central Clinical Services are also involved.

8.9 The Board **NOTED** the Performance Report.

PB05/18/9 Financial Performance Report

9.1 Karen Geoghegan presented the Finance report for Month 1, which was previously circulated.

9.2 Key points to note:
- The final Annual Accounts were submitted on 29th May.
- The Control Total deficit was confirmed at £65.4m and agreed with NHSI.
- Month 1 financial performance is in line with the deficit plan of £7.4m.
- Sustainability risk rating is 4.

9.3 **Income**

- 2018/19 contracts have now been agreed with CCG commissioners and NHSE Specialised Commissioning.
- The Trust has now agreed contracts for 85% of patient related income, which is a good position to be in before the end of May.

9.4 **Pay**

- The Trust is almost £1m under pay for Month 1. The plan to recruit to vacant posts was ambitious and is under plan, although there has been some success in F&E.
- The new agency ceiling set by NHSI is £8m. Expenditure was marginally above the ceiling at £1k for April, so there has been good work in reducing.

9.5 **Efficiency Plan**

- The Plan is set to deliver £30m and plans are in place with approximately one third of them graded High risk of delivery due to complexity. The aim is to have fully agreed PIDs for end of Q1.
- The strategic capital forecast for the year is £138m with significant investments in the Emergency Floor and Estates Backlog Maintenance schemes. As business cases are developed, some natural slippage is expected in the over programming which is currently £6.9m.

9.6 **Cash**

- At end of April Cash was higher than plan, partly due to spending less capital, but invoices were also a factor.

9.7 In summary, Karen predicted that the year ahead is likely to be challenging, not least because of the scale of the efficiency programme, but also around income. Specialist Services was thought to be a potential area for concern, but the new contract should help to improve relationships.

9.8 Jon Furmston raised a query as to why April was planned to be the biggest budgeted deficit. Karen responded that working days have a material impact, but that April is influenced more by the phasing of the efficiency plan. The challenge is to ensure that the efficiency plan does deliver.

9.9 The Chair asked about the (Quality Assurance Committee) QAC element of risk. Karen responded that no work had been started in Month 1 that is required to go through the Quality Impact Assessment process, but this would continue to be monitored.

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

PATIENT SAFETY / EXPERIENCE ITEMS

PB05/18/10 Nursing Staffing and Capacity Levels Report

10.1 Nicola presented the report, which provides a six-monthly overview to Board and was previously circulated. Key points were highlighted.

10.2 Work is progressing regarding sickness rates, particularly among nursing assistants. Critical Care has managed to reduce its rates from 6.9% to 1.6% in March and the work done with this team will be followed in all wards where the sickness rate is high.

10.3 Recruitment is still a concern. In April, the vacancy rate reduced to 260 and this has been halved from October 2017. However, turnover has improved from

14.9% to 12.5%. The Trust is only just keeping up with demand and this is a concern despite recent activity.

10.4 Regarding fill rates, the focus is on ensuring there are enough nurses to care for patients. There is more support available from senior teams and staffing at night is fully mitigated.

10.5 Nicola is working closely with universities in Surrey and Hampshire to get a greater pool of people on board, but the Trust is still heavily reliant on overseas recruitment. There are plans in place to ease the process for nurses to retire at 55 and return to work, and the Trust is trying to utilise the more senior and experienced nurses. Work is also in progress regarding nurse registrations from overseas to see if the system can be improved.

10.6 Malcolm Reed asked about the relationship between the University of Brighton School of Nursing and BSUH. Nicola responded that the relationship is not as strong as she would like it to be, although she is due to meet with the University in the next two weeks. Compared to Surrey, they have not been as responsive around close working and do not appear keen to tackle this issue. Pre-registration nurses tend to want to go to a Trust that scores highly in the league table if they are going to pay a fee. Nicola agreed with Malcolm that there is an opportunity to build a good relationship, hence the coming meeting.

10.7 In response to Lizzie Peers' query around the Model Hospital data and the nursing templates, Nicola advised that the core data has been analysed to check seasonal variations and the Trust's planned ratios are higher than Model Hospital guidelines, with a maximum seven patients per nurse. Nicola added that the majority of the RSCH site is high acuity and the majority of vacancies are at PRH so there is a possibility to be creative there.

10.8 Joanna queried the possibility of having a nursing survey similar to the junior doctors' survey. Nicola advised that currently feedback is encouraged from nurses via a forum, but that a survey is a possibility. The Trust is trying to make changes to ensure that nursing students work within their team rather than just supervise others at work. Malcolm mentioned the national student survey which is completed during a student's final year and could be a useful tool in looking at students' experiences.

10.9 Referring to the table of registered nursing fill rates, Jon asked whether there is a 'tipping point' where an insufficient number of nurses could lead to ward closures. Nicola reported that at PRH there has been a vacancy rate of over 25% and some beds have been closed. At Royal Sussex County Hospital (RSCH), there are only two wards (respiratory care and an elderly care ward) with a rate over 20%, which is the 'tipping point'. She added that Ward Sisters at RSCH are supervisory so can mitigate the issue. They can also move staff, although this is not ideal. Jon suggested the Board should be made aware if the percentage is close to a tipping point in order to avoid ward closures. Nicola advised that the fill rate is 87%, which must be taken into consideration against planned staffing. George echoed Nicola's comments, reiterating that this is a mandatory reporting tool and BSUH is not in an unusual situation compared to other organisations. The impact on patients is the most important consideration and the feedback from patients has been good. The Board can take assurance from the Trust's low risk of falls as an indicator.

10.10 The Board **NOTED** the report.

PB05/18/11 Quarterly Learning from Deaths Report

11.1 George presented the report for Quarter 4, which was previously circulated, and highlighted key points.

- There were 474 deaths at BSUH in Quarter 4.
- All deaths on the RSCH site undergo a review with a Medical Examiner. The outcome of this review is fed into the Trust Mortality Review Group which determines whether a Serious Incident review is required.
- The number of Structured Judgement Reviews (SJRs) being completed is increasing each month.14 SJRs were completed in March. There are four training sessions booked across both the RSCH and Princess Royal Hospital (PRH) sites during June and July 2018 in order to increase the Trust's capacity to undertake reviews.
- There was one Never Event at the Trust recently regarding misplacement of a nasogastric tube and it is currently under investigation.
- There is some work to be done with the clinical coding team to see how some of the cases are being coded.

11.2 It was noted that most patients who die have undergone good care at BSUH. George acknowledged that there is further learning required in end of life care and he is planning to invite Stephen Bass, Specialist Palliative Care Team Leader, to attend a future QAC and/or Board to talk about this subject. George confirmed that there is a plan to reintroduce an End of Life Board. **GF**

11.3 George referenced the Medical Examiner (ME) Programme, which the Trust is embedding going forward with a national rollout due next year. There is 100% coverage at RSCH and George is working with Steven Drage and pathologists at PRH to expand the ME Programme at that site.

11.4 Joanna asked whether Learning Disability (LD) deaths could be included in the quarterly report. George advised that LD deaths are part of a national programme and to date it has been difficult to obtain any information. He added that the Maternal Deaths framework is also changing and they will no longer be investigated internally An independent body will be covering this and WSHT teams are currently involved in changing their processes. How these figures are captured in the report needs to be established going forward.

11.5 The Board **NOTED** the report.

PB05/18/12 Adults Annual Safeguarding Report 2017/18

12.1 Nicola summarised key points from the report which was previously circulated.

12.2 The discharge process remains an underlying theme in safeguarding concerns raised against BSUH. A number of issues have been raised around poor communication between the hospital and nursing home staff or care providers regarding specific care plans, for example wound care. A multi-agency discharge practice group has been formed to address these issues.

12.3 Further work is required around the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) as mandatory training has not yet achieved 90%. A vast number of DoLS applications have been received, primarily in geriatric wards and neuro patients. It has proved difficult to agree these in a timely fashion due to sheer numbers and the Department of Health is reviewing the process as a result.

12.4 Some safeguarding concerns have been raised regarding the use of physical restraint. There is work to do with both the nursing and security staff and a training programme has been introduced for nursing assistants.

12.5 There have been 168 safeguarding referrals made around domestic violence, with the highest number coming from ED, A&E and Maternity. As a result a large number of staff in these departments have received relevant training.

12.6 Martin Sinclair thanked Nicola for her report and asked for an update on the points raised during the internal audit around data quality and training. Nicola responded that the Audit Report had been a helpful tool and the team is now committed to transferring data from Excel to the DATIX system, which will be much more useful. Safeguarding training has not yet reached its target, but staff have booked on to additional sessions. Nicola confirmed that the recommendations would be agreed and actioned.

12.7 The Chair suggested it might be helpful for the Adult Safeguarding team to come to a future Public Board, as they did in WSHT. Nicola will follow up. **NR**

12.8 The Board **NOTED** the report.

PB05/18/13 Healthy Food CQUIN

13.1 Nicola summarised the report, previously circulated for information, which outlines the progress made on all four hospital sites to achieve the CQUIN (Commissioning for Quality and Innovation) 2017-18 in providing healthy food for NHS staff, visitors and patients.

13.2 BSUH has been working with internal and external food outlets on the hospital sites to reduce the sugary and high calorie food and drinks on sale in an effort to reduce obesity levels. A number of positive actions have been achieved.

13.3 During 2018/19, the CQUIN requires a further shift in percentages:

- 80% of drinks stocked must be sugar free: less than 5g of sugar per 100ml.
- 80% of confectionery and sweets should not exceed 250 kcal.
- 75% of pre-packed sandwiches and pre-packed meals should contain 400kcal or less per serving and not exceed 5g saturated fat per 100g.

13.4 The Board **NOTED** the report.

GOVERNANCE ITEMS

PB05/18/14 Use of Trust Seal

14.1 Chipo Kazoka summarised the report, which was previously circulated. It is a requirement of the Trust Standing Orders (Section 8.3) that a register of sealings is maintained. Use of the Common Seal is reported to the Trust Board on a quarterly basis and the report covers the use of the seal for the period 1st January 2018 to 30th April 2018. There were no additional comments received from the Board.

14.2 The Board **NOTED** the report.

PB05/18/15 Provider Self Certification

15.1 Chipo introduced the report, which was previously circulated. He explained that whilst NHS Trusts are exempt from holding a provider licence, nevertheless they are required to self-certify that they can meet specified regulatory

obligations and that they have complied with governance requirements.

15.2 The Board's attention was drawn to the Appendices to the paper which contained a number of statements requiring the Board to either confirm as true or not. The self-certification would then be signed on behalf of the Board by the Chief Executive and the Trust Chair before being published on the Trust's website. There were no further comments to note.

15.3 The Board **NOTED** the statements in the self-certification document; how they were substantiated and confirmed each one of them. The Board also **APPROVED** that the self-certification statements for 2017/18 be signed by the Chief Executive and the Trust Chair as having been confirmed by the Board and thereafter that they be published on the Trust website.

OTHER ITEMS

PB05/18/16 Any Other Business

16.1 There was no other business to report.

PB05/18/17 Resolution into Board in Private

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

PB05/18/18 Date of the next meeting

18.1 The next meeting will be held on Wednesday 25th July 2018 in Lecture Theatre 1, Euan Keat Education Centre, Princess Royal Hospital, Haywards Heath.

PB05/18/19 The Chair formally closed the meeting.

PB05/18/20 Questions from members of the public

20.1 The first question referred to the radiotherapy demand and capacity modelling work done by the Surrey and Sussex Cancer Alliance which recommended that the LINAC (Linear Accelerator) should be located in Chichester. The Board was asked about BSUH's role in taking forward this development. George responded that both BSUH and WSHT were supportive of the plan to locate two LINACs in Chichester and the key step is how the Alliance engages with commissioning. Their report will determine how this is taken forward. George confirmed that although the Alliance is leading on this project, BSUH still has an interest.

20.2 A member of the public referred to the national government statistics on Delayed Transfers of Care (DTOCs) and asked the Board to clarify where BSUH stands in relation to the 61.6% of delays being attributable to the NHS, the main reasons locally for DTOCs and the current plans and prospects for eliminating such delays. George responded that the DTOC figure was 10% around 12 months ago and he had been impressed by the system leadership of the CCG in managing this figure to a lower level; it was 4% at its lowest. A multi-agency team including various Trusts, commissioners and Adult Social Care are all involved in driving down this figure. The predominant reason for delays is the same as the national picture, which is the number of patients awaiting further non-acute NHS care. The local Community Trust works very closely with BSUH. One issue is that as patients have more acute illnesses or are more complex, some facilities are no longer able to take them. A large constraint is workforce and finding the staff to cover packages of care at home.

20.3 The final question referred to the Quality Report and the incident of measles at BSUH and asked whether this was in a particular department. Nicola responded and advised that this referred to staff who had come into contact with a patient who contracted measles. There were several patients identified with measles over a period of time.

Sally Reeves
Assistant Board Secretary
May 2018

Signed as an accurate record of the meeting

……
Chair

……
Date

MATTERS ARISING
BSUH Board of Directors (in Public)

AGENDA ITEM: 4

Meeting	Minute Ref	Action	Person Responsible	Deadline	Status
31st January 2018	PB01/18/7.8	**Organisational Development and Workforce:** Follow up required on local housing options for essential workers.	Denise Farmer	tbc by Denise	To be included in the Organisational Development and Workforce Report
31st January 2018	PB01/18/7.12	**Organisational Development and Workforce:** Equality and Diversity national benchmark data, when available, to be brought back to Board.	Denise Farmer	July 2018	Data to be included when available
28th March 2018	PB02/18/6.7	**Quality Report:** report to be provided on the learning around infection control this winter.	Nicola Ranger	June 2018	To be included in the Quality Report
28th March 2018	PB02/18/6.13	**Quality Report:** patient feedback report to be brought to a future Board.	Nicola Ranger	June 2018	Agenda item – July Public Board
28th March 2018	PB02/18/10.7	**Learning from Deaths:** detail in the narrative around deteriorating patient to be provided.	George Findlay	June 2018	To be included in the Quarterly Learning From Deaths report (from June 2018)
28th March 2018	PB02/18/12.6	**Gender Pay Gap:** this data to form part of the Equality and Diversity agenda.	Denise Farmer	July 2018	To be included in Equality and Diversity report
30th May 2018	PB05/18/5.5	**CEO's Report:** WRES staff-owned action plan to be provided to Board.	Denise Farmer	July 2018	Agenda item – July Public Board
30th May 2018	PB05/18/6.8	**Quality Report:** A regular update on gram-negative bacteria to be provided to Board	Nicola Ranger	June 2018	To be included in the Quality Report
30th May 2018	PB05/18/6.10	**Quality Report:** SHMI reporting to show 13 months to highlight seasonal issues.	George Findlay	June 2018	To be included in the Quality Report
30th May 2018	PB05/18/6.10	**Quality Report:** Fractured Neck of Femur data to move from Performance to Quality Report.	George Findlay/ Pete Landstrom	June 2018	To be included in the Quality Report
30th May 2018	PB05/18/6.11	**Quality Report:** Further detail to be provided around the increased study leave cancellations.	George Findlay/ Pete Landstrom	June 2018	To be included in the Quality Report
30th May 2018	PB05/18/6.12	**Quality Report:** Joint WSHT/BSUH session to be arranged on tissue viability.	Nicola Ranger	tbc	Nicola to confirm a date
30th May 2018	PB05/18/7.2	**Organisational Development and Workforce:** Further info on stress and depression in the workforce to be provided to QAC.	Denise Farmer	June 2018	To be reported back to Quality Assurance Committee
30th May 2018	PB05/18/11.2	**Learning from Deaths:** Stephen Bass to be invited to give a presentation on end of life care	George Findlay	tbc	Agenda item – George to confirm whether Public Board and/or QAC
30th May 2018	PB05/18/12.7	**Safeguarding:** Adult Safeguarding team to give a presentation to Board, as at WSHT.	Nicola Ranger	tbc	Nicola to confirm a date

Brighton and Sussex University Hospitals NHS Trust

To: Trust Board

Date of Meeting: 25th July 2018 Agenda Item: **5**

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

To: Trust Board
Date: 25th July 2018

Chief Executive's Report

1. Financial Special Measures

As was widely reported at the beginning of July, the trust is no longer in special measures for financial reasons. This is another important step on our improvement journey.

First and foremost, this is a welcome recognition of what NHSI described as "the significant work the trust has undertaken to stabilise its financial position". But it is also an important endorsement of our approach to sustainability and a measure of the strength of focus and discipline we will need to continue our progress towards financial stability over the longer run, and confirmation that we cannot shy away from difficult decisions in the months ahead.

We know that care of patients is our absolute top priority and emerging from financial special measures is central to that, not an end in itself.

We have not got to this point by making short-term cuts to services or staffing; we agreed a deficit reduction plan with NHSI and we have delivered on it. That cannot be a one-off effort though; the financial discipline we have achieved over the last year has to be the new normal and we have to continue seeking out better value and cost savings everywhere we can.

The reality is that we are still years away from breaking even – but we know that we have a formula for sustainable improvement that works financially as well as in service quality terms. The investments we are making in services show what we can do if we are free to control our own destiny, and continuing to reduce our deficit is the only way that autonomy will be earned.

We know there is a clear and established link between financial sustainability and quality of patient services. Quite simply, you can't come out of special measures for quality without having come out of special measures for finance first – so this is a hugely important step towards our long-term goal of providing outstanding care for our communities.

2. WRES and Culture – maintaining the momentum

In May, we held our first Workforce Race and Equality conference at the Brighton Metropole Hotel. The feedback from this outstanding and oversubscribed event was excellent with colleagues finding it inspirational, vibrant and valuable.

On Wednesday 18th July, we held a follow up event at Brighton Race Course. Colleagues from across the organisation took the opportunity to find out exactly what we are doing across the Trust to implement the commitments made at the May event.

This was another incredible event, and it is clear how willing our colleagues are to build an open, inclusive culture throughout the trust.

This is the start of a journey for the trust, and I am extremely encouraged by the strong start we have made.

3. Leaders' Conference – progress and challenge

Directly following our Race and Culture Conference, we hosted a Leaders' Conference. I was delighted to see over 100 leaders from across the trust join the event, spending time focusing on our Patient First progress and the priorities for the future.

We heard from colleagues implementing Patient First live and had the chance to question them on their experiences. As is to be expected with a change of this magnitude, there were some pebbles and road bumps along the way, but I am very pleased to report that every single one of the wards who are now using Patient First have become passionate advocates for it.

I am also extremely grateful to the challenging session delivered by The Kings Fund, which looked at how we create a culture of leadership throughout the trust. It is important for us to be able to create the time and space to give our staff the opportunity to further their professional development and, in so doing, continually improve the care that we are able to offer our patients.

4. NHS70 – a welcome chance to reflect

Since the last public Board meeting, we celebrated the NHS' 70th Birthday with events taking place across both BSUH and WSHT. This was a real moment to stop and reflect on 70 amazing years for the NHS, and on everything that we offer here at BSUH.

Without the dedication, skill and compassion of our staff at all levels and from all specialities, the health service would simply not exist, nor be able to achieve so many amazing things for so many people.

This really is cause for celebration and NHS70 was the perfect opportunity to remind ourselves of what we do and how much that means to the people we serve.

It was also an opportunity to spend a moment looking forward to the service changes and improvements which we are all making together.

Our Patient First improvement huddles are a great example of this – anyone can contribute, raise issues, and be part of the solution, irrespective of professional background or grading – and we are already seeing great results coming from these.

In combination with applying structured lean problem-solving, this an exciting cultural shift which will enable us to keep improving and care for more and more people for at least the next 70 years.

5. National recognition for our staff and the innovations they are making in patient care

Since the last Board meeting, we have received some very welcome national attention for the care colleagues are delivering throughout the trust.

For example, we are in the top 15% of trusts in the country for helping patients with diabetes control their blood sugar levels. This represents the outcome of two years of hard work with colleagues innovating and reimagining how we provide care.

Our Radiography team has just been recognised with the national 'Make It Better' award from the British Institute of Radiographers for their Radiographer Led Discharge pilot. Taking peer-reviewed practice from other areas and tailoring it for our unique patient care needs here at

BSUH, the team was able to improve flow through our Emergency Department during the pilot and show how, by looking at a problem differently, we can deliver a workable, caring solution.

Jowers Ward Manager, Karen Lee, has been shortlisted for a Nursing Times Award for dramatically reducing falls on the ward through the introduction of picture blankets on patient beds. She will be making a presentation to the Nursing Times judges in September, so perhaps by the time of the next Board meeting we will have a further update to share with you.

Our Emergency Department has also been "Highly Commended" in the Patient Safety category of the Health Service Journal (HSJ) awards this month. Their prompt cards project aims to standardise care and reduce the opportunities for human factors errors, keeping patients safe and enabling staff to follow the same processes under even the most pressing conditions.

These are just a few examples where our innovations and focus on providing outstanding patient care at every opportunity have gained external attention. But every day, we receive compliments from our patients, identifying colleagues who have gone above and beyond in the pursuit of delivering the best patient care experience possible.

This is just one example of the feedback we receive – and I think that it really speaks for itself.

I'm at home now getting used to having a broken bone in my hand, but I feel compelled to pass on some praise. I had to wait in A and E a while but that was fine. When I was seen, I felt like I was the most important person in the world! I had checks that I didn't expect and felt such a genuine feeling of concern for my wellbeing. It was mostly a guy called Conor in A and E. He was so friendly and warm. He must have been really busy (because you all are) but I didn't feel rushed at all. I felt like a patient, not a number being processed and left with such a feeling of pride in the NHS as a UK staple.

6. Improving our care facilities in partnership with others

There were celebrations and tears as a new Bereavement Suite opened at the County Hospital's Labour Ward. The suite, which is located outside the main ward, has a delivery room and a living room/bedroom. It is designed to give parents and families a sympathetic environment in which to spend time with their babies.

Two of our staff, Hayley Stevenson and Shelley Trigwell, advocated for the creation of the bereavement suite and led the work with two neonatal bereavement charities, Abigail's Footsteps and Oscar's Wish Foundation. Novus Property Solutions became involved and donated £20,000 of free work to make the bereavement suite possible.

We have also welcomed the involvement of the Teenage Cancer Trust who funded the refurbishment of a space in The Royal Alexandra Hospital to provide an age appropriate space for the routine treatment of teenage cancer patients. This widens the options for patients, so that they can receive the care they need closer to home, as well as in London.

Care is not just the prerogative of the trust, or of the NHS as a whole. By working together with our supporters throughout the healthcare system and beyond, we can continue to improve the care we offer to our patients in a truly sustainable way.

I am so proud of what our staff are achieving and how they are looking 'outside of the box' for new initiatives and innovations to put the delivery of outstanding care at the heart of everything we do.

Brighton and Sussex University Hospitals NHS Trust

To: Trust Board of Directors

Date of Meeting: 25th July 2018 Agenda Item: **6**

Title
Quality Report Month 4
Responsible Executive Director
Dr George Findlay (Chief Medical Officer) and Nicola Ranger (Chief Nursing and Patient Safety Officer)
Prepared by
Mark Renshaw, Deputy Chief of Safety, Rob Haigh Medical Director
Status
Public
Summary of Proposal
The report describes performance against safety and quality key performance indicators in Month 3, in the domains of safety, effectiveness and patient experience
Implications for Quality of Care
The report includes exceptions in respect of pressure damage which is at its highest since 2012-13 and implementation of the alert.
Link to Strategic Objectives/Board Assurance Framework
This report incorporates key national, regional and local quality indicators relating to quality and safety providing assurance for the Board and highlighting issues of concern. **A safety and quality scorecard is appended**
Financial Implications
Future reports will include KPIs that have potential financial impact (e.g. CQUIN)
Human Resource Implications
Safer staffing levels are incorporated in the safety and quality scorecard
Recommendation
The Board is asked to NOTE the report.
Communication and Consultation
Not applicable
Appendices
None

1 INTRODUCTION

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

KEY QUALITY OBJECTIVES

2.1 Dashboard Definitions

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

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

2.2 Overview of Key Quality Objectives

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

Table 1: key performance indicators

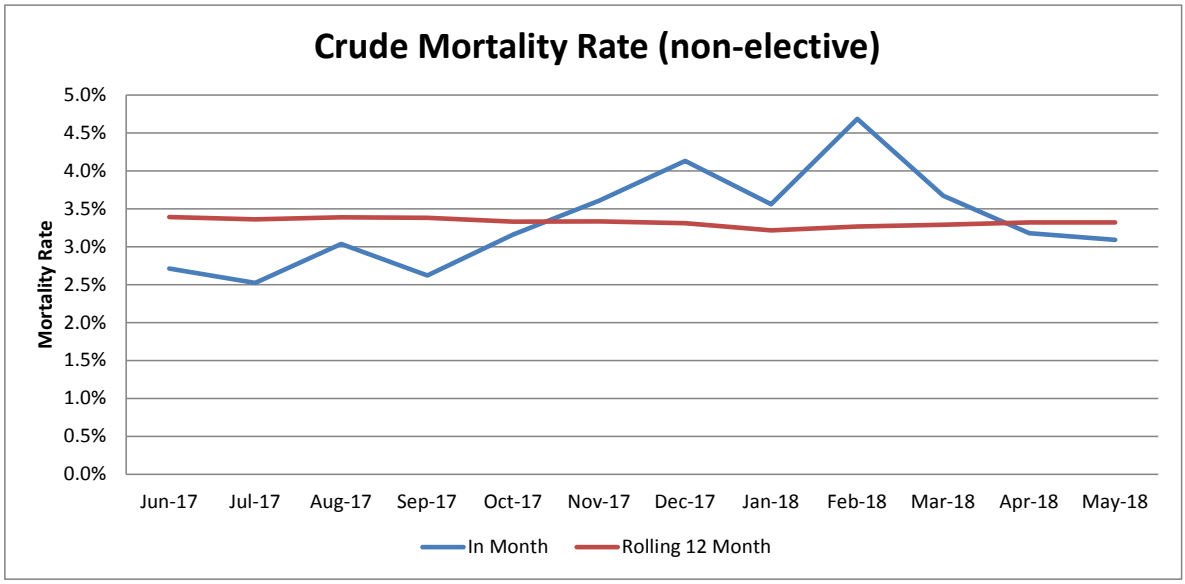
Indicator	April	May	June
Trust crude mortality rate (non-elective)	3.18%	3.09%	2.60%
Summary Hospital-Level Mortality Indicator	*Data not available*		
Hospital Standardised Mortality Ratio (Rolling)	*Data not available*		
Safety Thermometer (Harm-Free Care)	96.6	95.1	96.83
Number of Serious Incidents Requiring Investigation	4	5	2
Never Events	0	0	0
Grade 3 and 4 Pressure Ulcers	1	2	0
Falls resulting severe harm or death	0	0	0
Numbers of hospital attributable MRSA	2	1	1
Numbers of hospital C. diff cases	0	7	3
The Friends and Family Test: Percentage Recommending Inpatients	92%	91.9%	93.7%
The Friends and Family Test: Percentage return rate	30.2%	51.6%	38.8%
The Friends and Family Test: Percentage Recommending A&E	89.5%	89%	90.5%
Mixed Sex Accommodation breaches (number of breaches)	67	48	44
Number of formal complaints	48	39	44

3 EFFECTIVENESS

3.1 Crude Trust Mortality – Non-Elective

3.1.1 Figure 1 below illustrates the Trusts in-month and 12 month crude mortality rate for non-elective admissions. At the end of May the 12 month rolling mortality rate was 3.32%. (crude mortality rates are influenced by seasonal variation).

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

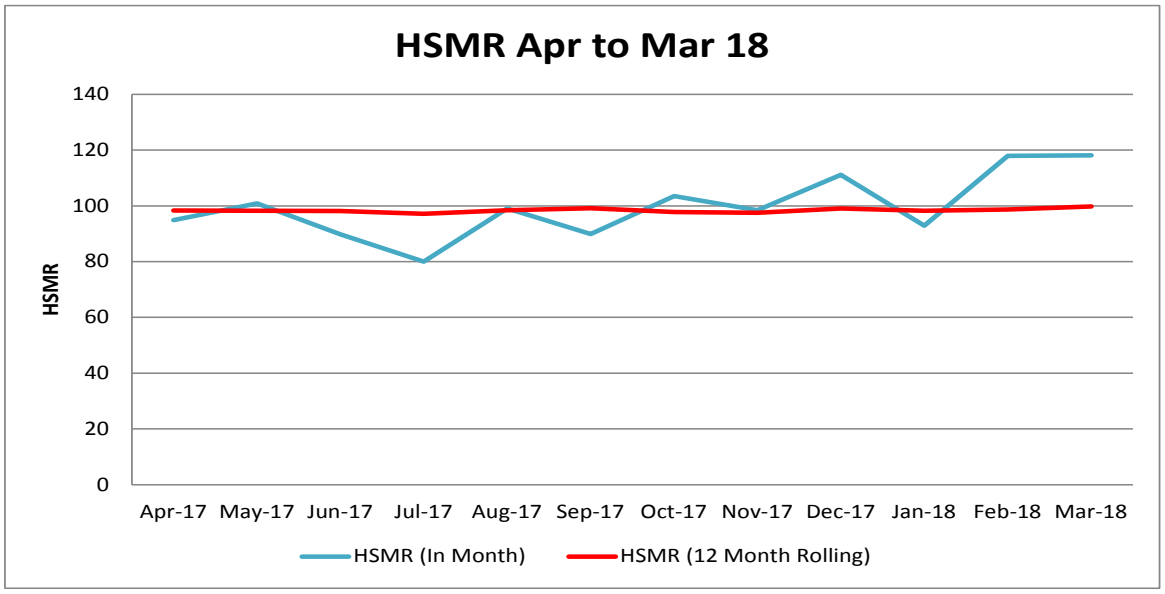


3.2 Hospital Standardised Mortality Ratio (HSMR)

3.2.1 Note: As a result of issues with NHS Digital's external supplier, Office for National Statistics the most recent data is not available.

3.2.2 HSMR is only available for the month of March when 121 patients died against an expected number of 102. The HSMR for March was 118. In the 12 months to April the HSMR was 99.81[1] (LCI 94.49, UCI 105.36). See figure 2 below.

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



Twelve months ago the annual HSMR was 97.61 (LCI 92.6, UCI 102.8).

3.3 Summary Hospital-Level Mortality Indicator (SHMI)

3.3.1 Like HSMR because of ongoing issues with NHS Digital's external data supplier, the Office for National Statistics are still unable to provide data, this problem will be resolved by 20th July 2018.

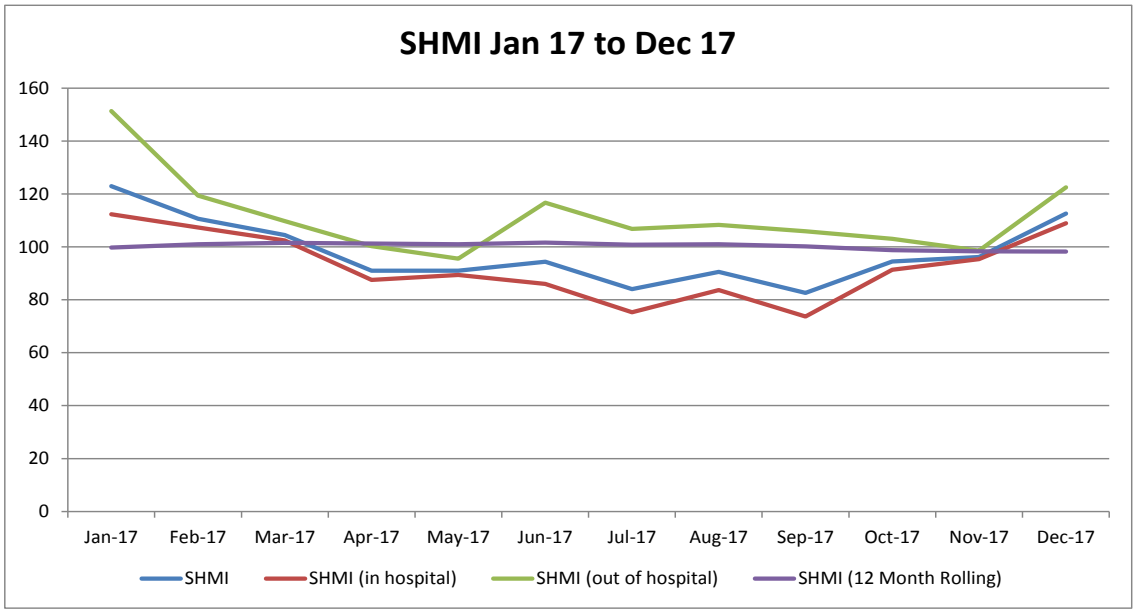
[1] *A value greater than 100 means that the patient group being studied has a higher mortality level than NHS average performance*

3.3.2 The most recent data available is for the 12 months up to December 2017 when the SHMI) was 98.18, i.e. mortality is 1.82% below the expected value. Table 2 below shows the in and out of hospital SHMI for the period January to December 2017. During this period 2362 patients died (expected number of 2405). In hospital deaths make up 69% of the total number of deaths, and are 6.9% below the expected number. Out of hospitals deaths are 11.69% above the expected rate. The 12 month rolling SHMI, is coming down.

Table 2: SHMI

Discharge Month	SHMI	SHMI (in-hospital)	SHMI (out of hospital)	Rolling 12 Month SHMI
Jan-17	122.91	112.28	151.31	99.74
Feb-17	110.62	107.36	119.37	100.97
Mar-17	104.42	102.43	109.69	101.53
Apr-17	91.00	87.47	100.27	101.21
May-17	91.00	89.37	95.55	100.97
Jun-17	94.38	86.01	116.68	101.62
Jul-17	84.01	75.32	106.80	100.82
Aug-17	90.58	83.68	108.32	101.02
Sep-17	82.60	73.66	105.87	100.19
Oct-17	94.50	91.33	103.03	98.79
Nov-17	96.18	95.36	98.59	98.33
Dec-17	112.58	108.97	122.45	98.18
Total	98.18	93.1	111.69	100.28

Figure 3: In-month and Rolling 12 Month SHMI



4 SAFETY

4.1 Patient Safety Alerts

One patient safety alert is currently open - Confirming removal or flushing of lines and cannulae after procedures. Closure of this alert is on schedule (August deadline).

4.2 Serious Incidents Requiring Investigation (SIRIs)

4.2.1 There were 11 Serious Incidents declared during the period April to June. One of these incidents is currently graded as death, two as severe, and five as moderate

4.2.2 Three of the Serious Incidents involved 12 hour breaches and five were patient falls.

4.2.3 The eight SI's, that were not 12 hour breaches, currently undergoing investigation are:

Title of investigation	Harm Caused
Air embolism	Death
Management of Subdural	Severe
Medication Error	Severe
Fall - L9a SSW	Moderate
Fall on Hurstpierpoint	Moderate
Fall on Level 8 Tower	Moderate
Fall on Level 9a	Moderate
Fall on Twineham	Moderate

4.1 Infection prevention

4.1.1 There were one outbreaks of diarrhoea type illness (i.e. norovirus, astrovirus) during May, zero outbreaks during April and June 2018

4.1.2 There were two cases of Hepatitis A admitted to the RACH during May. Public Health England informed and are managing the situation as it is community acquired. No further cases identified

4.1.3 There were three cases of Trust apportioned *Clostridium difficile* infections for June 2018, this brings the Trust apportioned cases to a total of 10 cases for quarter one. The target for 18/19 is no more than 45.

4.1.4 One case of Trust apportioned reported for June 2018, investigation is in the process of being undertaken.

Table 4: Gram negative blood stream infections;

Gram negative	Apr 18	May 18	Jun 18	YTE total
E. coli	5	2	2	9
Pseudomonas aeruginosa	1	0	1	2
Klebsiella	0	1	0	1
Total	**6**	**3**	**3**	**12**

4.3 Inpatient Falls

4.3.1 The rate of falls for the last financial year is 3.33 falls per 1000 bed stay days; this was the lowest recorded falls rate ever for the Trust. The National Falls rate is 6.63 falls per 1000 bed days.

4.3.2 During the past 3 months 210 patients have fallen at a rate of 3.38 falls per 1000 bed days. The adult inpatients falls rate for the period April to June was 3.38 falls per 1000 bed days.

4.3.3 Four wards have seen a rise in the rate of falls in quarter 1. The Matron for Renal and Level 8a Tower is coordinating a meeting for a deeper dive into the increase in the wards falls rate.

Table 5: ward with highest falls rate April to June

Ward	Rate 2017-18	Falls 2018-19	Rate 2019-18 Q1
Courtyard 8	5.36	5	6.72
Level 8 Tower	4.58	21	6.62
Renal	4.54	15	6.56
Emerald	4.59	9	6.36

4.4 Tissue Viability

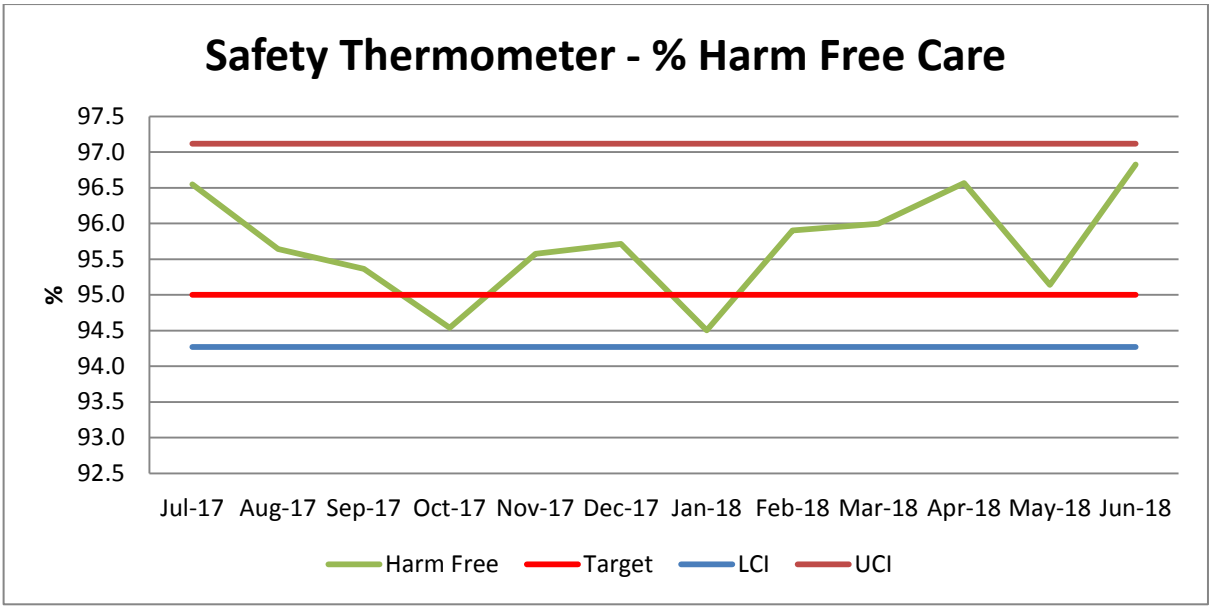
4.4.1 During the period April to June there were three grade 3 and 65 grade 2 hospital acquired pressure damage incidents reported. Damage to the sacrum, buttocks and heels remains the most common form of pressure damage. Inadequate documentation of skin assessment and changes of position are recurring themes.

4.4.2 The rate of pressure damage per 1000 bed stays days during the period April to June was 0.86. The pressure damage rate for 2017/18 was 0.68 incidents per 1000 bed stay days.

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.

Figure 5: Harm free care



4.6.2 The harm-free care score for the past 12 months was 95.69 against the target of 95%. The national average is 94.2%.

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

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

4.7 Malnutrition Universal Screening Tool MUST

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

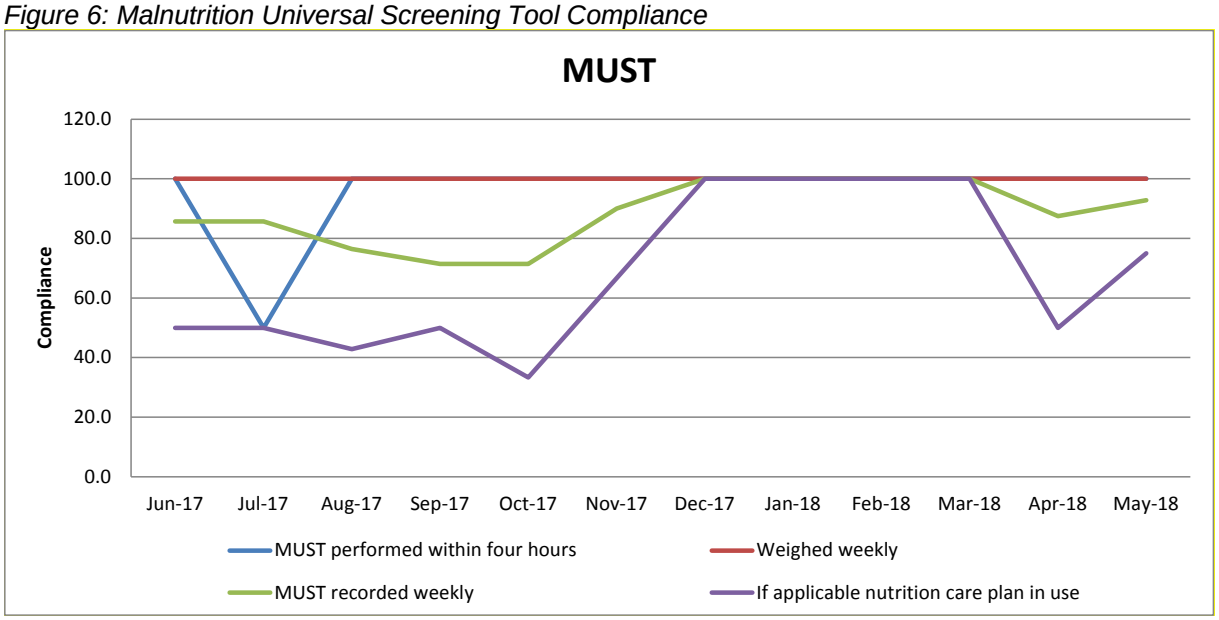
Data on MUST is captured via the Nursing Metrics database, which involves every adult ward screening 10 sets of notes each month. The analysis below is based on the review of 3826 sets of notes.

The proportion of patients receiving a full Nutritional Assessment and MUST score within four hours of admission / transfer to their ward has been increasing over the past 12 months. (Table 3 and Figure 6).

Table 3: Malnutrition Universal Screening Tool Compliance

Month	MUST performed within four hours	Weighed weekly	MUST recorded weekly	If applicable nutrition care plan in use
Jul-17	50.0	100.0	85.7	50.0
Aug-17	100.0	100.0	76.5	42.9
Sep-17	100.0	100.0	71.4	50.0
Oct-17	100.0	100.0	71.4	33.3
Nov-17	100.0	100.0	90.0	66.7
Dec-17	100.0	100.0	100.0	100.0
Jan-18	100.0	100.0	100.0	100.0
Feb-18	100.0	100.0	100.0	100.0
Mar-18	100.0	100.0	100.0	100.0
Apr-18	100.0	100.0	87.5	50.0
May-18	100.0	100.0	92.9	75.0
Jun-18	100.0	100.0	100.0	100.0
Total	**96.9**	**100.0**	**88.1**	**65.9**

Figure 6: Malnutrition Universal Screening Tool Compliance



5. PATIENT EXPERIENCE

5.1 PALS and Complaints

5.1.1 The Trust received an average of 46 formal complaints per month during Q1 2018/19.

5.1.2 1,232 concerns were received by the Trust in Q1 2018/19 (PALs and Complaints Team).

5.1.3 Of these, 1,095 concerns were resolved locally and 137 required a written response. During Q1, 95% of Early Resolutions were resolved within 25 working days and 34% of formal complaints received in April have been closed within 40 working days.

5.1.4 Currently the Trust has 7 formal complaints remaining open over six months.

5.1.5 The Trust currently has 6 complaints at second stage review by the Parliamentary and Health Service Ombudsman.

5.1.6 67 formal complaints citing the poor attitude of staff were reported in Q1 2018/19.

5.1.7 365 Plaudits received throughout Q1 2018/19.

5.2 Friends and Family Test (FFT)

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

Table 4: Friends and Family Test

	Percentage recommending BSUH June 18	Response Rate June 18
Inpatient care	93.7%	38.8%
A&E	90.5%	20.0%
Maternity	93%	N/A
Outpatient	94.2%	N/A

5.3 Friends and Family Test Response Rates:

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

5.3.2 A&E, in May 2018 the national average recommending was 87% and response rate was 12.4%, which BSUH has remained consistently above for all of quarter 1.

5.3.3 Maternity recommendation rate has dropped and this is particularly in relation to the question that is about post natal care, which the maternity team are addressing.

5.5 Mixed Sex

5.5.1 In June 44 mixed sex accommodation breaches were reported, this is a reduction from 48 in May these were all in cardiac surgery and neurosurgery and are reflective of some structural issues with the ward sizes and operational pressures..

