

Meeting of the Board of Directors

09.30 – 12.30 on Wednesday 29 January 2020
Lecture Theatre 1, Euan Keat Education Centre, Princess Royal Hospital,
Haywards Heath

AGENDA – MEETING IN PUBLIC

1.	09.30	Welcome and Apologies for Absence To note: Dame Marianne Griffiths	Verbal	Chair
2.	09.30	Declarations of Interests To note	Verbal	All
3.	09.30	Minutes of Board Meeting held on 27 November 2019 To approve	Enclosure	Chair
4.	09.35	Matters Arising from the Minutes held on 27 November 2019 To note	Enclosure	Chair
5.	09.40	Report from Chief Executive To receive and note overview of the Trust's activities	Enclosure	George Findlay
		<u>INTEGRATED PERFORMANCE REPORT</u>		
6.	09.55	Introduction from Chief Executive To receive and note overview of the Trust's activities	Enclosure	George Findlay
7.	10.00	Quality Improvement To receive and agree any necessary actions <i>After this section the Chair of Quality Assurance Committee will be invited to provide their report included at item 11</i> To receive assurance from Committee and recommendations from the Committee	Enclosure	Carolyn Morrice & Rob Haigh
8.	10.15	Systems and Partnerships To receive and agree any necessary actions	Enclosure	Jayne Black
9.	10.30	Sustainability To receive and agree any necessary actions	Enclosure	Karen Geoghegan
		<i>After these two sections the Committee Chairs will be invited to provide their report included at item 12-14</i> To receive assurance from Committee and recommendations from the Committee		
10.	10.45	Our People To receive and agree any necessary actions <i>At this point the Committee Chairs will be invited to provide any additional assurance from the work of their committees.</i>	Enclosure	Helen Weatherill

<u>ASSURANCE REPORTS FROM COMMITTEES</u>				
11.	-	Report from Quality Assurance Committee Chair - from the meeting on the 28 January To receive assurance and recommendations from the Committee	Verbal	Mike Rymer
11.	-	Reports from Finance and Performance Chair - from the meeting on the 28 January To receive assurance and recommendations from the Committee	Verbal	Patrick Boyle
12.	11.00	Board Assurance Framework To approve for publication on the website	Enclosure	Glen Palethorpe
<u>SERVICE PRESENTATION</u>				
13.	11.10	IM&T Update To receive and note	Presentation	Ian Arbuthnot
<u>OUR PEOPLE</u>				
14.	11.30	Annual Equality Report To approve for publication as part of statutory duty	Enclosure	Helen Weatherill
15.		INTENTIONALLY LEFT BLANK		
<u>WELL LED & COMPLIANCE</u>				
16.	11.45	Company Secretary Report To note	Enclosure	Glen Palethorpe
<u>OTHER</u>				
17.	11.55	Any Other Business To receive and action	Verbal	Chair
18.	12.00	Questions from the public To receive and respond to questions submitted by the public	Verbal	Glen Palethorpe
19.	12.05	Date and time of next meeting: The next meeting in private of the Board of Directors is scheduled to take place on Wednesday 25 March 2020 in the Level 6 Boardroom, Trust HQ, Royal Sussex County Hospital, Brighton	Verbal	Chair

Trust Board of Directors Quoracy

A meeting of the Board shall be quorate and shall not commence until it is quorate.

Quoracy is defined as meaning that at least half of the Board must be present, including one Non-executive Director and one Executive Director. This means that at least 6 voting members must be present. A Director shall be deemed as present if he joins the meeting by telephone or other means, provided that he can hear and be heard by all other Directors present at the meeting

Minutes of the Board of Directors (Public) meeting held at 10:30 on Wednesday 27 November 2019 in the Level 6 Boardroom, Trust Headquarters, Royal Sussex County Hospital, Brighton.

Present:

Alan McCarthy	Non- Executive Director (Chair)
Marianne Griffiths	Chief Executive
Mike Rymer	Non-Executive Director
Lizzie Peers	Non-Executive Director
Patrick Boyle	Non-Executive Director
Joanna Crane	Non-Executive Director
Jackie Cassell	Non-Executive Director
George Findlay	Chief Medical Officer
Karen Geoghegan	Chief Financial officer
Pete Landstrom	Chief Delivery & Strategy Officer
Jayne Black	Chief Operating Officer
Denise Farmer	Chief Workforce & Organisational Development Officer

In attendance:

Glen Palethorpe	Group Company Secretary
Tamsin James	Board and Committee Administrator
Dr Ollie Minton	Lead Clinician Palliative Medicine (Item 15)
Steve Bass	Lead Clinical Nurse Palliative & EOLC (Item 15)

B/11/19/1 WELCOME AND APOLOGIES

Action

- 1.1 The Chair welcomed those present to the meeting.
- 1.2 Apologies of absence were received from Kirstin Baker & Jon Furnmston.
- 1.3 The Board was confirmed as quorate.

B/11/19/2 DECLARATIONS OF INTEREST

- 2.1 There were no declarations of interest.

B/11/19/3 MINUTES FROM THE PREVIOUS MEETING HELD ON 25 September 2019

- 3.1 The minutes of the meeting held on 25 September 2019 were **APPROVED** as a correct record.

B/11/19/4 MATTERS ARISING

- 4.1 There were no Matters Arising for the Board to discuss.

B/11/19/5 CHIEF EXECUTIVE'S REPORT

- 5.1 Dame Marianne Griffiths' presented the Chief Executive's report, drawing out the key events and activities that occurred in October & November.

Headlines

- 5.2 The Trust is six weeks into the annual flu campaign and over 52% of frontline staff have already been vaccinated. The Flu Jab will still be available until early 2020 however the Trust is encouraging staff to get vaccinated within the first two months of the campaign to ensure they are protected before the flu season sets in. The campaign has also been extended to a number of the Trust's most

vulnerable patients and the wider community with some external messaging encouraging people to get vaccinated if they are in 'at-risk' groups.

- 5.3 Having been shortlisted for the HSJ Trust for Acute or Specialist Trust of the Year award with the awards event held on the 6th November. Marianne expressed her pride at being shortlisted for this prestigious award but unfortunately the Trust did not win on this occasion.
- 5.4 Over 50 executive and senior management team members from organisations across Europe and the UK attended a Patient First open day in November. Hosted at Worthing Hospital, the visitors gained an exclusive insight into the work of both Western Sussex Hospitals and Brighton and Sussex University Hospitals, seeing how staff across the organisations have taken up the Patient First approach, striving to continuously make things better, safer and more efficient for our patients.
- 5.5 With funding from Health Education England, Kent, Surrey & Sussex (HEKSS) four BSUH colleagues joined a collaborative programme with Western Sussex Hospitals giving them the opportunity to develop their research skills and help bring research evidence into their practice. The programme has been met with excellent feedback.
- 5.6 Congratulations were given to Clinical Scientist, Sam Blakemore, who has been awarded Audiologist of the Year Award by the British Academy of Audiology (BAA).
- 5.7 An inspirational day was had by all who attended the Annual BSUH Dementia Conference in October. The Conference was an opportunity to launch the Trust's new Dementia strategy which was presented in the last board meeting and sets out exactly how BSUH aims to work with patients and their families to provide excellent care. The strategy aims to deliver an individualised, person-centred care approach delivered by an educated and confident workforce.
- 5.8 Representatives from Sussex Health and Care Partnership met for the Workforce Race Equality Conference to discuss and develop ways the NHS can work together to achieve sustained change for Black and Minority Ethnic Staff.
- 5.9 128 members of staff attended the Trust's Long Service Awards, Between them this great group of outstanding staff have worked at the Trust for an incredible 3,237 years. 12 of these long serving staff all moved to England together from the Philippines 20 years ago.
- 5.10 Marianne was pleased to recognise the success at Western Sussex Hospitals which has received the outstanding care quality rating in every domain.

Diary Highlights

- 5.11 The Board was advised of some key meetings that the Executive team have attended in August & September.

Looking ahead

- 5.12 Marianne confirmed the Annual Staff Survey which launched early October was due to close at the end November, Marianne added that the Trust was hoping to better last year's response rate of 59%.
- 5.13 Marianne highlighted that after nearly three years of the management contract between Brighton & Sussex University Hospitals and Western Sussex Hospitals, it was decided to further develop the relationship between the two

Trusts with a continuation of the current leadership arrangements allowing this closer working over the longer term. The Trusts and their assets will remain separate, but they will operate as equal partners and the benefits of the current relationship will be maintained and extended into a group model. Work to determine the best group structure is ongoing and further details will be provided in due course as decisions are made.

5.14 The Board **NOTED** the report.

B/11/19/6 INTEGRATED PERFORMANCE REPORT

6.1 Dame Marianne Griffiths presented the Board with an introduction to the report, which provided the structure for the integrated performance report and provided information on the activity that is being undertaken by the Trust and how this links to the Trust's True North Objectives.

B/11/19/7 QUALITY IMPROVEMENT

7.1 George Findlay introduced the quality report, highlighting the key benchmarked indicators relating to Quality & Safety aligned to the organisational True North objectives.

7.2 The current Hospital Standardised Mortality Ratio (HSMR) for the Trust to July 19 has reduced for a further period. In the 12 months to July 2019 the HSMR was 89.16, BSUH is currently ranked 25/132 and stands in the 19th percentile.

7.3 The rate of inpatient falls for the past 12 months is 3.56 falls per 1000 bed stay days; equating to 948 falls in the past year compared to 866 in the previous year. The National Falls rate is 6.63 falls per 1000 bed days.

7.4 Carolyn Morrice, Chief Nurse informed the Board that the rate of harm free care was 94.98% in October, just below the Trust target of 95%. The harm-free care score for the past 12 months was 94.2% against the target of 95%.

7.5 The pressure ulcer rate for the past 12 months is 1.20 incidents per 1000 bed stay days. Carolyn assured the Board on the arrangements over the ongoing monitoring in this area.

7.6 The current rate of Friends & Family recommended rates for August were reported for Inpatients as 93.32%, in A&E this recorded a recommended rate of 87.4% and for Outpatients the rate was recorded as 93.5%.

7.7 Mike Rymer confirmed the Quality Assurance Committee had met the day before and through its work it was able to assure the Board over the Trust's delivery of these objectives. The Committee also received information and reports in respect of learning from incidents, Patient Experience, Safeguarding and External Visits reporting. Mike confirmed that at the conclusion of the meeting the Committee was assured over the quality of care being provided to the Trust's patients.

7.8 Alan McCarthy stated the Trust was performing well against the range of quality metrics and had strong plans to continue to improve.

7.9 The Board **NOTED** the report.

B/11/19/8 SYSTEMS AND PARTNERSHIPS

- 8.1 Jayne Black updated the Board in respect of a range of performance indicators.
- 8.2 Jayne informed the Board that for October the A&E performance was 82.6%, compared to a national average of 83.6%.
- 8.3 The Trust's 62 day cancer performance for GP referral to treatment improved by 10.4% to 73.8% in September 2019. The National average performance (August-19) was 84.8%.
- 8.4 The Trust's RTT Performance improved by 0.6% in October-19 to 67.2%, with the waiting list reduced by 691 patients to September-19. There were sixty seven 52 week breaches in the month this was an increase of 20 on the prior month. National average performance (September 19) was 84.8%. The Board was assured over the reduction in the waiting list since the date of this report with the aim that all remaining 52-week breaches would be eliminated by February 2020.
- 8.5 The Trust's Diagnostics 6-week performance improved by 0.43% to 13.89% in October 19 compared to September 19. Significant improvements have been made in Non-obstetric Ultrasound. National average performance (September 19) was 3.8%.
- 8.6 Jayne drew the section to a close by confirming that there whilst there have been challenges a number of extra measures have been implemented to reduce the wait times for patients and confirmed that Cancer, Endoscopy and Diagnostics are still working hard to deliver their trajectory.
- 8.7 The Chair asked Patrick Boyle, as Chair of the Finance & Performance Committee, to provide the Board with an update from that Committee's meetings. Patrick confirmed the Committee was able to assure the Board that the Trust is performing well despite the issues highlighted within the report just presented.
- 8.8 The Board **NOTED** the report.

B/11/19/9 SUSTAINABILITY

- 9.1 Karen Geoghegan reported to the Board the Trust's financial performance, reporting that for August, the Trust is reporting a deficit of £3.8m which is in line with plan.
- 9.2 At the end of M7, the Trust has delivered a deficit of £33.9m, in line with the plan, so has earned £11.4m of Provider Sustainability Fund (PSF) and Financial Recovery Fund (FRF) income. In addition the Trust has also received confirmation of a further £0.6m of 2018/19 PSF as a national post accounts reallocation of PSF was undertaken.
- 9.3 The Trust is on trajectory to deliver an underlying deficit of £53m; which will earn an additional £25.4m of PSF and FRF funding. This will achieve the year-end deficit control total of £25.7m.
- 9.4 Karen informed the Board that the delivery of the control total is challenging given impact of operational pressures, further increased into Winter.

- 9.5 The Trust's Finance and Use of Resources Risk Rating for October is 3, and the individual rating components are in line with plan.
- 9.6 The Efficiency and Transformation Programme although challenging is forecasting delivery of the £27m requirement.
- 9.7 The Chair asked Patrick Boyle, as Chair of the Finance & Performance Committee, to provide the Board with an update from that Committee's meeting in respect of Finance. Patrick confirmed the Committee was able to assure the Board that the Trust has robust plans to track the delivery of its year end control total.
- 9.8 The Board **NOTED** the report.

B/11/19/10 OUR PEOPLE

- 10.1 Denise Farmer presented the Board with an update on workforce developments and emphasised the positive outcomes for the annual staff survey and the more frequent Pulse surveys and how these results are used to drive improvements based on the captured feedback from staff.
- 10.2 Denise updated the Board on the monthly pulse survey results which provides a "snap shot" of how staff are feeling in relation to the 9 key engagement questions. These questions determine the overall engagement score. The overall score this month has remained at 7 out of 10. The best Acute Trust scored 7.6 out of 10 and Denise reminded the Committee the Trust's ambition is to be above average in 2019 National Staff Survey, this represents a significant increase over that recorded some three years ago.
- 10.3 Following the increase in the 2018 staff survey score of 'care is my organisations top priority' which is now in line with the national average for Acute Trusts, the Breakthrough Objective for Our People has been changed in in month to 'I would recommend the organisation as a place to work.' Focused staff input has created a developed plan of actions which is progressing against this target.
- 10.4 The Trust has run the NHS Staff Survey for all Trust employees since 2016 Participation has increased from under 40% in 2016 to 59.1% in 2018. The NHS staff survey is due to close on 30th November with results available between December 2019 and January 2020, with National results being available in February 2020.
- 10.5 An active Trust wide Health & Well Being service was initiated in 2017, combining support/activities around physical, mental and financial wellbeing; with a comprehensive on-line interactive platform developed in the Autumn of 2017. The website continues to grow and receives an average of 260 hits per month (September 2018-2019) and 32% of these are return visitors.
- 10.6 Helen Weatherill drew the Board's attention to the fact that there has been an improvement to staff turnover with rates reducing to 12.1% the lowest level achieved since 2015.
- 10.7 Patrick Boyle praised the work to date that has progressed within IM&T, highlighting the very impressive piece of work from Ian Arbuthnot and team that was reported to the Finance and Performance Committee the preceding day.

- 10.8 The Chair recognised actions were in place to review the increasing levels of sickness pressures within the Trust, with Denise confirming there were slow and steady improvements in this area.
- 10.9 The Board **NOTED the** information received from the Integrated Performance Report.

B/11/19/11 REPORT FROM QUALITY ASSURANCE COMMITTEE

- 11.1 Mike Rymer, Quality Assurance Committee Chair asked the Board to note the update from the meeting the previous day.
- 11.2 The Board were **ASSURED** following the update of the report.

B/11/19/12 REPORT FROM FINANCE AND PERFORMANCE COMMITTEE

- 12.1 Patrick Boyle, Chair of the Finance and Performance Committee asked the Board to note the update from the meeting the previous day and to note the report from the October meeting within the board papers.
- 12.2 The Board **NOTED** the update.

B/11/19/13 REPORT FROM FINANCE AND PERFORMANCE COMMITTEE

- 13.1 Lizzie Peers, Chair of the Audit Committee, asked the Board to note the update from 1 October 2019 drawing the Board's attention to the review undertaken of the BAF risks especially those relating to people and that the Committee was assured over the process for oversight and management of these risks.
- 13.2 The Board **NOTED** the update.

B/11/19/14 BOARD ASSURANCE FRAMEWORK

- 14.1 Glen Palethorpe drew the Board's attention to the summary of the key strategic risks within the Board Assurance Framework (BAF) and noted that the information received through the integrated performance report and assurance reports from Committee Chair's link to the details in the BAF. The Board agreed that the increase to risk 2.2 was appropriate and linked to the report presented by Karen Geoghegan. The Board was informed that the Finance and Performance Committee recommended that the reduction in risk 5.1 be deferred until further assurance is received over the actions taken across the system. The Board agreed with this recommendation.
- 14.2 The Board **APPROVED** the Board Assurance Framework and the increase to risk 2.2.

B/11/19/15 PALLIATIVE & END OF LIFE CARE PRESENTATION

- 15.1 Steve Bass, Lead Clinical Nurse Palliative & EOLC and Dr Ollie Minton Lead Clinician Palliative Medicine, presented the Board with an overview of the Palliative & End of Life Care service at BSUH.
- 15.2 Steve highlighted the Specialist Palliative Care Team (SPCT) operational ambition is to improve the quality of their experiences whilst they live and in respect of their choices in respect of their place of death for patients with advanced cancer and other advanced life limiting diseases through the

provision of multi-disciplinary assessments, advice and management of complex symptoms.

- 15.3 The SPCT dashboard outlined:
- 1809 patients reviewed in 2019, 1087 were discharged
 - 722 patients who died across BSUH were reviewed by SPCT
 - 1 in 3 patients in hospital are believed to be living in the last year of life
- 15.4 The specialist palliative care team is currently not funded to provide their ambition of a 7 day service limiting access to specialist advice for patients and practitioners at weekends and bank holidays. A business plan has been prepared for 2019/2020 as investment is required with the team will be asking the Board to consider funding for this Karen Geoghegan confirmed the Board would like to review the level of investment required and invited the team to discuss further offline.
- 15.5 The Service with the support of BSUH Charity and the League of Friends have established Small Acts of Kindness by developing bereavement Friendship bags and for families; Memory boxes for bereaved children; Memory prints for sudden deaths within ED; mobile library resource to explain illnesses to children; and a Swan room for the Care of The Elderly.
- 15.6 Dame Marianne Griffiths thanked Steve and Ollie for a wonderful and thought provoking presentation covering all aspects of the Trust's compassion values. Marianne questioned what the Trust's relationship was like with Hospices across Sussex. Ollie confirmed good relationships were in place with all, but given the current economic circumstances facing Hospices reliant on charitable donations the Service work hard to maximise these relationships. Marianne confirmed Carolyn Morrice, would help explore this further.
- 15.7 The Board thanked Steve and Ollie and **NOTED** the presentation.

B/11/19/16 NATIONAL APPROACH TO FLU VACCINATIONS

- 16.1 The Board welcomed the update from Carolyn Morrice on the current Flu Campaign.
- 16.2 The Trust undertakes an annual staff flu vaccination programme and over the last 3 years this has been set against a national CQUIN target of 80% of frontline staff to be vaccinated. In 2018 BSUH achieved a vaccination rate of 58% against a national target of 75%. The current 2019 flu vaccination programme launched in October and will continue to the end of February.
- 16.3 An in-depth discussion took place relating to the obligation of front line staff being vaccinated. Questions were raised whether it would be possible for a mandatory requirement to be stated within employment contracts; an agreement was reached this would not be required but should be included within the Trusts internal policy regarding professional obligations for front line staff. Carolyn agreed she would follow this up to support future campaigns.
- 16.4 The Board **NOTED** the update.

B/09/19/17 WINTER PLAN

- 17.1 Jayne Black presented the Winter Plan to the Board, and drew out the key areas.
- 17.2 Jayne asked the Board to note:

- Stranded patient numbers had increased alongside an increase in demand in A&E and admissions.
 - The Bed model confirmed a bed deficit at both RSCH and PRH.
 - The Trust lost significant elective capacity during 18/19 with over 60 cancellations per month during peak demand.
 - System capacity will benefit RSCH.
- 17.3 Jayne highlighted that a vast amount of solutions and plans had been created and owned by the Divisions providing a robust framework to progress programmes to optimise the use of theatres and beds.
- 17.4 Further focus on improvements around avoiding of admissions for patients likely to be stranded; improved discharge planning to reduce stranded patients and the length of stay; increase of early discharges to earlier in the day; and reducing non-admitted breaches.
- 17.5 Jayne confirmed a significant amount of work has been undertaken within bed demand and capacity modelling at both RSCH and PRH. George Findlay confirmed it as a complex plan for Winter there are now models in place for Acute and ED to include additional workforce.
- 17.6 The Chair thanked Jayne and the team for the work in progressing the plan
- 17.7 The Board **NOTED** the update.

B/11/19/18 COMPANY SECRETARIAL REPORT

- 18.1 Glen Palethorpe asked the Board to note both the Learning from Deaths report and the Health and Safety Annual Report.
- 18.2 Learning from Deaths – the Board was reminded this report had been scrutinised by the Quality Assurance Committee especially in respect of the Trust’s processes for learning from the review of deaths. The outcome of this learning manifests itself in the Trust’s mortality indices; these are tracked within the routine report to the Board as part of the Integrated Performance Report.
- 18.3 H&S Annual Report - The report is produced on the Trust’s compliance with its Health and Safety requirements. The detailed oversight of this work is delivered via the Health and Safety Committee. The overall conclusion for 2018/19 as supported by the Health and Safety Committee is that there has been continued improvement in H&S processes against the H&S priorities.
- 18.4 The Board **NOTED** the reports.