7. RECOMMENDATION

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

Brighton and Sussex University Hospitals NHS Trust

To: BSUH Trust Board

Date of Meeting: 25th July 2018 Agenda Item: **7**

Title
Organisational Development and Workforce Performance Board Report
Responsible Executive Director
Denise Farmer, Chief Workforce and OD Officer
Prepared by
Helen Weatherill, Director of HR
Status
Public
Summary of Proposal
This report details the Trust's performance in relation to workforce supply, development and engagement of its workforce to improve the organisations culture.
Implications for Quality of Care
There is a direct correlation between a highly engaged, performing workforce and quality of care.
Link to Strategic Objectives/Board Assurance Framework
Supports the delivery of the Trust's People and Sustainability True North Objectives.
Financial Implications
Supports effective and efficient financial performance.
Human Resource Implications
As above
Recommendation
The Board is asked to: NOTE this report
Communication and Consultation
n/a
Appendices
Appendix 1: Workforce Scorecard – Month 3 2018/19

Organisational Development and Workforce Report
Month 03 2018/19 (June 2018)

1. Introduction

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

2. Workforce Capacity

2.1 Workforce expenditure in June was £30.86m and is consistent with the previous month. At the end of June (Month 3) the Trust reported a pay underspend of £423k.

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2.2 The total Bank spend in June 2018 was £1.84m and the majority of this spend was to fill vacancies and cover periods of sickness absence.

2.3 The total Agency spend in June was £1.25m which is an increase of £184k from £1.06m in May 2018.

3. Staff Turnover

3.1 The Trust's 12 month Turnover rate (external leavers excluding Training Grade Doctors) was 14.3%. Although the Scientific and Technical staff remain the group with the highest turnover (17.9%), registered staff within this group have seen the highest reduction over the previous 3 months, down 1.8 percentage points from 22.3% in March to 20.5% in June 2018.

3.2 Looking at the longer term picture, the Admin & Clerical staff group has seen the largest increase over the past twelve months, up 2.0 percentage points since June 2017 to 16.1% in June 2018. Nursing, Midwifery and Health Care Assistants has seen the highest reduction of 2.5 percentage points from 15.6% in June 2017 to 13.1% in June 2018. Full details on turnover plans will be presented to the Workforce Transformation Group.

4. Recruitment and Selection

4.1 Divisional Recruitment days continue to support the filling of vacancies for Nursing and Healthcare assistant staff.

4.2 Three international nurses who recently joined us have successfully completed their OSCE. A further 8 international nurses are due to join us on the 16th July 2018.

4.3 The Trust are currently using a variety of recruitment methods including return to practice, flexible working and rotation programmes to our recruitment adverts.

4.4 We have a rolling programme of recruitment open days on both sites including weekend dates.

5. Workforce Efficiency

5.1 The Trust's 12 month sickness absence rate is currently 4.17% (May 2018). This is the lowest rate seen over the previous 12 months and is now the eighth month that the rate has fallen below the highest rate of 4.3% in September 2017.

5.2 The most common cause of absence remains as Stress/Depression (19.6% of total reasons) however this figure has now fallen for four consecutive months from 20.7% in January 2018. Cough/Cold/Flu remains as second most common cause at 11.1% of total reasons.

5.3 Work continues particularly in the key areas such as Facilities and Engineering where intensive support has been given to ensure all new managers are aware of the policy and process. In addition weekly support meetings are available for all managers, particularly around training and up-skilling managers. Focused work has also been carried out in Renal and Neuro-rehab to identify issues and areas for improvement.

5.4 Sickness absence workshops continue to be rolled out across the Trust. A detailed report on sickness absence is scheduled to be presented at the next Quality and Risk Committee.

6. Appraisals

6.1 The Trust appraisal rate has increased to 83.7% to end June, an increase of 3.1% on May. The Surgery Division is now the highest performing Division at 89.2%.

6.2 Of the 338 ward and Departments, 153 (45.26%) are at or above 90% compliance with a further 30 (8.87%) between 85% and 90% compliant.

6.3 Each Division receives monthly reports detailing staff who have not had an appraisal within the last 12 months, and those staff due an appraisal to the end of July. Also, weekly reports are being produced and provided to the HRBP's, so that any decline in appraisal rates can be picked up with the relevant leads in good time.

6.4 The HRBP's continue to work with Divisional teams to support improvement in hotspot areas, and to encourage additional completions in smaller areas where 100% is achievable. They also continue to support correction of any data issues, whether management or system related.

6.5 Appraisal rate is an improvement (driver) metric in some Divisions, and improvement tools (such as A3s and counter measures summaries) are therefore being completed to ensure suitable measures are taken to improve compliance.

6.6 A full review of the current appraisal process is currently underway as part of the development of our new Leadership Development Strategy.

7. Workforce Skills and Development

7.1 The Statutory and Mandatory (STAM) compliance rate for June 2018 (based on the 11 Board reportable subjects) has increased to 83.6% up 1.08% on May. Nine subjects have seen an increase in June, with Manual Handling Patients and Safeguarding Children and Young People Level 1 dropping very slightly by 0.3%. Four modules have a completion rate greater than 85%, five greater than 80%, with the remaining two achieving 77% (Manual Handling – Patients) and 75% (Safeguarding Children 3).

7.2 Reporting is currently at Divisional level, with a monthly master RAG which reports all subjects. However, HRBPs are working with the Learning and Development team to provide monthly Care Centre breakdowns.

7.3 STAM is an improvement (driver) metric in some Divisions, and improvement tools (A3s & counter measures summaries) are therefore being completed to ensure suitable measures are taken to improve compliance.

8. Health and Wellbeing

8.1 'Wellbeing Wednesday', part of NHS70 week was held on the 4th July. This included pop up lunchtime sessions - Pilates on the lawn at St Mary's, and mindfulness at RSCH and PRH chapels. In addition, the Health and Wellbeing team set up roadshows at the Alex at RSCH and the foyer at PRH to promote our wellbeing activities and our partners. Costco, Simply Health, cycle to work, Brighton swimming school, West Sussex Carer Support all attended.

8.2 A one page summary on actions taken so far since the staff survey 2017 and future actions was included in the 900+ NHS70 hampers that went to all staff. RSCH hampers included an additional poster promoting all the wellbeing activities at the site.

8.3 Further articles for 'what's on Wellbeing' in Buzz staff magazine have been published to raise awareness of the different elements of Wellbeing and the support available for staff, including mindfulness, follow up to the Wellbeing MOT's held in June including interviews with staff who took part, round up of wellbeing Wednesday and follow up item on Carer's Day.

8.4 National and local Wellbeing campaigns continue to be promoted via the Wellbeing Calendar and staff info-net.

8.5 Other actions include:

- Review of NHS Employers Health and Wellbeing Framework to ensure BSUH compliance. Review of 14 key areas to ensure BSUH is meeting NHS Employers standards for health and wellbeing of staff. Standards include: organisation enablers (leadership, culture, communication and data) and health interventions (focus support for staff on core health areas of MSK and Stress). Diagnostic review completed and gaps identified by 31st July 2018.

- An MSK Symptom survey has been distributed to staff on Jowers Ward as part of a pilot project with Occupational Health (including Staff Physiotherapy Service); to understand more about the causes of MSK related problems. Over half the ward has completed the survey and plans are in place to review and collate the results by the end of July. Next steps will be determined on the basis of the data collated.

- Mindfulness sessions for staff started at RSCH on the 9th July.

- Extensive work is currently underway to look at systems, processes, working methods to reduce the concerning number of violence and aggression incidents from patients to staff.

9. Exit Interviews

9.1 There were 78 leavers in June and 39 completed an Exit Questionnaire giving a response rate of 50%. The average response rate for the last 3 months is 43%. The highest number of leavers who responded were from the Central Clinical Services Division, Surgery Division and Corporate Directorates.

9.2 The top 3 reasons given for leaving were lack of promotion and career opportunities (which has featured as the top reason for leaving for the majority of the last year), relocation and better reward/pay.

9.3 The leavers last month had had 1 - 2 years' service at the Trust and had only been in their current role for 12 to 24 months (the same as the last two months). 38% of the leavers were nurses (15 in total: 8 registered nurses and 7 unregistered). The age profile of the leavers was once again 21 to 30, they were predominantly female and four stated they had a disability. Ethnicity reporting will be added next month.

9.4 The leavers who responded to the Exit Questionnaire indicated that some of the positive aspects of working at the Trust were good teamwork and colleagues (a repeated positive about the organisation), great challenges and support, helping patients, flexible working and training and development opportunities.

10. Communications and Engagement

10.1 Patient First Capability

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

By 19 July 2,646 staff had taken part in the survey, with the results as follows:

Have you heard of Patient First?

	Feb		Mar		Apr		May		Jun		Jun - Jul 19th		Grand Total	This Month		Last month	
No	65	17%	82	16%	66	13%	64	14%	53	16%	56	12%	386	15%	No	330	15%
Yes	316	83%	421	84%	447	87%	396	86%	276	84%	404	88%	2260	85%	Yes	1856	85%
Grand Tot	**381**		**503**		**513**		**460**		**329**		**460**					**2186**	
Cumulativ	381		884		1397		1857		2186		2646		**2646**				

Do you believe Patient First will help the Trust improve?

	Feb		Mar		Apr		May		Jun				Grand Total				
No	22	8%	22	6%	21	6%	18	6%	8	4%	33	9%	124	7%	No	91	6%
Yes	241	92%	326	94%	333	94%	300	94%	208	96%	322	91%	1730	93%	Yes	1408	94%
Grand Tot	**263**		**348**		**354**		**318**		**216**		**355**					**1499**	
	263		611		965		1283		1499		1854		**1854**				

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

	Feb		Mar		Apr		May		Jun				Grand Total				
No	33	14%	40	15%	37	12%	29	10%	17	9%	58	19%	214	13%	No	156	12%
Yes	201	86%	271	87%	279	88%	261	90%	180	91%	251	81%	1443	87%	Yes	1192	88%
Grand Tot	**234**		**311**		**316**		**290**		**197**		**309**					**1348**	
Cumulativ	234		545		861		1151		1348		1657		**1657**				

*The survey now includes those staff attending Health and Safety updates in person, as well as those completing it online. Patient First continues to be promoted in a number of ways including in *Buzz,* facilitating open staff sessions and video.

10.2 NHS 70

- NHS70 "Thank You" hampers – the communications team, with assistance from customer care and ambassador colleagues, arranged for every department to receive "Thank you" hampers containing supplies of tea and coffee, as well as biscuits and healthy eating snacks, funded by charitable

means and community support. Trust leaders, ambassadors and governors spent the day hand-delivering many hundreds of cardboard boxes full of goodies, to all clinical and non-clinical teams.

- Pop events ran across the hospitals throughout the week of NHS 70 celebrations with staff attending wellbeing events and poetry readings to a look back over the last 70 years with a bite size talk from Samantha Sharman our Heritage Officer and a special NHS 70 quiz designed by our volunteers to test your knowledge of the service.
- The 3Ts team also presented the future of the NHS in Brighton on July 6 sharing a glimpse of the Stage one developments from the top of the Helideck, broadcast using Facebook Live.
- Alongside all of this, we are running a Children's drawing competition to encourage our future talent to draw what mummy, daddy, granny or granddad does for the NHS. Winners will see their artwork displayed on hospital walls and online. We will also be promoting the NHS 70th Anniversary Concert taking place in September as well as the Big 7Tea events being run by the BSUH Charity.

10.3 Internal communications

Info-net usage for May: 37,000 users, which is approximately 1k less than the previous month. (Note that these are can't be translated directly as individuals; rather computer ids/IP addresses.)

Buzz: 4,697 page views in June at an average 1,174 online views per issue (up from 947 in May. This compares to a year-to-date average of 1,140. 250 paper copies are distributed and on average each issue was downloaded 75 times on info-net. This is an increase on the previous month's average.

10.4 Events and external media

Workforce Race Quality Standard (WRES): The Race and Culture event took place on July 18, building on the success of the WRES conference on 29 May. Colleagues from across the organization gathered to discuss progress since July 18, paying attention to the priority areas proposed by the WRES **working** group. A report following the event is included in the trust's weekly newsletter, Buzz as well as in the chief executive's weekly message.

This follows the support leading up to the event, including developing branding (based on our Patient First) and content to support awareness.

Leaders Network: The communications team also provided support for the Leaders Network event which took place on 18 July. Hosted by the executive team, more than 100 colleagues heard an update on progress against the organisation's priorities as well as a presentation from colleagues taking part in the Patient First Improvement System, the training programme for individual wards and department.

Care Quality Commission engagement events: The communications team has continued to provide support to teams hosting visits from the CQC. This has included highlighting the benefits of Patient First and standardising information and posters.

BSUH Workforce Scorecard

June 2018

Key Performance Indicators		Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	12mth position	Target	Amber	Trend
1 Workforce Capacity	*NB*																	
FTE - Budgeted		8,223.2	8,195.3	8,194.4	8,218.4	8,198.1	8,208.2	8,210.6	8,213.7	8,214.3	8,214.3	8,273.0	8,315.6	8,304.6	8,230.0			
FTE - Substantive contracted		7,250.7	7,251.8	7,279.4	7,285.2	7,306.7	7,356.3	7,332.8	7,352.4	7,358.9	7,372.0	7,398.9	7,407.6	7,419.6	7,343.5			
FTE - Substantive contracted variance from Budget		972.5	943.5	915.0	933.2	891.4	851.9	877.8	861.3	855.4	842.3	874.1	908.0	885.0	886.6			
Vacancy Factor (Substantive contracted FTE)		11.8%	11.5%	11.2%	11.4%	10.9%	10.4%	10.7%	10.5%	10.4%	10.3%	10.6%	10.9%	10.7%	10.8%	**10.1%**		
Spend - Bank as a % of total staffing		5.2%	5.2%	5.3%	5.8%	4.8%	5.0%	5.9%	4.9%	6.3%	5.5%	5.1%	5.5%	6.0%	5.5%			
Spend - Agency as a % of total staffing		3.3%	3.2%	3.9%	4.3%	2.8%	3.2%	3.2%	4.0%	4.0%	4.4%	3.4%	3.5%	4.1%	3.6%			
2 Workforce Efficiency	*NB*																	
Absence - Sickness (12 month)	1	4.2%	4.3%	4.3%	4.3%	4.3%	4.3%	4.3%	4.3%	4.2%	4.2%	4.2%	4.2%			**4.1%**		
Absence - Sickness in month		3.9%	4.0%	4.2%	4.2%	4.4%	4.6%	4.7%	4.7%	4.2%	3.7%	3.7%	3.8%		4.2%			
Absence - Maternity in month		2.5%	2.4%	2.3%	2.5%	2.4%	2.3%	2.2%	2.3%	2.2%	2.3%	2.2%	2.2%		2.3%			
Absence - Annual Leave in month		6.8%	6.9%	9.6%	7.0%	5.9%	4.7%	8.1%	6.0%	6.7%	8.4%	6.2%	7.0%		6.9%			
Absence - Special, Study & Other Leave in month		2.8%	2.8%	2.9%	2.9%	2.9%	2.9%	3.0%	3.0%	3.1%	3.2%	3.1%	3.2%		3.0%			
Absence - Total in month		16.0%	16.1%	19.0%	16.6%	15.6%	14.5%	18.0%	16.0%	16.3%	17.7%	15.2%	16.1%		16.4%			
Sickness - Short Term (< 28 days)		1.9%	1.9%	1.9%	2.0%	2.0%	2.1%	2.2%	2.2%	2.0%	1.8%	1.8%	1.8%		2.0%			
Sickness - Long Term (> 27 days)		2.1%	2.1%	2.2%	2.3%	2.3%	2.5%	2.5%	2.5%	2.2%	2.0%	1.9%	2.0%		2.2%	**2.2%**		
Sickness - Stress in month		0.9%	0.9%	0.9%	0.9%	1.0%	1.0%	0.9%	0.7%	0.7%	0.7%	0.7%	0.7%		0.8%			
Sickness - Gastro Intestinal in month		0.3%	0.3%	0.3%	0.3%	0.3%	0.4%	0.4%	0.3%	0.3%	0.3%	0.3%	0.3%		0.3%			
Sickness - Other Musculoskeletal in month		0.4%	0.5%	0.4%	0.4%	0.4%	0.3%	0.2%	0.3%	0.3%	0.3%	0.3%	0.4%		0.3%			
Sickness - Cough, Cold & Flu in month		0.2%	0.2%	0.2%	0.3%	0.5%	0.5%	0.7%	1.0%	0.7%	0.5%	0.4%	0.3%		0.5%			
Sickness - Back in month		0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%		0.2%			
Episodes - New sickness episodes in month		1,215	1,147	1,265	1,187	1,343	1,422	1,603	1,569	1,247	1,158	1,230	1,086		1,289			
Episodes - On-going sickness episodes in month		348	351	349	334	289	322	345	305	299	288	224	277		311			
Episodes - Total sickness episodes in month		1,563	1,498	1,614	1,521	1,632	1,744	1,948	1,874	1,546	1,446	1,454	1,363		1,600			
Triggers - 3 sickness episodes in 6 months breaches		687	558	561	535	564	611	676	736	747	729	709	657		648			
Triggers - 5 sickness episodes in 12 months breaches		672	661	638	652	615	618	593	550	546	554	552	548		600			
Triggers - Long term sickness breaches		125	133	158	139	143	136	102	131	116	105	110	110		126			
Triggers - Total sickness management breaches		1,484	1,352	1,357	1,326	1,322	1,365	1,371	1,417	1,409	1,388	1,371	1,315		1,373			
Triggers - Number of staff breaching one (or multiple) triggers		1,013	947	949	920	925	967	962	1,001	998	959	960	923		960			
Maternity - Number of staff on maternity leave		207	196	199	204	205	190	190	188	197	201	197	195		197			
Turnover - Trust (12 month)		14.5%	14.3%	14.3%	14.1%	14.2%	13.9%	13.9%	14.1%	14.3%	14.2%	14.1%	14.2%	14.3%	14.2%	**13.3%**		
Turnover - Medical & Dental		8.6%	8.1%	9.0%	9.3%	10.0%	10.0%	10.0%	10.7%	10.3%	9.9%	10.3%	9.9%	9.7%	9.8%			
Turnover - Nursing & Midwifery		15.6%	15.5%	14.8%	14.3%	14.2%	13.6%	13.3%	13.3%	13.4%	13.5%	13.2%	13.0%	13.1%	13.8%			
Turnover - Scientific, Therapeutic & Technical		16.1%	15.3%	16.0%	15.9%	16.2%	15.8%	16.9%	17.4%	17.9%	17.1%	17.6%	18.0%	17.9%	16.8%			
Turnover - Admin, Clerical & Estates		14.1%	14.3%	14.8%	14.9%	15.1%	14.9%	14.6%	14.5%	14.8%	14.8%	15.2%	16.3%	16.1%	15.0%			
Turnover - Support Staffing		11.8%	11.4%	12.4%	12.4%	12.4%	12.3%	13.1%	13.9%	13.8%	14.3%	13.7%	12.8%	13.9%	13.0%			
3 Training & Personal Development	*NB*																	
% of appraisals up to date (excl Medical staff)		80.9%	80.2%	77.7%	76.2%	76.1%	75.9%	77.0%	74.3%	71.7%	72.3%	77.1%	80.6%	83.7%	76.9%	**81%**		

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

Brighton and Sussex University Hospitals NHS Trust

To: Board of Directors

Date of Meeting: 25th July 2018 Agenda Item: **8**

Title
Month 03, 2018-19 Performance Report
Responsible Executive Director
Pete Landstrom, Chief Delivery & Strategy Officer
Prepared by
Giles Frost, Interim Director of Performance and Information
Status
Disclosable
Summary of Proposal
The paper sets out the organisational compliance against national and local key performance metrics. The report summarises in year performance for Brighton & Sussex University Hospitals Trust, as detailed in the dedicated performance scorecard relating the NHSI Single Oversight Framework, National Constitutional Targets, and other relevant operational indicators.
Implications for Quality of Care
Describes Quality Outcome KPIs
Link to Strategic Objectives/Board Assurance Framework
Compliance with National NHS Constitutional Standards and Trust True North Objectives
Financial Implications
Describes Operational KPIs which impact on Financial Sustainability and Efficiency
Human Resource Implications
Describes Operational KPIs which impact on Workforce
Recommendation
The Board is asked to: NOTE the Trust position against the NHS National Constitutional Standards
Communication and Consultation
Not applicable
Appendices
(1) Operational Performance Scorecard

PERFORMANCE REPORT: MONTH 03, 2018/19

1. INTRODUCTION

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

2. SUMMARY PERFORMANCE

2.1. The Trust saw further improvements to flow and occupancy during June 2018, and corresponding improvements in both non elective and elective performance despite continued high levels of emergency demand.

2.2. Key operational indicators during June to note:

- 15,054 A&E attendances compared to 13,810 in June 2017 (an increase of +9.0%). This includes A&E planned follow up attendances and Ambulatory Care. Excluding those activities there were 14,462 A&E attendances (an increase of +4.2% above 2018/19 plan and +4.7% above the same period last year).

- 4,519 non-elective spells compared to 4,499 in June 2017 (a small -0.4% decrease in activity).

- Formally reportable Delayed Transfers of Care increased in June to 5.7% from 5.2% May 2018. This does however remain an improvement from 7.2% in the same month last year.

- Average length of stay for patients reduced to 4.55 days for non-elective medicine in June 2018, compared to 5.02 days in May 2018. Non-elective surgery length of stay reduced marginally to 5.28 days June 2018, compared with 5.41 days May 2018 and 5.01 days in June 2017.

- Average Inpatient Bed Occupancy Trust wide was 94.8% May which peaked at 96.3% week ending 10th June. Occupancy each morning at 9am at the Royal Sussex County was on average 98.5% in June which was an improvement.

3. KEY AREAS OF PERFORMANCE

3.1. A&E Compliance

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

3.1.2. In June the BSUH system was non-compliant against the National four hour standard overall, with 88.4% of patients waiting less than four hours from arrival at A&E to admission, transfer, or discharge. This is a continued improvement for the system, and an increase of +0.7% from 87.7% the previous month. This also exceeds the agreed improvement trajectory with NHSI and NHSE as part of the 2018/19 planning, and National PSF (Provider Sustainability Funding).

3.1.3. The planned improvement trajectory for the system performance was 87.5% in June, which was exceeded. BSUH Trust itself also exceeded its target of 83.6% as part of the system plan with Type 1 & 2 performance of 85.7%

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

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

Site	Total Patient Attendances (excluding FUP patients)	Total Patients Waiting > 4 Hours	% Patients <4 Hour
Royal Sussex County Hospital	7489	1887	74.8%
Princess Royal Hospital	3469	148	95.7%
Royal Alexandra Children's Hospital	2385	7	99.7%
Sussex Eye Hospital	1119	19	98.3%
BSUH Trust	14462	2061	85.7%
Brighton Station Walk in Centre	1792	0	100.0%
Lewes Victoria and Uckfield MIUs	1606	6	99.6%
Total Trust Catchment	17860	2067	88.4%

3.1.6. June saw the 6th consecutive improvement in BSUH Trust performance

3.1.7. Performance at RSCH saw a continued improvement of +1.5% compared with May 2018.

3.1.8. Performance at PRH was 95.7%, achieving the 95% National target for the second month in a row.

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

3.1.10. Waiting for admission to an inpatient ward remained the highest single reason for patients waiting longer than 4 hours in A&E. Delayed transfers of care (DTOC) patients increased to 5.7%, an increase of 0.5% from May 2018 and decrease compared to 7.2% June 2017.

3.1.11. At time of writing the BSUH system performance has improved further to 89.4% for the catchment (July 2018 to date), with a further increase in Trust performance as part of that.

3.1.12. Nationally and regionally A&E delivery has improved since the start of April and the picture is improved from June in the previous year. National performance increased to 90.7% in June 2018 for all attendances. Board members should note these figures also include type 3 A&E attendances (such as minor injuries units) for non-acute providers, so should be compared to the BSUH system performance of 88.4% for June. Regionally, compliance for the South of England reduced to 90.9% from 92.0% in May.

3.2. Cancer

3.2.1. The Trust was compliant against 7 out of 9 metrics in May remaining below the 62 day treatment target for GP referrals (85.0%). Actual performance for May against this metric was 80.0%, an improvement from 78.7% delivered in April 2018.

3.2.2. The Trust returned to compliance against the 2 week wait standard with 93.03% against the 93% target.

3.2.3. The Trust matched agreed improvement trajectory for 62 days in May, with a total of 23.5 patients breaching the 62 day GP referral standard against a forecast trajectory of 23.0. Total treated patients against the 62 day GP referral standard for May was 117.5 against a forecast plan of 121.5.

3.2.4. Regional context of the 62 day performance standard for April 2018 shows BSUH being the highest performing tertiary cancer centre.

Regional Ranking	Trust	Cancer Centre	62 Day Performance
Surrey & Sussex Cancer Alliance			
1	Frimley Health NHS FT	No	93.46%
2	Ashford & St Peters Hospitals NHS FT	No	86.75%
3	Queen Victoria Hospital NHS FT	No	85.42%
4	East Sussex Healthcare NHS Trust	No	81.90%
5	Surrey and Sussex Healthcare NHS Trust	No	81.17%
6	Brighton and Sussex University Hospitals NHS Trust	Yes	80.17%
7	Western Sussex Hospitals NHS FT	No	77.78%
8	Royal Surrey County Hospital NHS FT	Yes	76.32%
Kent & Medway Cancer Alliance			
1	Dartford and Gravesham NHS Trust	No	87.23%
2	Medway NHS Foundation Trust	No	83.78%
3	East Kent Hospitals University NHS FT	No	65.12%
4	Maidstone and Tunbridge Wells NHS Trust	Yes	53.81%

3.2.1. For context, the latest national performance data for May 2018 shows 81.1% for treatment within 62 days from GP referral. In May 2018, approximately 55% of Trusts in England were non-compliant against this standard.

3.3. Referral to Treatment (RTT/18 Weeks)

3.3.1. There were 2 patients waiting more than 52 weeks for treatment as of the end of June. This was ahead of the agreed recovery trajectory. The Trust is anticipating no 52 week waits as planned for July 2018.

3.3.2. The Trust was non-compliant against the National Constitutional Target of 92% with a reported position in June of 83.9%. This was an improvement of +0.5% from May performance (83.4%).

3.3.3. Compliance was below the planned trajectory of 85.7% in June due to earlier workforce capacity constraints particularly within Head and Neck specialties. However, as part of surgical recovery plans, the Trust has commenced insourced additional capacity from June for ENT, and in Max Facs and GI services from July.

3.3.4. In mid-June the Trust also implemented the ring-fencing of the cardiac day case unit at RSCH. The unit has reported a 1% increase in patient flows and treatments as a result.

3.3.5. Latest published national data relates to May 2018 and shows national compliance has remained 87.7% from 87.5%. Over half (51%) of Trusts were non-compliant in May.

3.4. Diagnostic Test Waiting Times

3.4.1. The Trust compliance for June was 7.9% over 6 week waiters across all diagnostic modes, which is non-compliant against the <1% national target, and a deterioration in position since May (6.3%). This represents 686 out of a total of 8686 patients.

3.4.2. Contrary to the trust recovery plans, CT breaches increased with a reported 213 diagnostic 6 week breaches in June, an increase of 77 from the May position. There are currently 3 vacancies within the CT workforce and the directorate is experiencing a shortfall of anesthetic cover for General Anaesthetic paediatric cases. The replacement CT scanner also experienced technical break down on 3 occasions in early June. Additional sessions from August are planned at PRH to aid recovery for this modality.

3.4.3. As noted in last month's performance paper, overall diagnostic demand has increased 9.8% in the last 12 months which equates to circa 350 additional referrals per week. In particular Non-Obstetric ultra-sound remains a significant challenge both in terms of demand and capacity (workforce) constraints. The CCS Division and Imaging department continue to work closely with Brighton and Hove CCG to manage the direct access demand given the constraints on workforce both locally and nationally. Ultrasound long waiters have reduced to 139 in June compared to 187 in May. The ultrasound lists are constantly refreshed to capture any cancellations to avoid lost capacity. The team continue to source alternative capacity for Ultrasound including WLI, more consultant led lists, agency, and third party providers operating both on and offsite.

3.4.4. As highlighted at the previous Board meeting there is also an emergent imbalance in demand and supply for the echocardiogram modality with 249 over 6 week waits end June (compared to 145 in May). The service has 2 WTE vacancies which is severely impacting capacity, and has been unable to recruit in this highly specialized area. These workforce challenges are mirrored nationally with widespread staffing shortages for echocardiographers. 1 WTE is planned to start in late September, and the directorate are increasing cross-cover from in-house staff to stabilize and improve the August position. Inpatient echoes are also now being undertaken on the ward where possible to provide additional physical capacity to help support recovery.

3.4.5. Comparatively South of England Region aggregate compliance was 4.6% and National compliance was 2.7%. Just under half of all Acute Trusts (48.5%) were non-compliant in May 2018.

4. RECOMMENDATION

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

Pete Landstrom
Chief Delivery & Strategy Officer
20th July 2018

Brighton and Sussex NHS University Hospitals

OPERATIONAL PERFORMANCE SCORECARD

JUNE 2018

		Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	2018/19 YTD	2018/19 Target	Trend
NATIONAL AND OPERATIONAL PERFORMANCE TARGETS																			
O01	A&E : Four-hour maximum wait from arrival to admission, transfer or discharge *	85.3%	86.0%	86.5%	81.9%	83.6%	84.3%	87.0%	86.3%	82.8%	82.6%	82.0%	83.2%	86.5%	87.7%	88.4%	87.1%	95%	
O01A	A&E : 12 hour maximum wait from arrival to admission, transfer or discharge	0	0	0	0	7	6	0	1	50	27	19	36	5	0	0	5	0	
O02	Cancer: 2 week GP referral to 1st outpatient	93.4%	94.1%	94.7%	94.8%	93.8%	95.1%	93.8%	94.1%	94.8%	94.0%	94.1%	93.4%	91.1%	93.0%		92.2%	93%	
O03	Cancer: 2 week GP referral to 1st outpatient - breast symptoms	96.4%	98.2%	95.0%	94.4%	96.1%	96.2%	97.7%	96.0%	94.0%	95.2%	95.8%	94.3%	96.7%	96.0%		96.3%	93%	
O04	Cancer: 31 day second or subsequent treatment - surgery	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	96.6%	97.3%	100.0%	97.1%	100.0%	100.0%	100.0%	100.0%		100.0%	94%	
O05	Cancer: 31 day second or subsequent treatment - drug	100.0%	100.0%	97.5%	100.0%	100.0%	100.0%	98.7%	100.0%	100.0%	98.0%	100.0%	100.0%	100.0%	100.0%		100.0%	98%	
	Cancer: 31 day second or subsequent treatment - radiotherapy	100.0%	99.4%	99.3%	100.0%	98.6%	100.0%	98.5%	99.5%	100.0%	99.5%	100.0%	100.0%	100.0%	99.5%		99.7%	94%	
O06	Cancer: 31 day diagnosis to treatment for all cancers	99.1%	99.5%	100.0%	98.6%	99.2%	98.3%	99.6%	100.0%	98.3%	97.9%	100.0%	99.6%	100.0%	99.1%		99.6%	96%	
O07	Cancer: 62 day referral to treatment from screening	87.2%	76.7%	71.8%	80.0%	77.8%	78.4%	75.0%	78.4%	75.0%	74.3%	22.2%	38.7%	61.0%	37.0%		48.3%	90%	
O08	Cancer: 62 day referral to treatment from hospital specialist	88.9%	75.0%	100.0%	94.7%	85.7%	60.0%	72.7%	77.8%	76.9%	92.9%	72.7%	100.0%	88.9%	86.7%		87.5%	90%	
O09	Cancer: 62 days urgent GP referral to treatment of all cancers	86.1%	81.1%	74.3%	68.8%	81.4%	78.3%	80.3%	68.2%	80.3%	74.8%	73.0%	71.0%	78.7%	80.0%		79.4%	85%	
O14	RTT - Incomplete - 92% in 18 weeks	85.2%	86.1%	86.9%	87.0%	86.8%	86.0%	86.1%	86.3%	84.5%	84.6%	83.6%	83.1%	83.0%	83.4%	83.9%	83.9%	92%	
	RTT - Incomplete - 52Week Waiters	94	102	96	80	84	71	59	47	49	28	28	9	5	2	2	2	0	
O15	RTT delivery in all specialties (Incomplete pathways)	10	10	13	13	12	12	13	13	14	12	13	13	13	13	13	13	0	
O16	Maximum 6-week wait for diagnostic procedures	0.5%	0.9%	0.7%	0.6%	1.0%	0.7%	0.9%	1.3%	3.4%	4.3%	3.5%	6.1%	7.3%	6.4%	7.9%	7.9%	<1%	
O17	Cancelled operations not re-booked within 28 days	3	1	4	5	7	9	5	4	11	15	14	12	2	8	4	14	0	
O18	Urgent operations cancelled for the second time	0	0	2	1	2	5	3	0	1	0	0	2	0	0	1	1	0	
O19	Clinics cancelled with less than 6 weeks notice for annual/study leave	48	41	49	38	43	32	62	57	40	37	85	74	92	87	62	241	-	
O20	Mixed Sex Accommodation breaches	76	48	39	22	21	67	57	52	59	87	84	49	67	48	44	159	0	
O33	Delayed transfers of care	8.1%	7.4%	7.2%	8.3%	7.9%	8.1%	6.5%	5.1%	4.6%	4.9%	5.3%	4.8%	5.7%	5.2%	5.7%	5.7%	3%	
IMPROVING CLINICAL PROCESSES																			
O23	% hip fracture repair within 36 hours	76.90%	74.40%	67.00%	83.34%	57.50%	58.10%	81.12%	80.00%	65.72%	75.50%	85.46%	78.30%	87.00%	89.20%	88.60%		90%	
O24	Patients that have spent more than 90% of their stay in hospital on a stroke unit*	75.00%	80.70%	83.08%	85.00%	77.78%	82.76%	87.50%	85.25%	83.64%	84.91%	76.09%	80.00%	77.50%	82.93%		80.25%	80%	

Brighton and Sussex NHS University Hospitals

OPERATIONAL PERFORMANCE SCORECARD

JUNE 2018

		Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	2018/19 YTD	2018/19 Target	Trend
OPERATIONAL EFFICIENCY																			
O36	Average length of stay - Elective	2.43	2.12	2.51	2.22	2.35	2.53	2.61	2.21	2.43	2.23	2.54	2.14	2.29	2.22	2.42	2.26		
O37	Average length of stay - Non-elective Surgery	4.52	5.03	5.01	4.87	5.38	5.36	4.80	4.90	5.10	5.21	6.13	5.20	5.14	5.41	5.28	5.28		
O38	Average length of stay - Non-elective Medicine	4.85	4.16	4.42	4.50	4.61	4.56	4.65	4.94	4.71	4.67	4.82	5.05	4.80	5.02	4.55	4.79		
O39	Day case rate (CQC day case basket of procedures) source: HED (reported 2-3 months in arrears)	82.7%	87.7%	84.6%	87.2%	87.5%	86.9%	87.1%	84.9%	86.2%	85.3%	77.8%	85.5%				85.7%	75.0%	
O40	Elective day of surgery rate (DOSR)	94.8%	95.5%	94.9%	95.3%	95.1%	94.2%	95.5%	95.3%	95.2%	95.4%	93.2%	94.8%	95.0%	95.0%	95.1%	95.0%	90.0%	
O41	Did not attend rate (outpatients)	6.1%	6.6%	6.6%	6.9%	7.4%	7.3%	7.2%	7.8%	8.0%	8.2%	7.6%	8.1%	7.3%	7.5%	7.8%	7.6%	6.00%	
SUSTAINABILITY																			
O43	Bank staff - % of all staff pay	4.5%	4.1%	5.2%	5.2%	5.3%	5.8%	4.8%	5.0%	5.9%	4.9%	6.3%	5.5%	5.1%	5.5%	6.0%		7%	
O44	Agency staff - % of all staff pay	2.4%	3.1%	3.3%	3.2%	3.9%	4.3%	2.8%	3.2%	3.2%	4.0%	4.0%	4.4%	3.4%	3.5%	4.1%		2%	
O46	% nurses who are registered	73.0%	72.4%	72.1%	72.0%	71.8%	71.5%	71.8%	71.4%	71.1%	70.4%	70.5%	70.1%	69.4%	69.0%	69.1%		74%	
O47	% Staff appraised	82.8%	81.3%	80.9%	80.2%	77.7%	76.2%	76.1%	75.9%	77.0%	74.3%	71.7%	72.3%	77.1%	80.6%	83.7%		85%	
O48	Sickness Absence: % Sickness(reported one month in arrears)	4.2%	4.2%	4.2%	4.3%	4.3%	4.3%	4.2%	4.2%	4.2%	4.3%	4.2%	4.2%	4.2%	4.2%			3.5%	
O49	Staff Turnover: Turnover rate (YTD position)	14.5%	14.6%	14.5%	14.3%	14.3%	14.1%	14.2%	13.9%	13.9%	14.1%	14.3%	14.2%	14.1%	14.2%	14.3%	14.3%	12%	
ACTIVITY																			
A01	Day Cases	3355	4050	4232	3790	4228	3652	4122	3906	3302	3809	3385	3675	3221	3532	3450	10203		
A02	Elective Inpatients	1192	1259	1388	1299	1290	1240	1243	1305	1070	1192	1138	1268	1168	1310	1265	3743		
A03	Non-elective inpatients	4637	4890	4499	4680	4547	4579	4653	4674	4506	4727	4082	4635	4433	4521	4519	13473		
A04	Outpatient First attendances	8620	11132	10935	10169	10496	9950	10409	11282	8192	10982	9779	10387	9814	10968	11085	31867		
A05	Outpatient Follow-up attendances	21604	26190	25085	23710	24294	24133	25029	26341	19722	25891	22795	23757	22857	24127	23286	70270		
A06	Outpatients with procedure	7143	8096	8111	7362	7946	7826	7886	8580	6665	8422	7257	7828	8023	8545	7887	24455		
A07	A&E Attendances	13258	14089	13810	14037	13201	13055	13484	13698	13460	13485	12656	14516	14287	15147	15054	44488		

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.

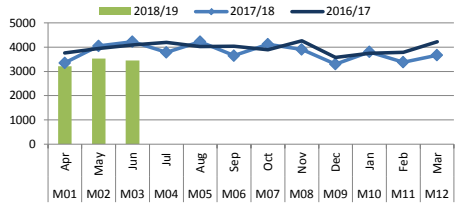
3 Staff sickness is reported one month in arrears.

* For consistency with NHSE monthly reporting, the Trust has included Lewes and Uckfield MIU attendances from April 2018, for the Trust STP footprint area. The breakdown of A&E performance by site is in the performance report.

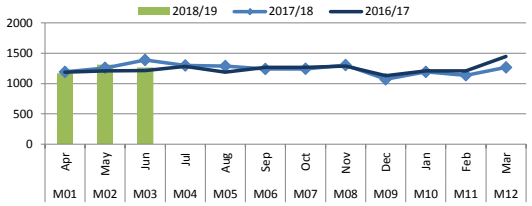
Brighton and Sussex University Hospitals NHS

Activity Trends

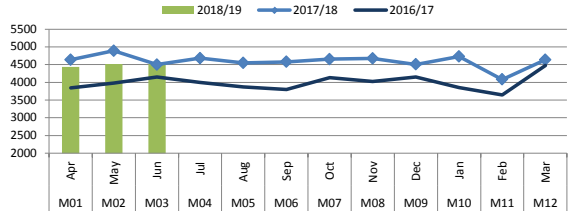
Day Cases



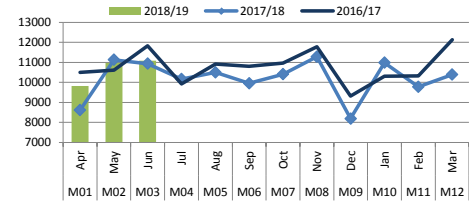
Elective Inpatients



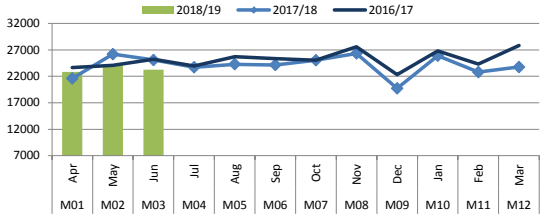
Non-elective Inpatients



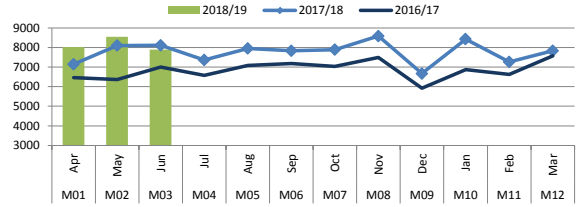
First Outpatients



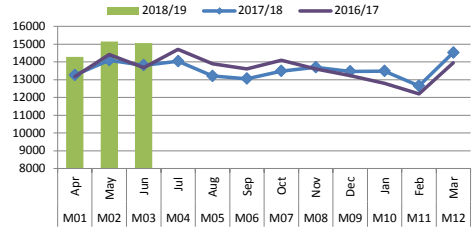
Follow-up Outpatients



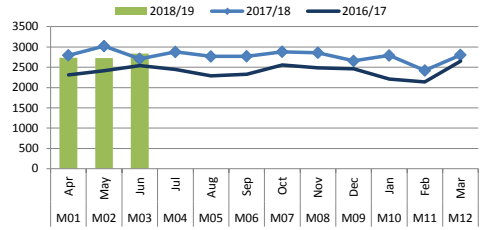
Outpatients with Procedure



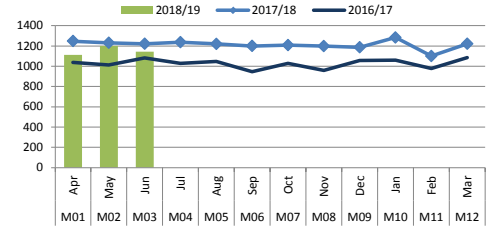
A&E Attendances



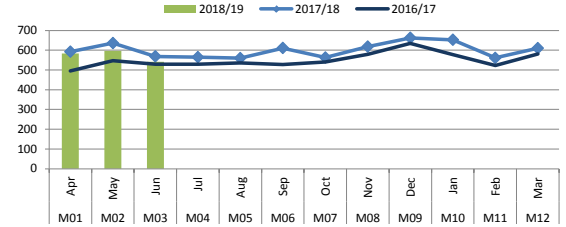
Emergency Admissions (age 0-64)



Emergency Admissions (age 65-84)



Emergency Admissions (age >85)



Brighton and Sussex University Hospitals NHS Trust

To: Trust Board

Date of Meeting: 25th July 2018

Agenda Item: **9**

Title
Finance Report Month 3 2018/19
Responsible Executive Director
Karen Geoghegan, Chief Financial Officer
Prepared by
Alan Macalister, Interim Deputy Director of Finance – Financial Management
Status
Public
Summary of Proposal
The Finance Report Month 3 2018/19 provides further detail on the in-month and year-to-date performance, and highlights key risks to delivery of the control total and mitigations. At Month 3 the Trust is reporting a deficit of £17.89m against the deficit plan of £17.90m; a favourable year-to-date variance of £0.02m.
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 Month 3 2018/19.
Human Resource Implications
N/A
Recommendation
The Board is asked to NOTE: • The Trust has delivered the Q1 Control total; • The Trusts acceptance of a revised control total • The key risks, and mitigations, to achievement of the full year plan • Further actions to be taken by Divisions and Directorates to recover the cost pressures and income risks identified
Communication and Consultation
N/A
Appendices
1. Month 3 I&E position – subjective 2. Month 3 I&E position – objective 3. Finance Report Month 3 2018/19

Brighton and Sussex University Hospitals NHS Trust

Report to:	Trust Board
Meeting date:	24th July 2018
Report from:	Karen Geoghegan, Chief Financial Officer
Author:	Alan Macalister, Interim Deputy Director – Financial Management
Title:	Finance Report Month 3 2018/19

Purpose

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

2. The paper also provides details of recent communications with NHS Improvement regarding the Trusts acceptance of a revised control total of £55.11m.

Executive Summary

3. The Month 3 financial position is £0.01m favourable to plan; an actual deficit of £4.82m against a deficit plan of £4.83m. The year-to-date (YTD) position is a favourable variance to budget of £0.02m; with an actual deficit of £17.89m against a deficit plan of £17.9m. A summary of the Month 3 and YTD performance is shown in Table 1 below.

Table 1: I&E Summary and Key Financial Metrics

Values in £m	**In Month**			**Year-to-Date**		
	Plan	**Actual**	**Variance**	**Plan**	**Actual**	**Variance**
Income	(49.11)	(47.44)	1.67	(143.44)	(141.56)	1.88
Pay	31.29	30.86	(0.42)	94.40	92.68	(1.72)
Non-pay	19.46	18.23	(1.23)	56.92	56.80	(0.12)
Operating Expenditure	50.74	49.10	(1.65)	151.32	149.48	(1.84)
Non-operating costs	3.17	3.16	(0.01)	9.45	9.40	(0.05)
Total Income & Expenditure	**4.80**	**4.82**	**0.02**	**17.33**	**17.32**	**(0.01)**
Technical adjustments	0.03	0.00	(0.02)	0.58	0.56	(0.01)
Net Reported Position	**4.83**	**4.82**	**(0.01)**	**17.90**	**17.89**	**(0.02)**
EBITDA	1.71	1.72	0.01	8.61	8.64	0.03
CIPs (per NHSI plan)	1.83	2.04	0.22	5.06	5.09	0.03
Capital	10.92	5.72	(5.20)	26.87	15.22	(11.65)
Cash	0.75	6.90	6.15	6.65	18.50	11.85

4. At the end of Q1, income is below plan by £1.88m. This includes under-performance on NHSE Income of £1.17m and £0.34m under-performance against CCG income. Other Operating income is lower than plan BY £0.44m, driven by under recovery on R&D income and Education and Training income.