B/11/19/19 ANY OTHER BUSINESS

- 19.1 There was no other business discussed.

B/11/19/20 QUESTIONS FROM THE PUBLIC

- 20.1 Two members of the public had previously submitted questions to the Board relating to: the level of the Trusts financial percentage liquidity and obligatory spend; and a public concern about the impact of Brighton and Hove NHS patients being treated in private hospitals.
- 20.2 Karen Geoghegan thanked Elliot for his question and confirmed the spend was obligated and mandated to the Healthcare of patients, 73% was within the

obligated spend of workforce, capital and interest payments and insurance premiums equating to £430m of the £580m income earned.

- 20.3 George Findlay thanked Judith for submitting questions relating to the impact of patients being treated in private hospitals. George confirmed October was operating at expected MSK levels and there were no instances of trainees unable to complete their training due to a shortfall of patients. George confirmed the Major Trauma Centre was not at risk whilst orthopaedics remains sustainable.
- 20.4 Dame Marianne Griffiths confirmed escalation meetings were required in this area with the CCG who are aware of the impact on the Trust in respect of MSK referrals. The CCG are supportive and remain committed and engaged with the Trust.
- 20.5 Alan informed the Board that no further questions had been submitted to Board

B/11/19/21 DATE AND TIME OF NEXT MEETING

The next meeting in **PUBLIC** of the Board of Directors is scheduled to take place on **Wednesday 29 January 2020** in the **Lecture Theatre 1, Euan Keats Education Centre, PRH, Haywards Heath**

Tamsin James
Board and Committee Administrator
November 2019

Signed as a correct 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
		There were no matters arising from the BSUH Public Board Minutes.			



Brighton and Sussex
University Hospitals
NHS Trust

Chief Executive's Report

January 2020



Content

- Headlines
- Diary highlights
- Looking ahead

Headlines



Patient First Wave 7 graduation

Tuesday (14th January) saw eight teams and over 50 people attend their Patient First Improvement System (PFIS) graduation - a great opportunity to celebrate and reflect on all they've achieved during their training.

They were joined by the new entrants on wave 8 who were able to ask questions and hear about the many improvements made by wave 7 colleagues. Our Chief Nurse, Carolyn Morrice, presented the certificates and congratulated the teams. Patient care is our organisation's top priority and Carolyn said it was great to see the improvements these teams are making play a key role in this goal - benefitting staff and ultimately our patients.

Major trauma ward officially open

A new, 24 bed Major Trauma ward has been opened at the Royal Sussex County Hospital today. The ward, in the Millennium Wing, will care for some of the hospital's most severely injured patients. It creates a dedicated facility for the treatment of these patients, who would previously have been cared for on other specialist or surgical wards.

Headlines

Chief Midwifery Officer Awards

Congratulations to midwives Ash Riddington and Helen Green who both received silver Chief Midwifery Officer Awards for their outstanding work in supporting members of the transgender and non-binary community in pregnancy.

It was fantastic to see their valuable work recognised by the Chief Midwifery Officer for England, Professor Jaqueline Dunkley-Bent, who spent some time before Christmas meeting the team at RSCH.



Finance Director of the year

Chief Financial Officer, Karen Geoghegan, was announced *Finance Director of the Year* at the Healthcare Financial Management Association (HFMA) Awards.

Karen was awarded the prestigious top prize for her work and leadership at both Brighton and Sussex University Hospitals and Western Sussex Hospitals. She paid tribute to her finance colleagues at both trusts. At BSUH Karen led a programme that strengthened financial leadership and the Trust achieved the control totals for 17/18, 2018/19 (delivering £50m savings) and is on-track for 2019/20. By January 2019, BSUH was taken out of financial and quality special measures.



Live Beds system launched

Thank you to all those involved in the launch of our Live Beds management system, launched this month. The system provides a real-time view of which beds are available, or about to become available across the trust and will help ensure patients access inpatient care in a timely way.



Headlines

Celebrating our staff

We took some time in the build up to Christmas to look back over the previous year and celebrate our staff. We included some of the fantastic nominations we for Star of the Month over the past 12 months in our 12 Days of Christmas series.

From housekeepers and nurses to administrative staff and theatre practitioners, it was a great way to showcase so many wonderful people working across the trust.

More than 150 nominations for Star of the Month were submitted during 2019

Welcoming our football and cricket teams

There was some sporty excitement at the Alex before Christmas with a visit from Sussex Cricket Foundation and Brighton and Hove Albion Football Club.

Both teams gave out cuddly toys and memorabilia for children on the wards and in A&E and were accompanied by their mascots Sid and Sandy the Sharks and Gully.



Headlines

Flu campaign – update

More than 65% of frontline staff have now been vaccinated with the campaign still in full force. The Jab will still be available until the end of next month and is available in a number of locations - attending a drop-in clinic, requesting a roaming vaccinator to come to their departments or by contacting their local workplace vaccinator.

Lots of information has been shared across all trust channels about the flu jab and why it's important. This has also been extended to our patients and the wider community with some external messaging encouraging people to get vaccinated if they are in 'at-risk' groups.



Welcoming Chinese delegates

A delegation coordinated by the Beijing Huatong Guokang Foundation (BHGF) visited the Trust today, 29th November, to hear about some of the fantastic innovations and education we have here at BSUH.

They were welcomed by Varadarajan Kalidasan, Director of Medical Education, and Dr Rob Haigh, Medical Director.

The visit is the latest in an ongoing relationship between the Trust and BHGF. Over 150 doctors from China have come to BSUH in the past five years for three-month placements and earlier this year over 20 of our consultants visited China on a fact-finding and teaching programme.



Diary highlights

- Meetings with partner organisations
 - Staff briefings at Royal Sussex County and Princess Royal
 - Sussex Integrated Care development
 - Improvement Framework Development Board
 - South East Leadership Summit
- 

Looking ahead

NHS Staff Survey

Thank you again to all those staff who completed the 2019 NHS staff survey, the results of which are due to be published next month.

More than 5,000 colleagues responded, which is a great improvement on last year's response rate. Well done to the following teams who all achieved 100% response rates: Wendy House Nursery, Portering Services PRH, PMO, Catering services PRH, Breast Care Nursing, Imaging – Advanced Practitioners, X-ray and Management, RACH Nurse Management and Play Specialists and GUM Health Advisors.



Planning for the future

Work continues on the development of the new group structure, following the decision to further develop the relationship between BSUH and WSHT. This new group structure is a strategic alliance which will ensure we can do what is best for our patients and people.

In practical terms, it is effectively a continuation of the current leadership arrangements but will also allow us to work more closely together over the longer term. The trusts and their assets will remain separate, operating as equal partners and the benefits of our current relationship will be maintained and extended. Work to determine the best group structure is ongoing and further details will be provided in due course as decisions are made.

Patient First STARS 2020

Final preparations are underway for the launch of this year's Patient First STAR awards, designed to recognise and celebrate the contribution of our staff and volunteers. Nominations are due to open on February 14 and we encourage all our staff, volunteers, patients and their relatives to consider putting a colleague or team forward. Visit [BSUH.nhs.uk](https://www.bsuh.nhs.uk) for more details.

Agenda Item:	6-10	Meeting:	Board	Meeting Date:	29/1/2020
Report Title:	Integrated Performance Report				
Sponsoring Executive Director:	Marianne Griffiths, George Findlay, Peter Landstrom, Karen Geoghegan and Helen Weatherill				
Author(s):	Marianne Griffiths, George Findlay, Peter Landstrom, Karen Geoghegan and Helen Weatherill				
Report previously considered by and date:	Individual elements considered by relevant Board Committee				
Purpose of the report:					
Information	<input type="checkbox"/>	Assurance	<input checked="" type="checkbox"/>		
Review and Discussion	<input checked="" type="checkbox"/>	Approval / Agreement	<input type="checkbox"/>		
Reason for submission to Trust Board in Private only (where relevant):					
Commercial confidentiality	<input type="checkbox"/>	Staff confidentiality	<input type="checkbox"/>		
Patient confidentiality	<input type="checkbox"/>	Other exceptional circumstances	<input type="checkbox"/>		
Link to Trust Strategic Themes:					
Patient Care	<input checked="" type="checkbox"/>	Sustainability	<input checked="" type="checkbox"/>		
Our People	<input checked="" type="checkbox"/>	Quality	<input checked="" type="checkbox"/>		
Systems and Partnerships	<input checked="" type="checkbox"/>				
Any implications for:					
Quality					
Financial					
Workforce					
Link to CQC Domains:					
Safe	<input checked="" type="checkbox"/>	Effective	<input checked="" type="checkbox"/>		
Caring	<input checked="" type="checkbox"/>	Responsive	<input checked="" type="checkbox"/>		
Well-led	<input checked="" type="checkbox"/>	Use of Resources	<input checked="" type="checkbox"/>		
Communication and Consultation:					
Executive Summary:					
Attached is the Trust's integrated performance report.					
Key Recommendation(s):					
To note the content and following receipt of the Committee assurance reports consider if there are areas for referral back to the Committees where enhanced assurance is required.					



Integrated Performance Report

January 2020



Brighton and Sussex
University Hospitals

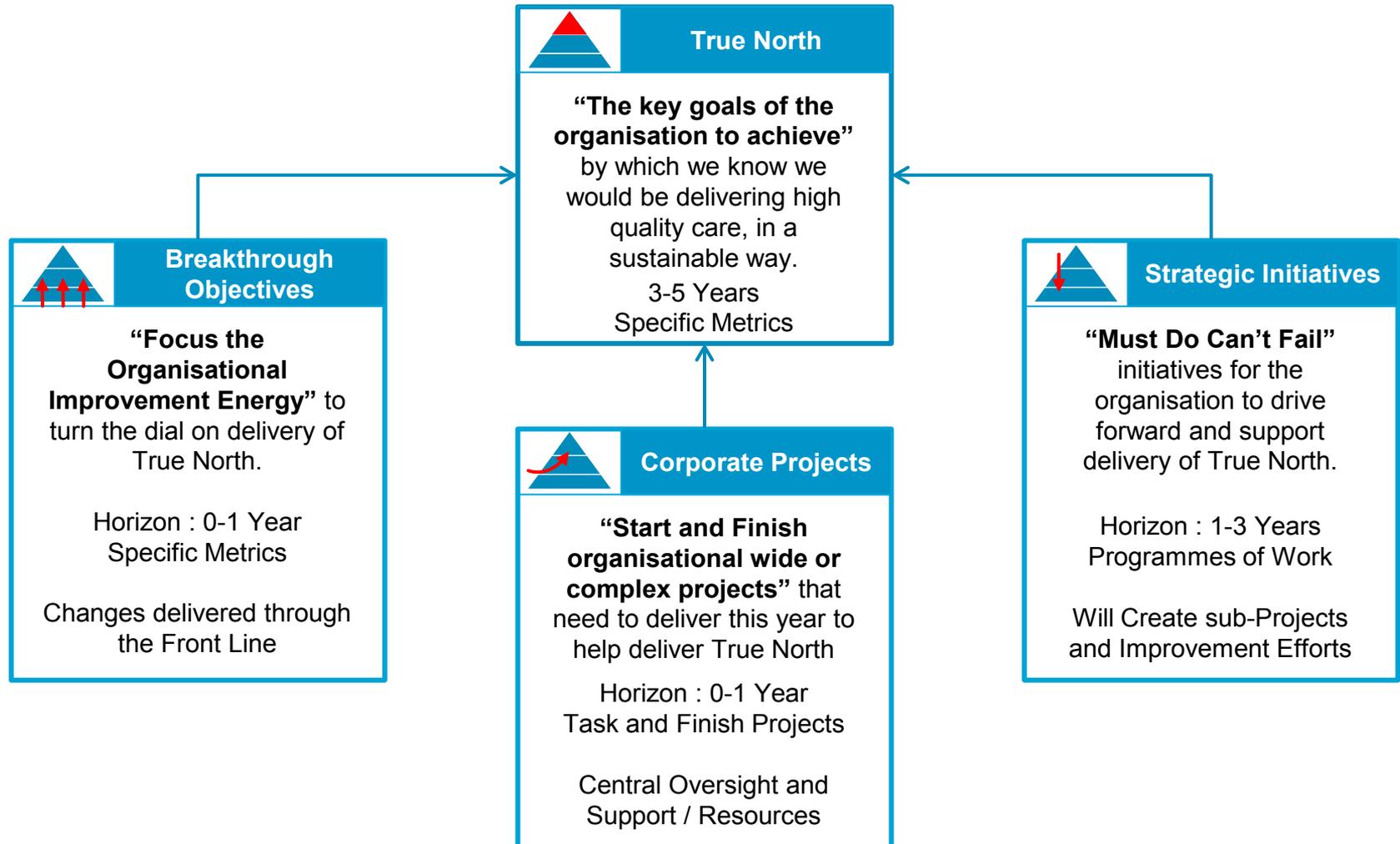
NHS Trust

Contents

Structure of the report

Introduction - Patient First
Quality Improvement
Systems and Partnership
Sustainability
People

Patient First Strategy Deployment Framework



Patient First True North

Key Goals for the Organisation to achieve sustainably

Patient

Patient Satisfaction

Target: Family & Friends Recommend Rate >96%

Sustainability

Financial Management

Target: Break Even

People

Staff Engagement

Target: Engagement Score Top 20% in the Country

Quality

Preventable Mortality

Target: HSMR Top 20% in the Country

Avoidable Harm

Target: Patient Safety Thermometer 99% Harm Free Care

Systems & Partnerships

Non Elective Care

Target: A&E 95% <4hrs

Elective Care

Target: RTT 92% <18wks

Quality Performance

Quality

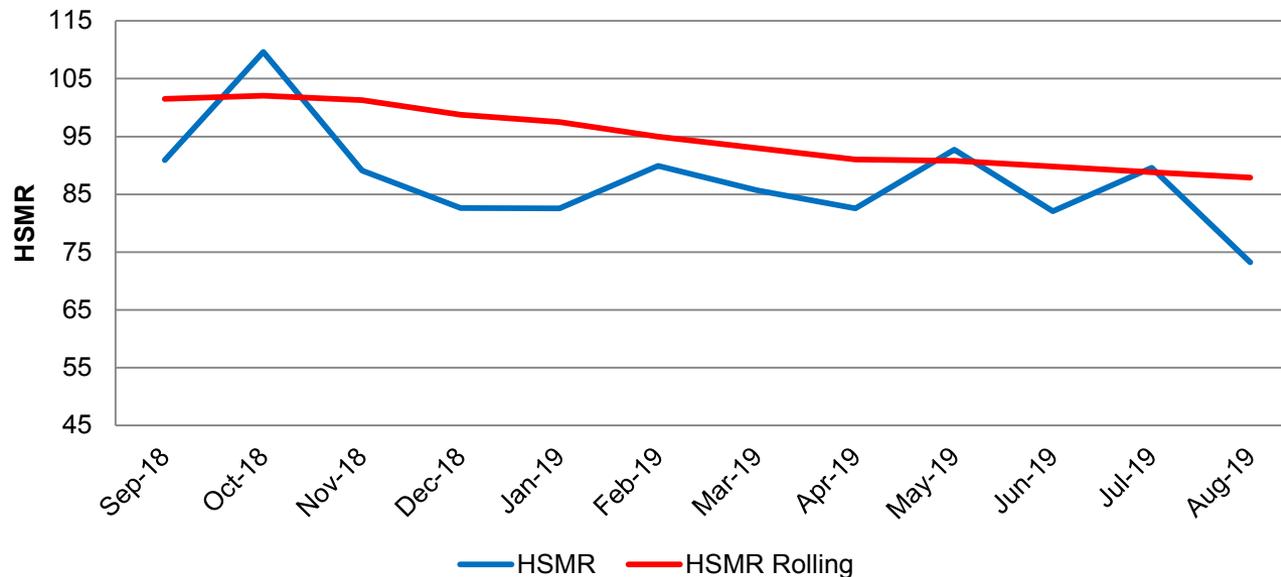
Preventable Mortality

Target: HSMR Top 20% in the Country

Avoidable Harm

Target: Patient Safety Thermometer 95%
Harm Free Care

HSMR September 18 to August 19



HSMR is available up until Aug 19 when 56 patients died against an expected number of 76. The in-month HSMR was 73.22. In the 12 months to Aug 19 the HSMR was 87.87. In the twelve months to Sept 18 HSMR was 101.52.

A HSMR of 87.87 means that BSUH is currently ranked 18th out of 132 organisations

The rate of harm free care was 94.98% in December, 0.02% below the Trust target of 95%. The national average is 94.2%.

Quality Performance

Quality

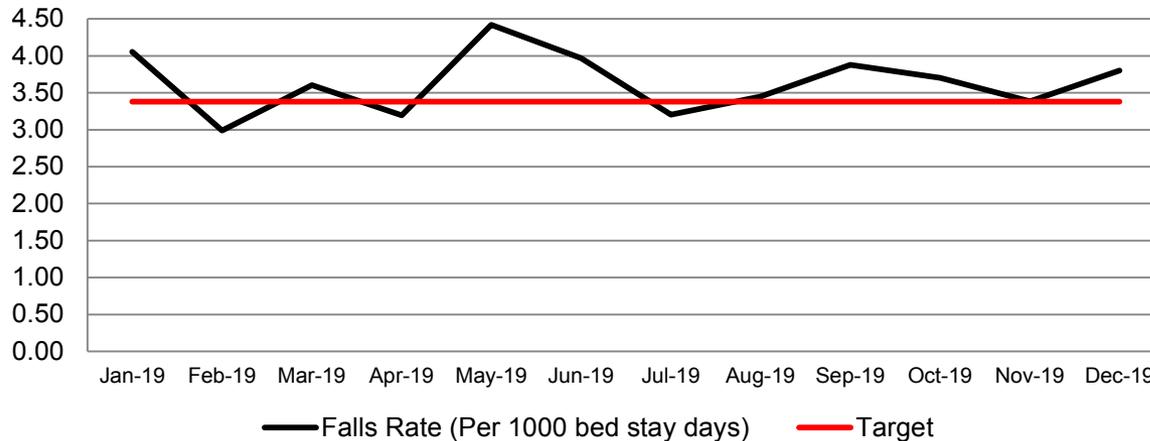
Inpatient Falls

Target: 3.38 falls per 1000 bed stay days

Pressure Ulcers

Target: 1.05 rate of acquired pressure ulcers per 1000 bed stay days

Inpatient falls rate per 1000 bed days



The rate of inpatient falls for the past 12 months is 3.64 falls per 1000 bed stay days; this equates to 982 falls in the past year compared to 838 in the previous 12 months. The National Falls rate is 6.63 falls per 1000 bed days.

The Patient Safety Team sends a monthly report to all inpatient area's detailing the falls on their ward for the past 12 months; this includes information to reinforce learning from past investigations.

The Head of Nursing in Quality Improvement is currently reviewing the data. A task and finish group is being setup and review and implement a programme of actions and SOP.

Quality Performance

Quality

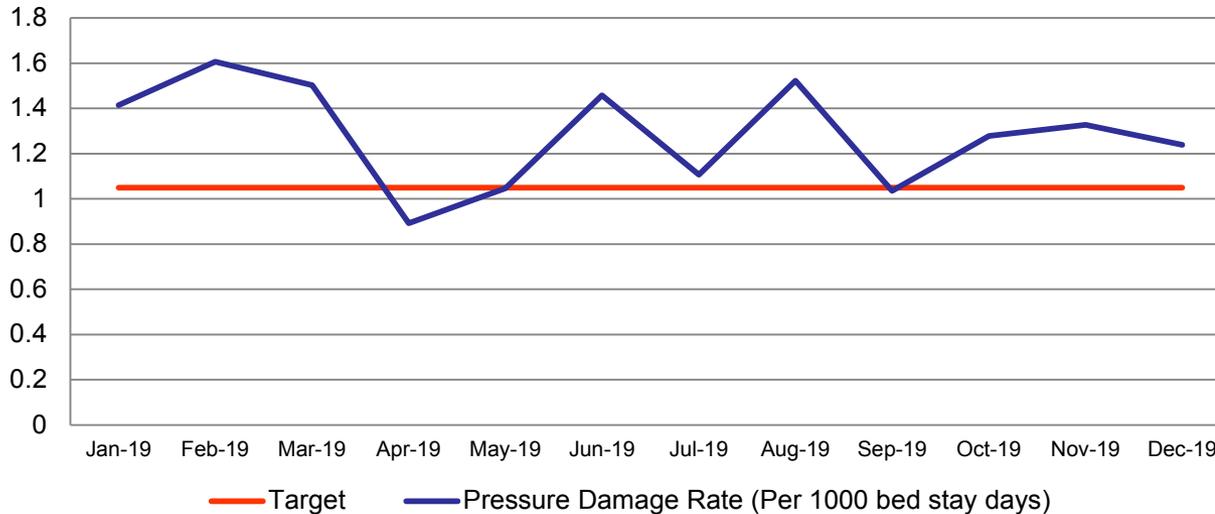
Inpatient Falls

Target: 3.38 falls per 1000 bed stay days

Pressure Ulcers

Target: 1.05 rate of acquired pressure ulcers per 1000 bed stay days

Pressure Ulcer rate per 1000 bed days



In December over 200 datix incidents were submitted in relation to pressure ulcers. The 200 datix reports were generated by 192 patients. Over the past 12 months the number of patients generating a pressure ulcer report has risen. The majority (68%) of these patients presented at A&E with a pressure ulcer.

Between October and December 6 acquired pressure ulcers have been treated as Duty of Candour incidents.