5. The underlying income shortfall is offset by non-related underspends in operating expenditure; pay is £1.72m below plan and non-pay £0.12m lower than plan.

6. The Trust's cash position is supported by monthly revenue deficit funding from the Department of Health and capital investment loans and Public Dividend Capital (PDC) for the capital programme. The revenue loan drawdown for June was £5.9m. The YTD balance of revenue loans is £17.5m.

7. The Trust submitted a refreshed 18/19 Financial Plan on 20 June 2018 to NHSI in line with issued guidance; to support the alignment of internal and external plans to the commissioner contracts that have been agreed.

8. The revisions to the plan related to final agreed contract positions for the CCGs and NHSE Specialised Commissioning, as previously shared with the Board, and also reflected a material additional Research & Development grant which had been secured. The overall plan after these adjustments remained at £65.4m deficit; consistent with the agreed original control total.

9. The Trust received a further letter from NHSI on 29 June 2018 offering £10.29m of Provider Sustainability Funding (PSF) in 2018/19. The Trust has accepted this funding allocation and therefore the 18/19 planned Control Total deficit has reduced from £65.4m to £55.1m.

10. To access the £10.29 PSF the Trust must deliver both the underlying financial control total and the agreed A&E trajectory.

11. The access to PSF provides additional cash resources to the Trust if secured in full. Although the PSF is a new income stream it does not provide the Trust with additional revenue funds but it do0es reduce the Trust deficit by an equivalent amount.

12. The planned additional cash resource does increase the net assets for the trust in 18/19 and this in turn does impact the PDC calculation for Trust, such that this now increases by £180k.This increase has not been reflected in the revised control total and therefore this increase will need to be mitigated by other reductions in non-operating costs.

13. The table below shows how PSF earnings are split across financial and A&E performance:

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

Income

14. Table 2 below shows a summary of the income position for Month 3 and YTD.

Table 2: Income Position

Values in £m	In Month			Year to Date		
	Plan	Actual	Variance	Plan	Actual	Variance
NHS Trusts Income	-0.68	-0.79	-0.11	-2.08	-2.17	-0.09
CCG Income	-24.18	-23.73	0.45	-73.06	-72.72	0.34
NHSE Income	-15.33	-15.33	0.00	-46.27	-45.10	1.17
SMSKP Income	-2.05	-1.98	0.08	-6.16	-5.93	0.23
Department Of Health Income	-0.00	0.00	0.00	-0.01	-0.00	0.01
Private Patients Income	-0.43	-0.33	0.10	-1.28	-1.17	0.12
Injury Cost Recovery	-0.12	-0.15	-0.03	-0.36	-0.53	-0.18
Local Authority Income	-0.34	-0.31	0.03	-1.03	-0.96	0.06
Overseas Visitors Income	-0.02	-0.06	-0.04	-0.05	-0.11	-0.06
Other Patient Related Income	-0.09	-0.10	-0.01	-0.16	-0.32	-0.16
Income from Activities	-43.23	-42.76	0.47	-130.46	-129.02	1.44
Education & Training Income	-2.24	-2.12	0.12	-6.72	-6.54	0.18
Research & Development Income	-1.39	-0.39	1.00	-2.13	-1.96	0.16
Income Generation	-0.18	-0.15	0.03	-0.53	-0.48	0.06
Other Income	-2.07	-2.01	0.06	-3.60	-3.55	0.04
Other Operating Income	-5.87	-4.68	1.20	-12.98	-12.53	0.44
Total Income	-49.11	-47.44	1.67	-143.44	-141.56	1.88

NB Variances in brackets reflect overachievement of income against plan

15. At the end of Q1 total income is £1.88m behind plan. The key component of the position are the performance against the plan for NHSE Specialised Commissioning activity.

16. NHSE income is behind plan by £1.17m in total. Activity under-performance is across a number of service lines including Neonatal £0.5m, Adult Critical Care £0.4m, Renal £0.2m and Radiotherapy £0.1m. All other service lines collectively account for £0.5m adverse to plan, offset by a favourable variance on PBR Exclusions £0.5m.

17. Other Operating Income is behind plan due to R&D income £0.16m although offset by an equal reduction in expenditure. In addition Education and Training income is £0.18m lower than plan due to the Health Education England contract, which the Trust is reviewing.

Operating Expenditure

18. At the end of Q1 operating expenditure is £1.84m less than plan comprising of underspends on pay £1.72m and non-pay £0.12m.

Pay

19. The in-month position is favourable against budget by £0.42m comprising underspends across all staff groups except Medical pay and also Ancillary and Maintenance staff; as shown in the table below. The overall underspend is in part due to the 2018/19 planning assumption that a proportion of vacancies that were not backfilled in 2017/18 would be recruited into; posts have not been filled to the level assumed but the cost benefits of this have been reduced by the overspends on medical pay and within Estates and Facilities.

20. Medical Staff costs are adverse to budget by £0.14m in month mainly within the Surgery Division. At the end of Q1 all the divisions except Medicine are adverse to

budget by £0.39m, relating to Consultant pay. Recovery plans at a granular level are being developed across Divisions to reduce current spend and this is a particular focus within the Workforce Efficiency steering group.

21. The Ancillary staff variance is due to high levels of vacancies in Facilities being offset by bank, agency and overtime/enhanced payments. A recruitment plan has been agreed to address the impact of vacancies for this staff group to increase substantive appointments and improve budget performance.

Table 3: Pay Variances to Plan

£m	In Month			Year-to-Date		
	Plan	Actual	Variance	Plan	Actual	Variance
Medical & Dental Staff	9.31	9.42	0.11	27.95	28.34	0.39
Nursing & Midwifery	11.65	11.48	(0.17)	35.35	34.57	(0.78)
Other Healthcare Staff	4.28	4.10	(0.18)	12.84	12.28	(0.56)
Management	1.45	1.39	(0.06)	4.35	4.17	(0.19)
Administrative & Clerical	2.97	2.78	(0.18)	8.95	8.38	(0.57)
Ancillary Staff	1.25	1.29	0.04	3.78	3.96	0.18
Maintenance & Works	0.22	0.31	0.09	0.70	0.73	0.03
Other Staff	0.17	0.08	(0.09)	0.48	0.25	(0.23)
Total pay	**31.29**	**30.86**	**(0.42)**	**94.40**	**92.68**	**(1.72)**

22. Per NHSI Month 3 reporting guidance, pay expenditure includes an accrual for a 1% pay award, equating to £0.30m (£0.9m YTD). The pay award recently agreed will be paid in July and backdated pay in August. This does not impact the overall financial position.

23. Agency expenditure in June is £1.25m which is above the agency ceiling by £0.25m in month; however this includes a non-recurrent reclassification of £0.1m of Maintenance & Works costs. The Q1 position is £0.33m above the ceiling and marginally lower than the 17/18 Q4 monthly spend of 1.28m. The ceiling has reduced by £1m from 2017/18 and meeting the 2018/19 £11.8m ceiling will require further actions to reduce expenditure. These include: exit from use of high cost, non-framework agencies, improved recruitment and retention and application of rostering best practice across the Trust.

Non-pay

24. At the end of June non pay budgets are underspent by £0.12m. The budget for Premises is £0.45m above plan in Q1 due to estates reactive maintenance. A review of estates costs is being undertaken in July to establish actions to address the on-going overspend specifically in relation reactive maintenance and a recovery plan is required to ensure this does not continue. This overspend is being offset by under-spends across other non-pay categories

Non-operating Costs

25. Non-operating costs are slightly ahead of year to date plan at Month 3 with a combined favourable variance of £0.05m reflecting the actual costs of depreciation.

Performance Against Delegated Budgets

26. Budget sign-off meetings have now been held with all clinical divisions, and the Facilities and Estates Directorate. All budgets have been signed-off by management teams with any outstanding issues being captured for investigation and resolution as required. Budget adjustments totalling £9m have been made in Month 3 to reflect the impact of budget setting sign off actions and also the full maturity of CIP plans.

Efficiency Programme

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

28. At Month 3 £5.09m of savings have been delivered against a target of £5.06m. A separate more detailed Efficiency performance paper is presented to the Finance and Investment Committee.

Cash

29. The Trust received £17.5m of revenue deficit support loans up to June to support the year to date deficit.

30. Capital funding is a combination of Public Dividend Capital (PDC) and Capital Investment Loans. The Trust carried forward unspent PDC and Loan funding from 2017/18 amounting to £8.1m; hence the first drawdown for capital funds was in June. It comprised PDC drawdown of £4.3m and £2.6m as a capital loan.

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

32. The allocation of Sustainability and Transformation Fund cash for 2017/18 of £8.3m will be received in July 2018 following confirmation from DHSC.

Capital

33. The strategic capital forecast for the year is £137.8m. This comprises £101.9m for 3Ts, £13.9m for the Emergency Floor scheme, £9.0m for the Emergency Backlog Maintenance scheme, £11.5m for the Pathology scheme and a residual £1.4m for the Radiotherapy East scheme.

34. Strategic capital expenditure up to the end of June amounted to £13.8m; compared to the plan of £26.9m. The Trust is currently working to revised cashflow projections of the main contractor for 3Ts and an Executive led review of the works profiling to assess forecast expenditure has taken place. This has resulted in a forecast which defers some capital spend from 18/19 into 19/20 whilst ensuring the timescales for Stage 1 completion are not compromised.

35. The operational capital forecast for the year is £18.1m. Expenditure up to the end of June was lower than planned; actual expenditure of £1.4m against the plan of £3.6m. The underspend relates to IT schemes however TEC has approved several new schemes this month.

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

Key Risks

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

38. **NHSE Specialised Commissioning Contract**

Agreement has now been reached on the 2018/19 contract. This is a PbR based contract so the Trust will get paid for the activity it delivers; underperformance is therefore an income risk. The contract also limits the Trust's 2018/19 exposure to some legacy charging issues with transitional arrangements agreed. Although Month 3 was in line with plan the year to date underperformance is a significant risk to the delivery of the plan in full so a deep-dive review is being undertaken and will be shared with the Finance and Investment committee at Month 3. There is an emerging risk of up to £1m relating to the NHSE position on CUR CQUIN which the Trust is disputing at Executive level.

39. **CCG Contract**

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

40. **Provider Sustainability Funding (PSF)**

The Trust has agreed to £10.29m PSF allocation in 2018/19. To access this funding the Trust has to deliver the underlying control total excluding PSF to earn 70% of the allocation; with the remaining 30% contingent on delivering the agreed A&E trajectory for 2018/19. The PSF performance is confirmed on a quarterly basis. If achievement is not met in the quarter there is the opportunity to earn this back if a future quarter's year to date position is met. The PSF is weighted as follows: Q1 (15%), Q2 (20%), Q3 (30%) and Q4 (35%). This means that the risk of not meeting the plan in Q3 and Q4 has a larger impact on the Trust's position. Quarter 1 PSF has been met in full.

41. **PAS Replacement**

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

42. **CIP**

Delivery of the £30m CIP target in full; whilst the target is fully identified there are £5.9m of schemes that are rated as higher risk due to the complexity of delivery. These schemes will be subject to more development and like the rest of the programme monitored through the PMO and the executive led efficiency steering group will provide further support and challenge. Mitigations are sought to offset any under-delivery.

43. **Capital**

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

Conclusions and Recommendations

44. The Trust Board is asked to:

- Note the Trust has re-submitted the 18/19 Financial Plan to NHSI and agreed to £10.29m of Provider Sustainability Funding. The revised 18/19 control total deficit is £55.11m
- Note the Trust has delivered the Q1 Control total
- Note the key risks to delivering the control total deficit of £55.11m; and
- Note further actions to be taken by Divisions and Directorates to recover the cost pressures and income risks identified.

Appendix 1 - I/E Report Month 3 2018/19

	In - Month			Year to Date			Forecast		
	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
NHS Trusts Income	(677)	(786)	(109)	(2,085)	(2,172)	(87)	(8,375)	(8,450)	(75)
CCG Income	(24,179)	(23,728)	451	(73,063)	(72,719)	343	(293,158)	(293,209)	(51)
NHSE Income	(15,329)	(15,325)	4	(46,271)	(45,099)	1,172	(185,527)	(184,355)	1,172
SMSKP Income	(2,052)	(1,975)	77	(6,157)	(5,929)	228	(24,818)	(24,590)	228
Department Of Health Income	(3)	0	3	(9)	(4)	5	(37)	(32)	5
Private Patients Income	(427)	(328)	99	(1,281)	(1,166)	115	(5,126)	(5,011)	115
Injury Cost Recovery	(120)	(152)	(32)	(359)	(535)	(176)	(1,436)	(1,612)	(176)
Local Authority Income	(342)	(308)	34	(1,027)	(964)	63	(4,099)	(4,036)	63
Overseas Visitors Income	(17)	(57)	(41)	(50)	(113)	(63)	(200)	(263)	(63)
Other Patient Related Income	(87)	(99)	(13)	(155)	(319)	(163)	(2,381)	(2,145)	236
Income from Activities	**(43,233)**	**(42,759)**	**474**	**(130,457)**	**(129,021)**	**1,437**	**(525,157)**	**(523,703)**	**1,454**
Education & Training Income	(2,240)	(2,122)	118	(6,719)	(6,539)	180	(26,857)	(26,663)	194
Research & Development Income	(1,391)	(394)	997	(2,127)	(1,965)	163	(5,627)	(5,361)	266
Income Generation	(178)	(153)	25	(535)	(476)	59	(2,052)	(2,016)	37
Other Income	(2,066)	(2,007)	59	(3,597)	(3,554)	43	(18,344)	(18,308)	36
Other Operating Income	**(5,875)**	**(4,676)**	**1,199**	**(12,978)**	**(12,534)**	**444**	**(52,880)**	**(52,347)**	**533**
TOTAL INCOME	**(49,108)**	**(47,435)**	**1,673**	**(143,436)**	**(141,555)**	**1,881**	**(578,037)**	**(576,050)**	**1,987**
Pay - Management	1,448	1,392	(56)	4,353	4,165	(188)	17,402	17,238	(164)
Medical and Dental Staff	9,306	9,420	114	27,947	28,338	391	108,468	108,610	142
Nursing & Midwifery - Registered	9,319	9,106	(213)	28,268	27,498	(771)	111,246	109,408	(1,838)
Nursing & Midwifery - Unregistered	2,328	2,376	48	7,080	7,075	(5)	28,214	29,209	994
Pay Other Healthcare	4,277	4,099	(178)	12,842	12,282	(561)	50,283	49,742	(541)
Ancillary Staff	1,251	1,293	43	3,781	3,961	180	15,059	15,210	151
Administrative & Clerical	2,967	2,782	(184)	8,950	8,376	(574)	35,137	34,551	(586)
Maintenance & Works	222	313	91	701	735	34	2,804	2,889	84
Pay - Other Staff	168	82	(86)	480	253	(227)	1,834	1,750	(85)
TOTAL PAY	**31,287**	**30,865**	**(422)**	**94,402**	**92,683**	**(1,719)**	**370,449**	**368,606**	**(1,843)**
Drugs - in tariff	1,079	1,019	(60)	3,177	3,145	(32)	12,269	12,235	(34)
Drugs - PbR exclusion and CDF	5,358	4,934	(425)	16,747	16,577	(170)	67,176	67,006	(170)
Supplies and Services - Clinical - in tariff	4,717	4,636	(81)	13,818	13,478	(340)	53,114	52,737	(378)
Supplies and Services - Clinical - PbR exclusion	665	822	157	1,986	2,194	208	7,967	8,175	208
Supplies and Services General	595	591	(4)	1,797	1,845	48	6,938	6,972	33
Establishment Expenses	533	349	(184)	1,240	1,124	(116)	4,960	4,834	(127)
Transport Expenses	235	154	(81)	457	440	(18)	1,788	1,770	(19)
Premises	1,833	1,808	(25)	5,431	5,888	457	21,481	22,040	559
Purchase of Healthcare from Non NHS provider	476	489	13	1,397	1,602	205	6,142	6,347	205
Consultancy	119	125	7	406	373	(34)	1,477	1,437	(40)
Other Non Pay	900	192	(708)	1,585	1,348	(237)	2,882	2,615	(266)
CNST Premium	2,001	2,001	(0)	6,003	6,003	(0)	23,261	23,261	(0)
Education and Training	313	321	8	938	901	(38)	3,749	3,708	(41)
Operating Lease Expenditure	250	588	338	750	682	(68)	3,004	2,936	(68)
Services from Other NHS Bodies	365	180	(186)	1,130	1,127	(3)	4,669	4,675	6
Audit Fees	10	20	10	30	55	25	121	146	25
Trust Chair & Non-Executive Directors	8	4	(4)	24	20	(4)	100	96	(4)
TOTAL NON-PAY	**19,457**	**18,231**	**(1,226)**	**56,918**	**56,799**	**(119)**	**221,099**	**220,988**	**(111)**
TOTAL EXPENDITURE	**50,744**	**49,096**	**(1,648)**	**151,321**	**149,483**	**(1,838)**	**591,547**	**589,594**	**(1,954)**
Depreciation & Impairments	1,746	1,735	(11)	5,240	5,199	(41)	31,777	31,764	(13)
Interest Payable	973	981	8	2,858	2,866	8	12,147	12,155	8
Interest Receivable	(2)	(7)	(5)	(6)	(22)	(16)	(24)	(40)	(16)
PDC Dividend Payable	451	451	0	1,353	1,353	0	5,592	5,592	0
TOTAL NON OPERATING INC & EXP	**3,168**	**3,159**	**(9)**	**9,445**	**9,396**	**(49)**	**49,492**	**49,471**	**(21)**
TOTAL INCOME & EXPENDITURE	**4,804**	**4,820**	**16**	**17,330**	**17,324**	**(6)**	**63,002**	**63,015**	**13**
Donations Inc Charitable Funds	**(74)**	**(55)**	**19**	**(724)**	**(715)**	**9**	**(2,595)**	**(2,587)**	**8**
Depn. On Donated Assets	**49**	**50**	**1**	**149**	**151**	**2**	**491**	**493**	**2**
Fixed Asset Impairments	**0**	**2**	**2**	**0**	**2**	**2**	**10,000**	**10,002**	**2**
NET REPORTED POSITION	**4,829**	**4,823**	**(6)**	**17,905**	**17,885**	**(20)**	**55,106**	**55,106**	**(0)**

Appendix 2 - I/E Report Month 3 2018/19

	In-Month			Year-to-Date		
	Plan	Actual	Variance	Plan	Actual	Variance
	£000's	£000's	£000's	£000's	£000's	£000's
Children & Women Division	3,834	4,040	206	11,510	12,205	696
Central Clincial Services Division	7,309	7,504	195	21,869	22,907	1,038
Medicine Division	5,164	5,302	139	14,835	15,920	1,086
Specialist Services Division	6,861	6,688	(173)	19,460	19,962	503
Surgery Division	7,150	7,585	436	21,641	22,376	736
Clinical Services Total	**30,318**	**31,120**	**802**	**89,314**	**93,372**	**4,058**
Chief Financial Officer	1,176	1,096	(80)	3,530	3,317	(213)
Chief Executive	286	288	1	859	958	99
Chief Nursing & Patient Safety Officer	2,342	2,366	23	7,027	6,969	(59)
Chief Operating Officer	3,556	3,812	256	10,146	11,441	1,295
Chief Medical Officer	(805)	(937)	(132)	(2,416)	(2,705)	(289)
Chief Delivery & Strategy Officer	41	11	(30)	179	41	(139)
Chief Workforce & Organisation Development Officer	402	496	95	1,207	1,286	79
Corporate Services Total	**6,998**	**7,131**	**134**	**20,533**	**21,306**	**773**
Central Income	(36,749)	(36,672)	77	(107,967)	(106,690)	1,277
Capital Charges & Financing Costs	2,905	2,920	15	8,155	8,781	626
Central Reserves	12	316	304	7,295	561	(6,735)
Efficiency Programme	1,320	1	(1,319)	0	0	0
Financial Central Services	**(32,511)**	**(33,431)**	**(920)**	**(92,517)**	**(97,354)**	**(4,837)**
Directorate Total	**4,804**	**4,820**	**16**	**17,330**	**17,324**	**(6)**
Below the line Adjustments	25	3	(22)	575	561	(14)
Total	**4,829**	**4,823**	**(6)**	**17,905**	**17,885**	**(20)**

Finance Report Month 03 2018/19

Summary

Brighton and Sussex University Hospitals NHS Trust

Summary

A control total deficit of £55.11m has been set by the Trust in agreement with NHSI, and the year to date position is slightly ahead the year-to-date plan of £17.905m. The capital programme is underspent. The Efficiency and Transformation Programme has delivered £5.09m during the first three months of the financial year.

Finance and Use of Resources Risk Rating — R

YTD

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

The risk ratings are in line with plan.

Control Total (Surplus) / Deficit £k — G

	Plan	Actual / Forecast	Variance
Year-to-date	17,905	17,885	(20)
Year-end Forecast	55,106	55,106	(0)

The Trust is reporting a deficit of £17.885m compared to the YTD plan of £17.905m. The forecast is to meet the control total.

Agency Ceiling £k — A

	Ceiling	Actual / Forecast	Variance
Year-to-date	3,007	3,331	324
Year-end Forecast	11,783	11,086	(697)

Agency costs of £3.331m represent 3.6% of the total pay bill and are over the Month 3 agency cap of £3.007m. Agency expenditure was less than M12, but the agency cap has reduced by £1m year on year. The total cost of Agency, bank and substantive staff usage was below the Month 3 budget.

Income £k — R

	Plan	Actual / Forecast	Variance
Year-to-date	(143,436)	(141,555)	1,881
Year-end Forecast	(578,037)	(576,050)	1,987

Total income was £47.44m in-month, £1.67m below the plan increasing the year to date deficit to £1.88m. The in month position includes £1m R&D adjustment to align the YTD plan. YTD Income from activity from specialised commissioning is behind plan by £1.17m.

Operating Costs £k — G

	Plan	Actual / Forecast	Variance
Year-to-date	151,321	149,483	(1,838)
Year-end Forecast	591,547	589,594	(1,954)

Operating costs for the year are underspent against budget, primarily due to pay costs relating to vacancies. The Forecast is to continue to underspend in these areas to offset forecast income reductions, in order to come in on budget.

Agency Expenditure — G

Expenditure as % of total Pay bill (YTD)	**2016-17**	**2017-18**	**2018-19**
Medical	1.0%	0.8%	1.0%
Nursing	0.8%	0.9%	1.1%
Other staff groups	1.1%	1.3%	1.4%
All Agency	**2.9%**	**3.0%**	**3.6%**

Agency costs have increased as a proportion of the total paybill compared to the same period last year, primarily in the area of nursing and medical and are £0.3m above the ceiling.

Cash £k — G

	Plan	Actual	Variance
Year-to-date	6,651	18,479	11,828
Year-end Forecast	3,529	3,529	0

The revenue deficit funding for June was £5.9m. Capital drawdowns in June comprised £2.6m in capital loans and £4.3m of PDC. The cash holding is above plan to ensure adequate funds are available in the first two weeks of June as a result of a shortfall on some contracted income to June. The year end forecast is aligned to the year-end EFL cash control total, which is slightly above the DH maximum cash holding assumed for an organisation with revenue support.

Capital £k — A

	Plan	Actual	Variance
Year-to-date	26,869	15,217	(11,652)
Year-end Forecast	155,849	155,849	0

With regards to strategic capital, the Trust is liaising with the main contractor for an updated cashflow. The YTD underspend for operational capital predominantly relates to IM&T schemes; however TEC has recently approved all IM&T schemes. It is expected that the expenditure will pick up significantly in the coming months. The forecast for both strategic and operational capital assumes the plan level of expenditure is achieved.

Efficiency and Transformation Programme £k — G

	Plan	Actual / Forecast	Variance
Year-to-date	5,061	5,086	25
Year-end Forecast	30,000	30,000	(0)

The efficiency programme has delivered the £5.09m in the year to Month 3 which is £0.114m in excess of the internal target and £0.03m higher than the NHSI target. The Quarter 1 gateway reviews have firmed up a number of placeholder projects, and the forecast is to acheive the full plan of £30m.

Key risks include:

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

Finance Report Month 03 2018/19	Finance and Use of Resources Risk Rating	R

The Trust hasn't received actual ratings from NHSI in month 1. Whilst we can calculate them using the metric formulas, there will be an over-ride. Metrics will be reported next month.

Financial Rating YTD	Plan Metric	Plan Rating	Actual Metric	Actual Rating
Capital Service Capacity	0.0	4		4
Liquidity	0.4	4		4
I&E Margin	(0.10%)	4		4
Distance from Financial Plan				2
Agency Spend	10.94%	1		2
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%	0.107416

Finance Report Month 03 2018/19 — Surplus — G

The Trust is reporting a deficit of £17.885m compared to the YTD plan of £17.905m. The forecast is to meet the control total.

Year to Date

	Plan £k	Actual £k	Variance £k
(Surplus)/Deficit	**17,905**	**17,885**	**(20)**

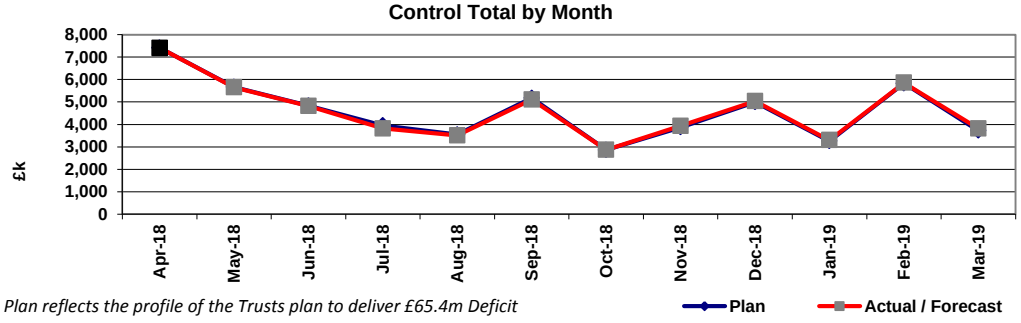
Year End Forecast

	Plan £k	Forecast £k	Variance £k
(Surplus)/Deficit	**55,106**	**55,106**	**(0)**

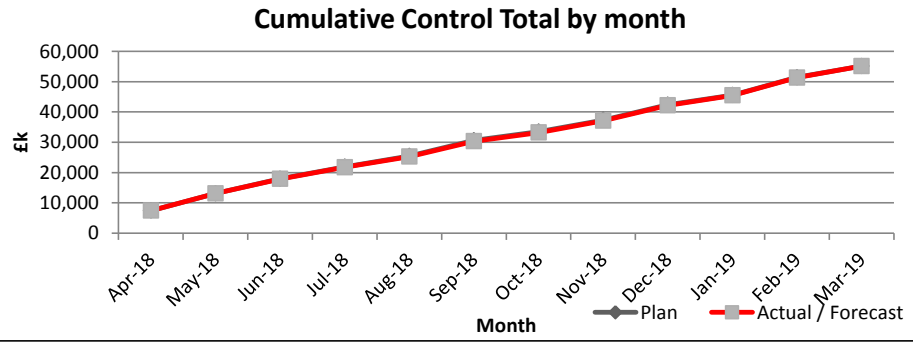
Income for the year to date is lower than budget by £1.88m. More detail is provided in the Income dashboard.
Expenditure compared to budget is underspent for the year to June 2018, mainly in the areas of pay costs. See the operating costs dashboard for more detail.

	Year to Date				Full year			
	PY Actual £k	Plan £k	Actual £k	Variance £k	Plan £k	Actual £k	Variance £k
Income	(135,490)	(143,436)	(141,555)	1,881	(578,037)	(576,050)	1,987
Pay	89,046	94,402	92,683	(1,719)	370,449	368,606	(1,843)
Non-Pay - in tariff	36,669	38,186	38,029	(157)	145,956	145,807	(149)
Non-Pay - PBR exclusions and CDF	19,152	18,733	18,771	38	75,142	75,180	38
EBITDA *	**9,377**	**7,885**	**7,928**	**43**	**13,510**	**13,544**	**34**
EBITDA %	**-6.9**	**-5.5**	**-5.6**		**-2.3**	**-2.4**	
Profit / Loss on Disposal of Fixed Assets	-	-	-	-	-	-	-
Interest Payable	2,241	2,858	2,866	8	12,147	12,155	8
Interest Receivable	(7)	(6)	(22)	(16)	(24)	(40)	(16)
Depreciation	5,636	5,240	5,197	(43)	21,777	21,762	(15)
Impairments	0	0	2	2	10,000	10,002	2
Public Dividend Capital	1,652	1,353	1,353	0	5,592	5,592	0
Net (Surplus) / Deficit	**18,899**	**17,330**	**17,324**	**(7)**	**63,002**	**63,015**	**13**
Reverse Impairment	0	0	(2)	(2)	(10,000)	(10,002)	(2)
Other Adjustments	(164)	575	564	(11)	2,104	2,094	(10)
Reverse IFRS technical charge	0	0	0	0	0	0	0
Performance against Control Total	**18,736**	**17,905**	**17,885**	**(20)**	**55,106**	**55,106**	**(0)**
Surplus %	**-13.8**	**-12.5**	**-12.6**		**-9.5**	**-9.6**	

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



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



Contract income is underperforming by £2.0m year-to-date. The underperformance relates to NHSE specialised activity. The Trust has an Aligned Incentive Contract with Susses CCG's. Detailed activity plans by Specialty and point of delivery are still to be confirmed with Commissioners.

Contract Agreement 2017/18

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

	Reported Values for June 2018			
	£'000			
	FYE Plan	YTD Plan	YTD Actual	YTD Var
Sussex CCG's	286,000	71,277	70,877	400
MSK	24,818	6,157	5,929	228
NHS England (Specialised)	168,431	41,997	40,735	1,262
NHS England (Dental & Screening)	11,658	2,914	2,811	104
Integrated Sexual Health Services	3,655	906	826	80
Non Contracted Activity	5,666	1,413	1,467	(55)
TOTAL COMMISSIONING INCOME	**500,228**	**124,665**	**122,645**	**2,019**

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	11,514	10,091	(1,424)	-12.4%	9,960	8,957	(1,003)	-10.1%
Elective Spells	3,755	3,701	(55)	-1.5%	9,507	9,494	(13)	-0.1%
Non Elective Spells	10,384	10,380	(4)	0.0%	27,837	29,318	1,481	5.3%
Non Elective Spells - Short Stay	1,220	1,021	(199)	-16.3%	910	793	(117)	-12.9%
Ambulatory Care	2,293	1,976	(317)	-13.8%	2,022	2,004	(18)	-0.9%
Elective Excess beddays	818	646	(172)	-21.1%	214	172	(42)	-19.5%
Non Elective excess beddays	4,770	3,489	(1,281)	-26.9%	1,271	955	(316)	-24.8%
A&E	40,625	44,488	3,863	9.5%	5,307	5,925	618	11.6%
Outpatients - New	30,557	31,207	651	2.1%	5,955	5,723	(232)	-3.9%
Outpatients - Follow Up	72,221	68,781	(3,440)	-4.8%	4,916	5,110	195	4.0%
Outpatient Procedures	23,161	24,008	848	3.7%	3,084	3,247	163	5.3%
Outpatient Imaging	11,154	10,618	(537)	-4.8%	1,340	1,182	(158)	-11.8%
Direct Access	904,737	945,965	41,228	4.6%	3,536	3,801	265	7.5%
Bowel Screening	0	0	0	0.0%	530	576	46	8.7%
Breast Screening	0	0	0	0.0%	697	708	11	1.5%
Critical Care	8,295	7,785	(510)	-6.1%	8,543	8,010	(534)	-6.2%
Maternity Pathway	2,767	2,682	(85)	-3.1%	2,783	2,843	61	2.2%
HIV	7,070	7,050	(19)	-0.3%	1,272	1,268	(3)	-0.3%
Renal	22,913	21,819	(1,095)	-4.8%	3,018	2,907	(110)	-3.6%
Other	57,113	52,375	(4,738)	-8.3%	10,678	9,308	(1,370)	-12.8%
PbR Excluded Drugs / Devices					18,527	18,545	18	0.1%
CQUIN					2,623	2,623	0	0.0%
Provision for challenge and Risk					(825)	(825)	0	0.0%
Phasing correction					961	0	(961)	-100.0%
					124,665	**122,645**	**(2,019)**	**-1.6%**

Table 3 - Reconciliation to Income Reporting

Contract Monitoring Performance -(unadjusted)	490,598	122,867	120,022	2,845
CQUIN 2.5%	10,455	2,623	2,623	0
Contract Penalties / Adjustments (Estimated)	(825)	(825)	(0)	(825)
	500,228	**124,665**	**122,645**	**2,020**
Other Income from Activities				
NHS Trust / FT Income	8,375	2,085	2,170	(85)
Commissioning Income - Non Activity	6,930	1,733	1,931	(199)
Department Of Health Income	37	9	4	5
Private Patients Income	5,126	1,281	1,166	115
Injury Cost Recovery	1,436	359	535	(176)
Other Patient Related (remove MSK included above)	2,381	155	319	(163)
Local Authority Income (remove value included above)	445	121	137	(17)
Overseas Visitors Income	200	50	113	(63)
				0
Income from Activities as reported in Income Section	**525,157**	**130,457**	**129,021**	**1,437**

Table 4 - Income from CCG's

	£'000		
	YTD Plan	YTD Actual	YTD Var
NHS BRIGHTON AND HOVE CCG	32,796	32,796	0
NHS COASTAL WEST SUSSEX CCG	4,141	4,141	0
NHS CRAWLEY CCG	796	796	0
NHS EASTBOURNE, HAILSHAM AND SEAFORD CCG	2,635	2,635	0
NHS HASTINGS AND ROTHER CCG	1,179	1,179	0
NHS HIGH WEALD LEWES HAVENS CCG	12,013	12,013	0
NHS HORSHAM AND MID SUSSEX CCG	16,885	16,885	0
NHS EAST SURREY	141	141	0
Dermatology SCDS	693	693	0
Commissioning Income CCG's	**71,277**	**71,277**	**0**

Finance Report Month 03 2018/19 — Income — A

For the year-to-June, Income reports an underperformance of £1.9m, an deterioration of £1.7m on the previous month. The variance on income from activates has increased by £475k, a continuation of the monthly trend this year. As shown on the contract performance sheet activity is behind plan for day case and critical care activity. In operating income the budget on the european project which gave a large positve variance in M2 has been rephased with R&D income now behind plan.

Year-to-Date

	Plan £k	Actual £k	Variance £k
Total Income	**(143,436)**	**(141,555)**	**1,881**

Year-end Forecast

	Plan £k	Forecast £k	Variance £k
Total Income	**(578,037)**	**(576,050)**	**1,987**

Income from activities has improved in May by £0.2k due mainly to a high month for injury cost recovery. Other operating income improved by £0.635k, due mainly to a European research trail EE Merge, which has made payments offset by income in May.

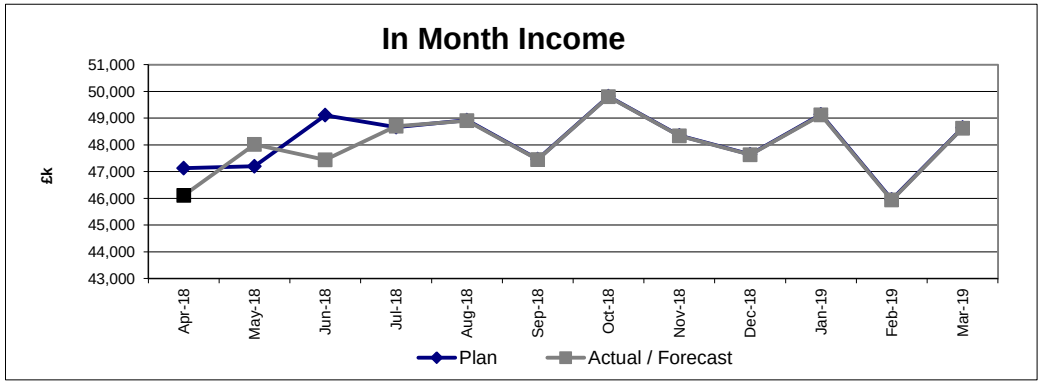
The income Forecast reflects the activity under performance on the NHSE and MSK contracts. Education & Training and Research & Development are both behind plan.

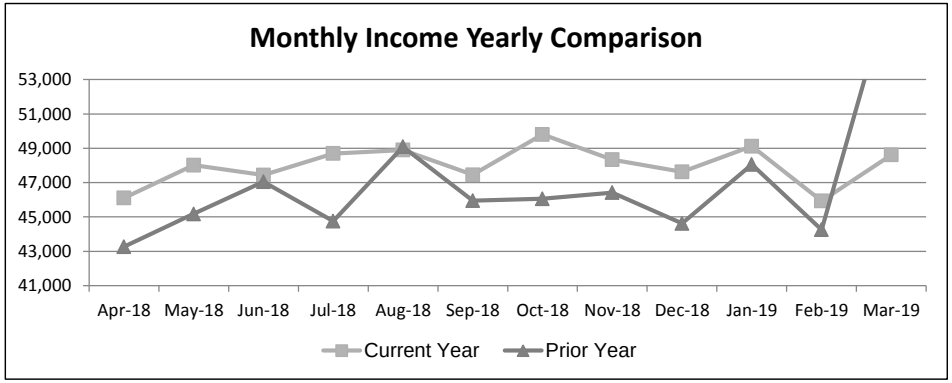
Year-to-Date

	PY Actual £k	Plan £k	Actual £k	Variance £k
Income				
NHS Trusts Income	(1,829)	(2,085)	(2,172)	(87)
CCG Income	(114,410)	(73,063)	(72,719)	343
NHSE Income	(964)	(46,271)	(45,099)	1,172
SMSKP Income	0	(6,157)	(5,929)	228
Department Of Health Income	(17)	(9)	(4)	5
Private Patients Income	(1,025)	(1,281)	(1,166)	115
Injury Cost Recovery	(427)	(359)	(535)	(176)
Local Authority Income	(1,133)	(1,027)	(964)	63
Overseas Visitors Income	(35)	(50)	(113)	(63)
Other Patient Related Income	(6,139)	(155)	(319)	(163)
Income From Activities	**(125,979)**	**(130,457)**	**(129,021)**	**1,437**
Education & Training Income	(6,712)	(6,719)	(6,539)	180
Research & Development Income	(782)	(2,127)	(1,965)	163
Income from Donated Reserve	0	0	0	0
Income Generation	(609)	(535)	(476)	59
Other Income	(1,408)	(3,597)	(3,554)	43
INCETI - Education & Training Income	0	0	0	0
Other Operating Income	**(9,511)**	**(12,978)**	**(12,534)**	**444**
TOTAL INCOME	**(135,490)**	**(143,436)**	**(141,555)**	**1,881**
Of Which PBRX Drugs/Devices	(11,900)	(18,207)	(17,988)	220

Year-end Forecast

	Plan £k	Forecast £k	Variance £k
Income			
NHS Trusts Income	(8,375)	(8,450)	(75)
CCG Income	(293,158)	(293,209)	(51)
NHSE Income	(185,527)	(184,355)	1,172
SMSKP Income	(24,818)	(24,590)	228
Department Of Health Income	(37)	(32)	5
Private Patients Income	(5,126)	(5,011)	115
Injury Cost Recovery	(1,436)	(1,612)	(176)
Local Authority Income	(4,099)	(4,036)	63
Overseas Visitors Income	(200)	(263)	(63)
Other Patient Related Income	(2,381)	(2,145)	236
Income From Activities	**(525,157)**	**(523,703)**	**1,454**
Education & Training Income	(26,857)	(26,663)	194
Research & Development Income	(5,627)	(5,361)	266
Transfers from Donated Asset Reserve	0	0	0
Income Generation	(2,052)	(2,016)	37
Other Income	(18,344)	(18,308)	36
INCETI - Education & Training Income	0	0	0
Other Operating Income	**(52,880)**	**(52,347)**	**533**
Total Income	**(578,037)**	**(576,050)**	**1,987**





Finance Report Month 03 2018/19 — Operating Costs — A

Operating costs for the year are underspent against budget, primarily due to pay costs relating to vacancies. The Forecast is to continue to underspend in these areas to offset forecast income reductions, in order to come in on budget.

Year-to-date

	PY Actual £k	Plan £k	Actual £k	Variance £k
Pay	**89,046**	**94,402**	**92,683**	**(1,719)**
Non-pay	**55,820**	**56,918**	**56,799**	**(119)**
Operational Costs	**144,867**	**151,321**	**149,483**	**(1,838)**

Year-end Forecast

	Plan £k	Forecast £k	Variance £k
Pay	**370,449**	**368,606**	**(1,843)**
Non-pay	**221,099**	**220,988**	**(111)**
Operational Costs	**591,547**	**589,594**	**(1,954)**

Pay: costs in June were in line with May. The Trust has 883 WTE vacancies (substantive contracted staff vs funded establishment), of which 364 are nurse vacancies. Some of these are covered by overtime and use of bank and agency staff.

Non-pay: underspent compared to budget overall. The YTD non pay overspend of £0.12m relates to Premises £0.45m on reactive maintenance being offset by under-spends across other non-pay categories.

Year-to-date

	PY Actual £k	Plan £k	Actual £k	Variance £k
Pay				
Management	4,050	4,353	4,165	(188)
Medical and Dental Staff	26,812	27,947	28,338	391
Nursing & Midwifery - Registered	26,887	28,268	27,498	(771)
Nursing & Midwifery - Unregistered	6,534	7,080	7,075	(5)
Other Healthcare Staff	12,212	12,842	12,282	(561)
Ancillary Staff	3,587	3,781	3,961	180
Administrative & Clerical	8,207	8,950	8,376	(574)
Maintenance Staff	669	701	735	34
Other Staff	89	480	253	(227)
Total Pay	**89,046**	**94,402**	**92,683**	**(1,719)**
Non-pay				
Drugs & Medical Gases - in tariff	2,946	3,177	3,145	(32)
Drugs & Medical Gases - PbR exclusion and CDF	17,284	16,747	16,577	(170)
Supplies and Services - Clinical - in tariff	13,953	13,818	13,478	(340)
Supplies and Services - Clinical - PbR exclusion	1,868	1,986	2,194	208
Supplies and Services General	1,773	1,797	1,845	48
Establishment Expenses	1,081	1,240	1,124	(116)
Transport Expenses	404	457	440	(18)
Premises	5,267	5,431	5,888	457
Purchase of Healthcare from Non NHS provider	1,784	1,397	1,602	205
Consultancy	184	406	373	(34)
Other Non Pay/Reserves	729	1,585	1,348	(237)
CNST Premium	5,380	6,003	6,003	(0)
Education and Training	859	938	901	(38)
Operating Lease Expenditure	0	750	682	(68)
Services from Other NHS Bodies	2,228	1,130	1,127	(3)
Audit Fees	62	30	55	25
Trust Chair & Non-Executive Directors	19	24	20	(4)
Total Non-Pay	**55,820**	**56,918**	**56,799**	**(119)**
Total Expenditure	**144,867**	**151,321**	**149,483**	**(1,838)**

Full-year

	Plan £k	Forecast £k	Variance £k
Pay			
Management	17,402	17,238	(164)
Medical and Dental Staff	108,468	108,610	142
Nursing & Midwifery - Registered	111,246	109,408	(1,838)
Nursing & Midwifery - Unregistered	28,214	29,209	994
Other Healthcare Staff	50,283	49,742	(541)
Ancillary Staff	15,059	15,210	151
Administrative & Clerical	35,137	34,551	(586)
Maintenance Staff	2,804	2,889	84
Other Staff	1,834	1,750	(85)
Total Pay	**370,449**	**368,606**	**(1,843)**
Non-pay			
Drugs & Medical Gases - in tariff	12,269	12,235	(34)
Drugs & Medical Gases - PbR exclusion and CDF	67,176	67,006	(170)
Supplies and Services - Clinical - in tariff	53,114	52,737	(378)
Supplies and Services - Clinical - PbR exclusion	7,967	8,175	208
Supplies and Services General	6,938	6,972	33
Establishment Expenses	4,960	4,834	(127)
Transport Expenses	1,788	1,770	(19)
Premises	21,481	22,040	559
Purchase of Healthcare from Non NHS provider	6,142	6,347	205
Consultancy	1,477	1,437	(40)
Other Non Pay/Reserves	2,882	2,615	(266)
CNST Premium	23,261	23,261	(0)
Education and Training	3,749	3,708	(41)
Operating Lease Expenditure	3,004	2,936	(68)
Services from Other NHS Bodies	4,669	4,675	6
Audit Fees	121	146	25
Trust Chair & Non-Executive Directors	100	96	(4)
Total Non-Pay	**221,099**	**220,988**	**(111)**
Total Expenditure	**591,547**	**589,594**	**(1,954)**

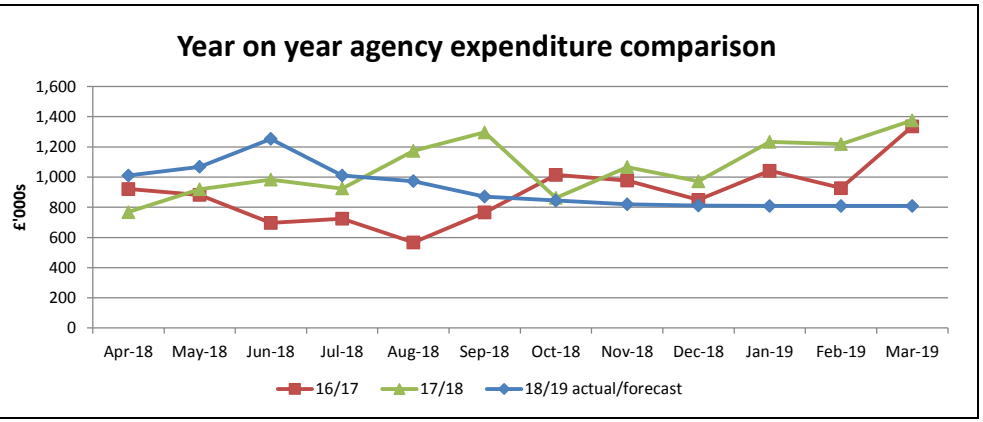
Finance Report Month 03 2018/19 — Payroll and Agency costs — G

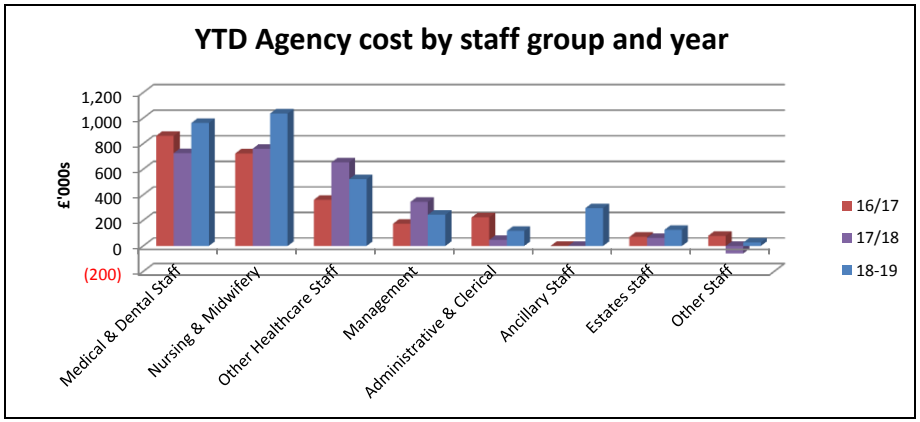
Agency costs of £3.331m represent 3.6% of the total pay bill and are over the Month 3 agency cap of £3.007m. Agency expenditure was less than M12, but the agency cap has reduced by £1m year on year. The total cost of Agency, bank and substantive staff usage was below the Month 3 budget.