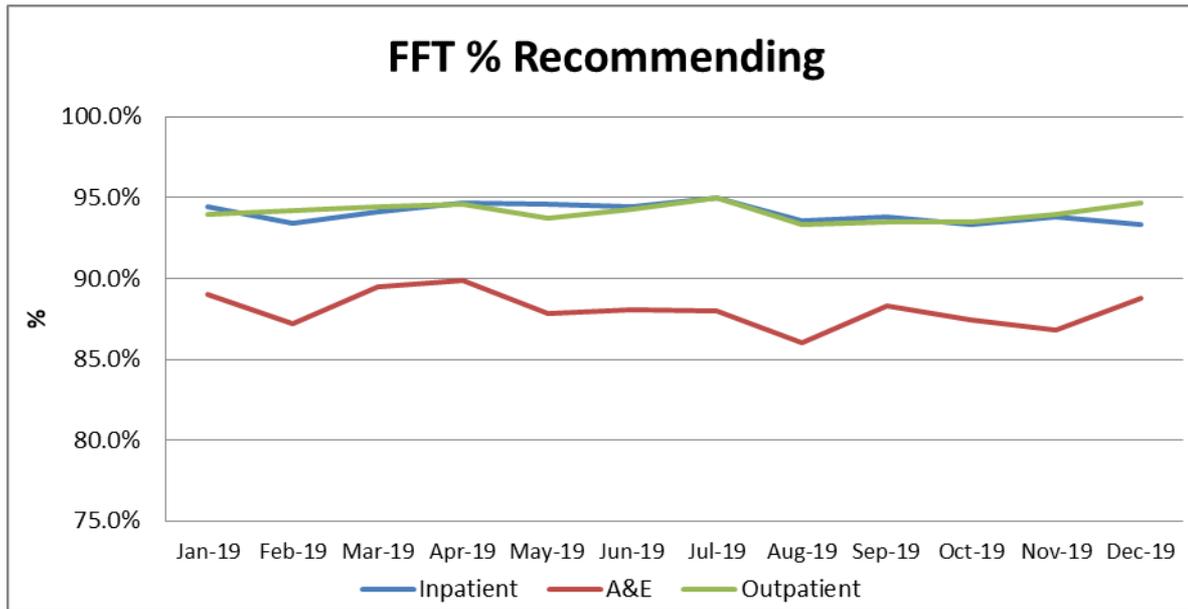
The Head of Nursing in Quality Improvement is currently reviewing the data. A task and finish group is being setup and review and implement a programme of improvement actions to reduce harm.

Quality Performance

Quality

Friends and Family Test

Target: 96% of inpatients who would recommend the trust to their family and friends



Our current recommended rates for December are:

Inpatient 93.3%

A&E 88.8%

Outpatient 94.7%

Breakthrough objective for 19/20 is improvement at discharge

Systems and Partnerships – Summary

Systems & Partnerships

Non Elective Care

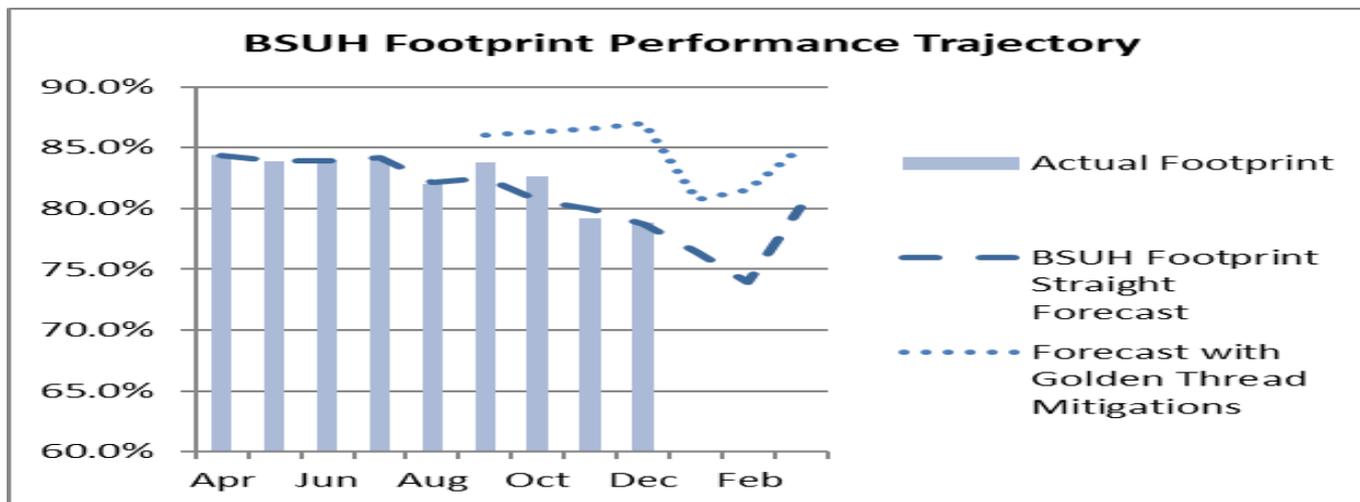
Target: A&E 95%
<4hrs

Elective Care

Target: RTT 92%
<18wks

- A&E Performance reduced to 78.8% (acute footprint) in Dec -19 compared to the national performance of 79.8%.
- 62 day cancer performance for GP referral to treatment remained the same at 73.1% in Nov -19. National average performance (Nov -19) was 77.4%.
- RTT Performance improved by 0.03% in Dec -19 to 68.05%. The waiting list reduced by 1317 patients compared to Nov -19. There were 35 52 week breaches in the month a reduction of 13 on the prior month. National average performance (Nov -19) was 84.4%.
- Diagnostics 6 week performance adversely increased by 1.8% to 15.7% in Dec - 19 compared to Nov -19. Significant improvements have been made in imaging however the recovery of endoscopy is behind. National average performance (Nov -19) was 2.9%.

Systems and Partnerships – True North Metrics

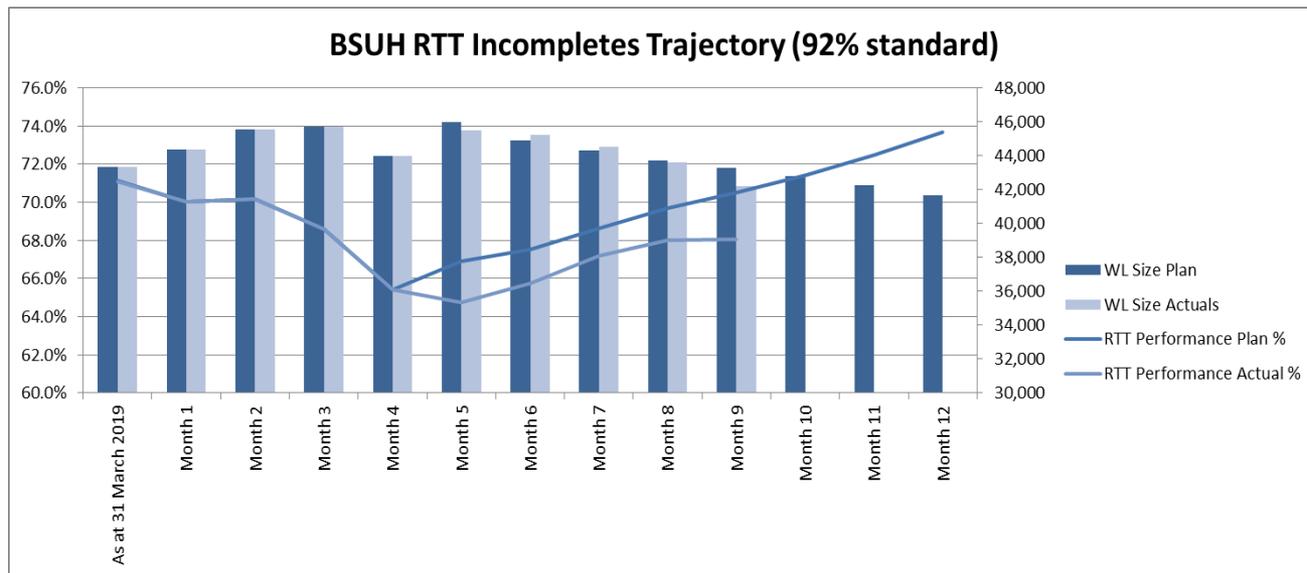


- Trust A&E Performance for Dec -19 was 78.8% including the NHSE allocated type 3.
- This is 0.4% lower than Nov - 19. Performance remains below the original trajectory.
- The trust had 3726 4 hour A&E breaches which was 19% more than the same month last year.
- The trust was below the national average performance of 79.8% in Dec – 19.
- Average time to triage remains good at 13 minutes.
- Average bed occupancy in Dec was 99.5% at RSCH and 97.9% at PRH.
- BSUH was ranked 18/36 in the south for Type 1 performance.
- BSUH was ranked 43/123 nationally for Type 1 performance.

Improvement Focus:

- Improvements at the front door relating to increased same day emergency care, ambulatory care and configuration for UCC. This includes work to improve patient streaming.
- Enhanced Targeted review of long stay (stranded) patients, expediting discharge.
- The Trust is also reviewing current bed configuration to optimise its use in accordance with patient demand.
- The new acute medical model was implemented w/c 2nd December.

Systems and Partnerships – True North Metrics



- Trust performance for RTT in Dec - 19 was 68.05% for all specialties, an improvement of 0.03% compared to Nov - 19.
- There were 35 52 week waiters at end Dec - 19. This was a reduction of 13 compared to the previous month.
- The RTT incomplete Waiting List fell by 13171 waiters in Dec - 19 compared to Nov -19.
- The overall backlog of patients waiting over 18 weeks reduced by 457 compared to the previous month.
- The tail of patients waiting over 41 weeks has reduced by 750 since August.