Year-to-date Agency

	16/17 £k	17/18 £k	Ceiling £k	18-19 £k	Variance £k
Medical & Dental Staff	862	727	791	962	171
Nursing & Midwifery	723	761	1,019	1,036	17
Other Healthcare Staff	362	654	569	522	(47)
Management	173	344	188	244	56
Administrative & Clerical	224	47	251	117	(134)
Ancillary Staff	0	0	126	297	171
Estates staff	71	64	63	126	63
Other Staff	80	(58)		27	27
Trust	**2,495**	**2,539**	**3,007**	**3,331**	**324**

3331
92680
3.59%





Payroll

(Excludes non executive directors)

	Prior year actual £k	Plan £k	Actual £k	Variance £k
Medical & Dental Staff	26,085	27,713	27,376	(337)
Nursing & Midwifery	32,659	35,344	33,537	(1,807)
Other Healthcare Staff	11,559	12,803	11,760	(1,043)
Management	3,706	4,353	3,921	(432)
Administrative & Clerical	8,160	8,950	8,259	(691)
Ancillary Staff	3,455	3,735	3,665	(70)
Maintenance Staff	605	701	609	(92)
Other Staff	147	456	226	(230)
Trust	**86,375**	**94,055**	**89,353**	**(4,702)**

Staff in post including bank staff

	Prior year actual WTE	Plan WTE	Actual WTE	Variance WTE
Medical & Dental Staff	1080.1	1,198	1,126	(72)
Nursing & Midwifery	3439.28	3,584	3,530	(54)
Other Healthcare Staff	1107.23	1,270	1,126	(143)
Management	202.09	245	207	(38)
Administrative & Clerical	1188.2	1,306	1,205	(101)
Ancillary staff	567.47	614	619	6
Maintenance Staff	63.36	84	65	(19)
Other Staff	14.66	16	16	(0)
Trust	**7,662**	**8,317**	**7,895**	**(422)**

Finance Report Month 03 2018/19 — Statement of Financial Position

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

	1 April 18	Year-to-Date				Full-Year			
	Actual	Plan	Actual	Variance	Notes	Plan	Actual	Variance	Notes
	£k	£k	£k	£k		£k	£k	£k	
Property, Plant and Equipment	422,387	444,062	432,404	(11,658)	1	547,137	547,137	0	
Intangible Assets	550	504	549	45		372	372	0	
Other Assets	4,784	4,472	4,513	41		4,487	4,487	0	
Non Current Assets	**427,721**	**449,038**	**437,466**	**(11,572)**		**551,996**	**551,996**	**0**	
Inventories	8,788	8,784	8,771	(13)		8,360	8,360	0	
Trade and Other Receivables	45,610	45,273	49,675	4,402	2	50,901	50,901	0	
Cash and Cash Equivalents	15,872	6,652	18,479	11,827		3,529	3,529	0	
Non Current Assets Held for Sale	0	0	0	0		0	0	0	
Current Assets	**70,270**	**60,709**	**76,925**	**16,216**		**62,790**	**62,790**	**0**	
Trade and Other Payables	(65,102)	(58,325)	(75,511)	(17,186)	2	(67,301)	(67,301)	0	
Borrowings	(24,583)	(24,583)	(24,583)	0	3	(7,379)	(7,379)	0	
Other Financial Liabilities	0	0	0	0		0	0	0	
Provisions	(1,725)	(3,249)	(1,169)	2,080		(807)	(807)	0	
Other Liabilities	0	0	0	0		0	0	0	
Current Liabilities	**(91,410)**	**(86,157)**	**(101,263)**	**(15,106)**		**(75,487)**	**(75,487)**	**0**	
Borrowings	(242,341)	(266,287)	(261,881)	4,406	3	(342,020)	(342,020)	0	
Trade and Other Payables	(10)	(27)	(16)	11		(33)	(33)	0	
Provisions	(2,030)	(2,051)	(2,031)	20		(2,062)	(2,062)	0	
TOTAL ASSETS EMPLOYED	**162,200**	**155,225**	**149,200**	**(6,025)**		**195,184**	**195,184**	**0**	
Financed by:									
Public Dividend Capital	337,972	349,872	342,296	(7,576)	4	433,958	433,958	0	
Retained Earnings	(229,577)	(229,577)	(229,577)	0		(229,577)	(229,577)	0	
Surplus/(Deficit) for Year	0	(18,875)	(17,324)	1,551		(63,002)	(63,002)	0	
Revaluation Reserve	53,805	53,805	53,805	0		53,805	53,805	0	
TOTAL TAXPAYERS EQUITY	**162,200**	**155,225**	**149,200**	**(6,025)**		**195,184**	**195,184**	**0**	

1. Strategic and Operational Capital expenditure to date is behind plan but it is assumed that the full year forecast capital expenditure will be the same as plan.
2. Trade and other receivables is slightly above plan although there are some historic balances and shortfall on SLA debts in the outstanding debtors. The trade and other payables variance against plan is a combination of a reallocation of balances from provisions to accruals and the delay to loanand PDC funding for capital which has been substituted by internal resources.
3. The borrowings variance relates to the Emergency schemes loan funding which was scheduled to be drawn down in May but was not required because part of the loan in 2017-18 has been carried forward and actual expenditure to date is behind plan. It is assumed that the full loan planned will be drawn down in year.
4. The PDC variance is because unspent PDC from 2017-18 was carried forward and has been used in April and May before any further PDC is drawn down. It is assumed that the full PDC planned will be drawn down in year.

Finance Report Month 03 2018/19 — Cash — G

The 3Ts funding is drawn down to match capital expenditure, subject to utilisation of internal funding sources first. PDC of £4.3m has been drawn down to date. The Trust will continue to assess the need for additional drawdowns relative to the phasing of the 3T's project. There was also £1.9m carried forward from 2017-18 on the Emergency Capital loan so the first drawdown was in June for £2.6m. Both Strategic and Operational capital expenditure has been lower than planned which accounts for the variance against plan in the capital expenditure line and the variances on the PDC and drawdown on debt lines. It is assumed that the full drawdown of loan funding and PDC will be used by the end of the year and that capital outturn will be the same as the original plan.
The revenue deficit funding drawn down to date amounts to £17.5m and is based on the actual and planned deficit. The full year drawdown is aligned to the planned deficit.
The month end cash holding is above plan because cash has been retained to cover revenue expenditure in July in the event that the SLA shortfall to June is not paid over in July. The year end forecast is aligned to the year-end cash control total, which is slightly above the DH maximum cash holding assumed for an organisation with revenue support.

Year-to-date

	Plan £k	Actual £k	Variance £k
Cash Balance	**6,651**	**18,479**	**11,828**

Year-End Forecast

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

Year-to-Date

	Plan £k	Actual £k	Variance £k
Operating deficit	(13,125)	(13,127)	(2)
Non Cash I&E Items	4,516	4,525	9
Movement in Working Capital	(9,765)	5,897	15,662
Provisions	689	(886)	(1,575)
Cash outflow from Operations	**(17,685)**	**(3,591)**	**14,094**
Capital Expenditure	(23,672)	(15,515)	8,157
Cash receipt from asset sales	0	0	0
Cash outflow before financing	**(41,357)**	**(19,106)**	**22,251**
PDC Received	11,900	4,324	(7,576)
PDC Repaid	0	0	0
Dividends Paid	0	0	0
Interest on Loans, PFI and capital repayments on PFI	(2,308)	(2,308)	0
Interest received	7	22	15
Drawdown on debt	22,961	20,099	(2,862)
Repayment of debt	(424)	(424)	0
Cash inflow from financing	**32,136**	**21,713**	**(10,423)**
Net Cash Inflow / (Outflow)	**(9,221)**	**2,607**	**11,828**
Opening Cash Balance	15,872	15,872	0
Closing Cash Balance	**6,651**	**18,479**	**11,828**

Year-End Forecast

	Plan £k	Forecast £k	Variance £k
Operating deficit	(45,287)	(45,307)	(20)
Non Cash I&E Items	29,182	29,177	(5)
Movement in Working Capital	(1,224)	(726)	498
Provisions	(1,814)	(1,814)	0
Cash outflow from Operations	**(19,143)**	**(18,670)**	**473**
Capital Expenditure	(154,768)	(154,768)	0
Cash receipt from asset sales	0	0	0
Cash outflow before financing	**(173,911)**	**(173,438)**	**473**
PDC Received	95,986	95,986	0
PDC Repaid	0	0	0
Dividends Paid	(5,105)	(5,592)	(488)
Interest on Loans, PFI and capital repayments on PFI	(12,354)	(12,354)	0
Interest received	25	40	15
Drawdown on debt	87,596	87,596	0
Repayment of debt	(4,581)	(4,582)	(1)
Cash inflow from financing	**161,568**	**161,095**	**(473)**
Net Cash Outflow	**(12,344)**	**(12,344)**	**0**
Opening Cash Balance	15,872	15,872	0
Closing Cash Balance	**3,529**	**3,529**	**0**

Finance Report Month 03 2018/19 — Capital — A

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

Year-to-date

	Plan £k	Actual £k	Variance £k
Strategic Capital	**23,265**	**13,776**	**(9,489)**
Operational Capital	**3,604**	**1,441**	**(2,163)**
Total	**26,869**	**15,217**	**(11,652)**

Year-end actual

	Plan £k	Forecast £k	Variance £k
Strategic Capital	**137,748**	**137,748**	**0**
Operational Capital	**18,101**	**18,101**	**0**
Total	**155,849**	**155,849**	**0**

Strategic Capital Handover of L6 and L7 of the Clinical Administration Building has taken place in April. The electrical infrastructure work and external works will be completed by August. Work on the Helideck steel framework is complete and the next 10 weeks will see the scaffolding removed. The trauma lift will be available in January 2019 and a work stream is underway to identify revenue implications and when these will occur. This will be complete by end September. Work continues in the Hanbury building to rectify defects and to secure MHRA accreditation of the radiopharmacy in September. The main buildings work and installation for the Radiotherapy East scheme is complete, but there remains some IT work to be completed to finalise the scheme. Work on the Emergency schemes continue but at relatively low level.

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

	Plan £k	Actual £k	Variance £k
Source of Funds - (CRL)	**(26,869)**	**(15,217)**	**(11,652)**
Expenditure			
Strategic Capital			
3Ts	17,332	11,851	5,481
ED - Floor Development	2,967	437	2,530
ED - Backlog Maintenance	1,533	1,343	190
Pathology	0	40	(40)
Radiotherapy East	1,433	105	1,328
Total Strategic Capital	**23,265**	**13,776**	**9,489**
Operational Capital			
Medical Equipment Replacement	1,000	373	627
IM&T Infrastructure	2,437	314	2,123
Estates Infrastructure	0	132	(132)
Service Development	93	567	(474)
Charitably Funded Schemes	74	55	19
Total Operational Capital	**3,604**	**1,441**	**2,163**
(Under)/Overspend against CRL	**0**	**0**	**0**
	26,869	15,217	11,652

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

Finance Report Month 03 2018/19 — Aged Debtors

The Trust debtors are a mixture of invoiced debtors, accrued income and prepayments. The level of invoiced debtors has reeduced by £0.2m since the end of May and the value of overdue debts has increased by £16k.

Invoiced Debtors	Within Terms 1-30 Days £k	1 Month Overdue 31-60 Days £k	2 Months Overdue 61-90 Days £k	3 Months Overdue Over 90 Days £k	Total	Current Month Over 30 Days £k	Prior Month Over 30 Days £k	Notes
CCGs	912	217	277	1,505	2,911	1,999	2,410	1
Trusts	350	376	226	4,547	5,499	5,149	5,325	2
Other NHS	2,449	41	149	149	2,788	339	1,667	3
Other Debtors	2,257	2,023	3,640	2,614	10,534	8,277	6,560	4
Private Patients	353	250	11	949	1,563	1,210	1,090	5
Overseas	38	32	1	386	457	419	325	
Total Invoiced Debtors	**6,359**	**2,939**	**4,304**	**10,150**	**23,752**	17,393	17,377	
Provision for Bad Debts (including RTA Provision)					(4,336)			
Accrued Income					20,591			
Prepayments					7,132			
Other Debtors					2,536			
Total Trade & Other Receivables					**49,675**			

Other Receivables	Current Month £k	Prior Month £k
Accrued Income		
Work In Progress	3,978	3,978
CCG Service Level Agreements	8,012	9,562
Injury Cost Recovery Fund	1,987	1,835
Other	6,614	6,858
Total Accrued Income	**20,591**	**22,233**
Prepayments		
Maintenance & Other Contracts	7,132	6,010
NHS Litigation	0	0
Other	2,536	1,099
Total Prepayments	**9,668**	**7,109**

1. CCGs. The CCGs overdue balance has improved by £0.4m compared to last month . £1.3m relates to unpaid 3Ts invoices from several of the CCGs which are expected to be paid in the next two months.

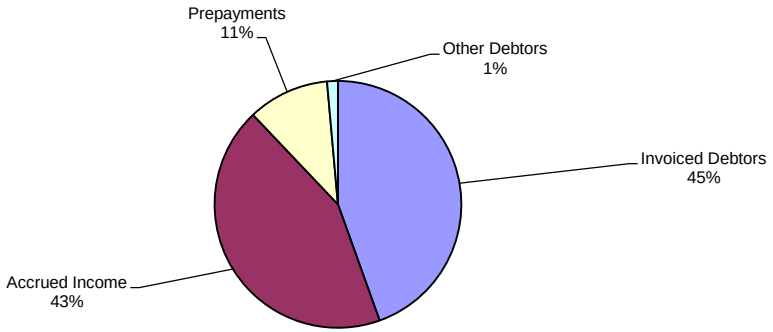
2. Trusts. The overdue debts have improved by £0.2m.

3. Other NHS. The overdue balance has reduced by £1.3m.

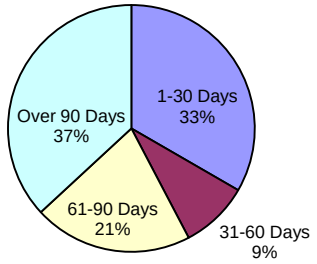
4. Other Debtors. The over 30 days balance has deteriorated by £1.7m mainly because of the shortfall on the commissioning income funding from BICS.

5. Private Patient overdue debts have increased by £120k.

Trade and Other Receivables



Invoiced Debtors Ageing



Children & Women Division:

Income:
Credit raised for £90k for SLA overcharge in prior year and the income for this year is now £24k below plan. However, income for PBR excluded drugs is above plan as is income for education, particularly for placements in midwifery

Pay:
There is an overspend of £231k against medical staffing from additional sessions and fixed-term cover for rota gaps, particularly within Children's Services. The unallocated CIP target is £243k YTD which is adding to the variance. The nursing underspend of (£129k) is related to the high number of vacancies and offsets some of the variance.

Non-Pay (tariff):
Expenditure on clinical supplies is high and is £119k above plan, however it is expected to reduce in line with activity. There have been one-off costs in relation to room rental for midwifery clinics and drugs spend is high compared to plan, but in line with 17/18. The unallocated non-pay CIP target is £39k.

Non-Pay (non-tariff):
Expenditure on high cost drugs within Children's is above plan but consistent with last year.

	PY Actual £k	Plan £k	Actual £k	Variance £k	RAG
Income	(693)	(729)	(626)	103	R
Pay	10,617	10,559	10,913	354	R
Non-Pay (tariff)	1,513	1,322	1,550	228	R
Non-Pay (PBR exc & CDF)	330	358	369	11	R
EBITDA *	**11,767**	**11,510**	**12,206**	**696**	R

Central Clinical Services Division:

Income: Overperformance in Cancer (largely CDF charged to NHSE) masking underperformance in Cancer Private Patients and across most income categories for Pathology. In Pathology unusually high supplies to SASH (at cost) are partially offsetting general ongoing difficulties achieving income targets.

Pay: The key problem area is Medical pay (agency in Cancer and WLIs in Histology and Imaging). There is a large underspend on other staff groups (Allied Health Professionals in all areas except Physiotherapy and Dietetics, and on Nursing and A&C staff). Distortions to the budget due to run-rate CIPs and phasing of CIP targets in the budget being more aggressive than the underlying plans more than explain the overall ytd position.

Non-Pay (tariff): The key problem area is Imaging, £320k, 1) healthcare from non-NHS Suppliers (MRI, ultrasound and PET scans, and associated reporting costs), 2) CT hire at PRH, 3) other ongoing cost pressures. The balance relates to the flat phasing of the bulk of the non-pay CIP target and contains substantial run rate savings. Non-pay overspent through 17/18, offset by pay savings.

Non-Pay (non-tariff): Activity and spend significantly above plan primarily relating to Cancer (CDF).

Overall: Most of the variance relates to CIPs that have not commenced at M3 and/or are impacting Divisional or Trust run-rate but which do not enable budget reductions. However there are issues in Imaging with one-off costs and continued outsourcing/premium spend and increasing pay spend.

	PY Actual £k	Plan £k	Actual £k	Variance £k	RAG
Income	(6,890)	(7,221)	(7,335)	(114)	G
Pay	17,956	18,344	18,693	349	R
Non-Pay (tariff)	6,321	5,937	6,552	615	R
Non-Pay (PBR exc & CDF)	4,621	4,808	4,998	190	R
EBITDA *	**22,008**	**21,868**	**22,908**	**1,040**	R

Medicine Division:

Income: This increase mainly relates to PBR exc drug income which is offset by overspend in PBR drugs expenditure and overseas income is higher than anticipated at this time of the year.

Pay: There are overspends in pay (£772k) of which £348k relates to CIPS, £141k of this is attributable to the carry forward of unidentified CIPs from 2017/18 the remainder relates to the current year which will reduce when the budgets are phased to match the plans that are being implemented. The remaining £424k net overspend relates to Nursing (£298k), Ancillary & Other healthcare staff (£87k) and net overspend in Management and Admin Staff (£39k) and the balance relates to medical staff.

The overspend in nursing, in part, relates to budget pressures in Newhaven Downs (£64k) and Ardingly (£73k), the remainder is relates to overspends across the Acute Floor the most significant areas being ED (£99k), AAU (£85k), Balcombe (£40k) and Pyecombe (£46k) which have arisen from using bank and agency to fill vacancies as well as resourcing the holding area, streaming, F-bay and one to one care. These overspends have, in part, been offset by underspends in Speciality Medicine (£109k) in respiratory and HIV/GUM however the later are identified as CIP savings.

The overspend in Ancillary & Other healthcare staff mainly relates to NHD budget pressure (£29k) and Chichester (£15k) where one to one care has been required. Management is overspending by £87k which is in part being offset by underspendins in admin of £48k

Non-Pay: Drugs in Tariff is contributing to £197k of this overspend, which is in part being offset by underspends in supplies and services (£31k). Cleaning materials are higher than budget (£25k) to the the costs beind devolved with no associated budget . Current year CIPs account for £153k of the overspend this is mainly due to the phasing of the savings plans identified not being in twelths as the has been budget is phased.

	PY Actual £k	Plan £k	Actual £k	Variance £k	RAG
Income	(3,945)	(3,990)	(4,654)	(664)	G
Pay	13,288	13,256	14,028	772	R
Non-Pay (tariff)	2,384	1,855	2,199	344	R
Non-Pay (PBR exc & CDF)	3,682	3,714	4,347	633	R
EBITDA *	**15,409**	**14,835**	**15,920**	**1,085**	R

Specialist Services Division: **Income:**
PBR ahead of plan £120k, due to increase in activity within Cardiac. CCG ahead by £20k and other income by £19k.

Pay:
Neuro medical expenditure overspent by £186k due to additional WLI due to RTT and OP follow up's over 1,000, run rate cips, security costs relate to specials on the Cardiac wards £20k and overspends within 6A day case of £34k, however access to beds now ring fenced costs have decreased.

Non Pay:
In Tariff: Drugs and dialysis fluid linked to Renal activity 5% over plan £206k, Drugs in tariff £54k due to increase pricie cost pressure of piperacillian.

PBR Exc & CDF: PBR off set by Income £120k remaining £41k relates to prior year costs received in FY 17-18.

	PY Actual £k	Plan £k	Actual £k	Variance £k	RAG
Income	(5,822)	(6,430)	(6,589)	(159)	G
Pay	15,590	15,984	16,224	240	R
Non-Pay (tariff)	5,751	5,178	5,438	260	R
Non-Pay (PBR exc & CDF)	4,694	4,728	4,889	161	R
EBITDA *	**20,213**	**19,460**	**19,962**	**502**	R

Surgery:

Income: Behind plan due to PbR income being significantly lower than expected. This relates to a 60% reduction from May in the price of drugs related to Hep C, this is offset by reduced expenditure as shown below. Excess Training and Private Patient Income has partially reduced the variance.

Pay: Pay costs tear to date are exceeding the plan by £974k of which £615k relates to unallocated CIPS. The balance is an excess of Locum/Agency cost in medical staffing over and above the medical establishment savings. The medical spend run rate has materially remained the same and needs to reduce for which the division has written a Counter Measure Summary.

Non-Pay: Excluding PbR the division to date has underspent by £190k. Whilst there are a number of areas with variations the majority of the balance relates to a lower spend on other operating costs than planned which includes the cessation of outsourcing in the Abdominal specialty area.

	PY Actual £k	Plan £k	Actual £k	Variance £k	RAG
Income	(6,033)	(5,939)	(4,710)	1,229	R
Pay	17,447	16,991	17,965	974	R
Non-Pay (tariff)	5,801	5,144	4,954	(190)	G
Non-Pay (PBR exc & CDF)	5,493	5,445	4,167	(1,278)	G
EBITDA *	**22,708**	**21,641**	**22,376**	**735**	R

Chief Financial Officer:

Pay: Underspend on pay mainly due to vacancies not fully backfilled within Business Support (£37k), Financial Services (£40k), Procurement (£40k) & PMO (£66k)

Non-Pay: Although broadly breakeven but largely due to lower than expected consultancy costs within finance (£167k), offset by overspend on Printing costs related to the budget phasing (£103k) and also FTI consultancy spend within PMO (£25k)

	PY Actual £k	Plan £k	Actual £k	Variance £k	RAG
Income	(345)	(211)	(202)	9	R
Pay	2,052	2,008	1,825	(183)	G
Non-Pay	1,594	1,739	1,716	(23)	G
EBITDA *	**3,301**	**3,536**	**3,339**	**(197)**	G

Chief Nursing & Patient Safety Officer:

Pay: Adverse; Adverse; Primarily relating to Redundancy Pay out/ in Lieu of Notice for Deputy Chief Nurse - Effciencies and Workforce,

Non-Pay: Underspend driven by low spend on CQC Investment & Bed Maintenance.

	PY Actual £k	Plan £k	Actual £k	Variance £k	RAG
Income	(37)	(27)	(33)	(6)	G
Pay	682	654	690	36	R
Non-Pay	5,805	6,401	6,311	(90)	G
EBITDA *	**6,450**	**7,028**	**6,968**	**(60)**	G

Chief Operating Officer: (Clinical Operations)

Pay: High levels of vacancies not backfilled in the 18 Week Validation team (£49k)

Non-Pay: Overspend is largely due Patient transport costs from Wealden Amb. Services and spend in relation to stretcher hire related to winter pressures (£50k)

	PY Actual £k	Plan £k	Actual £k	Variance £k	RAG
Income	(11)	(1)	0	1	R
Pay	796	829	780	(49)	G
Non-Pay	(4)	(17)	40	57	R
EBITDA *	**781**	**811**	**820**	**9**	R

Chief Medical Officer:

Income: underachievement mainly due to R&D and Education. R&D - £142k budget overstatement re EU projects, correcponds with non-pay and £42k adjustmenmt for RCF Grant reduction. Education £111k due to Undergraduate Medical Students Tariff income less than expected as a result of recalculation of students WTEs and £66k re PGME tariff payment shortfall to be rectified M04

Pay: underspent due to vacancies mainly within R&D

Non-Pay: underspent to date, R&D budget overstatement re EU projects, correcponds with income. This underspend is being reduced by overseas nurse recruitment overspend, budget expenditure/budget to be reviewed/rectified

	PY Actual £k	Plan £k	Actual £k	Variance £k	RAG
Income	(7,144)	(8,528)	(8,172)	356	R
Pay	3,167	3,199	3,032	(167)	G
Non-Pay	1,666	2,913	2,435	(478)	G
EBITDA *	**(2,311)**	**(2,416)**	**(2,705)**	**(289)**	G

Chief Delivery & Strategy Officer:

Income: 3T's related variance in line with transitional funding, and offset by underspends in pay and non-pay.

Pay: Favourable, solely driven by vacancies reported under Strategic Business Management & 3T's

Non-Pay: Underspend driven by 3T's related variance in line with transitional funding

	PY Actual £k	Plan £k	Actual £k	Variance £k	RAG
Income	(657)	(726)	(630)	96	R
Pay	335	401	306	(95)	G
Non-Pay	340	504	365	(139)	G
EBITDA *	**18**	**179**	**41**	**(138)**	G

Chief Workforce & Organisation Development Officer:

Income: Adverse variance mainly driven by Occupational Health Income by £51k unachievable owing to loss of CCG contract.

Pay: Favourable variance mainly driven by vacancies across the directorate and low spend on STAM in bank temp staffing

Non-Pay: Overspent by 67k mainly under Communication owing to interim consultant costs covering Head of Communication vacancy B8a & Events Manager post, other spend incurred on provisions & venue hire (costs are charity & HE funded which need to be transfered out). Additionally costs incurred on computer software implementation & licences relating to e-jobplan/e-roster now centralised under HR (awaiting budget transfer from Clinical Directorates).

	PY Actual £k	Plan £k	Actual £k	Variance £k	RAG
Income	(338)	(307)	(248)	59	R
Pay	1,202	1,189	1,142	(47)	G
Non-Pay	296	324	391	67	R
EBITDA *	**1,160**	**1,206**	**1,285**	**79**	R

Chief Executive's Office:

Pay: Overspend driven Agency staffing cost within HQ PA's office covering vacancies

Non-Pay: Primarily driven by consultancy costs from Good governance Institute for phase 2 work, to support implementing Quality Management Structure, costs of interim Corporate Governance consultant

	PY Actual £k	Plan £k	Actual £k	Variance £k	RAG
Income	(45)	0	0	0	A
Pay	583	792	800	8	R
Non-Pay	131	67	158	91	R
EBITDA *	**669**	**859**	**958**	**99**	R

Facilities and Estates (Separated out from Chief Operating Officer)

Income: ar parking income at PRH is consistently falling short of the target by £88k for the year so far due to Parking ticketing machines issues.

Pay: Overspend is largely due to the Ancillary staffing cost (£330k) within Soft FM and Security due to enhancements and overtime payments to current staff workforce to cover 77.00 WTE vacancies within the service. Management Pay adverse by £90k due to Agency staff covering senior management vacant posts

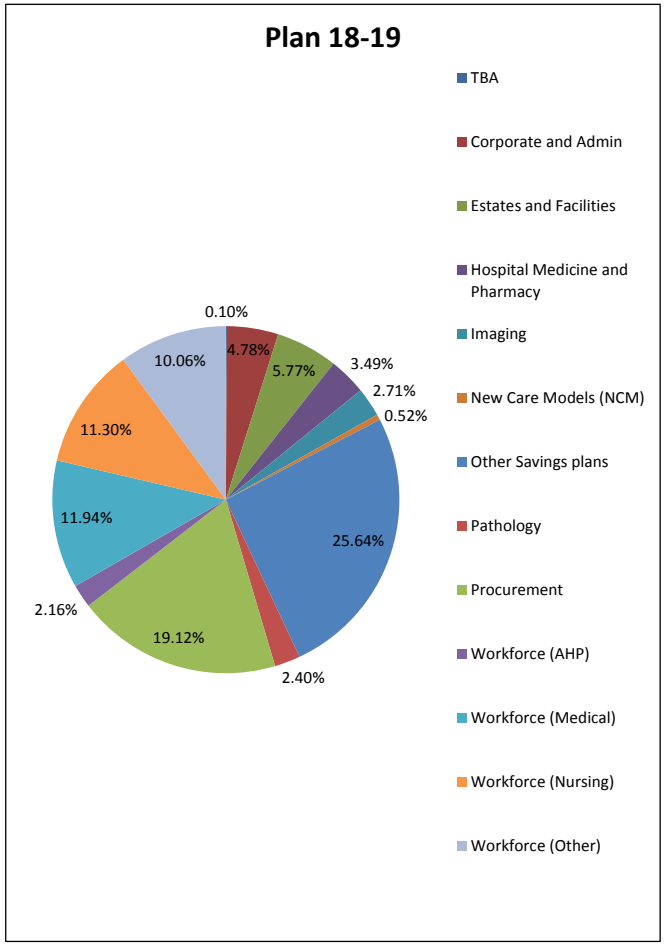
Non-Pay: Premises cost is overspend by £704k mainly within estates which due to reactive maintenance mainly at Thomas Kemp Tower contributing £300k approx. towards the overspend. There is an overspend relating to the PFI of £129k due largely to budget phasing and by PFI finance lease repayments. Utilities cost overspend by £180k partly due to heating oil for temporary generators at Barry building.

	PY Actual £k	Plan £k	Actual £k	Variance £k	RAG
Income	(775)	(866)	(768)	98	R
Pay	4,556	4,724	5,139	415	R
Non-Pay	4,575	4,904	5,677	773	R
EBITDA *	**8,356**	**8,762**	**10,048**	**1,286**	R

Finance Report Month 03 2018/19 — Efficiency and Transformation programme — G

The efficiency programme has delivered the £5.09m in the year to Month 3 which is £0.114m in excess of the internal target and £0.03m higher than the NHSI target. The Quarter 1 gateway reviews have firmed up a number of placeholder projects, and the forecast is to acheive the full plan of £30m.

		Year to Date			Year End		
		Plan	Actual	Variance	Plan	Forecast	Variance
		£k	£k	£k	£k	£k	£k
Themes							
Corporate and Admin	Income (Patient Care Activities)	16	0	(16)	60	62	2
Corporate and Admin	Non pay	100	100	0	550	546	(4)
Corporate and Admin	Pay (Skill Mix)	149	149	0	825	820	(5)
Estates and Facilities	Non pay	158	166	8	1,102	1,099	(3)
Estates and Facilities	Pay (Skill Mix)	39	39	0	104	105	1
Estates and Facilities	Pay (WTE reductions)	83	83	0	283	284	1
Estates and Facilities	Income (Other operating income)	0	0	0	243	241	(2)
Hospital Medicine and Pha	Non pay	66	84	18	1,048	974	(74)
Imaging	Income (Patient Care Activities)	4	2	(2)	12	15	3
Imaging	Non pay	88	66	(22)	389	456	67
Imaging	Pay (Skill Mix)	34	27	(7)	412	334	(78)
New Care Models (NCM)	Income (Patient Care Activities)	6	6	(0)	12	13	1
New Care Models (NCM)	Pay (WTE reductions)	0	0	0	144	61	(83)
Other Savings plans	Income (Patient Care Activities)	19	19	0	2,313	1,857	(456)
Other Savings plans	Non pay	1,156	1,152	(4)	4,057	4,328	271
Other Savings plans	Pay (Skill Mix)	28	40	12	892	1,037	145
Other Savings plans	Pay (WTE reductions)	56	56	0	429	328	(101)
Other Savings plans	Income (Other operating income)	0	0	0	0	17	17
Pathology	Non pay	56	104	48	122	237	115
Pathology	Pay (Skill Mix)	0	0	0	599	388	(211)
Procurement	Non pay	1,361	1,413	52	5,736	6,051	315
Workforce (AHP)	Income (Patient Care Activities)	22	0	(22)	84	89	5
Workforce (AHP)	Pay (Skill Mix)	86	82	(4)	565	394	(171)
Workforce (Medical)	Pay (Skill Mix)	307	307	0	1,667	1,664	(3)
Workforce (Medical)	Pay (WTE reductions)	121	121	0	1,914	1,984	70
Workforce (Nursing)	Pay (Skill Mix)	379	371	(8)	2,413	2,555	142
Workforce (Nursing)	Pay (WTE reductions)	158	184	26	976	974	(2)
Workforce (Other)	Pay (Skill Mix)	234	231	(3)	1,688	1,755	67
Workforce (Other)	Pay (WTE reductions)	245	284	39	1,331	1,330	
TBA	Pay (Skill Mix)	0	0	0	30	0	(31)
Efficiency Plan Total		**4,972**	**5,086**	**114**	**30,000**	**30,000**	**(0)**
Plan adjustment to NHSI return/Forecast Risk Adjustment		89	0	(89)			0
Efficiency Requirement in NHSI Plan		**5,061**	**5,086**	**25**	**30,000**	**30,000**	**(0)**



Brighton and Sussex University Hospitals NHS Trust

To: Board of Directors

Date of Meeting: 25th July 2018 Agenda Item: **10**

Title
Learning from Deaths
Responsible Executive Director
Dr George Findlay (Chief Medical Officer) and Nicola Ranger (Chief Nursing and Patient Safety Officer)
Prepared by
Dr Stephen Drage - Deputy Medical Director: Safety and Quality, Della Morris - Safety & Quality Lead and Mark Renshaw - Deputy Chief of Safety
Status
Public
Summary of Proposal
This report has been produced in line with National Guidance on Learning from Deaths published in March 2017, to provide the Executive with information relating to the percentage of inpatient deaths that have been reviewed using a Structured Judgment Review and the themes and learning that are emerging from this work. As this relates to new national guidance the report also provides an update on progress made to roll out this across the Trust.
Implications for Quality of Care
For many people death under the care of the NHS is an inevitable outcome and they experience excellent care from the NHS. However, some patients experience poor care resulting from a variety of factors. The purpose of reviews of deaths which problems in care may have contributed to is to learn in order to prevent a recurrence.
Link to Strategic Objectives/Board Assurance Framework
The Trust's True North Objective is for the mortality rates (HSMR) to be in the lowest 20% of Trusts.
Financial Implications
Human Resource Implications
Recommendation
The Board is asked to NOTE the report.
Communication and Consultation
Not applicable
Appendices
None

1. Learning from Deaths Dashboard

1.1 The Department of Health provide a dashboard for Trust's to use to publish data on the number of deaths that have been reviewed in their organisations. See attachment

1.2 The table below shows the Q1 18/19 data for BSUH. LD refers to deaths in patients with learning disabilities. These deaths are reviewed independently of the Trust by the LEDER programme.

1.3 Data for April 18 is higher than May and June due to the End of Life Care National Audit, the palliative care team are using the opportunity to undertaken SJRs on the cases identified for the national audit.

	Total Deaths (not LD)	Total Deaths Reviewed (not LD)	Deaths Avoidable > 50% (not LD)	LD Deaths	LD Deaths Reviewed	LD Deaths Avoidable > 50%	Total % of deaths reviewed
Apr 18	128	29	0	0	0	0	23%
May 18	126	4	0	0	0	0	3%
June 18	97	6	0	0	1	0	6%
Total (Q1 18/19)	351	39	0	0	1	0	11%

2. Outcomes from Structured Judgement Reviews

2.1 The SJRs review 6 discreet areas of care. Table1 shows the level of care that the patients have been recorded as receiving. 78 SJRs have been input onto the database allowing analysis of the themes. The tool has improved over time so some fields have less that 100% completion.

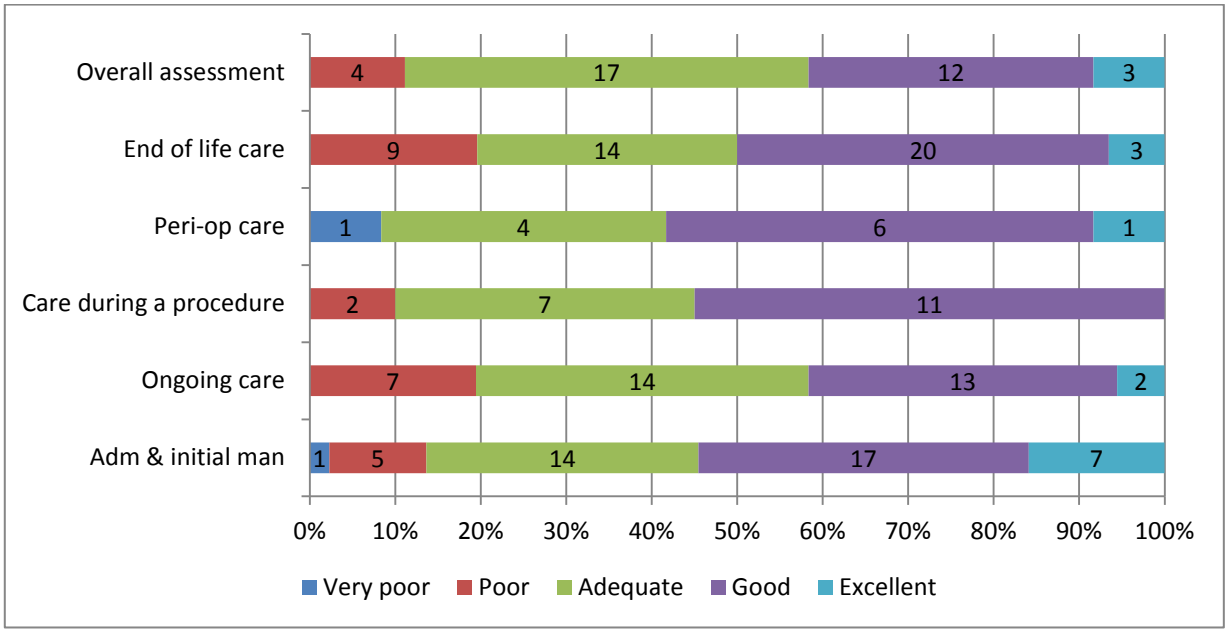


Table 1: Data labels show the number of responses for the criteria

2.2 Concerns raised during Q1 18/19 regarding the first 24 hours of care include a lack of clerking and escalation, and an absence of end of life care discussions. Whilst good/excellent care was characterised by recognition of sepsis, treatment escalation plans in place with early palliation and senior review.

2.3 In addition to concerns regarding a lack of Consultant review, the communication with the patients and/or family regarding DNAR and on-going care were noted to be poor. In cases where the care was deemed good or excellent the reviewers highlighted clear evidence of consultant led care, completion of appropriate

documentation and charts and timely diagnosis. On one occasion the good dietetic input into a long complex case was offset by a lack of evidence to show that this was followed.

2.4 As not all patients undergo a procedure, the number of cases reviewed for 'care during a procedure' and 'peri-operative care' is lower; the one case where 'peri-operative care' was graded poor was the result of a lack of senior review for a patient deteriorating patient with a NEWS score of 6.

2.5 Concerns regarding 'end of life care' are highlighted throughout all sections of the review, however there are many examples of excellent care, notably in Q1 this included; patients families updated regularly, consideration of preferred place of death and organ donation.

2.6 Unfortunately, it was noted that for a small number of patients their care was graded 'poor' in the overall assessment. In 2 cases a failure to recognise dying and deterioration resulted in missed opportunities to implement palliative care at an earlier opportunity. A 3rd patient was not cared for in an appropriate environment having been transferred to Newhaven.

2.7 The Trust are introducing a new communication entitled Theme of the Week, which will be used as an addition route to share themes and learning from the reviews.

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

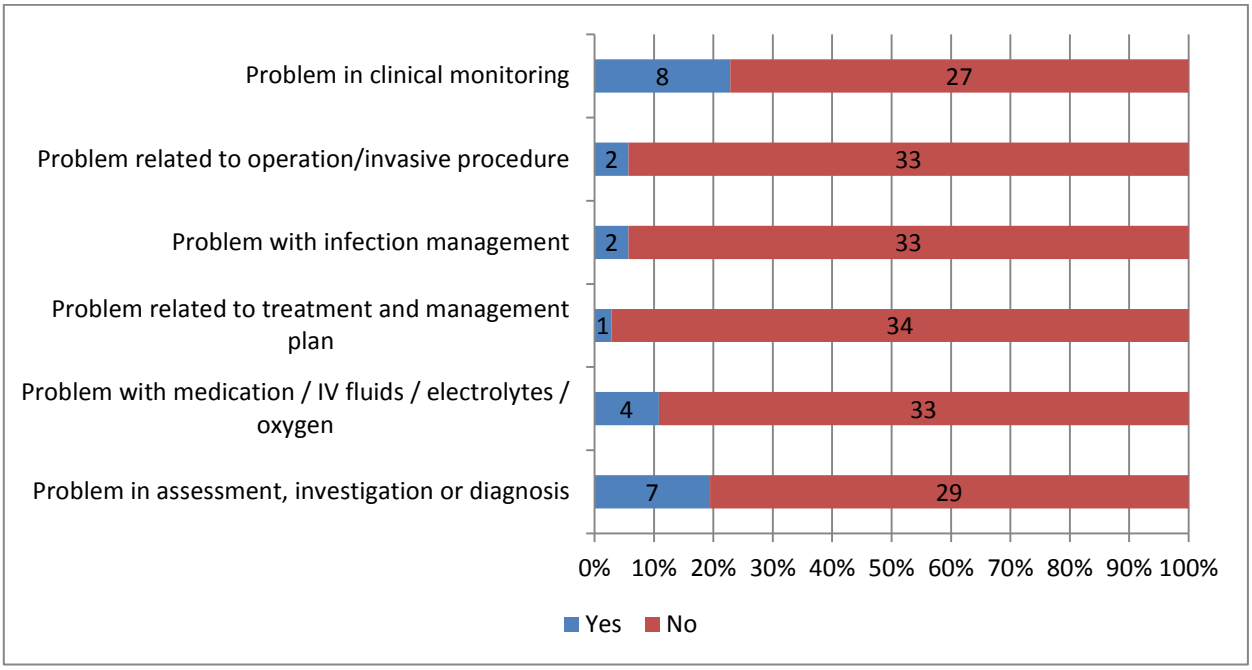


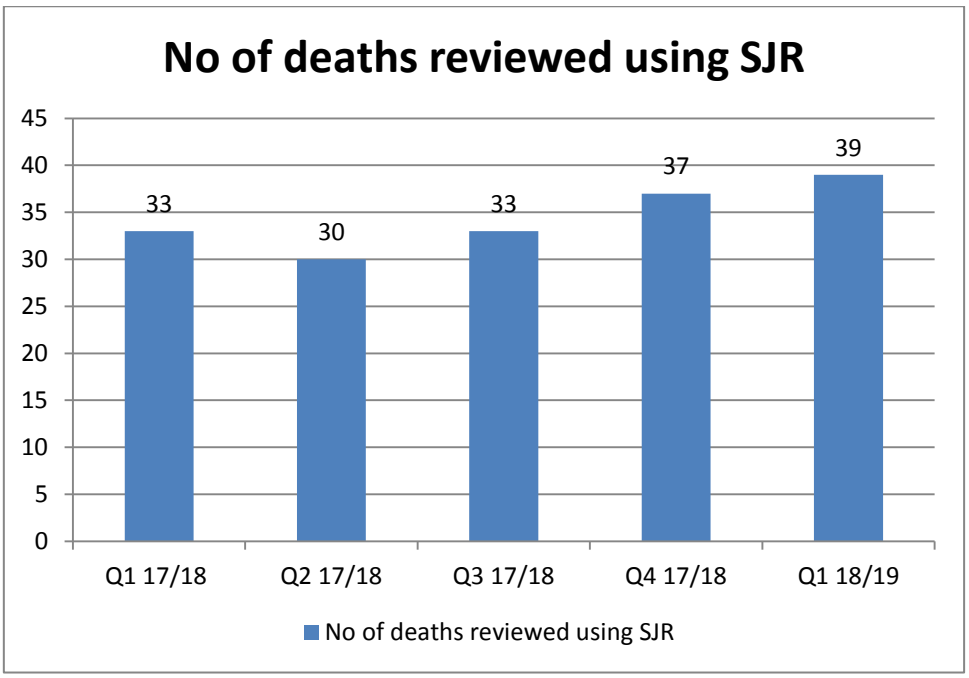
Table 2: Data labels show the number of responses for the criteria

2.9 The area with the most problems in care was 'clinical monitoring' (n=8) which includes 'failure to plan, to undertake or to recognise and respond to changes', followed by 'problems in assessment, investigation or diagnosis' (n=7) which includes assessment of pressure ulcer risk, VTE risk and history of falls.