Improvement Focus:

- Daily 52 week wait huddles – ENT/DD/urology and ophthalmology
- Daily Activity Huddles
- Focussed long waiter management with daily recovery review.
- Reduction in wait times to first OPAs across several specialties
- Specialty level recovery plans successfully progressing and a number of specialties cleared >40 week waiters and working to clear >30 week waiters
- Aim to have no >52 week waiters by March

Systems and Partnerships – Cancer

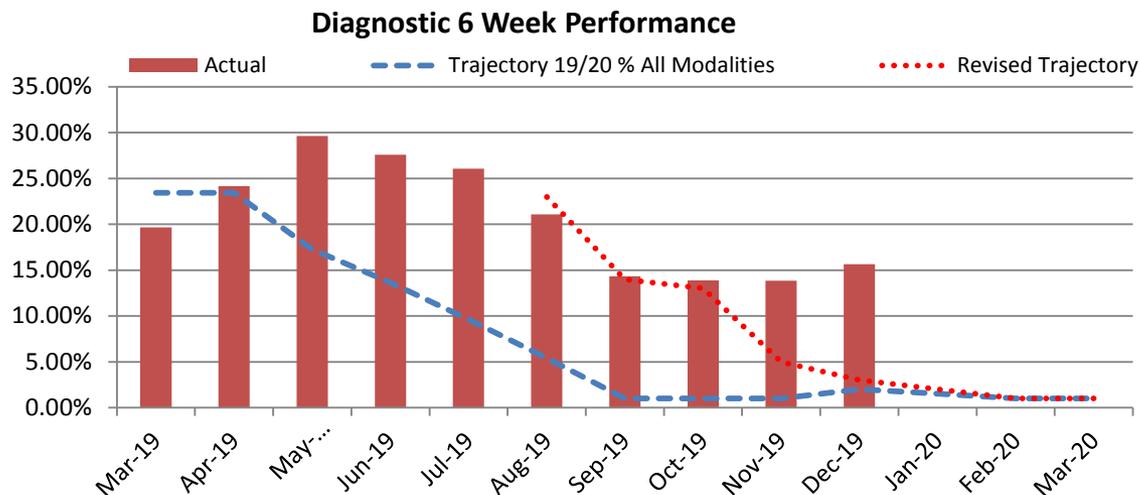
	2019/20		Var-18/19		Target
	Nov	YTD	Nov	YTD	
2 week GP ref to 1st OP	88.9%	88.2%	3.1%	1.3%	93%
2 week GP ref to 1st OP - breast symptoms	86.6%	82.3%	-2.0%	-13.9%	93%
31 day 2nd or subs trtmnt - surgery	96.9%	95.7%	-0.1%	-2.8%	94%
31 day 2nd or subs trtmnt - drug	95.0%	99.2%	-5.0%	-0.8%	94%
Cancer: 31 day second or subsequent treatment - radiotherapy	99.5%	99.9%	-0.5%	0.9%	94%
31 day diag to trtmnt all cancers	94.8%	94.9%	-1.7%	-3.6%	96%
62 day ref to trtmnt: screening	83.9%	69.0%	-1.5%	4.1%	90%
62 day ref to trtmnt : upgrade	94.1%	80.8%	14.1%	-3.6%	85%
62 days urgent GP ref to trtmnt : all cancers	73.1%	66.7%	-2.1%	-7.2%	85%

- The Trust was compliant in 3 of 8 reportable cancer metrics in Nov - 19.
- 2ww performance has dropped below target largely due to extended waits in colorectal.
- The Trust was non-compliant against the 62 day urgent referral to treatment target of 85%, with 73.1% of patients commencing treatment within 62 days. This is unchanged from the prior month.
- 36 patients were treated past the 62 day breach target out of a total of 134 treatments undertaken.
- Continued improvements have been made to reduce the number those waiting over 62 days for a definitive action.
- The total number of patients waiting over 104 days for a definitive action ha significantly reduced and is 10 as at 20th Jan 20.

19/20 Improvement Actions:

- Digestive Disease Straight to Test (STT) Pathway – expanding on the pilot delivering a straight to test pathway for 2WW colorectal referral (complete)
- Enhanced daily and weekly waiting list management
- Prostate-specific antigen (PSA) Monitoring - GP Surveillance of Patients with Prostate Cancer in Primary Care releasing capacity at the Trust (Q1)
- 28 day diagnostic delivery plan in progress

Systems and Partnerships – Diagnostics



- Trust diagnostics performance adversely increased by 1.8 % in Dec -19 compared to the previous month.
- The overall diagnostic waiting list has increased by 863 since Oct - 19.
- The diagnostic backlog of patients waiting over 6 weeks has increased by 275 since Oct - 19
- Non Obstetric Ultrasound remains compliant.
- The recovery plan in endoscopy is behind plan and has delayed overall diagnostic performance improvement.

Improvement Focus:

- The Trust have recast recovery plans by modality for imaging and endoscopic modalities which aim to reduce performance to a compliant position by March-20.
- Imaging recovery actions have delivered current performance improvement. Focus remains on reducing the wait time for cardiac CT/MRI.
- Reviewing cardiac CT protocol to become radiographer led (implementation Jan – 20)
- Endoscopy recovery plan approved and mobilised including outsourcing some endoscopy activity in the short term .

Financial Performance - Summary

Sustainability

Financial
Management

Target: Break Even

- For December, the Trust is reporting a deficit of £4.5m which is in line with plan.
- At the end of M9, the Trust has delivered a deficit of £42.5m, in line with the plan, so has earned £16.5m of PSF and FRF income. In addition the Trust has also received confirmation of £0.6m of 2018/19 as a post accounts reallocation PSF.
- The Trust is on trajectory to deliver an underlying deficit of £53m; which will earn an additional £25.4m of PSF and FRF funding. This will achieve the year-end deficit control total of £25.7m.
- Delivery of the control total will require close management of elective and non-elective capacity and control of the cost base, particularly in relation to medical pay, which is a break-through objective for 2019/20.

Financial Performance – Key Metrics

Finance and Use of Resources Risk Rating			A
	Plan	Actual / Forecast	Variance
Year-to-date	3	3	0
Year-end Forecast	3	3	0

At the end of December the aggregate rating is 3. Individual rating components are in line with plan apart from the agency spend rating as the ceiling has been exceeded year-to-date and is forecast to be exceeded by an estimated £2.30m.

Control Total (Surplus) / Deficit £k			G
	Plan	Actual / Forecast	Variance
Year-to-date exc PSF/FRF/MRET	42,504	42,464	40
Year-end Forecast exc PSF/FRF/MRET	52,996	52,964	32
Year-to-date	24,608	23,958	650
Year-end Forecast	25,747	25,105	642

The Trust deficit in Month 9, excluding PSF/FRF/MRET, is in line with the plan. As a result of delivering the underlying control total the Trust has earned £2.69m of PSF/FRF/MRET in-month (£17.90m year-to-date for 2019/20). In addition, the Trust has received £0.61m of 2018/19 post accounts reallocation PSF.

Efficiency and Transformation Programme £k			A
	Plan	Actual / Forecast	Variance
Year-to-date	17,350	16,518	(832)
Year-end Forecast	27,070	27,070	0

In Month 9, £2.70m of savings have been delivered against a plan of £2.60m. Year-to-date the Trust has delivered £16.52m against a plan of £17.35m and the Trust is forecasting full delivery of the £27.07m requirement.

Capital £k			A
	Plan	Actual / Forecast	Variance
Year-to-date	110,920	66,678	44,242
Year-end Forecast	147,440	107,124	40,316

Strategic Capital: expenditure of £51.9m; which is £38.0m behind plan due to a re-profile of the 3Ts project cash flow and the main contractor is currently in the process of finalising their latest programme.

Operational Capital: expenditure of £8.2m; which is £0.8m ahead of plan. Schemes are progressing through the capital investment group. The Endoscopy Fleet Replacement order for £2.9m has been placed, with £2.2m delivered in November and £0.7m expected in February 2020.

Financial Performance – Key Metrics

Income £k R

	Plan	Actual / Forecast	Variance
Year-to-date	(471,593)	(467,569)	(4,024)
Year-end Forecast	(634,819)	(628,858)	(5,961)

Income was above plan by £1.13m in-month giving a year-to-date adverse variance of £4.02m. Of this total, £4.03m relates to Patient Care Activities income.

Operating Costs £k G

	Plan	Actual / Forecast	Variance
Year-to-date	480,327	478,187	2,140
Year-end Forecast	649,645	680,870	(31,225)

In December operating costs were £1.59m above plan, £0.61m due to pay and £0.98m due to non-pay. Pay expenditure year-to-date is overspent by £1.85m, the key driver being medical workforce which is £4.14m above budget.

Agency Ceiling £k R

	Ceiling	Actual / Forecast	Variance
Year-to-date	8,906	10,795	(1,889)
Year-end Forecast	11,783	14,086	(2,303)

Agency expenditure in December was £1.08m, exceeding the agency ceiling target by £0.10m in-month (£1.89m year-to-date). The Trust is forecasting to exceed the target at year-end by an estimated £2.30m.

Cash £k G

	Plan	Actual / Forecast	Variance
Year-to-date	3,004	14,809	11,805
Year-end Forecast	3,004	3,605	601

The month-end consolidated cash balance was £14.8m against a plan of £3.0m. £10.0m will be required to pay capital invoices in January.

Financial Performance - Action & Recommendations

There are no actions required of the Board.

The Board is asked to note the following:

- Operational budgets are significantly challenged due to operational pressures seen in recent months and meeting service needs at a premium cost. Revised trajectories have been agreed and are key to ensuring delivery of the control total.
- The efficiency requirement is challenging and this increases as the year progresses. Plans are in place to deliver this but operational pressures will increase the risk of delivery; as such mitigations continue to be developed.
- The Trust is continuing to forecast delivery of the control total of £25.7m deficit; including securing PSF and FRF in full.

Our People - Improving Staff Engagement

People

Staff Engagement
Target: Top 20% Engagement
Score

Staff Engagement Score (Pulse Survey)

- Score of 6.8 in November and December 2019. This is against a target of 7. Year to our highest score was in June and July when we scored 7.2. The best performing Trust scored 7.6 in the national staff survey
- The Leadership, Culture and Workforce programme has been revised and updated

Breakthrough Objective (Pulse Survey)

- The percentage of staff recommending BSUH as a place to work in December was 69% compared to 73.6% of staff in November. This is against a target of 62%. November was our highest score year to date

Staff Survey

- The Trust has seen a year on year improvement in participation results from under 40% in 2016 to 59.1% in 2018 to our highest participation score of 61.5% in 2019.
- Staff Survey results will be available at the end of January 2020, with National results being available 18th February 2020.

Our People - Communications

People

Staff Engagement
Target: Top 20% Engagement
Score

Improving internal communications

Workplace. Forty percent of staff are now using the online communications and collaboration platform which was launched in October 2019. More than 210 groups have been created covering a wide range of wards, teams and interest groups. Workplace is now being used to deliver key operational messages around winter planning, including Reset weeks and the roll out of Live Beds.

Work is ongoing to increase sign up amongst key staff groups, in particular those that do not regularly sit in front of computer screens.

Leadership, Culture and Workforce

Patient First improvement stories are regularly featured in Buzz and on Workplace. Staff nominated throughout the year for a Star of The Month award were featured in a Christmas campaign which was widely viewed on the Trust social media channels. Reach figures to follow.

Support has also been provided to encourage colleagues to have the annual flu vaccination and included articles in Buzz, Workplace and the Intranet.

Work has begun on the Patient First Stars Award 2020 communications campaign ahead of a Trust wide launch on February 14.

Best of BSUH

The team have supported cricket and football team visits to The Alex, arranged proactive media coverage of the hospital's specialist play team on ITV Meridian and provided winter features on discharge planning and the pyjama paralysis campaign to local media across Sussex.

A large number of reactive media enquiries have been responded to covering a range of subjects including closer working with Queen Victoria Hospital

Our People - Capacity and Capability

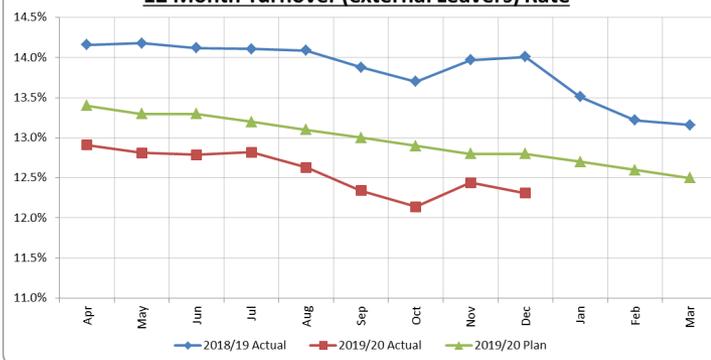
In M9, overall workforce spend was £33.64m against a plan of £33.03m. YTD workforce spend is overspent by £1.85m against a plan of £299.25m. Medical is the key driver of this YTD position with an overspend of £4.14m (of which £2.75m relates to Junior Doctors, £1.62m is Consultants and the balance is an underspend on SAS Doctors). The YTD position is partially mitigated by significant underspends in 'Other' Healthcare (£880k) which are largely AHP and STT staff and Management (£1.18m).