3. Roll out of Learning from Deaths Programme across BSUH

3.1 In Q1 the TMRG have been focusing on increasing the capacity within the organisation to undertake structured judgement reviews. 4 training sessions have been held, 2 at PRH and 2 at RSCH to train an additional 25 Consultants and Senior Nursing colleagues. This brings the total number of trained staff to 47. Further sessions are being planned for the autumn, to include the Allied Healthcare Professions.

3.2 The organisation is now in a position to potentially increase the number of SJRs that are undertaken, however a lack of administrative resources to identify patients, distribute case notes and monitor compliance means that this process is currently working very slowly. At present there is no dedicated time allocated within job plans for SJR. A single SJR takes approximately one hour to complete which is a significant increase on the time previously allocated to mortality review by specialities.



3.3 Following feedback from the LeDer Steering group regarding delays in actioning reviews, the TMRG have decided to return to the process of internal SJRs while we await the formal LeDer review to ensure that learning is captured in a timely manner.

3.4 The new database to capture the work of the Medical Examiners, using DATIX has been piloted with the Bereavement Office. The pilot was a partial success in that the Bereavement Office team were able to load all deaths onto the database; however roll out to the Medical Examiners was not possible, in part due to the Medical Examiner who sits on the TMRG leaving the organisation. The pilot has now been put on hold.

3.5 Plans are in place to embed the SJR into PANDA, this has the benefit of prepopulating many fields and is easily available to all clinical staff. The IT team are currently building the form and anticipate this will be ready by September.

4. Medical Examiner Programme

4.1 BSUH was part of a pilot programme to introduce the review of every death by a medical examiner. The review includes a discussion with bereaved relatives. The pilot was successful and the programme was continued. The national implementation of ME is due to take place in April 2019.

4.2 The ME programme is now the backbone of our mortality review programme. A recruitment programme is now underway to appoint up to five new medical examiners. This process will conclude in mid-August 2018.

5. Mortality Governance Arrangements

5.1 The TMRG works closely with the Serious Incident Review Group, Medical Examiners, Child Death Overview Panel and the Medico-Legal Department to identify deaths that are mandated by the national guidance for structured judgement review:

- All deaths where bereaved families and carers, or staff, have raised a significant concern
- All deaths of patients with a learning disability or severe mental illness
- All deaths in a service specialty, particular diagnosis or procedure group where an ‘alarm’ has been raised
- All deaths where patients are not expected to die
- Deaths where learning will inform improvement work
- A further sample of other deaths

5.2 Following review of the governance structure, the TMRG now reports monthly to the Clinical Effectiveness and Outcomes group on a monthly basis. The inaugural meeting was held on the 10 July 2018.

5.3 Departmental and Divisional Clinical Governance M&M and QSPE groups also feed into and receive learning back from the TMRG

5.4 The Learning from Deaths programme also forms part of the wider governance structures within the organisation, SJRs have been used to inform coronial cases, including in cases where poor overall care has been identified. morrid

Brighton and Sussex University Hospitals NHS Trust

To: Board of Directors (Public)

Date of Meeting: 25th July 2018 Agenda Item: **11**

Title
Patient Experience, PALS and Complaints Annual Report 2017/18
Responsible Executive Director
Nicola Ranger, Chief Nurse
Prepared by
Jane Carmody, Head of Patient Experience, PALS and Complaints Hannah Pacifico, Patient Experience Manager
Status
Disclosable
Summary of Proposal
The purpose of this report is to provide an update and analysis of Patient Experience, PALS and Complaints in 2017/18 and Quarter 1 2018/19
Implications for Quality of Care
Patient Experience feedback provides an opportunity to identify trends and make service improvements
Link to Strategic Objectives/Board Assurance Framework
Financial Implications
Not applicable
Human Resource Implications
Not applicable
Recommendation
The Board/Committee is asked to: NOTE
Communication and Consultation
Not applicable
Appendices
Not applicable

Patient Experience, PALS and Complaints Annual Report 2017/18

1. Introduction

1.1. The purpose of this report is to bring to the attention of the Board Patient Experience data collected through patient and public engagement, the Friends and Family Test (FFT), National Patient Surveys and informal and formal concerns received by the Trust.

1.2. Since April 2017, the Trust has experienced considerable change and with the True North of the organisation being 'The patient, first and foremost' and the Patient First improvement methodology underpinning everything we do, there is greatly enhanced staff engagement in every aspect of care. This has also been strengthened by the implementation of the new divisional structure, which provides greater accountability and visibility of patient experience from ward to board. In addition to this, improved data collection for the Friends and Family Test and complaints means that is truly able to drive the changes in patient experience.

1.3. In the new clinical governance structure patient experience and complaints will report monthly to the Patient Experience and Engagement quality management group, enabling greater visibility and triangulation of issues relating to patient experience.

2. Friends and Family Test (FFT)

2.1. We aim to give every patient the opportunity to respond to the FFT question 'How likely are you to recommend our ward (or department) to friend and family if they need similar treatment or care' within 48 hours of discharge.

2.2. Our goal: to achieve a greater than the national average of 22% response rate with a satisfaction score more than 96%.

2.3. Since April 2013 Inpatient and Outpatient FFT data collection and analysis has been run collaboratively by the Patient Experience and Patient Safety teams without dedicated resource with an external contractor collecting and analysing FFT data in our ED and maternity services. The monthly return data is then reported to NHS England by the Trust's Central Information Unit.

2.4. From 1 April 2018 an external company has been contracted to collect Friends and Family Test (FFT) data electronically across all areas of the Trust. Since that time 23% (24,544) of patients surveyed have responded. This represents a 130% increase in patients providing their views on the quality of their care and is above the national response rate.

2.5. All departments and wards now have access to a live dashboard of their results. This is accessible online and details comments and voice recordings which have been gathered through paper surveys, voicemail and a texting service. The variety of survey methods gives the opportunity for a wider range of patients to respond. Patients can view the FFT score, monthly, on the Trust's website and on NHS Choices.

2.6. During Q4 2017/18 10% of eligible inpatients responded to the question complaints compared to the national average of 22%. Following the improvements in our data collection we Q1 18/19 has seen an average response rate of 40.2%

2.7. In May 2018 BSUH had the highest response rate for inpatients FFT from any NHS or Foundation Trust in England at 51.6% of patients being surveyed.

2.8. During Q1 we have seen an expected reduction in the percentage of people recommending our inpatient wards this is due to the change in collection method, from paper based whilst the patient is on the ward to an electronic survey once a patient has been discharged. It is well documented that surveying outside of the environment will gather data which is more truthful of the respondents' experience. This means the data we have is richer and enables us to use it for service improvement. Further to this, due to the volume of patients being surveyed and increase in demographics responding, the comments and results now reflect the opinion of more of our patients. Overall, we have had a higher number of recommend responses since 1 April 2018.

2.9. Quarter 1 2018/19 FFT Results

Table 2: Inpatient FFT Results

	Inpatients									
	Total responses in each category for each ward						Total Number of people eligible to respond	Response Rate	Inpatient Percentage Measures	
	1 - Extremely Likely	2 - Likely	3 - Neither likely nor unlikely	4 - Unlikely	5 - Extremely unlikely	6 - Don't Know		Inpatient	Recommend %	Not Recommend %
Apr-18	1702	341	88	31	30	28	7360	30.2%	92.0%	6.7%
May-18	3115	622	121	75	86	46	7882	51.6%	91.9%	6.9%
Jun-18	2397	441	82	36	35	38	7799	38.8%	93.7%	5.1%

Table 3: Outpatient FFT Results

	Outpatients							Inpatient Percentage Measures	
	Total responses in each category for each ward								
	1 - Extremely Likely	2 - Likely	3 - Neither likely nor unlikely	4 - Unlikely	5 - Extremely unlikely	6 - Don't Know	Nos Responses	Recommend %	Not Recommend %
Apr-18	1211	175	25	18	12	38	1479	93.7%	3.7%
May-18	2123	503	91	42	50	30	2839	92.5%	6.4%
Jun-18	2101	387	73	25	30	24	2640	94.2%	4.8%

Table 4: Maternity FFT Results

	1 - Extremely Likely	2 - Likely	3 - Neither likely or unlikely	4 - Unlikely	5 - Extremely unlikely	6 - Don't Know	Total Responses	Total number of people eligible to respond for each site	% Responses	Recommend %	Not Recommend %
2018/19											
Apr-18	212	17	3	3	1	0	236	438	21.9%	97.0%	1.7%
May-18	205	15	3	3	3	0	229	416	25.0%	96.1%	2.6%
Jun-18	190	24	6	4	5	1	230	468	20.5%	93.0%	3.9%

Table 5: Emergency Department FFT Results

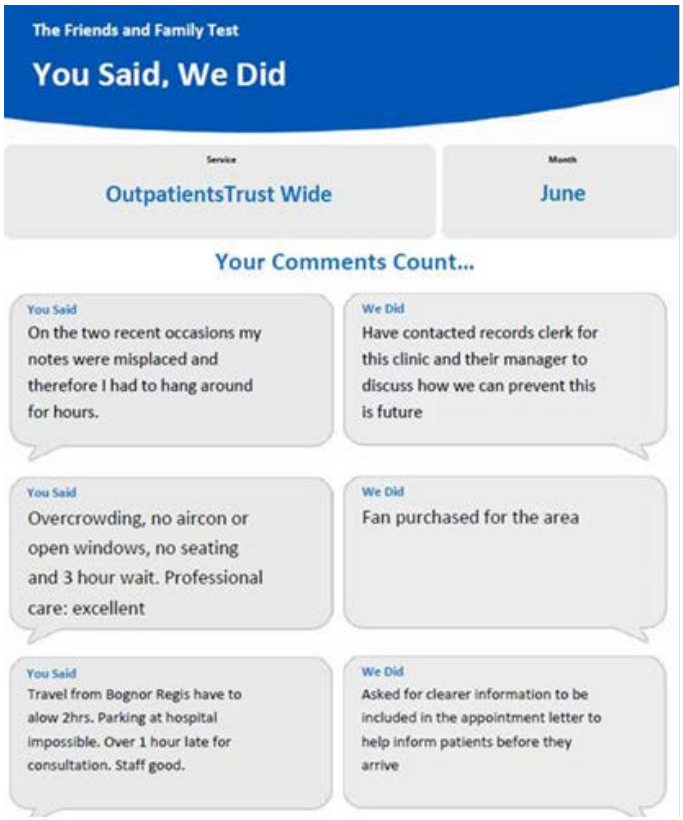
	A&E									
	Total responses in each category for each ward						Total Number of people eligible to respond	Response Rate	A&E	
	1 - Extremely Likely	2 - Likely	3 - Neither likely nor unlikely	4 - Unlikely	5 - Extremely unlikely	6 - Don't Know		A&E	Recommend %	Not Recommend %
Apr-18	1977	406	79	78	91	33	12412	21.5%	89.5%	9.3%
May-18	1916	378	104	62	102	16	13252	19.5%	89.0%	10.4%
Jun-18	1809	351	70	54	81	23	13067	18.3%	90.5%	8.6%

2.10. The improvements have enabled better use of the FFT data, for example the Acute Respiratory Wards is using it weekly as part of their huddles on the ward. Time is being spent looking at the comments received and ensuring that staff are aware of the feedback their area is receiving. Due to the ease of data extraction from the new system staff are able to see improvements being made for their patients and focus on what they can do better on a weekly or daily basis. By using real time data the areas are able to react to feedback quickly and ensure that any issues are resolved before they escalate.

Women's Services had feedback regarding the overbooking of clinics and this has been used to inform restructuring of clinic slots

In specialty medicine there was regarding staff attitude which has informed the introduction of standardised greetings and orientation to the ward and FFT data supports these improvements with a much larger data set. A key component for future developments is that this is the first time we have had reliable data.

As part of the new system wards and departments are able to quickly display feedback to patients about actions that they have taken, in the form of 'You Said – We Did' posters, that can be easily printed from the electronic system.



2.11.

Healthcare Communications

Envoy Messenger™

Every patient counts

3. National Patient Surveys

Table 6: National Surveys the Trust participated in 2017/18

2017	Patients sampled	Published	Reported to
2017 Maternity	April – August 2017	January 2018	Reported to the Patient Experience and Engagement Group and Trust Board Quality Assurance Subcommittee
2017 Adult Inpatients	September 2017 to January 2018	January 2018	To be reported to the Patient Experience and Engagement Group and Trust Board Quality Assurance Subcommittee

3.2. In 2017 The Picker Institute was commissioned by 81 trusts to undertake the annual Adult Inpatient Survey 2017. A total of 1250 eligible BSUH inpatients were sent a questionnaire in July 2017 of which 496 completed and returned. This is a response rate of 40% which is higher than the average for all participating trusts (38.3%).

3.4. Of the respondents:
36% were on a waiting list / planned in advance
61% were emergency admissions
66% had an operation or procedure during their stay
48% male; 53% female
5% were aged 16-39; 16% were aged 40-59; 21% were aged 60-69 and 58% were aged 70+

3.5. The survey results show some promising findings and our patients have said they feel well looked after by clinical and non-clinical staff alike and that our teams work well together to deliver care. The findings also suggest that our patients report being treated with respect and dignity, were kept well informed about their care and had confidence in both the nurses and the doctors treating them.

3.6. Several areas were highlighted positively, including
Overall: 85% rated care 7+ out of 10
Overall: treated with respect and dignity 85%
Doctors: always had confidence and trust 83%
Hospital: room or ward was very/fairly clean 97%
Hospital: toilets and bathrooms were very/fairly clean 96%
Care: always enough privacy when being examined or treated 91%

Table 7: BSUH scored significantly better than the national average on one question:

Lower score the better	Trust	Average
Nurses: did not always know which nurse was in charge of care	43%	49%

Table 8: Overall, 56% of the survey results were static or showed improvement on the 2016 scores as below:

Lower score the better	2016	2017
Planned admission: should have been admitted sooner	37%	32%
Planned admission: admission date changed by hospital	23%	20%
Hospital: did not always get enough help from staff to wash or keep clean	29%	28%
Hospital: did not always get enough help from staff to eat meals	41%	36%
Doctors: talked in front of patients as if they were not there	26%	25%
Nurses: did not always get clear answers to questions	29%	28%
Nurses: talked in front of patients as if they weren't there	17%	16%
Care: staff did not do everything to help control pain	29%	25%
Procedure: questions beforehand not fully answered	25%	20%
Procedure: not told how to expect to feel after operation or procedure	45%	43%
Discharge: not asked to give views on quality of care	75%	69%

Following the 2016 Inpatient survey focus was placed on developing the discharge process for patients and 76% of the scores for questions in the Leaving Hospital section of the 2017 survey show improvement or consistency.

Whilst there has been an increase in patients reporting delayed discharge and poor notice of the time of discharge (which may have been as a result of operation pressures), in comparison to the 2016 Adult Inpatient survey results there has been an 8% improvement in the information provided about discharge arrangements and patients' involvement in it. An 8% increase has also been seen in patients feeling better informed about their planned surgical procedure.

Following last year's Picker results focus has been placed on developing the discharge process, including the development of a Daily Complex Discharge Dashboard. A report is then sent to the wards and responsible teams to ensure that everyone is aware of the individual plans and actions required. This gives the opportunity for any further updates to be provided and ensure that consistent information is share with everyone involved in the patients care.

Since April 2018, Multi Agency Discharge Events (MADE) have held Inpatient reviews each week at both RSCH and PRH. These meetings involve each ward presenting their patients to a Multi-Agency Panel which allows them to together to identify opportunities and support the wards in progressing discharge or management planning.

Overall, this is helping to improve the patients experience and streamline communication between the wards, other teams and external agencies involved.

The Trust has seen improvement or consistency in 76% of the scores for questions in the Leaving Hospital section of the survey in 2017.

The 'Let's Get You Home' initiative is being used at BSUH this an NHS wide policy outlining expectations with patients, their families and carers about the discharge

process in hospital and when they are back in the community. This works alongside the Home First project which has been developed to ensure that patients are fully supported to get them home safely when they no longer require acute care. This is Discharge to Assess pathway with dedicated care hours, social workers and therapists providing packages of care and enablement at home for our patients. This prevents some patients waiting in hospital for a long term package of care from the community or placement into a care home, working on the assessment at home preparing for long term arrangements.

The Trust has also increased its capacity for Hospital at Home, which is a virtual ward caring for patients still under the care of our BSUH Consultants. This enables some of our patients to receive treatments such as intravenous antibiotics, vacuum assisted closure therapy in their homes which means they do not have to remain in hospital longer than required.

The number of patients reporting having shared a sleeping area with patients of the opposite sex in our hospitals in July 2017 scored significantly worse than the national average, whilst sharing of washing and toilet facilities were comparable to the national average. Mixed sex accommodation (MSA) is a significant pressure at RSCH, particularly in cardiac, trauma and neurosciences where there are issue with bed configuration. This remains a crucial area of focus for the trust and is one of the key operational indicators discussed at each and every site meeting with a clear escalation process in place. To further address this we are working with NHSI and the CCG on initiatives that may improve this, however whilst the hospital runs at a 99% bed occupancy rate, this remains a substantial challenge.

The number of patients rating the hospital food as poor or fair was higher than the national average and slightly worse than our 2016 score. A Food Improvement Group has been established to support the Facilities and Estates Strategy work streams. During 2017/18, and in response to feedback from patients and staff, meal preparation has changed on our wards allowing catering staff to accommodate variants in portion size and accompaniments of the dishes, meaning that patients have greater choice and a reported increased satisfaction. Further information and new menu choices will be available over the coming months.

Further improvements include: dietetic review of nutritional value of food offered on wards. New Gluten Free Packs are now available at both sites. The serving of meals is now being championed in Nursing Forums as an essential part of care.

Following feedback from patients and staff food served on wards is going through a transition with most of the meals being prepared and heated in bulk (approximately six portions). By serving food in this way the catering staff are able to allow for variants in portion sizes and accompaniments of the dishes, meaning that patients have more choice. The trust still has single portion meals available, these are only meant to be used if a patient has missed a meal due to being off the ward and wants a substantial dinner, if they want a snack box this is also available but there are only to be used when essential and not to supplement patient meals.

There are also ‘Survival Packs’ available from catering if patients do not have any one to help with shopping and they are returning home, this includes a pint of milk, bread and other staples.

BSUH scored below the national average for privacy and dignity for patients admitted to the ED in July 2017. There have, however, been significant improvements to the ED environment since that time including the introduction of privacy boards and additional assessment cubicles which means that patients are always examined in a private space no matter how busy the ED is. The ED and Acute Services have also received the ‘Acute Services Redesign’ 2018 award from the HSJ for the single clerking initiative. This is an outstanding piece of patient care

innovation which has halved the time ED patients wait to see senior specialists and reduced the time needed for the entire clerking process by two-thirds.

4. Local improvements benefitting Patient Experience

4.1. Using the Always Events toolkit designed by NHS England and the Institute for Healthcare Improvement Women's Services are working to strengthen the voice of those using maternity services from "what is the matter?" to "what matters to you?" The focus is being placed on the attitude of staff, ensuring that patients feel listened to during their appointments. We have been able to agree support from Healthwatch volunteers in undertaking a local survey of patients. The aim of this project is to and the co-design service improvements with patients.

4.2. Specialty Medicine services have focused on nursing staff attitude as part of their PFIS driver and improvements have been demonstrated using patient experience data. The team has worked with patients and staff to identify the critical factors for a standardised approach to welcoming patients to the wards and at handover. This has resulted in no complaints about staff attitude on either of the wards involved in the improvements, for the last three months. A best practice video is also being produced which will be shared with all staff

5. Plaudits

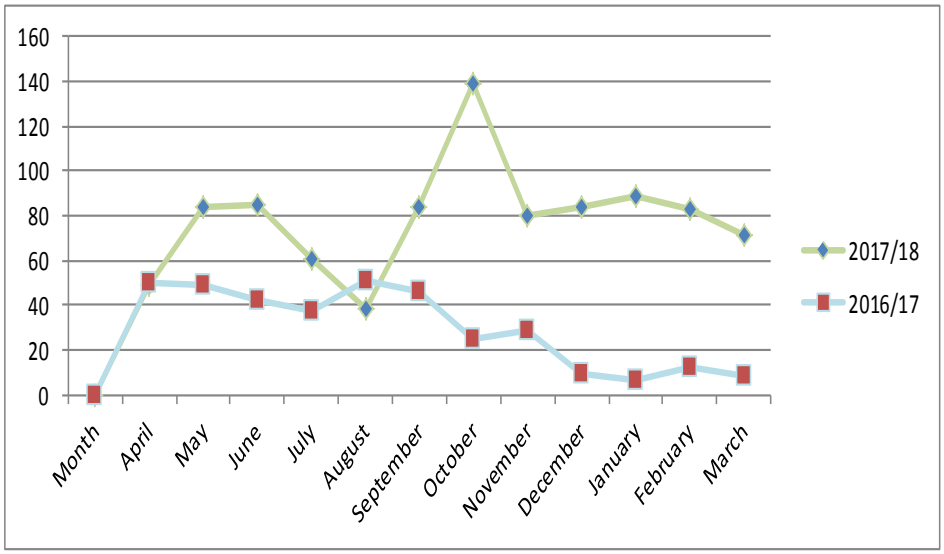
5.1. Many patients, their families and visitors to the Trust take the time to give thanks for the care they or their loved one has received. These are received either directly to staffteams, via the Trust website and NHS Choices. It is just as important for our staff to know when they have done things well and there is valuable learning from the positive feedback received.

5.2. In 2017/18 we saw a 65% increase in plaudits received. All plaudits are logged on our central complaints system, shared with the CEO and the teams involved, and are appropriately acknowledged by the Patient Experience Team or the CEO.

Table 9: Plaudits received by Division 2017/18

	17/18 Q1	17/18 Q2	17/18 Q3	17/18 Q4	Total
Central Clinical Services	4	7	12	13	36
Corporate / Other	7	8	8	18	41
Medicine	99	85	108	113	405
Specialist Services	16	10	25	29	80
Surgery	70	54	128	90	342
Womens & Childrens	19	14	19	21	73

Graph 1: Plaudits received 2016/17 and 2017/18



5.3. Examples of Plaudits received

Albourne ward
"I would just like to say what great group of staff looked after me on Albourne ward from 28thFebruary until 2nd March. They were all very professional, helpful & extremely kind & considerate nothing was too much trouble & always had time to have a quick chat while still doing their very busy jobs. Staff nurse Juliette I think that was her name was incredible such a kind & caring person with a great personality always made me feel better"

IBD Nurse Clinic
"I would like to send this email to say what a fantastic asset Jo and Kate are to the hospital, They are at the end if the phone any time you need them and if they don't know the answer they will find out for you and get back to you, I have text the team this morning and within ten mins I had a reply answering my question. I know you have so many complaints to deal with but i feel praise should also be given when it's due"

Emerald Ward
"I just wanted to say on behalf of my family that the care my Mum received in her final days on Emerald unit were the very best we could have hoped for in her last days. From the HCS's to the senior Nursing staff especially Tom and Fab were of the very highest level of nursing care we had experienced. They could not have been any kinder to our family so thank you all from the bottom of our hearts. Emerald Unit is amazing and run by a team of highly professional staff who are outstanding"

6. Complaints and PALS

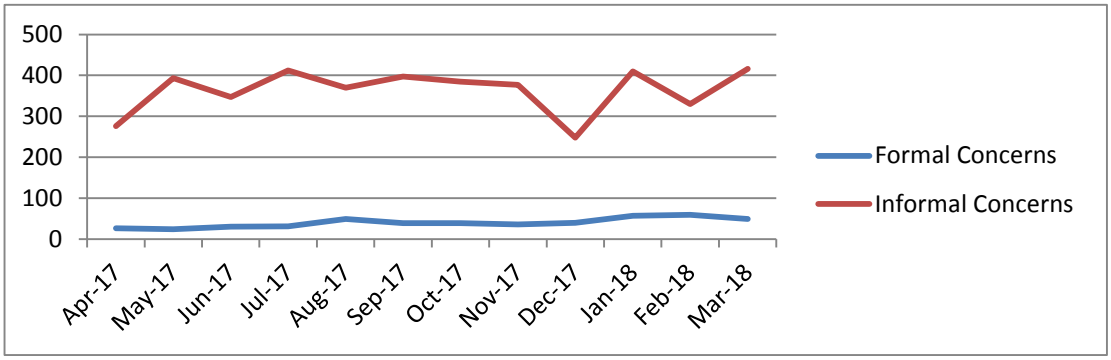
6.1. Complaints overview

2017/18 data reflects changes to practice in the reporting of formal and informal concerns. All concerns received by the trust are triaged by the PALS team and, wherever possible, resolved quickly and without the need for a formal written response from the Medical or Nurse Director. All concerns managed in this way, by either the PALS or Complaints team, are now reported and counted as informal concerns.

Table 10: Formal & Informal Concerns received by year

	Formal Concern	Informal Concern	No of Informal Concerns Closed Within 25 WD	% of Informal Concerns Closed within 25 WD	No Formal Complaints Closed Within 40 WD	% of Formal Complaints Closed within 40 WD
15/16	511	4486	3677	90.8%	158	37.3%
16/17	501	4816	4002	98.2%	152	39.8%
17/18	528	4713	3437	95.1%	179	48.2%

Graph 2: Informal and Formal Concerns received April 2017 – March 2018



6.2. Complaints and lessons learned

Learning lessons is the most important action that can come from complaints and during the last year there are numerous examples of this. Below is described just a few:

Issue of Complaint	Learning
Delay in reporting MRI and lack of clarity regarding process for obtaining results	The MRI reporting process has been refreshed. All clinical and ward staff now have access to a centralised imaging results system allowing clarity and more timely access to patient information.
Delay to the surgical management of miscarriage	The Obstetric team now has an escalation plan in place to ensure that women requiring the surgical management of miscarriage routinely have their procedure undertaken within 5 days.
Failure to consider specific needs of individual patients when cancelling appointments	Ophthalmology booking staff now check Oasis and consider the individual needs of patient (protected characteristics) when rescheduling patients to ensure that the appropriate support is available to them.
Poor communication regarding a dementia patient's delay to surgery	As a result of this complaint the theatre team have introduced a communication process to ensure that they are made aware of the specific needs of MSK patients (i.e. dementia) to improve the patients pathway

7. Formal Complaints Summary

7.1. 528 formal complaints received by the Trust between 1 April 2017 and 31 March 2018 which is a 19% rise from 2016/17

7.2. As envisaged, since the restructuring and expansion of the PALS team in 2017 81% of the remaining complaints, which formed part of a significant back log (affected by significant and sustained staffing issues during 2015/16 – 2016/17) have been closed in 2017/18.

7.3. Following the restructure of the Patient Experience services all formal concerns are now directed to the PALS team in the first instance who will seek to quickly resolve the issues raised wherever possible and appropriate.

7.4. This means that PALS Advisers now take forward concerns that require more comprehensive investigation and would previously have been managed via the formal complaints process as an informal concern. PALS Advisers work closely with the specialties to ensure that such concerns are resolved swiftly and efficiently and without the need for a formal written response from the Chief Executive Officer (CEO) or her representative.

7.5. In 2017/18 we have been able to resolve 75% of informal concerns raised with our PALS team in two working days.

7.6. Informal concerns which are resolved via an early resolution represent a significant percentage of our workload and in 2017/18 there was a 4% increase of informal concerns received by the Trust in comparison to 2016/17.

7.7. Approximately 90% of concerns received by the Trust are now managed as an informal concern, which includes a variety of interventions such as telephone feedback and meetings with clinical staff without the need for a formal written response from the CEO or her representative.

7.8. The changes described have already significantly and positively impacted on the service and response times are showing a steady improvement. The Trust is now responding to 95% of informal concerns within 25 working days and, whilst our response rate for formal concerns responses are below our local response target of 80%, we project that by 2018/19 year end this target will be consistently achieved.

7.9. Overall less than 1% of our patients contact our services citing a concern or query

8. Categorisation of Formal & Informal Concerns

8.2. Each concern received by the Trust is assigned a trigger according to the issues raised in the complaint to ensure that themes and trends are easily identified, reported and acted upon.

8.3. All complaints received are also categorised as either being upheld or not upheld against the triggers ascribed to them which provides additional, valuable information regarding where service improvement is required.

8.4. Surgery Division has received the highest number of complaints in 2017/18, which is historically the same.

Table 12: Highest number of Trigger cited by Division

Surgery	Women's & Children's	Medicine
Communication	Communication	Communication
Wait for outpatient appointment	Clinical care/treatment	Clinical care/treatment
Clinical care/treatment	Wait for outpatient appointment	Lost Property
Wait for surgery date	Attitude of staff	Discharge
Attitude of staff	Wait for surgery date	Attitude of staff
Specialist	Central Clinical Services	Other*
Communication	Communication	Communication
Wait for outpatient appointment	Wait for outpatient appointment	Parking issues
Clinical care/treatment	Administrative error/failings	Medical records request/query
Wait for surgery date	Delays in results - bloods, scans etc.	Attitude of staff
Cancelled	Clinical care/treatment	Cleanliness/hygiene

*includes corporate, facilities & estates and unidentifiable

Table 13: Top triggers for informal concerns

	Informal Concerns	Formal Complaints	Total
Communication	1055	139	1194
Wait for outpatient appointment	622	25	647
Clinical care/treatment	268	227	545
Wait for surgery date	194	17	211
Attitude of staff	190	82	272
Delays in results - bloods, scans etc.	134	3	137
Administrative error/failings	127	29	156
Cancelled	106	18	124
Discharge	71	37	108
Medical records request/query	46	0	46

8.5. Trigger Theme – Staff Attitude

8.6. Organisational culture and staff attitude are vital to the delivery of good care and the 2017 National Adult Inpatient Survey found that 86% (>1% from 2016) of patients surveyed felt they were treated with dignity and respect by our staff.

8.7. Following an extensive review of all formal concerns citing attitude in 2017/18 a new matrix has been designed to allow additional information at the time of recording the concerns to ensure robust data to inform improvements. This means we now identify all staff attitude concerns by at least one trigger from column (see table 4).

Table 14: Patient Experience Staff Attitude Matrix

Trigger	Staff Groups
Rude	Doctor
Uncaring	Consultant
Dismissive	Nurse
Aggressive	Midwife
Unhelpful	Reception
Disinterested	Secretary
No Empathy	Hub
Unprofessional	Admin Other
Arrogant	Allied Health Professional
Derogatory	HCA
Disrespectful	Porter, Estates & Security
Patronising	
Insensitive	
Prejudiced	

8.8. In order to support staff learning and personal development from such feedback the Complaints team recommends that specialties ensure that a reflective meeting is routinely held with the staff member involved. It is also recommended that the staff member writes a reflection on the events described to form part of their appraisal and that evidence of this is provided to ensure accountability at all levels. This will also essential for professional revalidation.

A monthly report sharing details of all concerns raised citing staff attitude in month including staff names is shared with the Nurse Director and Medical Director.

9. Second Stage Review Of The NHS Complaints Process – The Parliamentary and Health Service Ombudsman

9.1. The Parliamentary and Health Service Ombudsman (PHSO) represents the second and final stage of the NHS complaints process. The Trust continues to work directly with PHSO to satisfactorily resolve complaints.

9.2. The PHSO's Principles for Remedy are central to the Trust's management of complaints. We always try to speak directly with anyone who is unhappy with the care either they or their family members have received and hope to agree with them how best to resolve their concerns. Once the issues of the complaint have been thoroughly investigated patients and/or their representatives will receive a verbal or written response from the CEO or, if they prefer, will be invited to meet with senior medical and nursing staff to discuss their experiences in person. If, despite all our efforts, complainants remain unhappy with our response to their concerns they can request an independent review of their complaint by the Ombudsman.

9.3. In 2017/18 ten complaints were accepted for second stage review by the PHSO. This represents 2.4% of all formal concerns received by the Trust in year. Of these, none were fully upheld and three complaints were partially upheld and, requiring additional work to be undertaken to ensure that lessons have been learnt and that the PHSO Principles of Remedy have been applied as appropriate.

9.4. All partially upheld and upheld PHSO investigations are reported in the Patient Experience Quarterly Board Report and are detailed in the Divisional monthly reports for action.

9.5. The PHSO recommended financial remedy for two of the partially upheld cases meaning £650 in total has been awarded for identified service failings.

10. Patient and Public Engagement

10.1. Patient Experience Panel (PEP)

The Trust runs two Patient Experience Panels, one for the RSCH site and one for PRH. The Panels meet on a quarterly basis, in turn, so that along with the Patient Experience Committee, there is a meeting focused on some aspect of patient experience every month. The Panels are the key vehicle for patient representation / participation, and the panel is a formal, business/assurance meeting comprised of Trust staff, Healthwatch representatives, CCG representatives and other third sector organisations.

10.2. The role of the PEP is to:

- Advise the Trust on issues of concern to local people/ patients
- Form patient/representative led working groups to help develop priorities for action and ensure regular feedback on outcomes of actions
- Help develop Trust strategies, appraise information for the public developed by the Trust and help determine priorities for patient engagement
- Consider service changes and proposals for local NHS services and participate in a range of schemes to gather patient/ carer intelligence on Trust services including surveys, walkabouts, fly on the wall observations and ward visits

10.3. The Panels have a maximum of 8 patient/carer representatives who have demonstrable links to allow feedback to other parts of the community and each meeting is themed to concentrate on a specific topic.

10.4. The PEP reports to the Patient Experience and Engagement Group as a sub-Committee of the Board's Quality & Performance Committee.

11. NHS Choices

NHS Choices is a website where patients and the public can comment on any NHS service. Positive and negative comments are posted, usually anonymously, and the site is monitored by the Care Quality Commission (CQC). The CQC monitors issues and concerns raised and the responses from the service provider. Patients are able to provide feedback on the care they have received at our hospitals via the NHS Choices website. This is reviewed several times a week by the Patient Experience Project Manager and all posts are responded to, both thanking plaudits and sharing them with the staff teams involved or inviting further contact from those patients reporting a poor experience.

12. Healthwatch Peer Review Panel

Since 2014, following a recommendation of the Francis Report, the Patient Experience Team have allowed access to anonymised information about complaints with the local health watchdog, Healthwatch Brighton & Hove. During this time Healthwatch volunteers have undertaken a quarterly review of anonymised complaints, providing feedback to the Trust on the standard and quality of the response which is used to inform future complaints practice.

13. Next Steps

Considerable advances have been in made in the last year in how we use, collect and analyse patient experience information. The new clinical governance structure enables greater visibility from ward to board of patient feedback and divisions and wards are beginning to truly use this to inform their services.

There will be a number of projects in the next year and there is an aim to:

- Now that the complaints backlog has been addressed to reach the response target of 80% of formal complaints being answered in 40 days by the end of 2018/19
- To roll out the standard work on greeting patients to wards, to all clinical areas.

- To fully implement the Always Events service co-design in gynaecology
- To enable all wards and departments to be confident in the use of the Friends and Family Realtime data to improve care and provide feedback to staff.
- Develop KPIs for patient experience, PALS and complaints to report to the Patient Experience and Engagement Group.

Brighton and Sussex University Hospitals NHS Trust

To: Trust Board

Date of Meeting: 25th July 2018 Agenda Item: **13**

Title
Medical Appraisal and Revalidation Annual Update
Responsible Executive Director
Dr George Findlay, Chief Medical Officer and Deputy Chief Executive Officer
Prepared by
Dr Rob Haigh, Medical Director, BSUH
Status
Not confidential
Summary
This paper updates the Board on the end of year position with regard to medical appraisal and revalidation and seeks Board sign off of the NHS England statement of compliance. There has been an improvement in end of year appraisal rate this year compared to the previous year: • 2017-18 end of year appraisal rate for all doctors with a prescribed connection for revalidation 92% (vs 85% in 2016-17). • For substantive medical and dental staff only, end of year appraisal rate was 93% (vs 93% in 2016-17). • There is one missed appraisal in 2017-18; the Medical Director is involved with this case. **Recommendations / actions** 1. For the board to accept the report. 2. The report, along with **Appendix C** – Annual Organisational Audit will be shared with the higher level Responsible Officer (RO) at NHS England. 3. The board are requested also to approve **Appendix D** – Statement of Compliance, confirming that the organisation is in compliance with the regulations, prior to its submission to the higher level RO.
Implications for Quality of Care
Appraisal revalidation to ensure the medical practitioners are up to date and accredited to provide safe and effective patient care
Link to Strategic Objectives/Board Assurance Framework
Links to True North objectives: Patients, People, Quality
Financial Implications
Nil
Human Resource Implications
Plans in place to increase numbers of appraisers
Recommendation
The Board is asked to: NOTE the report

Communication and Consultation
Appendices
Appendix A – Appraisal and Revalidation KPI Data Appendix B – Appraisal and Revalidation KPI Dashboard Appendix C – Annual Organisational Audit Appendix D – Statement of Compliance

1. Background

1.1 For the purposes of revalidation, all licensed doctors are required to both participate in annual appraisal and collect supporting information about their practice – to improve patient care and outcomes and to increase public confidence in the medical system.

1.2 Provider organisations have a statutory duty to support their Responsible Officer (RO) in discharging his / her duties[1] and Trust Boards are expected to oversee compliance by:

- monitoring the frequency and quality of medical appraisals and ensuring that annual appraisals take place.
- checking that effective systems and processes are in place to monitor the conduct and performance of doctors;
- confirming that periodic feedback from patients and colleagues informs the appraisal and revalidation process
- providing appropriate pre-employment checks (including pre-engagement for locums) to ensure that medical practitioners have qualifications and experience appropriate to the work performed.

2. Appraisal, pre-employment checking and Revalidation Activities:

2.1

Number of doctors with a prescribed connection at 31 March 2018 – 697
Number of completed appraisals as at 31 March 2018 – 641

2.2 The number of doctors with a prescribed connection to BSUH has increased steadily in the last 3 years, to 697 on 1st April 2018 (709 with the addition of Dental and St Peter & St James Hospice colleagues). Throughout the year, the trust also loses doctors who have already been appraised, and recruits doctors yet to be appraised. The appraisal workload at BSUH is therefore substantial. It is not possible to reduce the number of prescribed connections to BSUH, which is contractually dictated.

2.3 The Medical Appraisal and Revalidation (MARR) Team monitor internal compliance with appraisal progress weekly, and review appraisal outputs against GMC and NHSE standards.

2.4 To ensure compliance, the MAAR team align and update the ESR and GMC Connect databases weekly; quality assure appraisal audit quarterly; provide feedback to appraisers at bi-yearly network meetings; provide individual feedback to medical appraisers.

(Further details about compliance with national requirements are included in Appendix B – Annual Organisational Audit).

2.5 The end of year appraisal number could have been increased with a greater pool of trained appraisers.

See Appendix A, section A - Audit of all missed or incomplete appraisals.

[1] The Medical Profession (Responsible Officers) Regulations, 2010 as amended in 2013' and 'The General Medical Council (Licence to Practise and Revalidation) Regulations Order of Council 2012'

2.6 The MAAR team also undertaken pre-engagement background checks for all new doctors starting in year

The numbers of new doctors (including all new prescribed connections) who have commenced working at BSUH in last 12 months (including locum doctors) is outlined below:-

New permanently employed doctors	53
New temporary employed doctors (inc.. doctors in training)	438
Locums brought in to the designated body through 'staff bank'	189
TOTAL	**680**

2.7 Revalidation Recommendations

The MAAR team provide the oversight and administrative support for all doctors being revalidated each year.

• Revalidation recommendations – during 12 months to March 31st	36
• Recommendations completed on time	35
• Recommendations not completed on time	1 *
• Positive recommendations	27
• Deferral requests	9
• Non-engagement notifications	0

***** *due to a delay in confirming the doctor's prescribed connection and supporting information.*

3. Appraiser Support and Development

Current numbers of appraisers – 77 April 2018 (74 in March 2017)
Current appraisee / appraiser ratio – 9:1 April 2018 (9:1 in March 2017)

3.1 The above ratio is high and a consequence of lower than required appraiser numbers.

3.2 Capacity within job plans is cited as the major challenge to more rapid appraiser recruitment. Several experienced appraisers are also approaching retirement age or have stepped down due to other commitments.

3.3 The RO Lead for Revalidation and Appraisal and the Divisional Chiefs are collaborating to identify additional appraisers, the goal being to achieve a ratio 1:6.within the next 12 months.

3.4 The expectation in each Division is that 20% of substantive middle grades and consultants are trained appraisers.

3.5 Regular scheduled appraiser training is now in place to make the role of the medical appraiser more attractive and to ensure that newly identified appraisers are trained in line with NHSE Guidelines.

3.6 In October 2017, improvements to training and support for appraisers were introduced, incorporating:

- New (quarterly) internal training, (reflecting current NHSE Guidelines).
- Twice yearly external appraiser network and skills training sessions.

- Monthly drop-in sessions (both sites) to support all doctors with the appraisal and revalidation process; there is additional remote access support and 121 training.

4. Quality Assurance (QA)

4.1 The MAAR teams Quality Assure both the appraisal process and each individual appraisal portfolio, including:-

- Appraisal inputs: pre-appraisal declarations; supporting information; PDP's; and sign off;
- Annual record of the appraisee's workload, self-reflection and CPD.
- 360° feedback to identify any outliers and support requirements.
- Appraisal audit by department - annually (Q4).

4.2 MAAR review all appraisal portfolios post completion and return any with patient identifiable data present. There were no IG breaches were reported in 2017-18.

See also Appendix A, section B - Quality assurance of appraisal inputs and outputs.

5. Revalidation Governance

5.1 Doctors are supplied with individualised data by the Patient Safety Teams, Complaints Team, Medical HR (conduct and capability) and GMC (external complaints and investigations). All data is collected and upload by MAAR onto the doctor's appraisal portfolio.

5.2 There is a prescribed timeline for appraisal in line with national guidance and pre and post appraisal checks are undertaken to minimise the risk of deferrals. Progress checking is by email, telephone and face-to-face contact if required.

5.3 All revalidation recommendations are reviewed 120 days in advance, to allow time for missing information or corrections to be rectified before the submission deadline.

5.4 To ensure that the minimum requirement of 15 colleague and 20 patient feedback responses is met, the 360 feedback period has been recently extended from 12 weeks to 24 weeks.

5.5 To spread appraisal meetings more evenly across the year, all doctors have been offered an earlier appraisal during 2018-19. Appraisers are allocated a maximum of 3 doctors per quarter.

Dr George Findlay Chief Medical Officer and Deputy Chief Executive Officer
Dr Rob Haigh BSUH Medical Director
Dr Rachael James Deputy Medical (Standards)/Lead for Appraisal and Revalidation
Caroline Wiggs, Medical Appraisal and Revalidation Manager

Appraisal and Revalidation KPI Data

Appendix A

A – Audit of all missed or incomplete appraisals

Doctor factors (total)	**Number**
Maternity leave during the majority of the 'appraisal due window'	7
Sickness absence during the majority of the 'appraisal due window'	3
Prolonged leave during the majority of the 'appraisal due window'	2
Suspension during the majority of the 'appraisal due window'	0
New starter within 3 month of appraisal due date	0
New starter more than 3 months from appraisal due date	4
Postponed due to incomplete portfolio/insufficient supporting information	2
Appraisal outputs not signed off by doctor within 28 days	6
Lack of time of doctor	12
Lack of engagement of doctor	1
Other doctor factors	0
(describe)	
Appraiser factors	**Number**
Unplanned absence of appraiser	1
Appraisal outputs not signed off by appraiser within 28 days	4
Lack of time of appraiser	0
Other appraiser factors (describe)	0
(describe)	
Organisational factors	**Number**
Administration or management factors	0
Failure of electronic information systems	0
Insufficient numbers of trained appraisers	14
Other organisational factors (describe)	0
Total number of all missed or incomplete appraisals (approved)	**56**

B – Quality assurance of appraisal inputs and outputs

	Number of appraisal portfolios sampled (to demonstrate adequate sample size)	Number of the sampled appraisal portfolios deemed to be acceptable against standards
Appraisal inputs	**Number audited**	**Number acceptable**
Scope of work: Has a full scope of practice been described?	79	78
Continuing Professional Development (CPD): Is CPD compliant with GMC requirements?	79	54
Quality improvement activity: Is quality improvement activity compliant with GMC requirements?	79	52
Patient feedback exercise: Has a patient feedback exercise been completed?	79	43
Colleague feedback exercise: Has a colleague feedback exercise been completed?	79	43
Review of complaints: Have all complaints been included?	79	78
Review of significant events/clinical incidents/SUIs: Have all significant events/clinical incidents/SUIs been included?	79	78
Is there sufficient supporting information from all the doctor's roles and places of work?	79	76
Is the portfolio sufficiently complete for the stage of the revalidation cycle (year 1 to year 4)? Explanatory note: For example • Has a patient and colleague feedback exercise been completed by year 3? • Is the portfolio complete after the appraisal which precedes the revalidation recommendation (year 5)? • Have all types of supporting information been included?	79	59
Appraisal Outputs		
Appraisal Summary	79	79
Appraiser Statements	79	79
Personal Development Plan (PDP)	79	79
Total number of appraisals completed		**641**

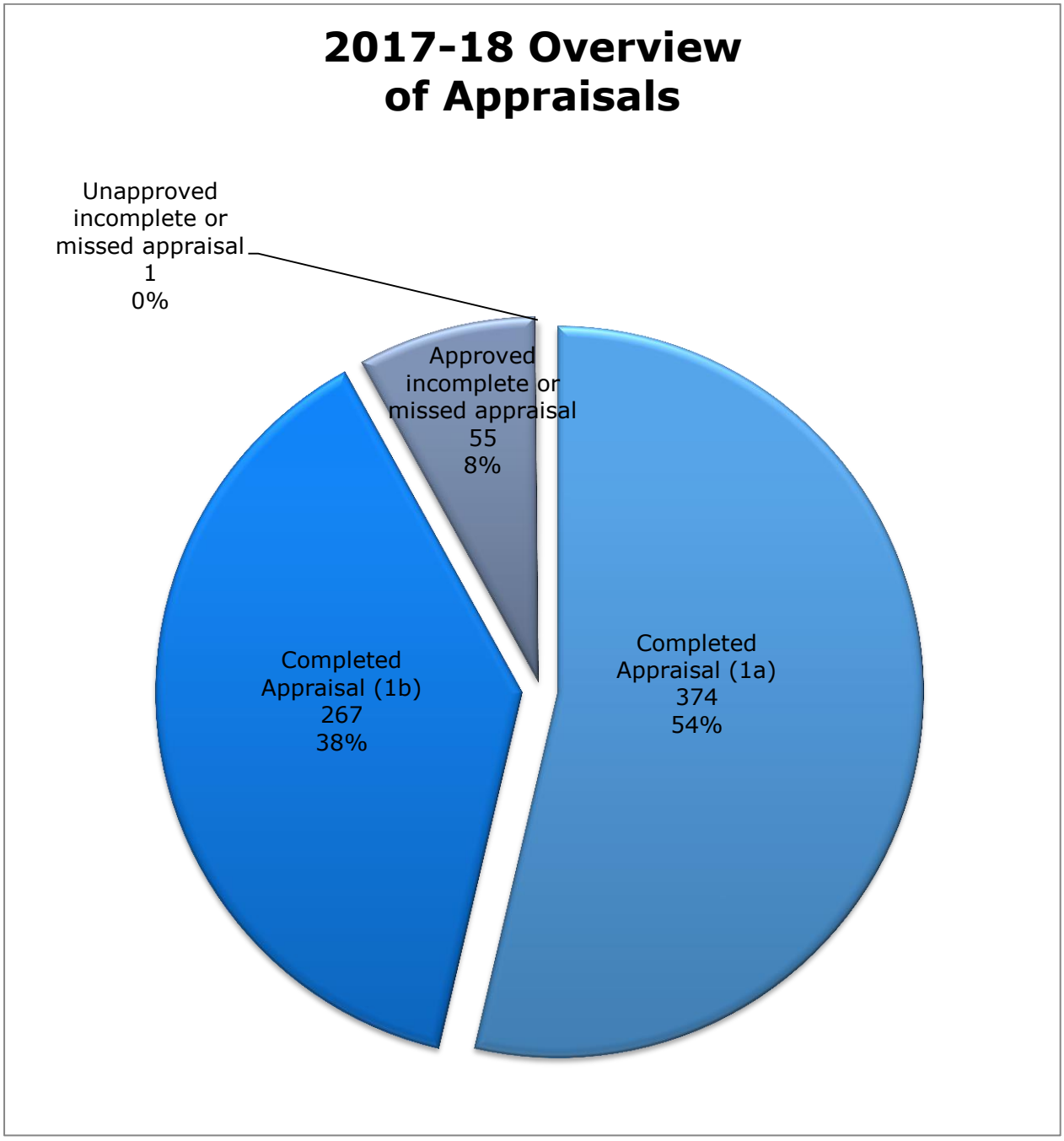
C – Audit of revalidation recommendations

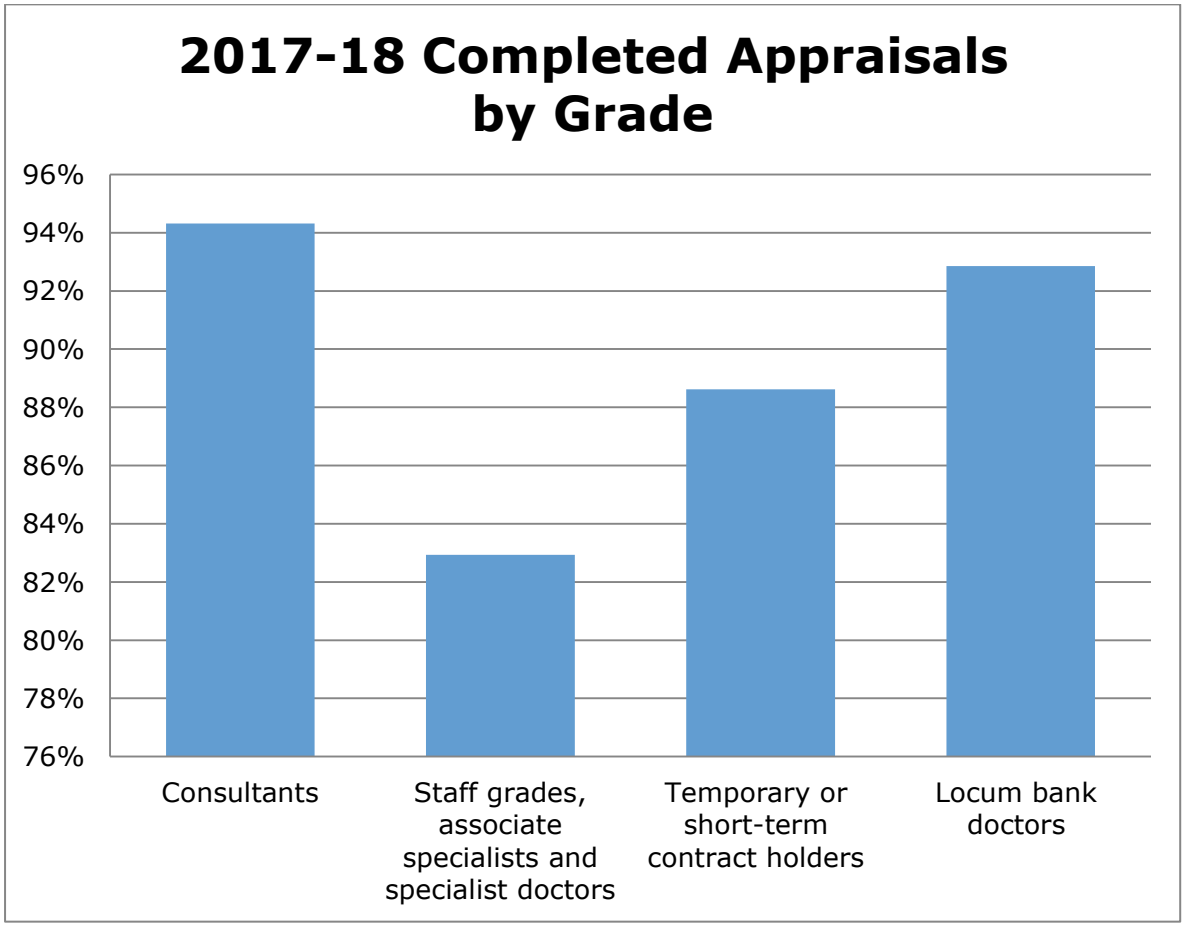
Revalidation recommendations between 1 April 2014 to 31 March 2015	
Recommendations completed on time (within the GMC recommendation window)	35
Late recommendations (completed, but after the GMC recommendation window closed)	1
Missed recommendations (not completed)	0
TOTAL	**36**
Primary reason for all late/missed recommendations For any late or missed recommendations only one primary reason must be identified	
No responsible officer in post	0
New starter/new prescribed connection established within 2 weeks of revalidation due date	1
New starter/new prescribed connection established more than 2 weeks from revalidation due date	0
Unaware the doctor had a prescribed connection	0
Unaware of the doctor's revalidation due date	0
Administrative error	0
Responsible officer error	0
Inadequate resources or support for the responsible officer role	0
Other	0
TOTAL	**36**

Brighton and Sussex University Hospitals NHS Trust

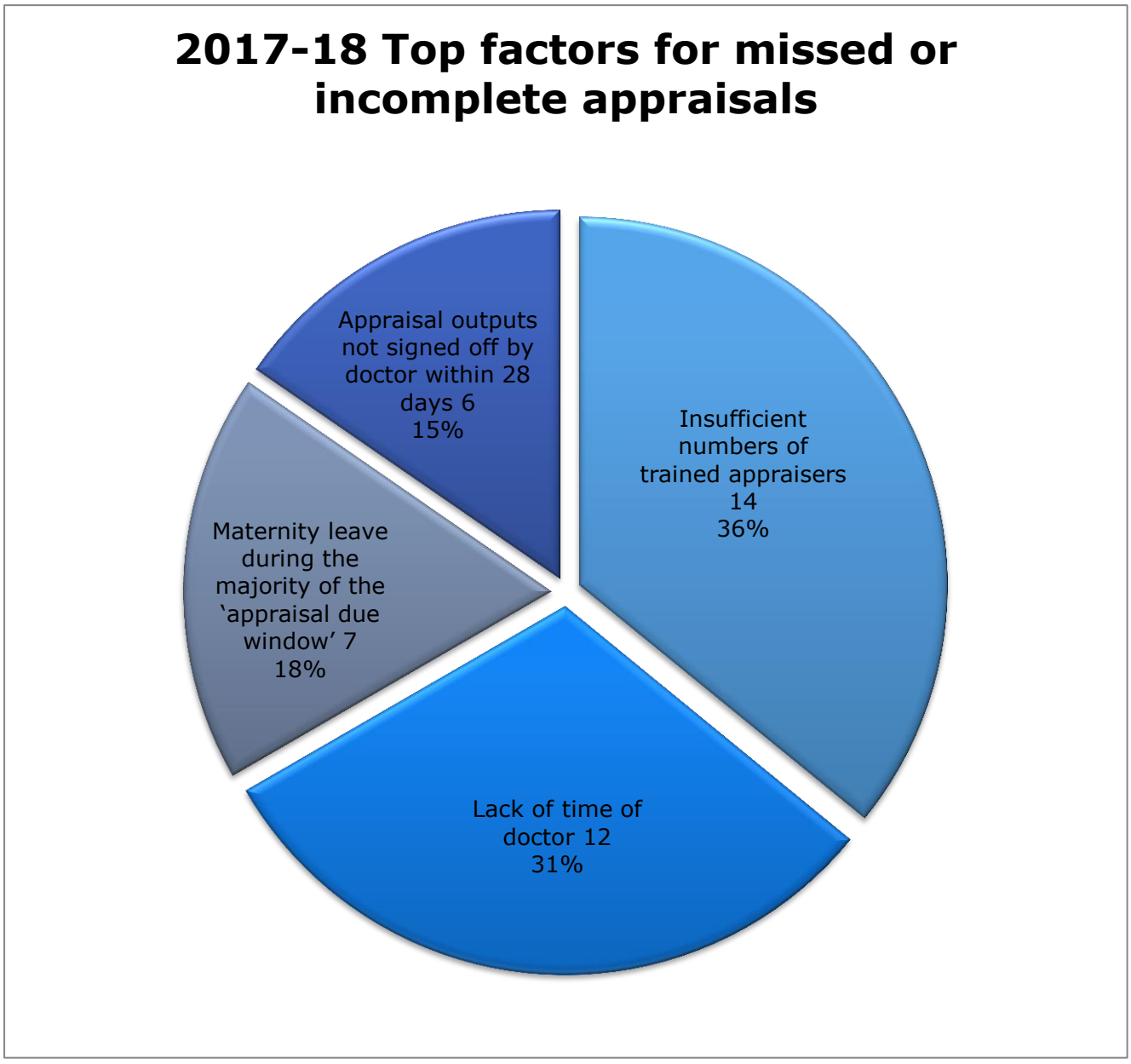
Appraisal and Revalidation KPI Dashboard

Appendix B

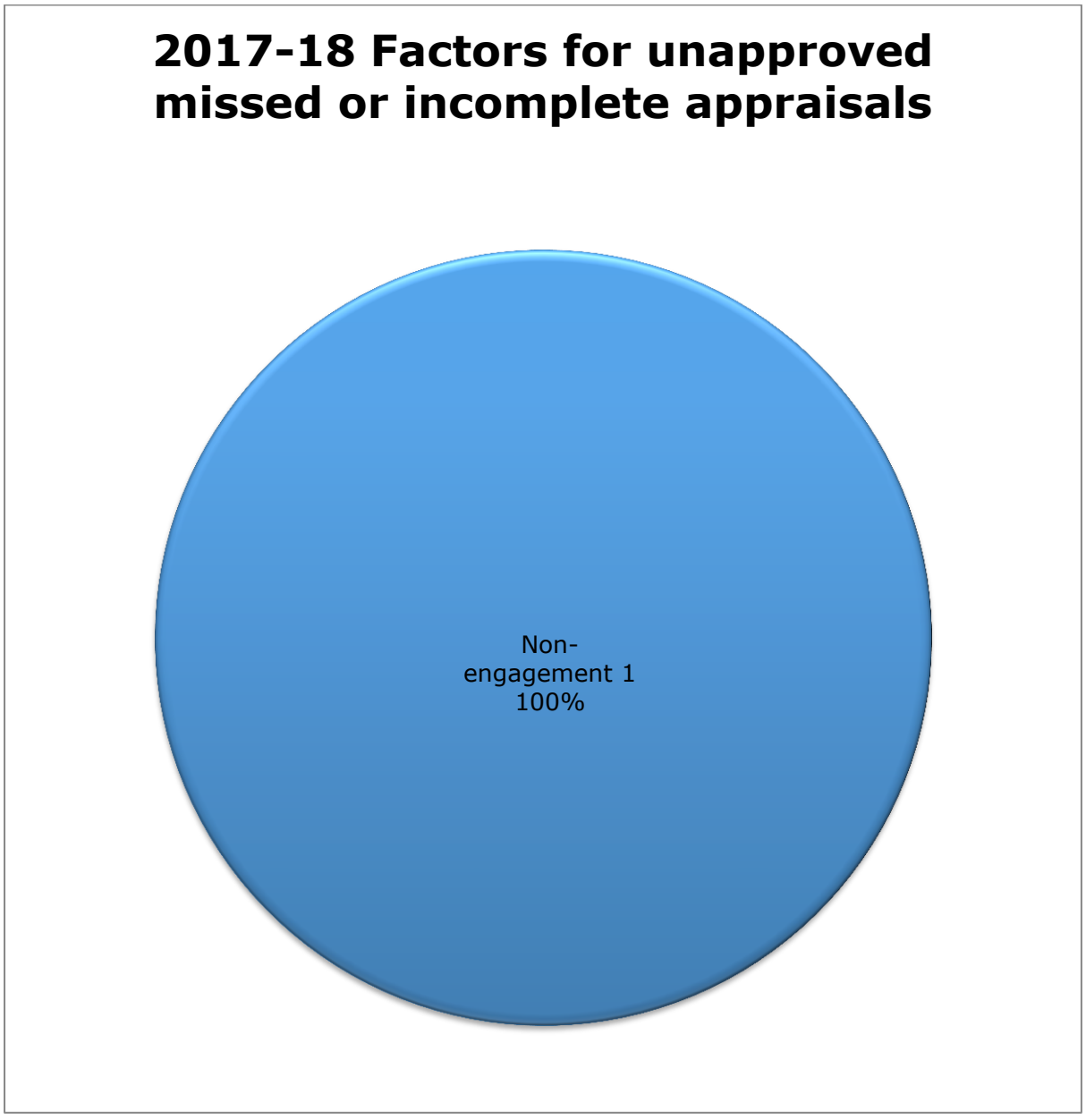



2017-18 Completed Appraisals by Grade
96%
94%
92%
90%
88%
86%
84%
82%
80%
78%
76%
Consultants
Staff grades, associate specialists and specialist doctors
Temporary or short-term contract holders
Locum bank doctors

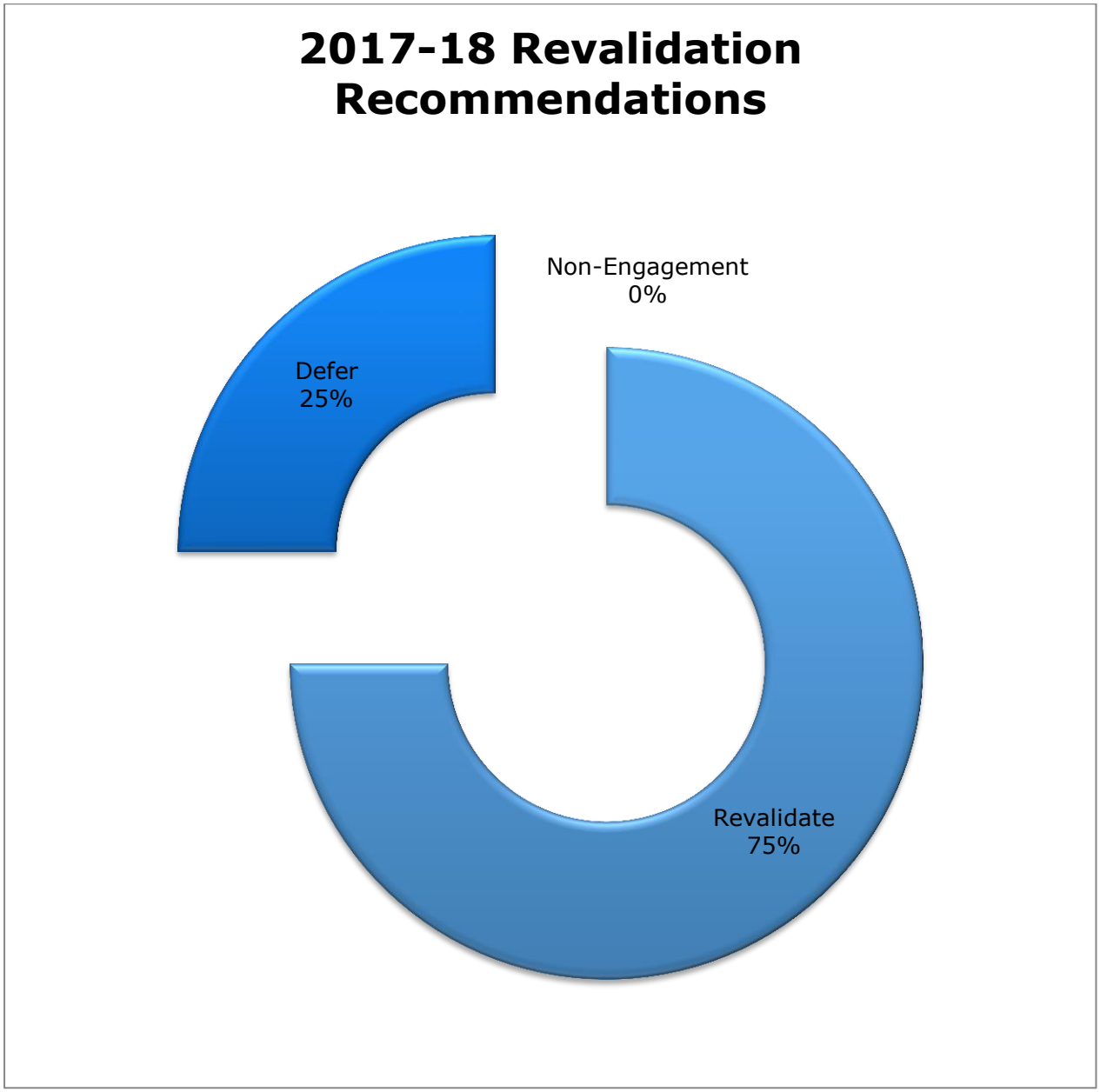
A – Audit of all missed or incomplete appraisals



B – Audit of unapproved missed or incomplete appraisals



C – Audit of revalidation recommendations



NHS England

Annual Organisational Audit (AOA)
End of year questionnaire 2017-18

NHS England INFORMATION READER BOX		
Directorate		
Medical	Commissioning Operations	Patients and Information
Nursing	Trans. & Corp. Ops.	Commissioning Strategy
Finance		

Publications Gateway Reference:	07760
Document Purpose	Resources
Document Name	Annual Organisational Audit Annex C (end of year questionnaire)
Author	Lynda Norton
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Target Audience	Medical Directors, NHS England Regional Directors, GPs
Additional Circulation List	
Description	The AOA (Annex C of the Framework for Quality Assurance) is a standardised template for all responsible officers to complete and return to their higher level responsible officer via the Revalidation Management System. AOAs from all designated bodies will be collated to provide an overarching status report of progress across England.
Cross Reference	A Framework for Quality Assurance for Responsible Officers & Revalidation April 2014 Gateway ref 01142
Superseded Docs (if applicable)	2016/17 AOA cleared with Publications Gateway Reference 06491
Action Required	
Timing / Deadlines (if applicable)	
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Document Status

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Annual Organisational Audit (AOA)

End of year questionnaire 2017-18

Version number: 2.0

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Prepared by: Lynda Norton, Project Manager for Quality Assurance, NHS England

Classification: OFFICIAL

Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have:

Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and

Given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.

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Contents

1 Introduction

The Framework of Quality Assurance (FQA) and the monitoring processes within it are designed to support all responsible officers in fulfilling their statutory duty, providing a means by which they can demonstrate the effectiveness of the systems they oversee. It has been carefully crafted to ensure that administrative burden is minimised, whilst still driving learning and sharing of best practice. Each element of the FQA process will feed in to a comprehensive report from the national level responsible officer to Ministers and the public, capturing the state of play of medical revalidation across the country.

The reporting processes are intended to be streamlined, coherent and integrated, ensuring that information is captured to contribute to local processes, whilst simultaneously providing the required assurance. The process will be reviewed and revised on a regular basis.

The AOA (Annex C) is a standardised template for all responsible officers to complete and return to their higher level responsible officer. AOAs from all designated bodies will be collated to provide an overarching status report of medical revalidation across England. Where small designated bodies are concerned, or where types of organisation are small in number, these will be appropriately grouped to ensure that data is not identifiable to the level of the individual.

The AOA is designed to assist NHS England regional teams to assure the appropriate higher level responsible officers that designated bodies have a robust consistent approach to revalidation in place, through assessment of their organisational system and processes in place for undertaking medical revalidation.

Learning from the experience of the Organisational Readiness and Self-Assessment (ORSA) the AOA has a dual purpose to provide the required assurance to higher level responsible officers whilst being of maximum help to responsible officers in fulfilling their obligations.

The aims of the annual organisational audit exercise are to:

- gain an understanding of the progress that organisations have made during 2017/18;
- provide a tool that helps responsible officers assure themselves and their boards/management bodies that the systems underpinning the recommendations they make to the General Medical Council (GMC) on doctors' fitness to practise, the arrangements for medical appraisal and responding to concerns, are in place;
- provide a mechanism for assuring NHS England and the GMC that systems for evaluating doctors' fitness to practice are in place, functioning, effective and consistent.

This AOA exercise is divided into five sections:

Section 1: The Designated Body and the Responsible Officer

Section 2: Appraisal

Section 3: Monitoring Performance and Responding to Concerns

Section 4: Recruitment and Engagement

Section 5: Additional Comments

The questionnaire should be completed by the responsible officer on behalf of the designated body, though the input of information to the questionnaire may be appropriately delegated. The questionnaire should be completed **during April and May 2018** for the year ending 31 March 2018. The deadline for submission will be detailed in an email containing the link to the electronic version of the form, which will be sent after 31 March 2018.

Whilst NHS England is a single designated body, for the purpose of this audit, the national and regional offices of NHS England should answer as a 'designated body' in their own right.

Following completion of this AOA exercise, designated bodies should:

- consider using the information gathered to produce a status report and to conduct a review of their organisations' developmental needs.
- complete a statement of compliance and submit it to NHS England by the 28 September 2018.
- The audit process will also enable designated bodies to provide assurance that they are fulfilling their statutory obligations and their systems are sufficiently effective to support the responsible officer's recommendations.

For further information, references and resources see pages 31-32
and www.england.nhs.uk/revalidation

2 Guidance for submission

Guidance for submission:

- Several questions require a ‘Yes’ or ‘No’ answer. In order to answer ‘Yes’, you must be able to answer ‘Yes’ to all of the statements listed under ‘to answer ‘Yes’’
- Please do not use this version of the questionnaire to submit your designated body’s response.
- You will receive an email with an electronic link to a unique version of this form for your designated body.
- You should only use the link received from NHS England by email, as it is unique to your organisation.
- Once the link is opened, you will be presented with two buttons; one to download a blank copy of the AOA for reference, the second button will take you to the electronic form for submission.
- Submissions can only be received electronically via the link. Please do not complete hardcopies or email copies of the document.
- The form must be completed in its entirety prior to submission; it cannot be part-completed and saved for later submission.
- Once the ‘submit’ button has been pressed, the information will be sent to a central database, collated by NHS England.
- A copy of the completed submission will be automatically sent to the responsible officer.
- Please be advised that Questions 1.1-1.3 may have been automatically populated with information previously held on record by NHS England. The submitter has a responsibility to check that the information is correct and should update the information if required, before submitting the form.

3 Section 1 – The Designated Body and the Responsible Officer

Section 1	The Designated Body and the Responsible Officer	
1.1	**Name of designated body:** Brighton & Sussex University Hospitals NHS Trust	
	Head Office or Registered Office Address if applicable line 1 Royal Sussex County Hospital	
	Address line 2 Eastern Road	
	Address line 3	
	Address line 4	
	City Brighton	
	County East Sussex	Postcode BN2 5BE
	Responsible officer: Title ***** GMC registered first name ***** GMC reference number ***** Email *****	GMC registered last name ***** Phone *****
	Medical Director: Title ***** GMC registered first name ***** GMC reference number ***** Email *****	No Medical Director ☐ GMC registered last name ***** Phone *****
	Clinical Appraisal Lead: Title ***** GMC registered first name ***** GMC reference number ***** Email *****	No Clinical Appraisal Lead ☐ GMC registered last name ***** Phone *****
	Chief executive (or equivalent): Title ***** First name ***** GMC reference number (if applicable) Email *****	Last name ***** Phone *****

1.2	**Type/sector of designated body:** (tick one)	NHS	Acute hospital/secondary care foundation trust	☐
			Acute hospital/secondary care non-foundation trust	☑
			Mental health foundation trust	☐
			Mental health non-foundation trust	☐
			Other NHS foundation trust (care trust, ambulance trust, etc)	☐
			Other NHS non-foundation trust (care trust, ambulance trust, etc)	☐
			Special health authorities (NHS Litigation Authority, NHS Improvement, NHS Blood and Transplant, etc)	☐
		NHS England	NHS England (local office)	☐
			NHS England (regional office)	☐
			NHS England (national office)	☐
		Independent / non-NHS sector (tick one)	Independent healthcare provider	☐
			Locum agency	☐
			Faculty/professional body (FPH, FOM, FPM, IDF, etc)	☐
			Academic or research organisation	☐
			Government department, non-departmental public body or executive agency	☐
			Armed Forces	☐
			Hospice	☐
			Charity/voluntary sector organisation	☐
			Other non-NHS (please enter type)	☐

1.3	**The responsible officer's higher level responsible officer is based at:** [tick one]	NHS England North	☐
		NHS England Midlands and East	☐
		NHS England London	☐
		NHS England South	☑
		NHS England (National)	☐
		Department of Health	☐
		Faculty of Medical Leadership and Management - for NHS England (national office) only	☐
		Other (Is a suitable person)	☐
1.4	**A responsible officer has been nominated/appointed in compliance with the regulations.** To answer 'Yes': • The responsible officer has been a medical practitioner fully registered under the Medical Act 1983 throughout the previous five years and continues to be fully registered whilst undertaking the role of responsible officer. • There is evidence of formal nomination/appointment by board or executive of each organisation for which the responsible officer undertakes the role.		☑ Yes ☐ No

1.5	**Where a Conflict of Interest or Appearance of Bias has been identified and agreed with the higher level responsible officer; has an alternative responsible officer been appointed?** (Please note that in The Medical Profession (Responsible Officers) Regulations 2010 (Her Majesty's Stationery Office, 2013), an alternative responsible officer is referred to as a second responsible officer) To answer 'Yes': The designated body has nominated an alternative responsible officer in all cases where there is a conflict of interest or appearance of bias between the responsible officer and a doctor with whom the designated body has a prescribed connection. To answer 'No': A potential conflict of interest or appearance of bias has been identified, but an alternative responsible officer has not been appointed. To answer 'N/a': No cases of conflict of interest or appearance of bias have been identified. Additional guidance Each designated body will have one responsible officer but the regulations allow for an alternative responsible officer to be nominated or appointed where a conflict of interest or appearance of bias exists between the responsible officer and a doctor with whom the designated body has a prescribed connection. This will cover the uncommon situations where close family or business relationships exist, or where there has been longstanding interpersonal animosity. In order to ensure consistent thresholds and a common approach to this, potential conflict of interest or appearance of bias should be agreed with the higher level responsible officer. An alternative responsible officer should then be nominated or appointed by the designated body and will require training and support in the same way as the first responsible officer. To ensure there is no conflict of interest or appearance of bias, the alternative responsible officer should be an external appointment and will usually be a current experienced responsible officer from the same region. Further guidance is available in *Responsible Officer Conflict of Interest or Appearance of Bias: Request to Appoint and Alternative Responsible Officer* (NHS Revalidation Support Team, 2014).	☐ Yes ☐ No ☑ N/A

1.6	**In the opinion of the responsible officer, sufficient funds, capacity and other resources have been provided by the designated body to enable them to carry out the responsibilities of the role.** Each designated body must provide the responsible officer with sufficient funding and other resources necessary to fulfil their statutory responsibilities. This may include sufficient time to perform the role, administrative and management support, information management and training. The responsible officer may wish to delegate some of the duties of the role to an associate or deputy responsible officer. It is important that those people acting on behalf of the responsible officer only act within the scope of their authority. Where some or all of the functions are commissioned externally, the designated body must be satisfied that all statutory responsibilities are fulfilled.	☑ Yes ☐ No
1.7	**The responsible officer is appropriately trained and remains up to date and fit to practise in the role of responsible officer.** To answer 'Yes': • Appropriate recognised introductory training has been undertaken (requirement being NHS England's face to face responsible officer training & the precursor e-Learning). • Appropriate ongoing training and development is undertaken in agreement with the responsible officer's appraiser. • The responsible officer has made themselves known to the higher level responsible officer. • The responsible officer is engaged in the regional responsible officer network. • The responsible officer is actively involved in peer review for the purposes of calibrating their decision-making processes and organisational systems. • The responsible officer includes relevant supporting information relating to their responsible officer role in their appraisal and revalidation portfolio including the results of the Annual Organisational Audit and the resulting action plan.	☑ Yes ☐ No

1.8	**The responsible officer ensures that accurate records are kept of all relevant information, actions and decisions relating to the responsible officer role.** The responsible officer records should include appraisal records, fitness to practise evaluations, investigation and management of concerns, processes relating to 'new starters', etc.	☑ Yes ☐ No
1.9	**The responsible officer ensures that the designated body's medical revalidation policies and procedures are in accordance with equality and diversity legislation.** To answer 'Yes': • An evaluation of the fairness of the organisation's policies has been performed (for example, an equality impact assessment).	☑ Yes ☐ No
1.10	**The responsible officer makes timely recommendations to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and the GMC Responsible Officer Protocol.** To answer 'Yes': • The designated body's board report contains explanations for all missed and late recommendations, and reasons for deferral submissions.	☑ Yes ☐ No
1.11	**The governance systems (including clinical governance where appropriate) are subject to external or independent review.** Most designated bodies will be subject to external or independent review by a regulator. Designated bodies which are healthcare providers are subject to review by the national healthcare regulators (the Care Quality Commission, the Human Fertilisation and Embryology Authority or Monitor, now part of NHS Improvement). Where designated bodies will not be regulated or overseen by an external regulator (for example locum agencies and organisations which are not healthcare providers), an alternative external or independent review process should be agreed with the higher level responsible officer.	☑ Yes ☐ No

1.12	**The designated body has commissioned or undertaken an independent review* of its processes relating to appraisal and revalidation.** **(*including peer review, internal audit or an externally commissioned assessment)**	☑ Yes ☐ No

4 Section 2 – Appraisal

Section 2	Appraisal						
2.1	IMPORTANT: Only doctors with whom the designated body has a prescribed connection at 31 March 2018 should be included. Where the answer is 'nil' please enter '0'. **See guidance notes on pages 16-18 for assistance completing this table**		1a	1b	2	3	
		Number of Prescribed Connections	Completed Appraisal (1a)	Completed Appraisal (1b)	Approved incomplete or missed appraisal (2)	Unapproved incomplete or missed appraisal (3)	Total
2.1.1	**Consultants** (permanent employed consultant medical staff including honorary contract holders, NHS, hospices, and government /other public body staff. Academics with honorary clinical contracts will usually have their responsible officer in the NHS trust where they perform their clinical work).	440	230	185	24	1	440
2.1.2	**Staff grade, associate specialist, specialty doctor** (permanent employed staff including hospital practitioners, clinical assistants who do not have a prescribed connection elsewhere, NHS, hospices, and government/other public body staff).	41	21	13	7	0	41
2.1.3	**Doctors on Performers Lists** (for NHS England and the Armed Forces only; doctors on a medical or ophthalmic performers list. This includes all general practitioners (GPs) including principals, salaried and locum GPs).	0	0	0	0	0	0
2.1.4	**Doctors with practising privileges** (this is usually for independent healthcare providers, however practising privileges may also rarely be awarded by NHS organisations. All doctors with practising privileges who have a prescribed connection should be included in this section, irrespective of their grade).	0	0	0	0	0	0
2.1.5	**Temporary or short-term contract holders** (temporary employed staff including locums who are directly employed, trust doctors, locums for service, clinical research fellows, trainees not on national training schemes, doctors with fixed-term employment contracts, etc).	216	123	69	24	0	216
2.1.6	**Other doctors with a prescribed connection to this designated body** (depending on the type of designated body, this category may include responsible officers, locum doctors, and members of the faculties/professional bodies. It may also include some non-clinical management/leadership roles, research, civil service, doctors in wholly independent practice, other employed or contracted doctors not falling into the above categories, etc).	0	0	0	0	0	0
2.1.7	**TOTAL** (this cell will sum automatically 2.1.1 – 2.1.6).	697	374	267	55	1	697

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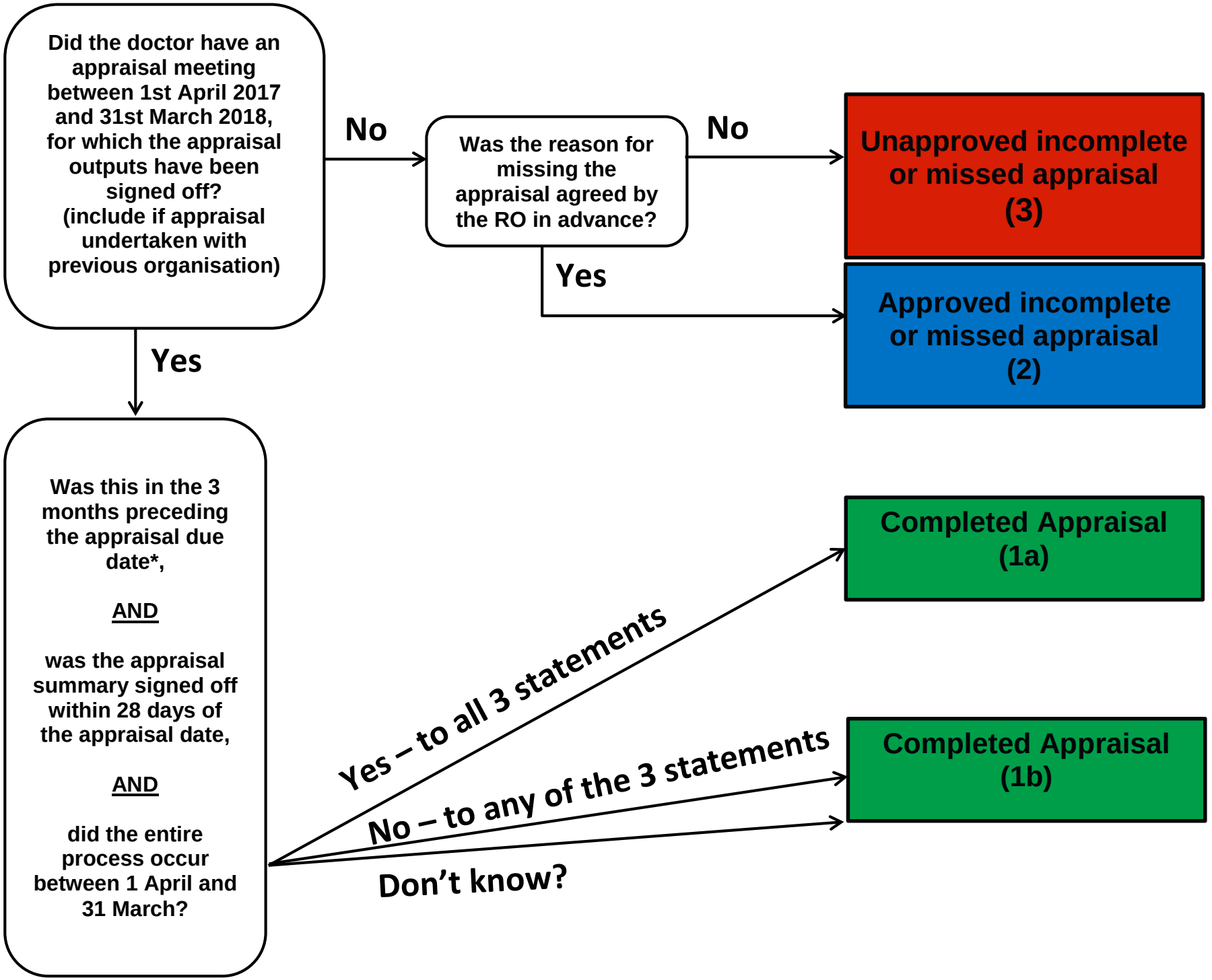
Did the doctor have an appraisal meeting between 1st April 2017 and 31st March 2018, for which the appraisal outputs have been signed off? (include if appraisal undertaken with previous organisation)
No
Was the reason for missing the appraisal agreed by the RO in advance?
No
Unapproved incomplete or missed appraisal (3)
Yes
Approved incomplete or missed appraisal (2)
Yes
Was this in the 3 months preceding the appraisal due date*,
AND
was the appraisal summary signed off within 28 days of the appraisal date,
AND
did the entire process occur between 1 April and 31 March?
Yes – to all 3 statements
Completed Appraisal (1a)
No – to any of the 3 statements
Completed Appraisal (1b)
Don't know?

2.1	**Column - Number of Prescribed Connections:** **Number of doctors with whom the designated body has a prescribed connection as at 31 March 2018** The responsible officer should keep an accurate record of all doctors with whom the designated body has a prescribed connection and must be satisfied that the doctors have correctly identified their prescribed connection. Detailed advice on prescribed connections is contained in the responsible officer regulations and guidance and further advice can be obtained from the GMC and the higher level responsible officer. The categories of doctor relate to current roles and job titles rather than qualifications or previous roles. The number of individual doctors in each category should be entered in this column. Where a doctor has more than one role in the same designated body a decision should be made about which category they belong to, based on the amount of work they do in each role. Each doctor should be included in only one category. For a doctor who has recently completed training, if they have attained CCT, then they should be counted as a prescribed connection. If CCT has not yet been awarded, they should be counted as a prescribed connection within the LETB AOA return. **Column - Measure 1a Completed medical appraisal:** A *Category 1a completed annual medical appraisal* is one where the appraisal meeting has taken place in the three months preceding the agreed appraisal due date*, the outputs of appraisal have been agreed and signed-off by the appraiser and the doctor within 28 days of the appraisal meeting, and the entire process occurred between 1 April and 31 March. For doctors who have recently completed training, it should be noted that their final ACRP equates to an appraisal in this context. **Column - Measure 1b Completed medical appraisal:** A *Category 1b completed annual medical appraisal* is one in which the appraisal meeting took place in the appraisal year between 1 April and 31 March, and the outputs of appraisal have been agreed and signed-off by the appraiser and the doctor, but one or more of the following apply: - the appraisal did not take place in the window of three months preceding the appraisal due date; - the outputs of appraisal have been agreed and signed-off by the appraiser and the doctor between 1 April and 28 April of the following appraisal year; - the outputs of appraisal have been agreed and signed-off by the appraiser and the doctor more than 28 days after the appraisal meeting. However, in the judgement of the responsible officer the appraisal has been satisfactorily completed to the standard required to support an effective revalidation recommendation.	

	Where the organisational information systems of the designated body do not permit the parameters of a *Category 1a completed annual medical appraisal* to be confirmed with confidence, the appraisal should be counted as a *Category 1b completed annual medical appraisal*. **Column - Measure 2: Approved incomplete or missed appraisal:** An a*pproved incomplete or missed annual medical appraisal* is one where the appraisal has not been completed according to the parameters of either a *Category 1a or 1b completed annual medical appraisal*, but the responsible officer has given approval to the postponement or cancellation of the appraisal. The designated body must be able to produce documentation in support of the decision to approve the postponement or cancellation of the appraisal in order for it to be counted as an *Approved incomplete or missed annual medical appraisal*. **Column - Measure 3: Unapproved incomplete or missed appraisal:** An *Unapproved incomplete or missed annual medical appraisal* is one where the appraisal has not been completed according to the parameters of either a *Category 1a or 1b completed annual medical appraisal*, and the responsible officer has not given approval to the postponement or cancellation of the appraisal. Where the organisational information systems of the designated body do not retain documentation in support of a decision to approve the postponement or cancellation of an appraisal, the appraisal should be counted as an *Unapproved incomplete or missed annual medical appraisal*. **Column Total:** Total of columns 1a+1b+2+3. The total should be equal to that in the first column (Number of Prescribed Connections), the number of doctors with a prescribed connection to the designated body at 31 March 2018. * Appraisal due date: A doctor should have a set date by which their appraisal should normally take place every year (the 'appraisal due date'). The appraisal due date should remain the same each year unless changed by agreement with the doctor's responsible officer. Where a doctor does not have a clearly established appraisal due date, the next appraisal should take place by the last day of the twelfth month after the preceding appraisal. This should then by default become their appraisal due date from that point on. For a designated body which uses an 'appraisal month' for appraisal scheduling, a doctor's appraisal due date is the last day of their appraisal month. For more detail on setting a doctor's appraisal due date see the Medical Appraisal Logistics Handbook (NHS England 2015).	