		Last Month	This Month	Variance
Worked	wte	8,151	8,333	↑
% Worked to Budget (WTE)	%	95.25	97.16	↑
Temporary Workforce	%	9.02	9.18	↑
Agency	%	3.85	5.90	↑
Bank	%	5.17	3.28	↓

Agency expenditure in December was £1.08m (3.2% of the total pay bill) , exceeding the agency ceiling target by £110k in-month (£1.89m year-to-date). The Trust year-end agency forecast is £14.08m, which will exceed the agency cap by an estimated £2.3m.

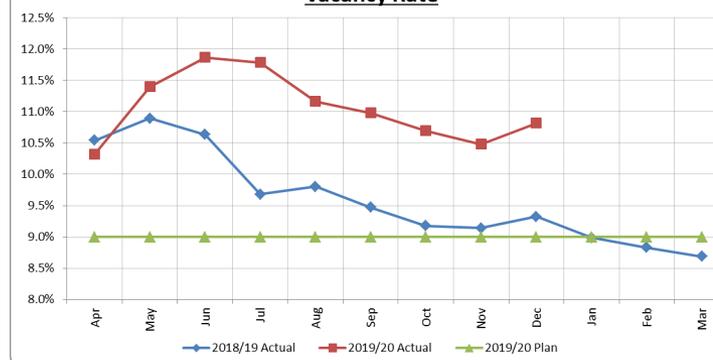
Our People – Key Metrics

12 Month Turnover (external Leavers) Rate



Turnover: In December the Trust’s Turnover (external leavers) rate reduced to 12.3%, and remains favourable to the 12.5% target for the 2019/20 plan. Turnover rates remain highest within the Scientific, Therapeutic & Technical staff group (15.5%) followed by Admin & Clerical staff (13.2%) and Unregistered Nursing (15.1%).

Vacancy Rate



Vacancies: In December the Trust’s overall Vacancy rate stood at 10.8%. Medical Vacancies have reduced by 9% (now 53WTE) and Ancillary Support Vacancies reduced by 27% (now 59WTE). Nursing shows the biggest growth of 39%, split 12% Registered and 138% Unregistered. An additional 109 WTE Unregistered Nursing Vacancies are largely due to an Establishment restructure reflecting Band 3&4 Nursing Associate roles.

Improvement Focus: Clinical divisions have prepared extensive operational and workforce plans for 2020-21 to address hotspots including pilot activities aimed at making a sustained difference to turnover, eg role re-design, nursing roster changes, identifying business critical roles and focusing on succession planning. Additionally, face to face and stay interviews continue to gather staff intelligence on reasons for leaving to further inform plans.

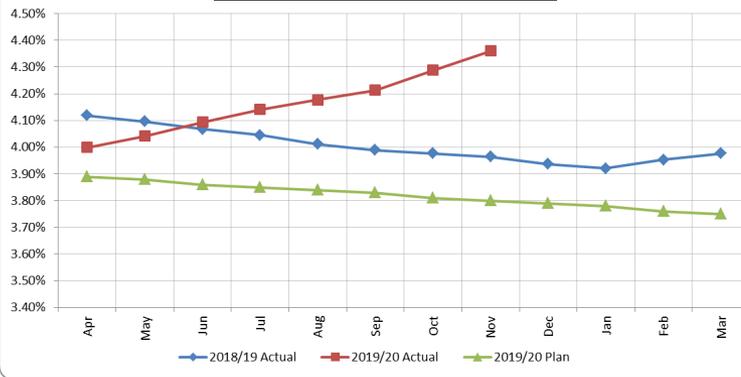
The Allocate programme have established a Corporate ‘Ways of Working’ group which will focus on the implementation of Allocate Rostering software and the effective optimisation of flexible patterns to provide staff opportunities for changing how and when they work.

Improvement Focus: To address our nursing vacancies we have invested in rolling recruitment days, one-stop shop healthcare assistant weekend recruitment days, an internal nursing transfer process and a thorough review of nursing skill mix across all nursing areas.

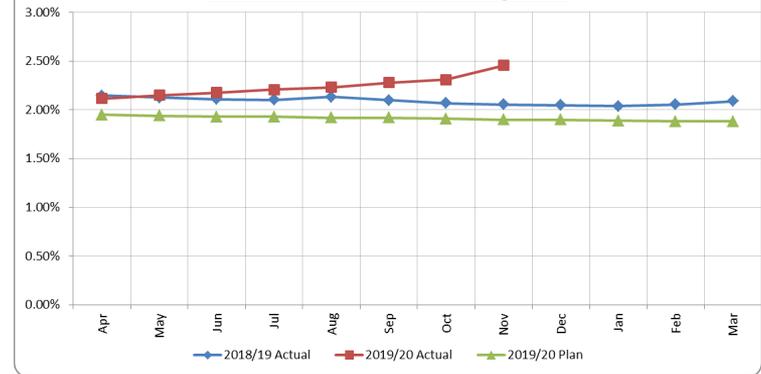
The new Chief Nurse is developing a comprehensive strategic workforce plan for Nursing, Midwifery and Therapy staff. A new rota for junior doctors in Speciality Medicine has improved engagement, reduced the need for temporary medical staff and promoted flexible ways of working.

Our People – Key Metrics

12 Month Sickness Absence Rate



Sickness Absence Rate - Long Term



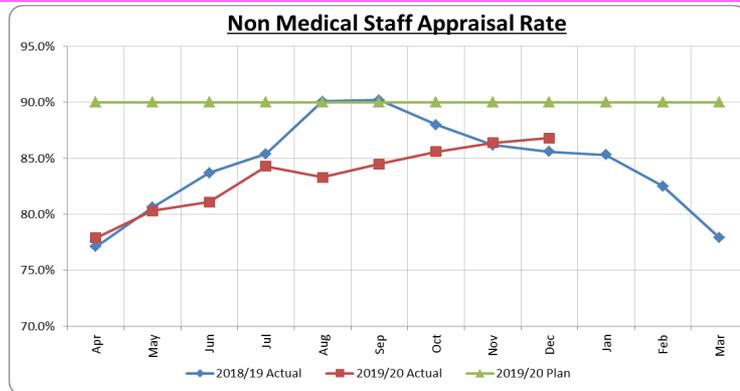
Sickness: The Trust's 12 month sickness absence rate continues an upwards trend, now standing at 4.36%. Short term sickness absence is 1.90% (from to 1.93% in November 2018) and long term absence is 2.46% (from 2.04% 12 months ago). The number of episodes of long term sickness (28 days or more) has risen by 22% in the past year to 1,168 from 956 in November 2018.

Improvement Focus:

The trust leadership team have agreed five key actions from this month:

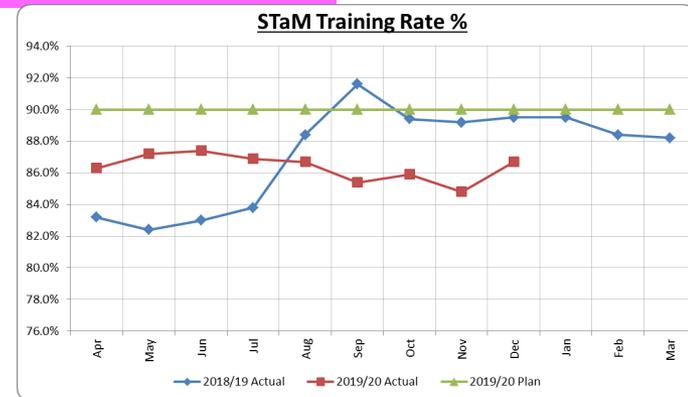
1. HRD led review of all long term sickness absence cases over 3 months to ensure that every member of staff is being supported and managed appropriately in line with Trust Policy/best practice.
2. A deep dive will be undertaken into the top 10 areas with the highest levels of sickness absence to establish the cause and remedies.
3. Nursing and Midwifery sickness and absence will be reviewed by the Chief Nurse and HR Director with the Heads of Nursing at the fortnightly Efficiency Programme Meetings.
4. The Director panel will review daily medical staff sickness absence and support divisions to address any specific issues.
5. The focus of the Health and Wellbeing Programme will be about going back to basics to enable managers to support their staff at work.

Our People – Key Metrics



Non-Medical appraisal: The Trust's Appraisal rate increased to 86.8% in December, the highest rate achieved since October 2018. While still below the target rate of 90%, the rate is better than 85.6% seen in December 2018 and is also the fourth best rate since records began.

Improvement Focus: The Divisional improvement plans continue to be implemented. There is an ongoing focus on quality of appraisals with appraisal policy training sessions available between January to March, to help support managers with the roll-out of the new policy and supporting documentation. Additionally, tailored training sessions are being actioned within divisions. The new incremental pay arrangements came in to place for new staff 1st April 2020.



STAM: The Statutory and Mandatory (STAM) compliance rate for December is 86.7 %. This figure is down 2.5 % from December 2018 (89.2%).

Improvement Focus: The focus is on addressing the decline in the overall compliance rate. Divisions are provided with monthly reporting to help address hotspot areas, with senior managers supporting divisional leads to improve compliance levels.

The new appraisal process supports the completion of STAM training to support overall Trust compliance, and there is a renewed focus at divisional and safety huddles during the busy Winter months on maintaining and improving compliance levels.