2.2	**Every doctor with a prescribed connection to the designated body with a missed or incomplete medical appraisal has an explanation recorded** If all appraisals are in Categories 1a and/or 1b, please answer N/A. To answer Yes: • The responsible officer ensures accurate records are kept of all relevant actions and decisions relating to the= responsible officer role. • The designated body's annual report contains an audit of all missed or incomplete appraisals (approved and= unapproved) for the appraisal year 2017/18 including the explanations and agreed postponements. • Recommendations and improvements from the audit are enacted. Additional guidance: A missed or incomplete appraisal, whether approved or unapproved, is an important occurrence which could indicate a problem with the designated body's appraisal system or non-engagement with appraisal by an individual doctor which will need to be followed up. Measure 2: Approved incomplete or missed appraisal: An a*pproved incomplete or missed annual medical appraisal* is one where the appraisal has not been completed according to the parameters of either a *Category 1a or 1b completed annual medical appraisal*, but the responsible officer has given approval to the postponement or cancellation of the appraisal. The designated body must be able to produce documentation in support of the decision to approve the postponement or cancellation of the appraisal in order for it to be counted as an *Approved incomplete or missed annual medical appraisal*. Measure 3: Unapproved incomplete or missed appraisal: An *Unapproved incomplete or missed annual medical appraisal* is one where the appraisal has not been completed according to the parameters of either a *Category 1a or 1b completed annual medical appraisal*, and the responsible officer has not given approval to the postponement or cancellation of the appraisal. Where the organisational information systems of the designated body do not retain documentation in support of a decision to approve the postponement or cancellation of an appraisal, the appraisal should be counted as an *Unapproved incomplete or missed annual medical appraisal*.	☑ Yes ☐ No ☐ N/A

2.3	**There is a medical appraisal policy, with core content which is compliant with national guidance, that has been ratified by the designated body's board (or an equivalent governance or executive group)** To answer 'Yes': • The policy is compliant with national guidance, such as *Good Medical Practice Framework for Appraisal and Revalidation* (GMC, 2013), *Supporting Information for Appraisal and Revalidation* (GMC, 2012), *Medical Appraisal Guide* (NHS Revalidation Support Team, 2014), *The Role of the Responsible Officer: Closing the Gap in Medical Regulation, Responsible Officer Guidance* (Department of Health, 2010), *Quality Assurance of Medical Appraisers* (NHS Revalidation Support Team, 2014). • The policy has been ratified by the designated body's board or an equivalent governance or executive group.	☑ Yes ☐ No
2.4	**There is a mechanism for quality assuring an appropriate sample of the inputs and outputs of the medical appraisal process to ensure that they comply with GMC requirements and other national guidance, and the outcomes are recorded in the annual report template.** To answer 'Yes': • The appraisal inputs comply with the requirements in *Supporting Information for Appraisal and Revalidation* (GMC, 2012) and *Good Medical Practice Framework for Appraisal and Revalidation* (GMC, 2013), which are: o Personal information. o Scope and nature of work. o Supporting information: 1. Continuing professional development, 2. Quality improvement activity, 3. Significant events, 4. Feedback from colleagues, 5. Feedback from patients, 6. Review of complaints and compliments. o Review of last year's PDP. o Achievements, challenges and aspirations. • The appraisal outputs comply with the requirements in the *Medical Appraisal Guide* (NHS Revalidation Support Team, 2014) which are: o Summary of appraisal, o Appraiser's statement, o Post-appraisal sign-off by doctor and appraiser.	☑ Yes ☐ No

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	Additional guidance: Quality assurance is an integral part of the role of the responsible officer. The standards for the inputs and outputs of appraisal are detailed in *Supporting Information for Appraisal and Revalidation* (GMC, 2012), *Good Medical Practice Framework for Appraisal and Revalidation* (GMC, 2013) and the *Medical Appraisal Guide* (NHS Revalidation Support Team, 2014) and the responsible officer must be assured that these standards are being met consistently. The methodology for quality assurance should be outlined in the designated body's appraisal policy and include a sampling process. Quality assurance activities can be undertaken by those acting on behalf of the responsible officer with appropriate delegated authority.	
2.5	**There is a process in place for the responsible officer to ensure that key items of information (such as specific complaints, significant events and outlying clinical outcomes) are included in the appraisal portfolio and discussed at the appraisal meeting, so that development needs are identified.** To answer 'Yes': • There is a written description within the appraisal policy of the process for ensuring that key items of supporting information are included in the doctor's portfolio and discussed at appraisal. • There is a process in place to ensure that where a request has been made by the responsible officer to include a key item of supporting information in the appraisal portfolio, the appraisal portfolio and summary are checked after completion to ensure this has happened. Additional guidance: It is important that issues and concerns about performance or conduct are addressed at the time they arise. The appraisal meeting is not usually the most appropriate setting for dealing with concerns and in most cases these are dealt with outside the appraisal process in a clinical governance setting. Learning by individuals from such events is an important part of resolving concerns and the appraisal meeting is usually the most appropriate setting to ensure this is planned and prioritised. In a small proportion of cases, the responsible officer may therefore wish to ensure certain key items of supporting information are included in the doctor's portfolio and discussed at appraisal so that development needs are identified and addressed. In these circumstances the responsible officer may require the doctor to include certain key items of supporting information in the portfolio for discussion at appraisal and may need to check in the appraisal summary that the discussion has taken place. The method of sharing key items of supporting information should be described in the appraisal policy. It is important that information is shared in compliance with principles of information governance and security. For further detail, see *Information Management for Revalidation in England* (NHS Revalidation Support Team, 2014).	☑ Yes ☐ No

2.6	**The responsible officer ensures that the designated body has access to sufficient numbers of trained appraisers to carry out annual medical appraisals for all doctors with whom it has a prescribed connection** To answer 'Yes': The responsible officer ensures that: • Medical appraisers are recruited and selected in accordance with national guidance. • In the opinion of the responsible officer, the number of appropriately trained medical appraisers to doctors being appraised is between 1:5 and 1:20. • In the opinion of the responsible officer, the number of trained appraisers is sufficient for the needs of the designated body. Additional guidance: It is important that the designated body's appraiser workforce is sufficient to provide the number of appraisals needed each year. This assessment may depend on total number of doctors who have a prescribed connection, geographical spread, speciality spread, conflicts of interest and other factors. Depending on the needs of the designated body, doctors from a variety of backgrounds should be considered for the role of appraiser. This includes locums and salaried general practitioners in primary care settings and staff and associate specialist doctors in secondary care settings. An appropriate specialty mix is important though it is not possible for every doctor to have an appraiser from the same specialty. Appraisers should participate in an initial training programme before starting to perform appraisals. The training for medical appraisers should include: • Core appraisal skills and skills required to promote quality improvement and the professional development of the doctor • Skills relating to medical appraisal for revalidation and a clear understanding of how to apply professional judgement in appraisal • Skills that enable the doctor to be an effective appraiser in the setting within which they work, including both local context and any specialty specific elements. Further guidance on the recruitment and training of medical appraisers is available; see *Quality Assurance of Medical Appraisers* (NHS Revalidation Support Team, 2014).	☑ Yes ☐ No

2.7	**Medical appraisers are supported in their role to calibrate and quality assure their appraisal practice.** To answer 'Yes': The responsible officer ensures that: • Medical appraisers have completed a suitable training programme, with core content compliant with national guidance (Quality Assurance of Medical Appraisers), including equality and diversity and information governance, before starting to perform appraisals. • All appraisers have access to medical leadership and support. • There is a system in place to obtain feedback on the appraisal process from doctors being appraised. • Medical appraisers participate in ongoing performance review and training/development activities, to include peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers). Additional guidance: Further guidance on the support for medical appraisers is available in *Quality Assurance of Medical Appraisers* (NHS Revalidation Support Team, 2014).	☑ Yes ☐ No

5 Section 3 – Monitoring Performance and Responding to Concerns

Section 3	Monitoring Performance and Responding to Concerns	
3.1	**There is a system for monitoring the fitness to practise of doctors with whom the designated body has a prescribed connection**. To answer 'Yes': • Relevant information (including clinical outcomes, reports of external reviews of service for example Royal College reviews, governance reviews, Care Quality Commission reports, etc.) is collected to monitor the doctor's fitness to practise and is shared with the doctor for their portfolio. • Relevant information is shared with other organisations in which a doctor works, where necessary. • There is a system for linking complaints, significant events/clinical incidents/SUIs to individual doctors. • Where a doctor is subject to conditions imposed by, or undertakings agreed with the GMC, the responsible officer monitors compliance with those conditions or undertakings. • The responsible officer identifies any issues arising from this information, such as variations in individual performance, and ensures that the designated body takes steps to address such issues. • The quality of the data used to monitor individuals and teams is reviewed. • Advice is taken from GMC employer liaison advisers, National Clinical Assessment Service, local expert resources, specialty and Royal College advisers where appropriate. Additional guidance: Where detailed information can be collected which relates to the practice of an individual doctor, it is important to include it in the annual appraisal process. In many situations, due to the nature of the doctor's work, the collection of detailed information which relates directly to the practice of an individual doctor may not be possible. In these situations, team-based or service-level information should be monitored. The types of information available will be dependent on the setting and the role of the doctor and will include clinical outcome data, audit, complaints, significant events and patient safety issues. An explanation should be sought where an indication of outlying	☑ Yes ☐ No

	quality or practice is discovered. The information/data used for this purpose should be kept under review so that the most appropriate information is collected and the quality of the data (for example, coding accuracy) is improved. In primary care settings this type of information is not always routinely collected from general practitioners or practices and new arrangements may need to be put in place to ensure the responsible officer receives relevant fitness to practise information. In order to monitor the conduct and fitness to practise of trainees, arrangements will need to be agreed between the local education and training board and the trainee's clinical attachments to ensure relevant information is available in both settings.	
3.2	**The responsible officer ensures that a responding to concerns policy is in place (which includes arrangements for investigation and intervention for capability, conduct, health, and fitness to practise concerns) which is ratified by the designated body's board (or an equivalent governance or executive group)**. To answer 'Yes': • A policy for responding to concerns, which complies with the responsible officer regulations, has been ratified by the designated body's board (or an equivalent governance or executive group). Additional guidance: It is the responsibility of the responsible officer to respond appropriately when unacceptable variation in individual practice is identified or when concerns exist about the fitness to practise of doctors with whom the designated body has a prescribed connection. The designated body should establish a procedure for initiating and managing investigations. National guidance is available in the following key documents: • *Supporting Doctors to Provide Safer Healthcare: Responding to Concerns about a Doctor's Practice* (NHS Revalidation Support Team, 2013). • *Maintaining High Professional Standards in the Modern NHS* (Department of Health, 2003). • The National Health Service (Performers Lists) (England) Regulations 2013. • *How to Conduct a Local Performance Investigation* (National Clinical Assessment Service, 2010). The responsible officer regulations outline the following responsibilities: • Ensuring that there are formal procedures in place for colleagues to raise concerns. • Ensuring there is a process established for initiating and managing investigations of capability, conduct,	☑ Yes ☐ No

	health and fitness to practise concerns which complies with national guidance, such as *How to conduct a local performance investigation* (National Clinical Assessment Service, 2010).
	• Ensuring investigators are appropriately qualified.
	• Ensuring that there is an agreed mechanism for assessing the level of concern that takes into account the risk to patients.
	• Ensuring all relevant information is taken into account and that factors relating to capability, conduct, health and fitness to practise are considered.
	• Ensuring that there is a mechanism to seek advice from expert resources, including: GMC employer liaison advisers, the National Clinical Assessment Service, specialty and royal college advisers, regional networks, legal advisers, human resources staff and occupational health.
	• Taking any steps necessary to protect patients.
	• Where appropriate, referring a doctor to the GMC.
	• Where necessary, making a recommendation to the designated body that the doctor should be suspended or have conditions or restrictions placed on their practice.
	• Sharing relevant information relating to a doctor's fitness to practise with other parties, in particular the new responsible officer should the doctor change their prescribed connection.
	• Ensuring that a doctor who is subject to these procedures is kept informed about progress and that the doctor's comments are taken into account where appropriate.
	• Appropriate records are maintained by the responsible officer of all fitness to practise information
	• Ensuring that appropriate measures are taken to address concerns, including but not limited to:
	  • Requiring the doctor to undergo training or retraining,
	  • Offering rehabilitation services,
	  • Providing opportunities to increase the doctor's work experience,
	  • Addressing any systemic issues within the designated body which may contribute to the concerns identified.
	• Ensuring that any necessary further monitoring of the doctor's conduct, performance or fitness to practise is carried out.	

3.3	**The board (or an equivalent governance or executive group) receives an annual report detailing the number and type of concerns and their outcome.**	☑ Yes ☐ No

3.4	**The designated body has arrangements in place to access sufficient trained case investigators and case managers.** To answer 'Yes': The responsible officer ensures that: • Case investigators and case managers are recruited and selected in accordance with national guidance *Supporting Doctors to Provide Safer Healthcare, Responding to concerns about a Doctor's Practice* (NHS Revalidation Support Team, 2013). • Case investigators and case managers have completed a suitable training programme, with essential core content (see guidance documents above). • Personnel involved in responding to concerns have sufficient time to undertake their responsibilities • Individuals (such as case investigators, case managers) and teams involved in responding to concerns participate in ongoing performance review and training/development activities, to include peer review and calibration (see guidance documents above). Additional guidance The standards for training for case investigators and case managers are contained in *Guidance for Recruiting for the Delivery of Case Investigator Training* (NHS Revalidation Support Team, 2014) and *Guidance for Recruiting for the Delivery of Case Manager Training* (NHS Revalidation Support Team, 2014). Case investigators or case managers may be within the designated body or commissioned externally.	☑ Yes ☐ No

6 Section 4 – Recruitment and Engagement

Section 4	Recruitment and Engagement	
4.1	**There is a process in place for obtaining relevant information when the designated body enters into a contract of employment or for the provision of services with doctors (including locums).** In situations where the doctor has moved to a new designated body without a contract of employment, or for the provision of services (for example, through membership of a faculty) the information needs to be available to the new responsible officer as soon as possible after the prescribed connection commences. This will usually involve a formal request for information from the previous responsible officer. Additional guidance The regulations give explicit responsibilities to the responsible officer when a designated body enters into a contract of employment or for the provision of services with a doctor. These responsibilities are to ensure the doctor is sufficiently qualified and experienced to carry out the role. All new doctors are covered under this duty even if the doctor's prescribed connection remains with another designated body. This applies to locum agency contracts and also to the granting of practising privileges by independent health providers. The prospective responsible officer must: • Ensure doctors have qualifications and experience appropriate to the work to be performed, • Ensure that appropriate references are obtained and checked, • Take any steps necessary to verify the identity of doctors, • Ensure that doctors have sufficient knowledge of the English language for the work to be performed, and • For NHS England regional teams, manage admission to the medical performers list in accordance with the regulations. It is also important that the following information is available: • GMC information: fitness to practise investigations, conditions or restrictions, revalidation due date, • Disclosure and Barring Service check (although delays may prevent these being available to the responsible officer before the starting date in every case), and	☑ Yes ☐ No

	• Gender and ethnicity data (to monitor fairness and equality; providing this information is not mandatory). It may be helpful to obtain a structured reference from the current responsible officer which complies with GMC guidance on writing references and includes relevant factual information relating to: • The doctor's competence, performance or conduct, • Appraisal dates in the current revalidation cycle, and, • Local fitness to practise investigations, local conditions or restrictions on the doctor's practice, unresolved fitness to practise concerns. See Good Medical Practice: Supplementary Guidance: Writing References (GMC, 2007) and paragraph 19 of Good Medical Practice (GMC, 2013) for further details. The responsible officer regulations and GMC guidance make it clear that there is an obligation to share information about a doctor when required to support the responsible officer's statutory duties, or to maintain patient safety. Guidance, published in August 2016, on the flow of information to support medical governance and responsible officer statutory function (2016) therefore aims to promote improvements to these processes: • setting out the common legitimate channels along which information about a doctor's medical practice should flow, describing the information that might apply and arrangements to support its smooth flow • providing useful toolkits and examples of good practice The guidance on information flows to support medical governance and responsible officer statutory functions can be accessed via the link below. https://www.england.nhs.uk/revalidation/ro/info-flows/	

7 Section 5 – Comments

Section 5	Comments	
5.1	We have one doctor being followed up under local policies with Medical Director and RO involvement (recorded as unapproved missed appraisal on AOA return.) We have seen an increase in 1b category returns this appraisal cycle due to appraisals being signed-off just outside of the 28 day period. We produce monthly reports which are sent to the Division Chiefs and routinely call doctors to expedite sign-off within the 28 day timeframe. There has been an increase in number of doctors with approved incomplete or missed appraisal. Doctors are asked to complete a formal postponement appraisal request; this is then reviewed and a new appraisal date agreed. There are a portion of doctors who were not able to hold their 2017-18 medical appraisal meeting by 31st March 2018 who have been given an extension until 31st May 2018; the vast majority of these have agreed meeting dates. The remainder approved missed appraisals are for maternity leave, sabbaticals or doctor start date after 31st December 2017. We are looking at new ways to recruit and incentivise appraisers. Unfortunately we have had a handful of appraisers step-down at the end of this cycle (2017-18) due to insufficient scope within their job plan, reduction in hours, retiring or leaving the Trust. Our goal is to achieve a 1:6 appraiser/appraisee ratio (current 1:8) We will be running new appraiser and top up training sessions in April 2018 and May 2018.	

8 Reference

Sources used in preparing this document

1. The Medical Profession (Responsible Officers) Regulations 2010 (Her Majesty's Stationery Office, 2013)
2. The Medical Profession (Responsible Officers) (Amendment) Regulations 2013 (Her Majesty's Stationery Office, 2013)
3. The Medical Act 1983 (Her Majesty's Stationery Office, 1983)
4. *Maintaining High Professional Standards in the Modern NHS* (Department of Health, 2003)
5. The National Health Service (Performers Lists) (England) Regulations 2013
6. *The Role of the Responsible Officer: Closing the Gap in Medical Regulation, Responsible Officer Guidance* (Department of Health, 2010)
7. *Revalidation: A Statement of Intent* (GMC and others, 2010)
8. *Good Medical Practice* (GMC, 2013)
9. *Good Medical Practice Framework for Appraisal and Revalidation* (GMC, 2013)
10. *Good Medical Practice: Supplementary Guidance - Writing References* (GMC, 2012)
11. *Guidance on Colleague and Patient Questionnaires* (GMC, 2012)
12. *Supporting Information for Appraisal and Revalidation* (GMC, 2012)
13. *Effective Governance to Support Medical Revalidation: A Handbook for Boards and Governing Bodies* (GMC, 2013)
14. The GMC protocol for making revalidation recommendations: Guidance for responsible officers and suitable persons (GMC, 2012, updated in 2014)
15. *The Medical Appraisal Guide* (NHS Revalidation Support Team, 2014)
16. *Quality Assurance of Medical Appraisers* (NHS Revalidation Support Team, 2014)
17. *Providing a Professional Appraisal* (NHS Revalidation Support Team, 2012)
18. *Information Management for Medical Revalidation in England* (NHS Revalidation Support Team, 2014)
19. *Supporting Doctors to Provide Safer Healthcare: Responding to Concerns about a Doctor's Practice* (NHS Revalidation Support Team, 2013)
20. *Guidance for Recruiting for the Delivery of Case Investigator Training* (NHS Revalidation Support Team, 2014)
21. *Guidance for Recruiting for the Delivery of Case Manager Training* (NHS Revalidation Support Team, 2014).
22. *Responsible Officer Conflict of Interest or Appearance of Bias: Request to Appoint and Alternative Responsible Officer* (NHS Revalidation Support Team, 2014).
23. *Appraisal in the Independent Health Sector* (British Medical Association and Independent Healthcare Advisory Services, 2012)
24. *Joint University and NHS Appraisal Scheme for Clinical Academic Staff* (Universities and Colleges Employers Association, 2002, updated in 2012)
25. *Preparing for the Introduction of Medical Revalidation: a Guide for Independent Sector Leaders in England* (GMC and Independent Healthcare Advisory Services, 2011, updated in 2012)

26. *How to Conduct a Local Performance Investigation (National Clinical Assessment Service, 2010)*
27. *Use of NHS Exclusion and Suspension from Work amongst Doctors and Dentists 2011/12 (National Clinical Assessment Service, 2012)*
28. *Return to Practice Guidance (Academy of Medical Royal Colleges, 2012)*
29. *Medical Appraisal Logistics Handbook (NHS England, 2015)*

A Framework of Quality Assurance for Responsible Officers and Revalidation

Annex E - Statement of Compliance

Statement of Compliance

Version number: 2.0

First published: 4 April 2014

Updated: 22 June 2015

Prepared by: Gary Cooper, Project Manager for Quality Assurance, NHS England

Classification: OFFICIAL

Publications Gateway Reference: 03432

NB: The National Health Service Commissioning Board was established on 1 October 2012 as an executive non-departmental public body. Since 1 April 2013, the NHS Commissioning Board has used the name NHS England for operational purposes.

Designated Body Statement of Compliance

The board / executive management team of **Brighton & Sussex University Hospitals NHS Trust** can confirm that

- an AOA has been submitted,
- the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013)
- and can confirm that:

1. A licensed medical practitioner with appropriate training and suitable capacity has been nominated or appointed as a responsible officer;

   Yes

2. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is maintained;

   Yes

3. There are sufficient numbers of trained appraisers to carry out annual medical appraisals for all licensed medical practitioners;

   Our current appraiser/appraisee ratio is 1:9. We are having a significant recruitment drive to reduce this to nearer 1:6.

4. Medical appraisers participate in ongoing performance review and training / development activities, to include peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[1] or equivalent);

   Yes

5. All licensed medical practitioners[2] either have an annual appraisal in keeping with GMC requirements (MAG or equivalent) or, where this does not occur, there is full understanding of the reasons why and suitable action taken;

   Yes

6. There are effective systems in place for monitoring the conduct and performance of all licensed medical practitioners[1] (which includes, but is not limited to, monitoring: in-house training, clinical outcomes data, significant events, complaints, and feedback from patients and colleagues) and ensuring that information about these matters is provided for doctors to include at their appraisal;

   Yes

7. There is a process established for responding to concerns about any licensed medical practitioners[1] fitness to practise;

[1] http://www.england.nhs.uk/revalidation/ro/app-syst/
[2] Doctors with a prescribed connection to the designated body on the date of reporting.

Yes

8. There is a process for obtaining and sharing information of note about any licensed medical practitioner's fitness to practise between this organisation's responsible officer and other responsible officers (or persons with appropriate governance responsibility) in other places where the licensed medical practitioner works;[3]

Yes

9. The appropriate pre-employment background checks (including pre-engagement for locums) are carried out to ensure that all licenced medical practitioners[4] have qualifications and experience appropriate to the work performed;

Yes

10. A development plan is in place that ensures continual improvement and addresses any identified weaknesses or gaps in compliance.

Yes

Signed on behalf of the designated body

Official name of designated body: **Brighton & Sussex University Hospitals NHS Trust**

Name:

Role:

Signed:

Date:

[3] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

Brighton and Sussex University Hospitals NHS Trust

To: Trust Board

Date of Meeting: 25th July 2018 Agenda Item: **14**

Title
Annual Review of Organ Donation at BSUH
Responsible Executive Director
Dr George Findlay, Chief Medical Officer
Prepared by
Renee van der Most, Consultant, ICU
Status
Public
Summary of Proposal
In terms of actions by Organ Donation Committee: 1) need for notifying SNOD now discussed on morning/evening Status sheet led board meetings on ICU 2) planning nurse led notification of SNODs to ensure earlier involvement of SNODs/reduce 'missed' notifications. Teaching and nurse support being prepared 3) new SNOD recently employed – training will take 6 months. Significant understaffing of SNODs currently (NHSBT addressing this issue).
Implications for Quality of Care
Few missed notification but little/no missed donation opportunity in clinical terms
Link to Strategic Objectives/Board Assurance Framework
Financial Implications
Funding changed in last year. Now £1000 for committee and then approx. £1160 per donor (number from previous financial year i.e. 15 in 2017/2018), paid in a single sum annually. Therefore £18468.23 for support of trust's organ donation work.
Human Resource Implications
Clinical Lead for Organ donation + 1.5 SNODs currently (+1 new trainee starting) –paid by NHS BT. ICU practice educators etc will be involved in supporting staff for new nurse led notification
Recommendation
The Board/Committee is asked to: NOTE the report
Communication and Consultation
Appendices

NHS
Blood and Transplant

Detailed Report

Actual and Potential Deceased Organ Donation

1 April 2017 - 31 March 2018

Brighton and Sussex University Hospitals NHS Trust

Table of Contents

Further Information

- Appendix A.1 contains definitions of terms and abbreviations used throughout this report and summarises the main changes made to the PDA over time.
- The latest Organ Donation and Transplantation Activity Report is available at https://www.organdonation.nhs.uk/supporting-my-decision/statistics-about-organ-donation/transplant-activity-report/
- The latest PDA Annual Report is available at http://www.odt.nhs.uk/statistics-and-reports/potential-donor-audit/
- Please refer any queries or requests for further information to your local Specialist Nurse - Organ Donation (SNOD)

Source

NHS Blood and Transplant: UK Transplant Registry (UKTR), Potential Donor Audit (PDA) and Referral Record.
Issued May 2018 based on data meeting PDA criteria reported at 9 May 2018.

1. Donor Outcomes

A summary of the number of donors, patients transplanted, average number of organs donated per donor and organs donated.

Data in this section is obtained from the UK Transplant Registry

Between 1 April 2017 and 31 March 2018, Brighton and Sussex University Hospitals NHS Trust had 15 deceased solid organ donors, resulting in 41 patients receiving a transplant. Additional information is shown in Tables 1.1 and 1.2, along with comparison data for 2016/17. Figure 1.1 shows the number of donors and patients transplanted for the previous ten periods for comparison.

Table 1.1 Donors, patients transplanted and organs per donor, 1 April 2017 - 31 March 2018 (1 April 2016 - 31 March 2017 for comparison)

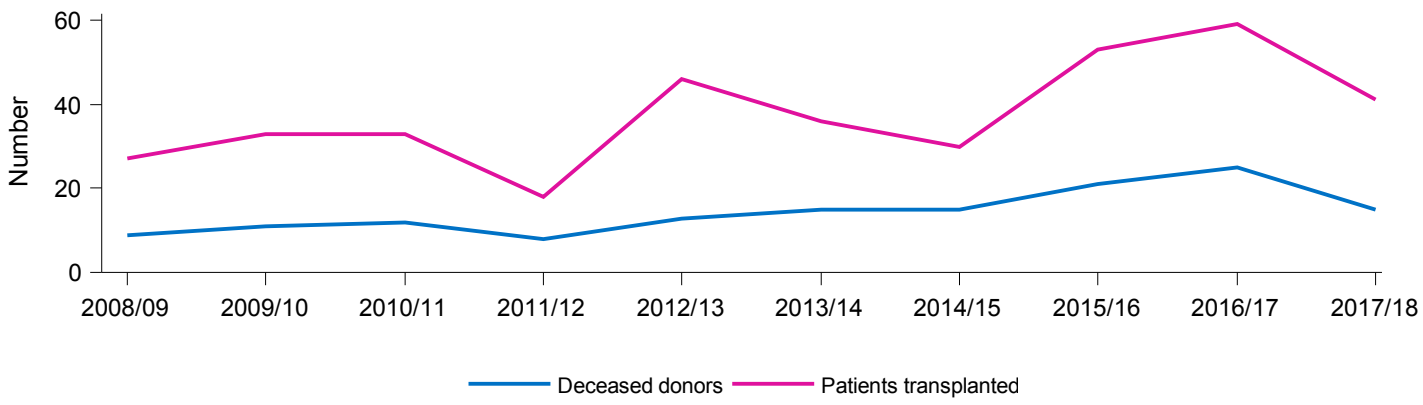
Donor type	Number of donors		Number of patients transplanted		Average number of organs donated per donor: Trust		Average number of organs donated per donor: UK	
DBD	11	(11)	32	(30)	3.9	(3.3)	3.7	(3.7)
DCD	4	(14)	9	(29)	2.3	(3.6)	2.8	(2.7)
DBD and DCD	15	(25)	41	(59)	3.5	(3.5)	3.3	(3.3)

In addition to the 15 proceeding donors there were 7 additional consented donors that did not proceed, 3 where DBD organ donation was being facilitated and 4 where DCD organ donation was being facilitated.

Table 1.2 Organs transplanted by type, 1 April 2017 - 31 March 2018 (1 April 2016 - 31 March 2017 for comparison)

Donor type	Number of organs transplanted by type: Kidney		Pancreas		Liver		Heart		Lung		Small bowel	
DBD	21	(20)	3	(0)	7	(8)	1	(0)	5	(4)	0	(0)
DCD	8	(22)	0	(1)	1	(6)	0	(2)	0	(4)	0	(0)
DBD and DCD	29	(42)	3	(1)	8	(14)	1	(2)	5	(8)	0	(0)

Figure 1.1 Number of donors and patients transplanted, 1 April 2008 - 31 March 2018



2. Key Rates in Potential for Organ Donation

A summary of the key rates on the potential for organ donation

Data in this section is obtained from the National Potential Donor Audit (PDA)

This section presents specific percentage measures of potential donation activity for Brighton and Sussex University Hospitals NHS Trust.

Performance in your Trust has been compared with UK performance in both Figure 2.1 and Table 2.1 using funnel plot boundaries and the Gold, Silver, Bronze, Amber, and Red (GoSBAR) colour scheme. When compared with UK performance, gold represents exceptional, silver represents good, bronze represents average, amber represents below average, and red represents poor performance. See Appendix A.3 for funnel plot ranges used.

It is acknowledged that the PDA does not capture all activity. In total there were 13 patients referred in 2017/18 who are not included in this section onwards because they were either over 80 years of age or did not die in a unit participating in the PDA. None of these are included in Section 1 because they did not become a solid organ donor.

Note that caution should be applied when interpreting percentages based on small numbers.

Goal: The agreed 2017/18 national targets for DBD and DCD consent rates are 73% and 67%, respectively.

Figure 2.1 Key rates on the potential for organ donation including UK comparison, 1 April 2017 - 31 March 2018

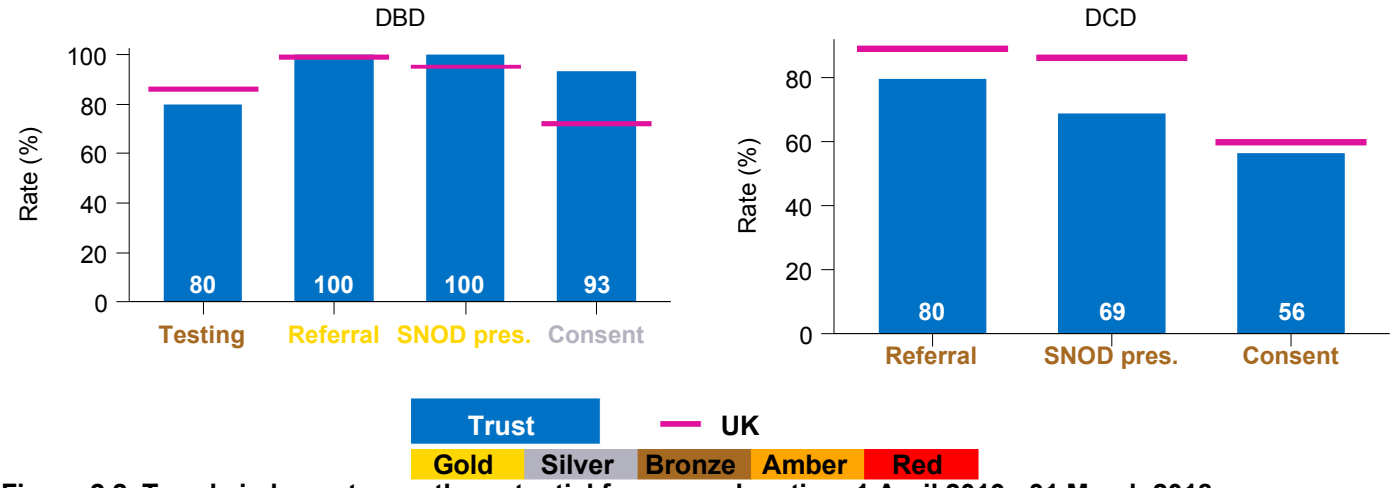


Figure 2.2 Trends in key rates on the potential for organ donation, 1 April 2013 - 31 March 2018

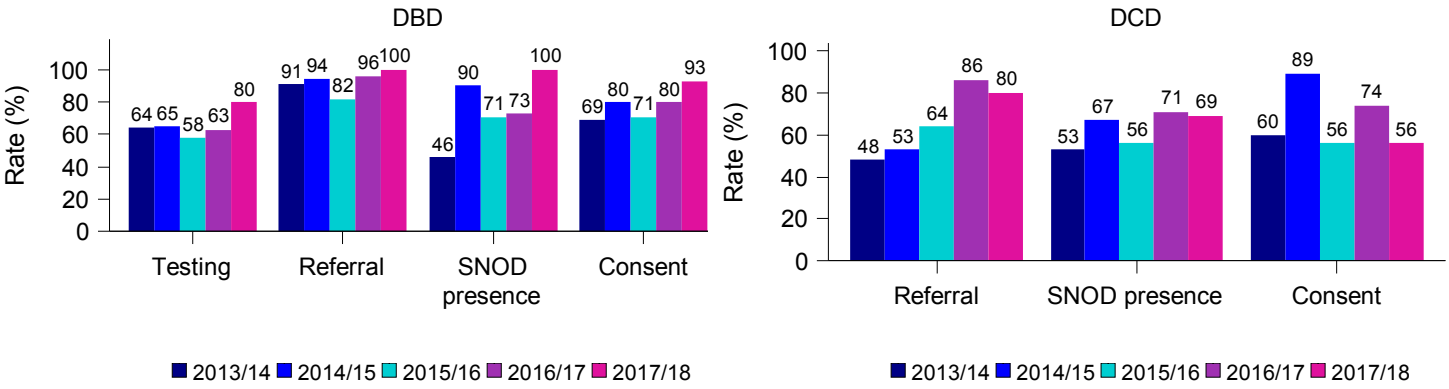


Table 2.1 Key numbers, rates and comparison with national rates, 1 April 2017 - 31 March 2018

	DBD		DCD		Deceased donors	
	Trust	UK	Trust	UK	Trust	UK
Patients meeting organ donation referral criteria[1]	25	1954	44	6281	65	7978
Referred to Organ Donation Service	25	1929	35	5615	56	7302
Referral rate %	G *100%*	*99%*	B *80%*	*89%*	B *86%*	*92%*
Neurological death tested	20	1676				
Testing rate %	B *80%*	*86%*				
Eligible donors[2]	20	1582	32	4456	52	6038
Family approached	15	1471	16	1858	31	3329
Family approached and SNOD present	15	1394	11	1591	26	2985
% of approaches where SNOD present	G *100%*	*95%*	B *69%*	*86%*	B *84%*	*90%*
Consent ascertained	14	1066	9	1115	23	2181
Consent rate %	S *93%*	*72%*	B *56%*	*60%*	B *74%*	*66%*
Actual donors (PDA data)	11	955	4	613	15	1568
% of consented donors that became actual donors	*79%*	*90%*	*44%*	*55%*	*65%*	*72%*

[1] DBD - A patient with suspected neurological death
DCD - A patient in whom imminent death is anticipated, ie a patient receiving assisted ventilation, a clinical decision to withdraw treatment has been made and death is anticipated within 4 hours

[2] DBD - Death confirmed by neurological tests and no absolute contraindications to solid organ donation
DCD - Imminent death anticipated and treatment withdrawn with no absolute contraindications to solid organ donation

Note that a patient that meets both the referral criteria for DBD and DCD organ donation is featured in both the DBD and DCD data but will only be counted once in the deceased donors total

Gold | Silver | Bronze | Amber | Red

3. Best quality of care in organ donation

Key stages in best quality of care in organ donation

Data in this section is obtained from the National Potential Donor Audit (PDA)

This section provides information on the quality of care in your Trust at the key stages of organ donation. The ambition is that your Trust misses no opportunity to make a transplant happen and that opportunities are maximised at every stage.

3.1 Neurological death testing

Goal: neurological death tests are performed wherever possible.

Figure 3.1 Number of patients with suspected neurological death, 1 April 2013 - 31 March 2018

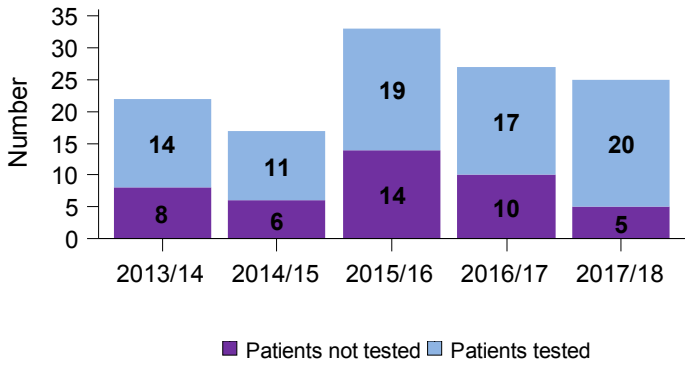


Table 3.1 Reasons given for neurological death tests not being performed, 1 April 2017 - 31 March 2018

	Trust	UK
Biochemical/endocrine abnormality	-	26
Clinical reason/Clinicians decision	2	64
Continuing effects of sedatives	-	17
Family declined donation	-	18
Family pressure not to test	-	21
Hypothermia	-	1
Inability to test all reflexes	1	12
Medical contraindication to donation	-	6
Other	-	18
Patient had previously expressed a wish not to donate	-	2
Patient haemodynamically unstable	2	69
Pressure on ICU beds	-	3
SN-OD advised that donor not suitable	-	9
Treatment withdrawn	-	9
Unknown	-	3
Total	**5**	**278**

If 'other', please contact your local SNOD or CLOD for more information, if required.

3.2 Referral to Organ Donation Service

Goal: Every patient who meets the referral criteria should be identified and referred to the Organ Donation Service, as per NICE CG135[1] and NHS Blood and Transplant (NHSBT) Best Practice Guidance on timely identification and referral of potential organ donors[2].

Aim: There should be no purple on the following charts.

Note that patients who met the referral criteria for both DBD and DCD donation will appear in both bar charts and both columns of the reasons table.

Figure 3.2 Number of patients meeting referral criteria, 1 April 2013 - 31 March 2018

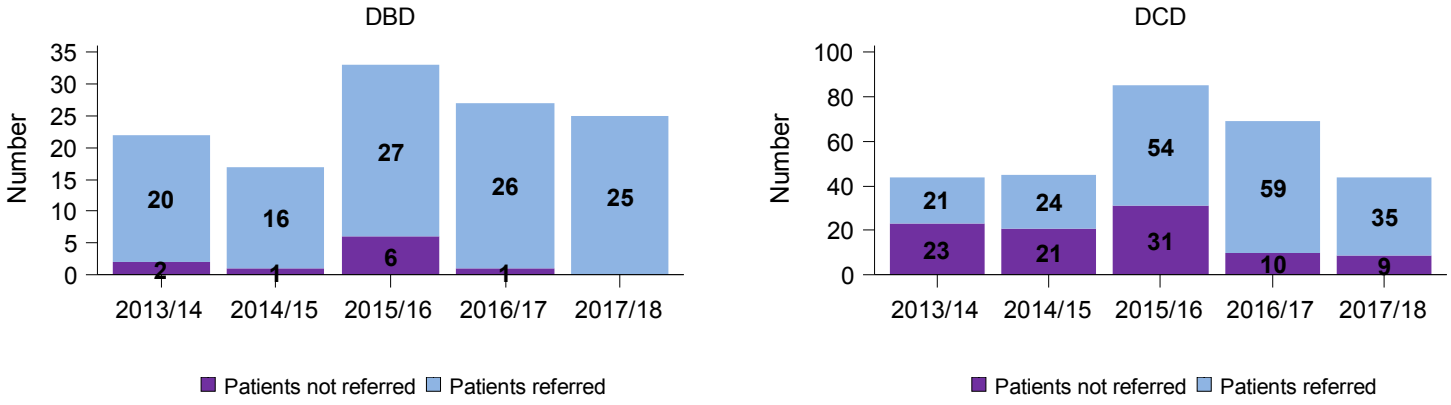


Table 3.2 Reasons given why patient not referred to SNOD, 1 April 2017 - 31 March 2018

	DBD		DCD	
	Trust	UK	Trust	UK
Clinician assessed that patient was unlikely to become asystolic within 4 hours	-	-	-	7
Coroner/Procurator Fiscal Reason	-	1	-	3
Family declined donation after neurological testing	-	2	-	-
Family declined donation following decision to withdraw treatment	-	-	1	24
Family declined donation prior to neurological testing	-	2	-	3
Medical contraindications	-	1	-	110
Neurological death not confirmed	-	1	-	-
Not identified as a potential donor/organ donation not considered	-	10	2	320
Other	-	5	1	76
Patient had previously expressed a wish not to donate	-	-	-	2
Pressure on ICU beds	-	-	-	7
Reluctance to approach family	-	2	-	8
Thought to be medically unsuitable	-	1	5	106
Total	**-**	**25**	**9**	**666**

If 'other', please contact your local SNOD or CLOD for more information, if required.

3.3 Contraindications

Table 3.3 shows the primary absolute medical contraindications to solid organ donation, if applicable, for potential DBD donors confirmed dead by neurological death tests and potential DCD donors in your Trust.

Table 3.3 Primary absolute medical contraindications to solid organ donation, 1 April 2017 - 31 March 2018

	DBD		DCD	
	Trust	**UK**	**Trust**	**UK**
Active (not in remission) haematological malignancy (myeloma, lymphoma, leukaemia)	-	15	-	212
All secondary intracerebral tumours	-	-	-	2
Any active cancer with evidence of spread outside affected organ within 3 years of donation	-	41	4	605
Choriocarcinoma	-	-	-	1
Definite, probable or possible case of human TSE, including CJD and vCJD	-	-	-	2
HIV disease (but not HIV infection)	-	2	-	14
Human TSE, CJD or vCJD; blood relatives with CJD; other infectious neurodegenerative diseases	-	-	-	6
Melanoma (except completely excised Stage 1 cancers)	-	4	-	9
No transplantable organ in accordance with organ specific contraindications	1	19	3	306
Other neurodegenerative diseases associated with infectious agents	-	-	-	1
Primary intra-cerebral lymphoma	-	-	-	3
TB: active and untreated	-	3	-	17
Total	**1**	**84**	**7**	**1178**

If 'other', please contact your local SNOD or CLOD for more information, if required.

3.4 SNOD presence

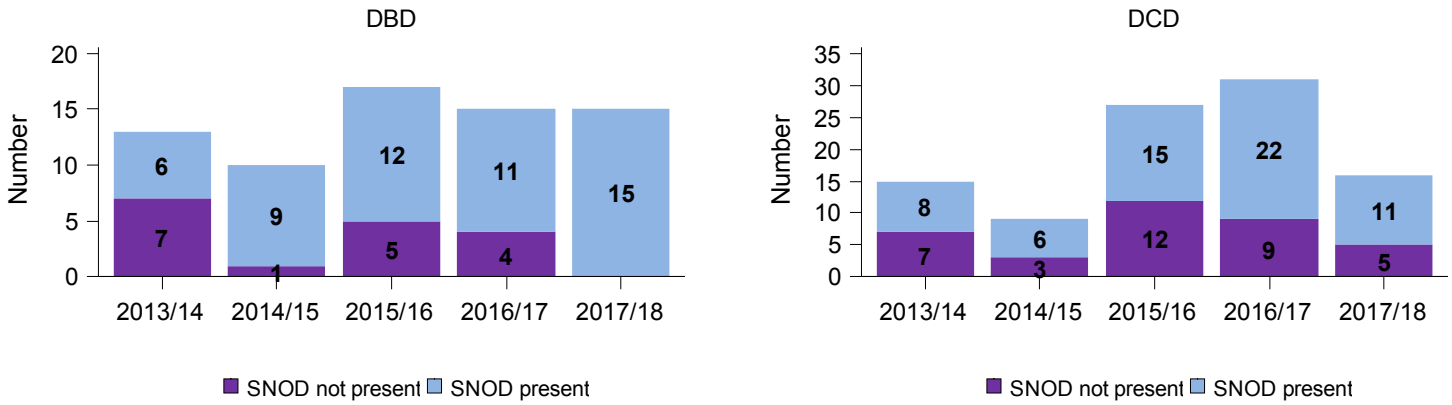
Goal: A SNOD should be present during the formal family approach as per NICE CG135[1] and NHS Blood and Transplant (NHSBT) Best Practice Guidance.[3]

Aim: There should be no purple on the following charts.

In the UK, in 2017/18, when a SNOD was not present for the approach to the family to discuss organ donation, DBD and DCD consent/authorisation rates were 36% and 18%, respectively, compared with DBD and DCD consent/authorisation rates of 74% and 67%, respectively, when a SNOD was present.

Every approach to those close to the patient should be planned with the multidisciplinary team (MDT), should involve the SNOD and should be clearly planned taking into account the known wishes of the patient. The NHS Organ Donor Register (ODR) should be checked in all cases of potential donation and this information must be discussed with the family as it represents the eligible donor's legal consent to donation.

Figure 3.3 Number of families approached by SNOD presence, 1 April 2013 - 31 March 2018



[1] NICE, 2011.
NICE Clinical Guidelines - CG135
[accessed 9 May 2018]

[2] NHS Blood and Transplant, 2012.
Timely Identification and Referral of Potential Organ Donors - A Strategy for Implementation of Best Practice
[accessed 9 May 2018]

[3] NHS Blood and Transplant, 2013.
Approaching the Families of Potential Organ Donors – Best Practice Guidance
[accessed 9 May 2018]

3.5 Consent

Goal: The agreed 2017/18 national targets for DBD and DCD consent/authorisation rates are 73% and 67%, respectively.

In 2017/18 the DBD and DCD consent rates in your Trust were 93% and 56%, respectively.

Figure 3.4 Number of families approached, 1 April 2013 - 31 March 2018

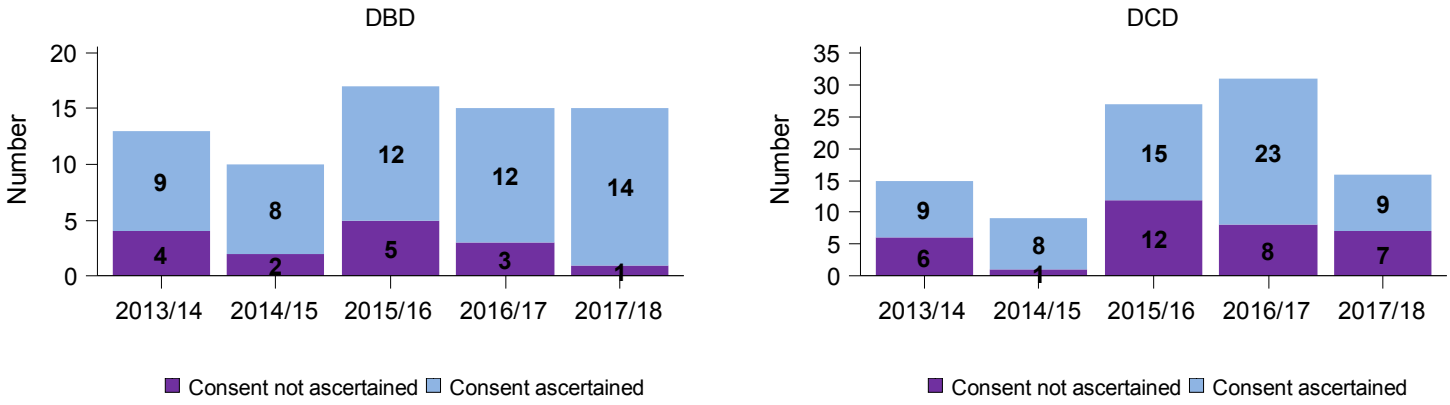


Table 3.4 Reasons given why consent was not ascertained, 1 April 2017 - 31 March 2018

	DBD		DCD	
	Trust	**UK**	**Trust**	**UK**
Families concerned about organ allocation	-	-	-	1
Family concerned donation may delay the funeral	-	2	-	1
Family concerned that organs may not be transplanted	-	2	-	11
Family did not believe in donation	-	13	-	29
Family did not want surgery to the body	-	52	-	72
Family felt it was against their religious/cultural beliefs	1	44	-	25
Family felt the body needs to be buried whole (unrelated to religious or cultural reasons)	-	39	1	24
Family felt the length of time for donation process was too long	-	23	1	128
Family felt the patient had suffered enough	-	15	2	57
Family had difficulty understanding/accepting neurological testing	-	3	-	-
Family wanted to stay with the patient after death	-	-	-	9
Family were divided over the decision	-	21	-	26
Family were not sure whether the patient would have agreed to donation	-	65	1	103
Other	-	24	1	79
Patient previously expressed a wish not to donate	-	91	1	162
Strong refusal - probing not appropriate	-	11	-	16
Total	**1**	**405**	**7**	**743**

If 'other', please contact your local SNOD or CLOD for more information, if required.

3.6 Solid organ donation

Goal: NHSBT is committed to supporting transplant units to ensure as many organs as possible are safely transplanted. The strategy for achieving this, including steps to minimising warm ischaemic injury in proceeding DCD donors, is set out in NHSBT Taking Organ Utilisation to 2020 [4].

Table 3.5 Reasons why solid organ donation did not occur, 1 April 2017 - 31 March 2018

	DBD		DCD	
	Trust	**UK**	**Trust**	**UK**
Cardiac Arrest	-	-	-	6
Coroner/Procurator Fiscal refusal	-	19	-	15
Family changed mind	-	4	-	25
Family placed conditions on donation	-	1	-	-
General instability	-	17	-	36
Logistic reasons	-	1	-	1
Organs deemed medically unsuitable by recipient centres	2	40	3	146
Organs deemed medically unsuitable on surgical inspection	1	17	-	8
Other	-	3	-	35
Positive virology	-	9	-	9
Prolonged time to asystole	-	-	2	221
Total	**3**	**111**	**5**	**502**

If 'other', please contact your local SNOD or CLOD for more information, if required.

[4] NHS Blood and Transplant, 2017.

Taking Organ Utilisation to 2020
[accessed 9 May 2018]

4. Comparative Data

A comparison of performance in your Trust/Board with national data

Data in this section is obtained from the National Potential Donor Audit (PDA)

This section compares the quality of care in the key areas of organ donation in your Trust with the UK rate using funnel plots. The UK rate is shown as a green dashed line and the funnel shape is formed by the 95% and 99.8% confidence limits around the UK rate. The confidence limits reflect the level of precision of the UK rate relative to the number of observations. Performance in your Trust is indicated by a black cross. The Gold, Silver, Bronze, Amber, and Red colour scheme is used to indicate whether performance in your Trust, when compared to UK performance, is exceptional (gold), good (silver), average (bronze), below average (amber) or poor (red).

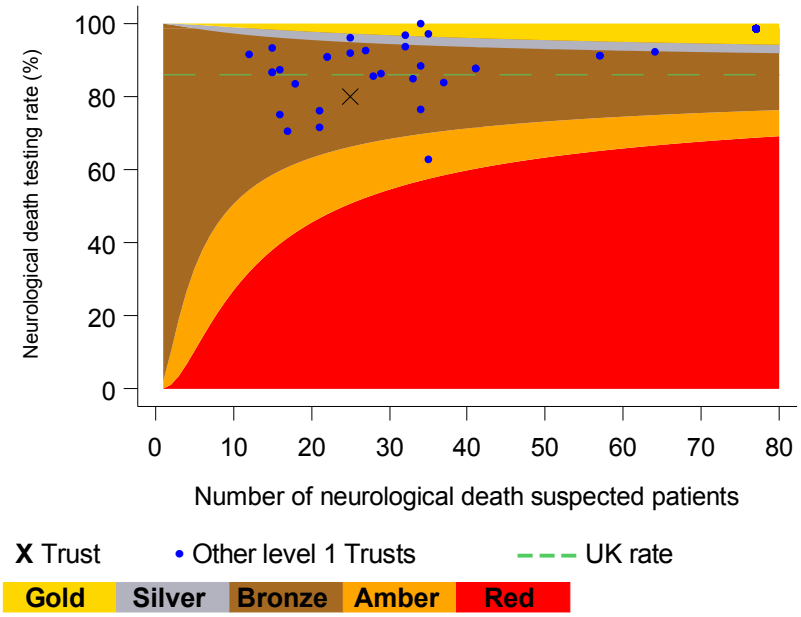
It is important to note that the differences in patient mix have not been accounted for in these plots. Further to these, separate funnel plots for DBD and DCD rates are presented in Section 7.

Note that caution should be applied when interpreting percentages calculated with numbers less than 10.

4.1 Neurological death testing

Goal: neurological death tests are performed wherever possible.

Figure 4.1 Funnel plot of neurological death testing rate, 1 April 2017 - 31 March 2018

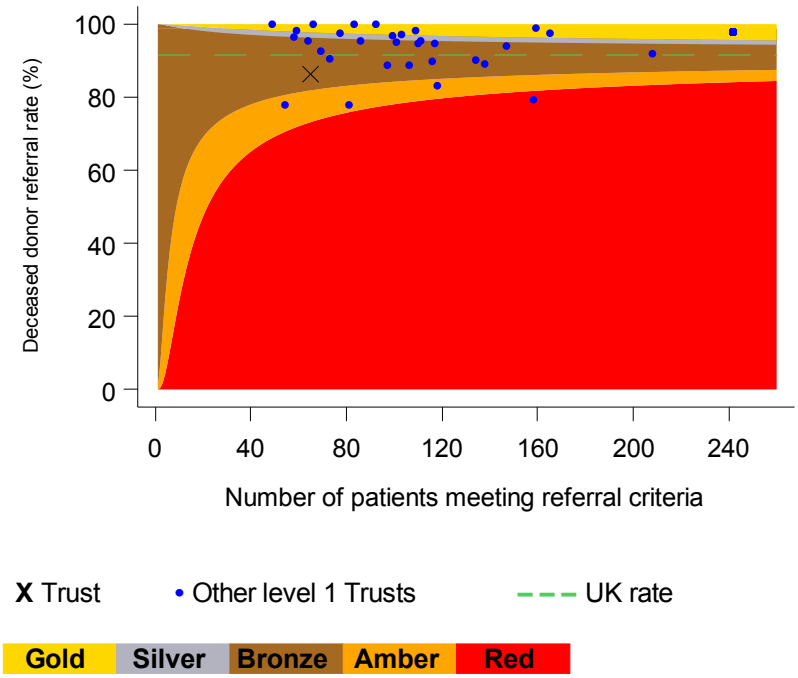


When compared with UK performance the neurological death testing rate in Brighton and Sussex University Hospitals NHS Trust was average (bronze).

4.2 Referral to Organ Donation Service

Goal: Every patient who meets the referral criteria should be identified and referred to NHSBT's Organ Donation Service, as per NICE CG135[1] and NHS Blood and Transplant (NHSBT) Best Practice Guidance on timely identification and referral of potential organ donors[2].

Figure 4.2 Funnel plot of deceased donor referral rate, 1 April 2017 - 31 March 2018

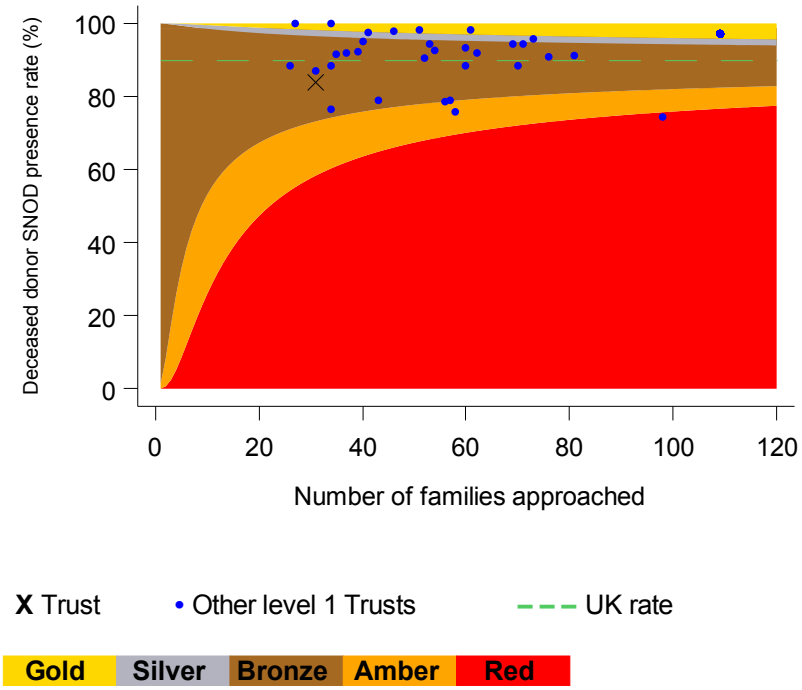


When compared with UK performance Brighton and Sussex University Hospitals NHS Trust was average (bronze) for referral of potential organ donors to NHS Blood and Transplant's Organ Donation Service.

4.3 SNOD presence

Goal: A SNOD should be present during the formal family approach as per NICE CG135[1] and NHS Blood and Transplant (NHSBT) Best Practice Guidance.[3]

Figure 4.3 Funnel plot of SNOD presence rate, 1 April 2017 - 31 March 2018

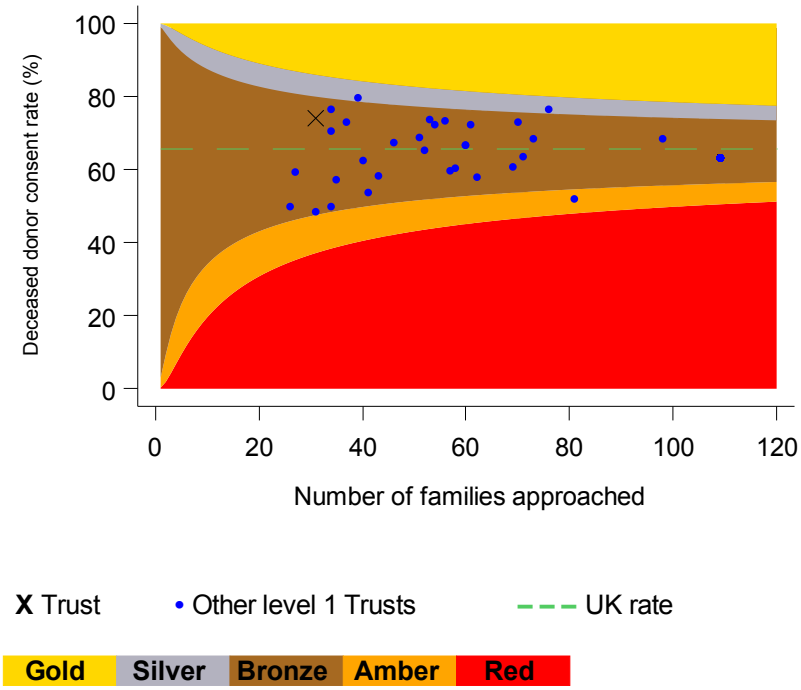


When compared with UK performance Brighton and Sussex University Hospitals NHS Trust was average (bronze) for Specialist Nurse presence when approaching families to discuss organ donation.

4.4 Consent

Goal: The agreed 2017/18 national targets for DBD and DCD consent/authorisation rates are 73% and 67%, respectively.

Figure 4.4 Funnel plot of consent rate, 1 April 2017 - 31 March 2018



When compared with UK performance the consent rate in Brighton and Sussex University Hospitals NHS Trust was average (bronze).

5. PDA data by hospital and unit

A summary of key numbers and rates from the PDA by hospital and unit where patient died

Data in this section is obtained from the National Potential Donor Audit (PDA)

Tables 5.1 and 5.2 show the key numbers and rates for patients who met the DBD and/or DCD referral criteria, respectively. Percentages have been excluded where numbers are less than 10.

Table 5.1 Patients who met the DBD referral criteria - key numbers and rates, 1 April 2017 - 31 March 2018

Unit where patient died	Patients where neurological death was suspected	Patients tested	Neurological death testing rate (%)	Patients referred	DBD referral rate (%)	Patients confirmed dead by neurological testing	Eligible DBD donors	Eligible DBD donors whose family were approached	Approaches where SNOD present	SNOD presence rate (%)	Consent ascertained	Consent rate (%)	Actual DBD and DCD donors from eligible DBD donors
Brighton, Royal Sussex County Hospital													
A&E	0	0	-	0	-	0	0	0	0	-	0	-	0
Cardio. ICU	0	0	-	0	-	0	0	0	0	-	0	-	0
Gen. ICU/HDU	23	18	78	23	100	18	18	13	13	100	12	92	10
Haywards Heath, Princess Royal Hospital													
A&E	0	0	-	0	-	0	0	0	0	-	0	-	0
Gen. ICU/HDU	2	2	-	2	-	2	2	2	2	-	2	-	1

Table 5.2 Patients who met the DCD referral criteria - key numbers and rates, 1 April 2017 - 31 March 2018

Unit where patient died	Patients for whom imminent death was anticipated	Patients referred	DCD referral rate (%)	Patients for whom treatment was withdrawn	Eligible DCD donors	Eligible DCD donors whose family were approached	Approaches where SNOD present	SNOD presence rate (%)	Consent ascertained	Consent rate (%)	Actual DCD donors from eligible DBD donors
Brighton, Royal Sussex County Hospital											
A&E	0	0	-	0	0	0	0	-	0	-	0
Cardio. ICU	0	0	-	0	0	0	0	-	0	-	0
Gen. ICU/HDU	39	31	79	34	27	15	10	67	8	53	4
Haywards Heath, Princess Royal Hospital											
A&E	0	0	-	0	0	0	0	-	0	-	0
Gen. ICU/HDU	5	4	-	5	5	1	1	-	1	-	0

Tables 5.1 and 5.2 show the unit where the patient died. However, it is acknowledged that there are some occasions where a patient is referred in an Emergency Department but moves to a critical care unit. In total for Brighton and Sussex University Hospitals NHS Trust in 2017/18 there were 6 such patients. For more information regarding the Emergency Department please see Section 6.

6. Emergency Department data

A summary of key numbers for Emergency Departments

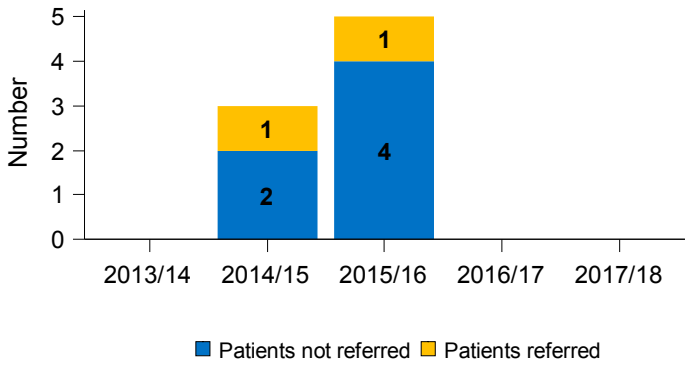
Data in this section is obtained from the National Potential Donor Audit (PDA)

Most patients who go on to become organ donors start their journey in the emergency department (ED). Deceased donation is important, not just for those people waiting on the transplant list, but also because many people in the UK have expressed a wish in life to become organ donors after their death. The overarching principle of the NHSBT Organ donation and Emergency Department strategy [5] is that best quality of care in organ donation should be followed irrespective of the location of the patient within the hospital at the time of death.

6.1 Referral to Organ Donation Service

Goal: No one dies in your ED meeting referral criteria and is not referred to NHSBT's Organ Donation Service.
Aim: There should be no blue on the following chart.

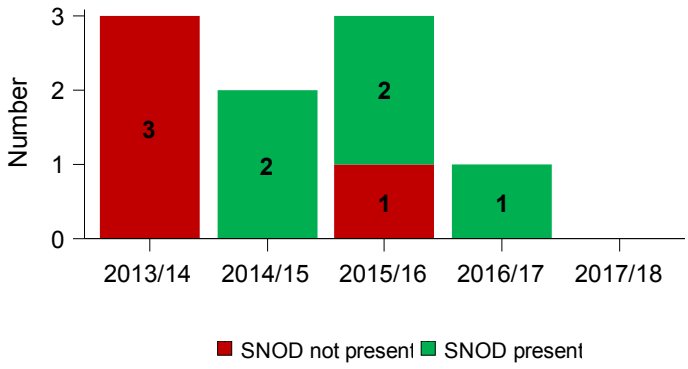
Figure 6.1 Number of patients meeting referral criteria that died in the ED, 1 April 2013 - 31 March 2018



6.2 Organ donation discussions

Goal: No family is approached in ED regarding organ donation without a SNOD present.
Aim: There should be no red on the following chart.

Figure 6.2 Number of families approached in ED by SNOD presence, 1 April 2013 - 31 March 2018



[5] NHS Blood and Transplant, 2016.

Organ Donation and the Emergency Department
[accessed 9 May 2018]

7. Additional data and figures

Regional donor, transplant, and transplant list numbers

Data in this section is obtained from the UK Transplant Registry

7.1 Supplementary Regional data

Table 7.1 Regional donors, transplants, waiting list, and NHS Organ Donor Register (ODR) data

	South East Coast*	UK
1 April 2017 - 31 March 2018		
Deceased donors	86	1,574
Transplants from deceased donors	224	4,012
Deaths on the transplant list	14	426
As at 31 March 2018		
Active transplant list	334	6,045
Number of NHS ODR opt-in registrations (% registered)**	1,993,087 (43%)	24,941,804 (38%)

*Regions have been defined as per former Strategic Health Authorities
** % registered based on population of 4.63 million, based on ONS 2011 census data

Key numbers and rates on the potential for organ donation

Data in this section is obtained from the National Potential Donor Audit (PDA)

7.2 Trust/Board Level Benchmarking

Brighton and Sussex University Hospitals NHS Trust has been categorised as a level 1 Trust. Levels were reallocated in July 2016 using the average number of donors in 2014/15 and 2015/16, Table 7.2 shows the criteria used and how many Trusts/Boards belong to each level.

Table 7.2 Trust/Board level categories

		Number of Trusts Boards in each level
Level 1	12 or more proceeding donors per year	33
Level 2	5-12 proceeding donors per year	45
Level 3	3-5 proceeding donors per year	47
Level 4	<3 proceeding donors per year	46

Tables 7.3 and 7.4 show the national DBD and DCD key numbers and rates for the UK by Trust/Board level, to aid in comparison with equivalent Trusts/Boards. Note that percentages have been excluded where numbers are less than 10.

Table 7.3 National DBD key numbers and rate by Trust/Board level, 1 April 2017 - 31 March 2018

	Patients where neurological death was suspected	Patients tested	Neurological death testing rate (%)	Patients referred	DBD referral rate (%)	Patients confirmed dead by neurological testing	Eligible DBD donors	Eligible DBD donors whose family were approached	Approaches where SNOD present	SNOD presence rate (%)	Consent ascertained	Consent rate (%)	Actual DBD and DCD donors from eligible DBD donors
Your Trust	25	20	80	25	100	20	20	15	15	100	14	93	11
Level 1	1012	893	88	1002	99	878	843	791	753	95	560	71	510
Level 2	416	352	85	413	99	341	328	302	283	94	220	73	192
Level 3	322	272	84	320	99	265	255	240	230	96	184	77	165
Level 4	204	159	78	194	95	157	156	138	128	93	102	74	88

Table 7.4 National DCD key numbers and rate by Trust/Board level, 1 April 2017 - 31 March 2018

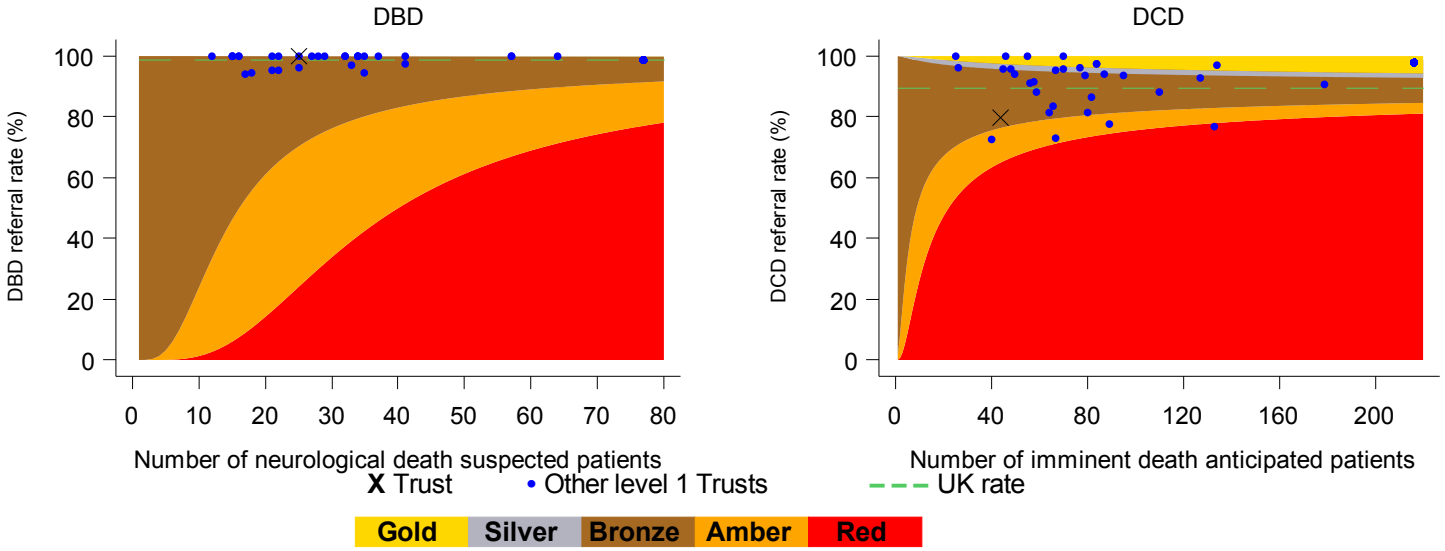
	Patients for whom imminent death was anticipated	Patients referred	DCD referral rate (%)	Patients for whom treatment was withdrawn	Eligible DCD donors	Eligible DCD donors whose family were approached	Approaches where SNOD present	SNOD presence rate (%)	Consent ascertained	Consent rate (%)	Actual DCD donors from eligible DBD donors
Your Trust	44	35	80	39	32	16	11	69	9	56	4
Level 1	2612	2372	91	2384	1906	978	841	86	596	61	349
Level 2	1510	1342	89	1355	1060	394	342	87	233	59	122
Level 3	1407	1253	89	1233	980	326	274	84	199	61	100
Level 4	752	648	86	668	510	160	134	84	87	54	42

7.3 Comparative data for DBD and DCD deceased donors

Funnel plots are presented in Section 4 showing performance in your Trust against the UK rate for deceased organ donation. The following funnel plots present data for DBD and DCD donors separately.

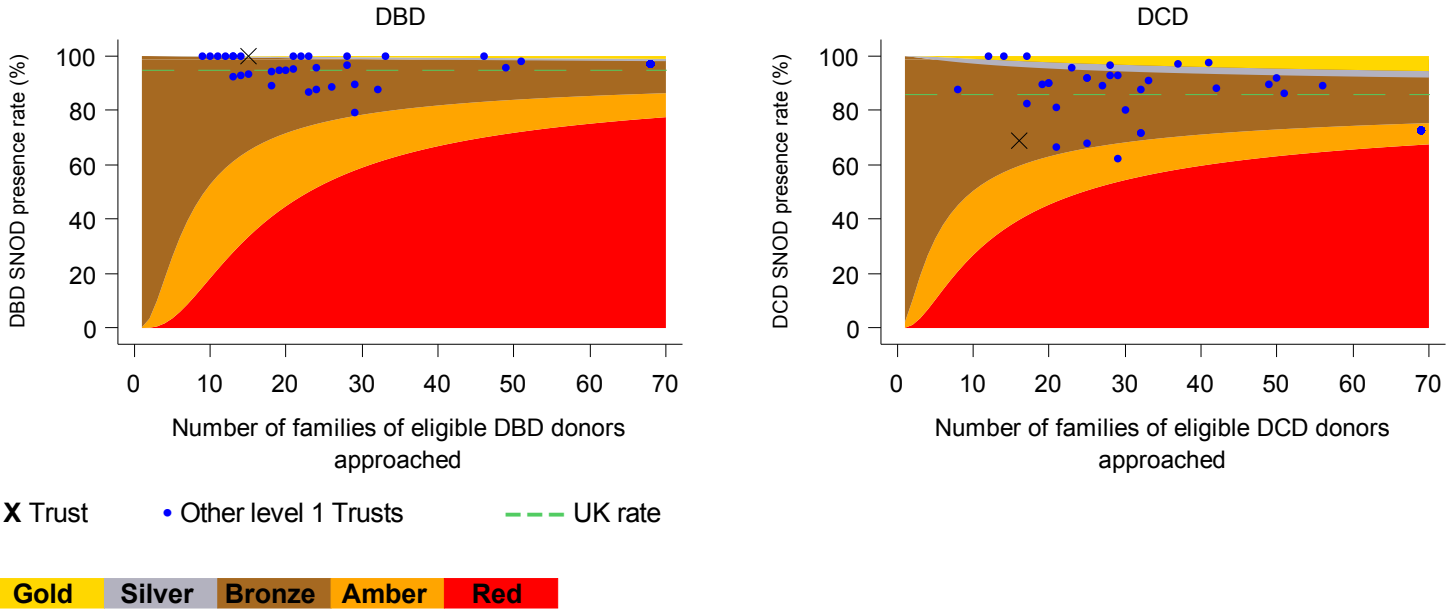
Note that caution should be applied when interpreting percentages calculated with numbers less than 10.

Figure 7.1 Funnel plots of referral rates, 1 April 2017 - 31 March 2018



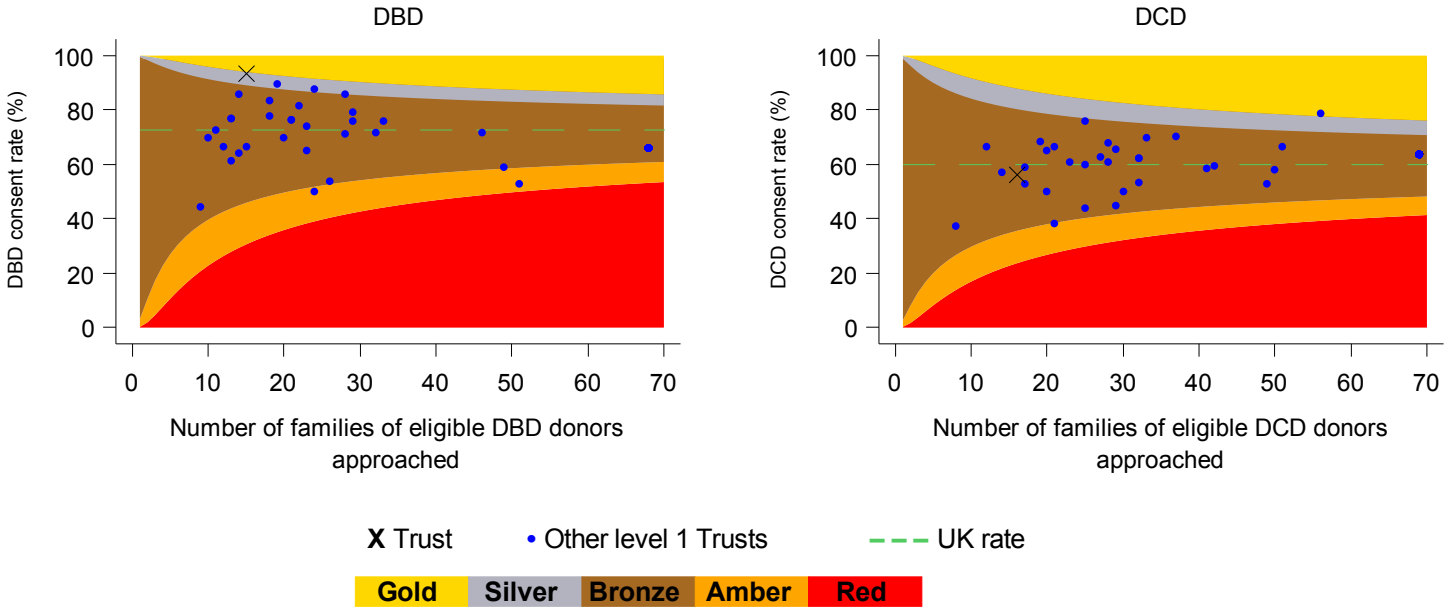
When compared with UK performance Brighton and Sussex University Hospitals NHS Trust was exceptional (gold) for referral of potential DBD organ donors and average (bronze) for referral of potential DCD organ donors to NHS Blood and Transplant's Organ Donation Service.

Figure 7.2 Funnel plots of SNOD presence rates, 1 April 2017 - 31 March 2018



When compared with UK performance Brighton and Sussex University Hospitals NHS Trust was exceptional (gold) and average (bronze) for Specialist Nurse presence in approaches to families of eligible DBD and DCD donors, respectively.

Figure 7.3 Funnel plots of consent rates, 1 April 2017 - 31 March 2018



When compared with UK performance the consent rate in Brighton and Sussex University Hospitals NHS Trust was good (silver) and average (bronze) for DBD and DCD donors, respectively.

Appendices

Appendix A.1 Definitions

Potential Donor Audit Definitions

Potential Donor Audit inclusion criteria	1 October 2009 – 31 March 2010 All deaths in critical care in patients aged 75 and under, excluding cardiothoracic intensive care units 1 April 2010 – 31 March 2013 All deaths in critical and emergency care in patients aged 75 and under, excluding cardiothoracic intensive care units 1 April 2013 onwards All deaths in critical and emergency care in patients aged 80 and under

Donors after brain death (DBD) definitions

Suspected Neurological Death	A patient who meets all of the following criteria: Apnoea, coma from known aetiology and unresponsive, ventilated, fixed pupils. Excluding those not tested due to reasons 'cardiac arrest despite resuscitation', 'brainstem reflexes returned', 'neonates – less than 2 months post term'.
Potential DBD donor	A patient who meets all four criteria for neurological death testing excluding those not tested due to reasons 'cardiac arrest despite resuscitation', 'brainstem reflexes returned', 'neonates – less than 2 months post term' (ie suspected neurological death, as defined above).
DBD referral criteria	A patient with suspected neurological death
Discussed with Specialist Nurse – Organ Donation	A patient with suspected neurological death discussed with the Specialist Nurse – Organ Donation (SNOD)
Neurological death tested	Neurological death tests were performed
Eligible DBD donor	A patient confirmed dead by neurological death tests, with no absolute medical contraindications to solid organ donation
Absolute contraindications	Absolute medical contraindications to organ donation are listed here: https://nhsbtdbe.blob.core.windows.net/umbraco-assets-corp/6455/contraindications_to_organ_donation.pdf
Family approached for formal organ donation discussion	Family of eligible DBD asked to support patient's expressed or deemed consent/authorisation, informed of a nominated/appointed representative, asked to make a decision on donation on behalf of their relative, or informed of a patient's opt-out decision via the ODR.
Consent/authorisation ascertained	Family supported expressed or deemed consent/authorisation , nominated/appointed representative gave consent, or where applicable family gave consent/authorisation
Actual donors: DBD	Neurological death confirmed patients who became actual DBD as reported through the PDA
Actual donors: DCD	Neurological death confirmed patients who became actual DCD as reported through the PDA
Neurological death testing rate	Percentage of patients for whom neurological death was suspected who were tested
Referral rate	Percentage of patients for whom neurological death was suspected who were discussed with the SNOD
Consent/authorisation rate	Percentage of families or nominated/appointed representatives approached for formal organ donation discussion where consent/authorisation was ascertained
SNOD presence rate	Percentage of formal organ donation discussions with families or nominated/appointed representatives where a SNOD was present
Consent/authorisation rate where SNOD was present	Percentage of formal organ donation discussions with families or nominated/appointed representatives where a SNOD was present where consent/authorisation was ascertained

Donors after circulatory death (DCD) definitions

Imminent death anticipated	A patient, not confirmed dead using neurological criteria, receiving assisted ventilation, a clinical decision to withdraw treatment has been made and death is anticipated within a time frame to allow donation to occur, as determined at time of assessment
DCD referral criteria	A patient in whom imminent death is anticipated (as defined above)
Discussed with Specialist Nurse – Organ Donation	Patients for whom imminent death was anticipated who were discussed with the SNOD
Potential DCD donor	A patient who had treatment withdrawn and death was anticipated within four hours
Eligible DCD donor	A patient who had treatment withdrawn and death was anticipated within four hours, with no absolute medical contraindications to solid organ donation
Absolute contraindications	Absolute medical contraindications to organ donation are listed here: https://nhsbtdbe.blob.core.windows.net/umbraco-assets-corp/6455/contraindications_to_organ_donation.pdf
Family approached for formal organ donation discussion	Family of eligible DCD asked to: support the patient's expressed or deemed consent/authorisation decision, informed of a nominated/appointed representative, make a decision themselves on donation, or informed of a patient's opt-out decision via the Organ Donor Register
Consent/authorisation rate	Percentage of families or nominated/appointed representatives approached for formal organ donation discussion where consent/authorisation was ascertained
SNOD presence rate	Percentage of formal organ donation discussions with families or nominated/appointed representatives where a SNOD was present
Consent/authorisation rate where SNOD was present	Percentage of formal organ donation discussions with families or nominated/appointed representatives where a SNOD was present where consent/authorisation was ascertained

UK Transplant Registry (UKTR) definitions

Donor type	Type of donor: Donation after brain death (DBD) or donation after circulatory death (DCD)
Number of actual donors	Total number of donors reported to the UKTR
Number of patients transplanted	Total number of patients transplanted from these donors
Organs per donor	Number of organs donated divided by the number of donors.
Number of organs transplanted	Total number of organs transplanted by organ type

Appendix A.2 Data Description

This report provides a summary of data relating to potential and actual organ donors as recorded by NHS Blood and Transplant via the Potential Donor Audit (PDA), the accompanying Referral Record, and the UK Transplant Registry (UKTR) for the specified Trust, Board, Organ Donation Services Team, or nation.

This report is provided for information and to facilitate case based discussion about organ donation by the Organ Donation Committee at your Trust/Board.

As part of the PDA, patients over 80 years of age and those who did not die on a critical care unit or emergency department are not audited nationally and are therefore excluded from the majority of this report. Data from neonatal intensive care units (ICU) have also been excluded from this report. In addition, some information may be outstanding due to late reporting and difficulties obtaining patient notes. Donations not captured by the PDA will still be included in the data supplied from the accompanying Referral Record or from the UKTR, as appropriate.

Percentages have not been calculated for level 3 or 4 Trust/Boards and where stated when numbers are less than 10.

Appendix A.3 Table and Figure Description

1 Donor outcomes	
Table 1.1	The number of actual donors, the resulting number of patients transplanted and the average number of organs donated per donor have been obtained from the UK Transplant Registry (UKTR) for your Trust/Board. Results have been displayed separately for donors after brain death (DBD) and donors after circulatory death (DCD).
Table 1.2	The number of organs transplanted by type from donors at your Trust/Board has been obtained from the UKTR. Further information can be obtained from your local Specialist Nurse – Organ Donation (SNOD), specifically regarding organs that were not transplanted. Results have been displayed separately for DBD and DCD.
Figure 1.1	The number of actual donors and the resulting number of patients transplanted obtained from the UKTR for your Trust/Board for the past 10 equivalent time periods are presented on a line chart.

2 Key rates in potential for organ donation	
Figure 2.1	Key percentage measures of DBD and DCD potential donation activity for your Trust/Board are presented in a bar chart, using data from the Potential Donor Audit (PDA). The comparative UK rate, for the same time period, is illustrated by the pink line. The key rates labels are coloured using the gold, silver, bronze, amber, and red (GoSBAR) colour scheme to show the performance of your Trust/Board, relative to the UK rate, as reflected in the funnel plots (see description for Figure 4.1 below.
Figure 2.2	Trends in the key percentage measures of DBD and DCD potential donation activity for your Trust/Board are presented for the past five equivalent time periods, using data from the PDA.
Table 2.1	A summary of DBD, DCD and deceased donor data and key numbers have been obtained from the PDA. A UK comparison is also provided. Note that caution should be applied when interpreting percentages based on small numbers. Appendix A.1 gives a fuller explanation of terms used. The key rates are highlighted using the gold, silver, bronze, amber, and red (GoSBAR) colour scheme to show the performance of your Trust/Board, relative to the UK rate, as reflected in the funnel plots (see description for Figure 4.1 below).

3 Best quality of care in organ donation	
Figure 3.1	A stacked bar chart displays the number of patients with suspected neurological death who were tested and the number who were not tested in your Trust/Board for the past five equivalent time periods.
Table 3.1	The reasons given for neurological death tests not being performed in your Trust/Board, have been obtained from the PDA, if applicable. A UK comparison is also provided.
Figure 3.2	Stacked bar charts display the number of DBD and DCD patients meeting referral criteria who were referred to the Organ Donation Service and the number who were not referred in your Trust/Board for the past five equivalent time periods.
Table 3.2	The reasons given for not referring patients to the Organ Donation Service in your Trust/Board, have been obtained from the PDA, if applicable. A UK comparison is also provided.
Table 3.3	The primary absolute medical contraindications to solid organ donation for DBD and DCD patients have been obtained from the PDA, if applicable. A UK comparison is also provided.
Figure 3.3	Stacked bar charts display the number of families of DBD and DCD patients approached where a SNOD was present and the number approached where a SNOD was not present in your Trust/Board for the past five equivalent time periods.
Figure 3.4	Stacked bar charts display the number of families of DBD and DCD patients approached where consent/authorisation for organ donation was ascertained and the number approached where consent/authorisation was not ascertained in your Trust/Board for the past five equivalent time periods.

Table 3.4	The reasons why consent/authorisation was not ascertained for solid organ donation in your Trust/Board, have been obtained from the PDA, if applicable. A UK comparison is also provided.
Table 3.5	The reasons why solid organ donation did not occur in your Trust/Board, have been obtained from the PDA, if applicable. A UK comparison is also provided.

4 Comparative data	
Figure 4.1	A funnel plot of the neurological death testing rate is displayed using data obtained from the PDA. Each Trust/Board, of the same level, is represented on the plot as a blue dot, although one dot may represent more than one Trust/Board. The UK rate is shown on the plot as a green horizontal dashed line, together with 95% and 99.8% confidence limits for this rate. These limits form a 'funnel', which is shaded using the gold, silver, bronze, amber, and red (GoSBAR) colour scheme. Graphs obtained in this way are known as funnel plots. If a Trust/Board lies within the 95% limits, shaded bronze, then that Trust/Board has a rate that is statistically consistent with the UK rate (average performance). If a Trust/Board lies outside the 95% confidence limits, shaded silver (good performance) or amber (below average performance), this serves as an alert that the Trust/Board may have a rate that is significantly different from the UK rate. When a Trust/Board lies above the upper 99.8% limit, shaded gold, this indicates a rate that is significantly higher than the UK rate (exceptional performance), while a Trust/Board that lies below the lower limit, shaded red, has a rate that is significantly lower than the UK rate (poor performance). It is important to note that differences in patient mix have not been accounted for in these plots. Your Trust/Board is shown on the plot as the large black cross. If there is no large black cross on the plot, your Trust/Board did not report any patients of the type presented. The funnel plots can also be used to identify the maximum rates currently being achieved by Trusts/Boards with similar donor potential.
Figure 4.2	A funnel plot of the deceased donor referral rate is displayed using data obtained from the PDA. See description for Figure 4.1 above.
Figure 4.3	A funnel plot of the deceased donor SNOD presence rate is displayed using data obtained from the PDA. See description for Figure 4.1 above.
Figure 4.4	A funnel plot of the deceased donor consent/authorisation rate is displayed using data obtained from the PDA. See description for Figure 4.1 above.

5 PDA data by hospital and unit	
Table 5.1	DBD key numbers and rates by unit where the patient died have been obtained from the PDA. Percentages have been excluded where numbers are less than 10.
Table 5.2	DCD key numbers and rates by unit where the patient died have been obtained from the PDA. Percentages have been excluded where numbers are less than 10.

6 Emergency department data	
Figure 6.1	Stacked bar charts display the number of patients that died in the emergency department (ED) who met the referral criteria and were referred to the Organ Donation Service and the number who were not referred in your Trust/Board for the past five equivalent time periods.
Figure 6.2	Stacked bar charts display the number of families of patients in ED approached where a SNOD was present and the number approached where a SNOD was not present in your Trust/Board for the past five equivalent time periods.

7 Additional data and figures

Table 7.1	A summary of deceased donor, transplant, transplant list and ODR opt-in registration data for your region have been obtained from the UKTR. Your region has been defined as per former Strategic Health Authority. A UK comparison is also provided.
Table 7.2	Trust/board level categories and the relevant expected number of proceeding donors per year are provided for information.
Table 7.3	National DBD key numbers and rates for level 1, 2, 3 and 4 Trusts/Boards are displayed alongside your local data to aid comparison with equivalent Trusts/Boards. Percentages have been excluded where numbers are less than 10.
Table 7.4	National DCD key numbers and rates for level 1, 2, 3 and 4 Trusts/Boards are displayed alongside your local data to aid comparison with equivalent Trusts/Boards. Percentages have been excluded where numbers are less than 10.
Figure 7.1	A funnel plot of the DBD and DCD referral rates are displayed using data obtained from the PDA. See description for Figure 4.1 above.
Figure 7.2	A funnel plot of the DBD and DCD SNOD presence rates are displayed using data obtained from the PDA. See description for Figure 4.1 above.
Figure 7.3	A funnel plot of the DBD and DCD consent/authorisation rates are displayed using data obtained from the PDA. See description for Figure 4.1 above.

Brighton and Sussex University Hospitals NHS Trust

To: Trust Board

Date of Meeting: 25th July 2018 Agenda Item: **15**

Title
Notification of Sealed Documents
Responsible Executive Director
Marianne Griffiths, Chief Executive Officer
Prepared by
David Haycox, Interim Company Secretary
Status
Disclosable
Summary of Proposal
It is a requirement of the Trust Standing Orders (Section 8.3) that a register of sealing is maintained and use of the Common Seal is reported to the Trust Board at least annually. This report covers the period 1st May 2018 to 30th June 2018. Appendix 1 details use of the Common Seal during this period.
Implications for Quality of Care
None identified.
Link to Strategic Objectives/Board Assurance Framework
Links to good governance requirements, Trust Standing Orders state reporting requirement to Trust Board.
Financial Implications
None identified
Human Resource Implications
None identified.
Recommendation
The Board/Committee is asked to: NOTE use of the Trust seal.
Communication and Consultation
Not applicable.
Appendices
Appendix I: Register of Use of Common Seal 1st May – 30th June 2018

Appendix 1

BSUH – Use of Seal 1st May – 30th June 2018

Register reference	Dated	Document	Signed in the presence of (1)	Signed in the presence of (2)
275	13/06/2018	Collateral Warranty Agreement for Minor Works at the Macmillan Horizon Centre	Karen Geoghegan	Nicola Ranger