Agenda Item:	12	Meeting:	Board	Meeting Date:	29 Jan 2020
Report Title:	Board Assurance Framework – 2019/20 – Q3				
Sponsoring Executive Director:	Glen Palethorpe, Group Company Secretary				
Author(s):	Glen Palethorpe, Group Company Secretary				
Report previously considered by and date:	TEC – 3 December 2019 F&P – 28 January 2020 QAC – 28 January 2020				
Purpose of the report:					
Information	<input type="checkbox"/>	Assurance	<input checked="" type="checkbox"/>		
Review and Discussion	<input type="checkbox"/>	Approval / Agreement	<input checked="" type="checkbox"/>		
Reason for submission to Trust Board in Private only (where relevant):					
Commercial confidentiality	<input checked="" type="checkbox"/>	Staff confidentiality	<input type="checkbox"/>		
Patient confidentiality	<input type="checkbox"/>	Other exceptional circumstances	<input type="checkbox"/>		
Link to Trust Strategic Themes:					
Patient Care	<input checked="" type="checkbox"/>	Sustainability	<input checked="" type="checkbox"/>		
Our People	<input checked="" type="checkbox"/>	Quality	<input checked="" type="checkbox"/>		
Systems and Partnerships	<input checked="" type="checkbox"/>				
Any implications for:					
Quality	Quality related strategic risks				
Financial	Finance related strategic risks				
Workforce	Workforce related strategic risks				
Link to CQC Domains:					
Safe	<input checked="" type="checkbox"/>	Effective	<input checked="" type="checkbox"/>		
Caring	<input checked="" type="checkbox"/>	Responsive	<input checked="" type="checkbox"/>		
Well-led	<input checked="" type="checkbox"/>	Use of Resources	<input checked="" type="checkbox"/>		
Communication and Consultation:					
The Board Assurance Framework has been prepared in conjunction with each of the five Chief Officers, focussing on respective strategic objectives and determining their associated strategic risks.					
Executive Summary:					
Introduction					
<p>The Trust has identified 12 strategic risks to the delivery of its objectives. The oversight of the management of these strategic risks is documented within the Board Assurance Framework. Each risk has an assigned oversight committee who review the detail of the listed assurances and their impact on the current score along with the delivery of the actions to reduce to or maintain the risk at its target score. The Target Risk Scores are set with reference to the Trust’s stated risk appetite at appendix A.</p> <p>For quarter 3 there have been TWO changes from the Q2 assessed score, with risks 2.2 and 5.2 both increasing.</p>					
BAF SUMMARY					
<p>The table overleaf shows by risk, their current score and their target risk score. Noting that for one risk (4.2) this continues to be scored at its target score and thus the BAF process for this risk is about securing assurance that this acceptable (target) level of risk is maintained.</p>					

The table also shows pictorially the movement in risk between the current score for Q3 and that recorded for Q1. (\longleftrightarrow No change, \uparrow an increase in risk and \downarrow a decrease in risk

BAF: Strategic Objectives and Strategic Risks (Key: I = Impact L = Likelihood T = Total)	Risk Scores											
	Opening risk			Q2			Target					
	I	L	T	I	L	T	I	L	T	I	L	T
1. Patient Quality Assurance Committee												
1.1 we are unable to deliver or demonstrate a continuous and sustained improvement in patient experience resulting in adverse reputational impact and loss of market share	3	3	9	3	3	9 \longleftrightarrow	3	3	9 \longleftrightarrow	3	2	6
2. Sustainability Finance and Performance Committee												
2.1 We are unable to align or invest in our workforce, finance, estate and IM&T infrastructure effectively to support operational resilience, deliver our strategic and operational plans and improve care for patients	4	4	16	4	4	16 \longleftrightarrow	4	4	16 \longleftrightarrow	4	2	8
2.2 We cannot deliver ongoing efficiencies and flex our resources in an agile way resulting in an increasing or unmanaged deficit and inefficient, unaffordable and unsustainable services	4	3	12	4	3	12 \longleftrightarrow	4	4	16 \uparrow	4	2	8
2.3 We are unable to meet high standards of financial stewardship meaning we cannot sustain compliance with our statutory financial duties	4	3	12	4	3	12 \longleftrightarrow	4	3	12 \longleftrightarrow	4	2	8
3. People Quality Assurance Committee												
3.1 We are unable to appropriately develop and sustain the leadership and organisational capability and capacity to lead on going performance improvement and build a high performing organisation.	4	3	12	4	3	12 \longleftrightarrow	4	3	12 \longleftrightarrow	4	2	8
3.2 We are unable to effect cultural change and involve and engage staff in a way that leads to continuous improvements in patient experience, patient outcomes, and staff morale and wellbeing	4	3	12	4	3	12 \longleftrightarrow	4	3	12 \longleftrightarrow	4	2	8
3.3 We are unable to meet our workforce requirements through the effective recruitment, development, training and retention of staff adversely impacting on patient experience and the safety, quality and sustainability of our services	4	3	12	4	3	12 \longleftrightarrow	4	3	12 \longleftrightarrow	4	2	8
4. Quality Improvement Quality Assurance Committee												
4.1 We are unable to deliver and demonstrate compliance with regulatory requirements or clinical standards adversely impacting on patient safety and our registration and accreditation by	3	4	12	3	4	12 \longleftrightarrow	3	4	12 \longleftrightarrow	3	3	9

regulatory and supervisory bodies														
4.2 We are unable to deliver service improvements and improve safety, care quality and outcomes for our patients or demonstrate that our services are clinically effective	3	2	6	3	2	6	↔	3	2	6	↔	3	2	6
5. Systems and Partnerships														
Finance and Performance Committee														
5.1 We are unable to develop and maintain collaborative relationships with partner organisations based on shared aims, objectives, and timescales leading to an adverse impact on our ability to operate efficiently and effectively within our health economy	4	3	12	4	3	12	↔	4	3	12	↔	3	3	9
5.2 We are unable to define and deliver the strategic intentions, plans and optimal configuration that will enable our services to be sustainable, leading to an adverse impact on their future viability.	4	3	12	4	3	12	↔	4	5	20	↑	4	2	8
5.3 We are unable to deliver and demonstrate consistent compliance with operational and NHS constitutional standards resulting in an adverse impact on patient care and financial penalties	4	4	16	4	4	16	↔	4	4	16	↔	4	3	12

Committee Review

Each BAF risk has an allocated lead oversight Committee, however, it is recognised that for some risks other Committees will also receive assurance against elements of control with respect to that risk.

Quality Assurance Committee

The Committee's review of the risks to which they have allocated oversight and their receipt of assurance at their meetings across Quarter 1, Quarter 2 and the start of Quarter 3 did not identify any negative assurance that required any risk to be referred back to the Executive for review for being under stated. The Committee at the request of the Finance and Performance Committee considered if there was any quality impact due to the increase in patient waits but were assured that for significant delay each case is clinically reviewed and no issues were identified that would require the quality risks to be increased.

Finance and Performance Committee

The Committee's review of the risks to which they have allocated oversight and their receipt of assurance at their meetings across Quarter 1 and the start of Quarter 2 did not identify any negative assurance that required any risk to be referred back to the Executive for review for being under stated. However at the end of Quarter 2 the Committee recognised the reports from the Executive showed increased risk in relation to the financial position of the Trust and the increase in demand as a pressure on risk 5.3 in relation to the delivery of the Trust's operational targets.

At the start of Quarter 3 the Committee agreed and recommended to the Board that the BAF risks and 2.2 be increased to a current score of 16. Countermeasure reports in the form of the Trust's road map to deliver the Trust's control total have been presented to Finance and Performance Committee which include information on planned mitigations and the delivery of which will be tracked within the routine reports to Finance and Performance Committee.

The Committee continues to recognise the pressure within the wider system which could increase the

risk in relation to strategic risk 5.1. The Board itself recognised the increased risk to the Trust's delivery of its Strategic Intentions relating to service configuration, which is reflected in potential longer term risks, and therefore agreed risk 5.2 should be increased. However the Board also received assurance on the steps being taken to mitigate these risks, and also was assured that there was no impact on current patient care.

Audit Committee

The Audit Committee considered the BAF along with the key highly scoring risks that underpin the BAF and felt there was no need to refer any risk to the Executive for review for being under stated.

The Committee did undertake a more detailed review at its October Committee meeting of risks 3.1 and 3.2 to complement the reviews undertaken by the Quality Assurance and Finance and Performance Committees and confirmed that the reported assurance did support the stated current risk scores for Q2.

Trust Executive Committee

The Trust Executive Committee considers the BAF alongside the highly scored divisional / corporate risks. The Committee within its meeting has not identified any increasing divisional risks that have required a reassessment of the scored strategic risks.

Key Recommendation(s):

The Board is recommended to consider the level of current risk recorded within the BAF against reported assurances via the various Committees and assurances provided direct to the Board over the period covered by this report and agree that this represents a balanced view of assurance and its impact on the key risks to the achievement of the Trust's stated objectives.

Appendix A

Risk Appetite Statement

The Boards of NHS Trusts are accountable for ensuring the quality, safety and sustainability of the services they provide to patients. Brighton and Sussex University Hospitals NHS Trust sets clear expectations for the Trust through strategic objectives.

The Trust operates in a high risk environment and the day to day management of risk is an expected and integral part of the business of any healthcare provider. Overall, the Board has a **moderate** appetite for risk in relation to the achievement of its objectives and takes active and ongoing actions as part of our daily operational management and strategic planning to reinforce our risk controls in order to minimise risk to a tolerable level.

Our Board Assurance Framework and risk registers will continue to reflect material risks that may prevent the Trust from fulfilling its role in delivering clinical services which meet regulatory and NHS Constitutional standards and the expectations of our stakeholders and patients. We have defined our appetite for risk in relation to our strategic objectives as follows:

Patient Care: We make delivering an excellent care experience for our patients our highest priority. However, we will accept **moderate** risks to patient experience if this is required to achieve patient safety and quality improvements.

We have a **low** risk appetite for actions and decisions that, whilst taken in the interests of ensuring quality, safety and sustainability, may affect the reputation of the Trust or of the wider NHS. Such actions and decisions would be subject to a rigorous risk assessment and be signed off by the Board.

Safety: We will deliver safe, high quality clinical services and demonstrate they achieve optimal clinical outcomes and deliver best practice for our patients whilst ensuring we meet regulatory standards. Overall, our risk appetite for safety is **low**. Specifically:

We have a **low** appetite for risks that could result in poor quality care or unacceptable clinical risk, non-compliance with standards or poor clinical or professional practice.

We have a **low** appetite for risks that may jeopardise patient safety.

We recognise that it can be in the best interests of patients to have a **moderate** appetite for some individual patient care and treatment risks in order to achieve the best outcomes. Therefore we support our staff to work in collaboration with the people who use our services to develop appropriate and safe care and treatment plans based on assessment of need and clinical risk.

We will apply strict safety protocols for all of clinical and non-clinical activity, when and wherever possible. We will report, record and investigate our incidents and ensure that we continue to learn lessons to improve the safety and quality of our services.

Sustainability: We strive to use our resources efficiently and effectively for the benefit of our patients and their care and ensure our services are clinically, operationally, and financially sustainable. We will always aim to achieve this objective; however, overall we have a **moderate** appetite for risk in this area. Specifically:

We have a **moderate** appetite for some financial risks where this is required to mitigate risks to patient safety or quality of care. We will ensure that all such financial responses deliver optimal value for money.

We are committed to providing patient care in a therapeutic environment and providing staff with an environment and supporting infrastructure in which to perform their duties. However, we have a **moderate** appetite for some risks related to our infrastructure and estate except where these adversely impact on patient safety, care quality and regulatory compliance

We will increase our appetite for financial risk to **significant** in some instances and consider all potential delivery options to ensure the delivery of our objectives. Our appetite for risk in this area recognises the financial environment in which NHS trusts are operating, and the requirement to maintain regulatory and constitutional standards. A decision to take this level of risk would be based on a rigorous risk assessment and a review of the robustness of the controls and would require sign off by the Board.

We are prepared to support investments for return and minimise the possibility of financial loss by managing associated risks to a tolerable level. Value and benefits will be considered and resources allocated in order to capitalise on opportunities.

People: We value and respect all our staff equitably, involve them in decisions about the services they provide and offer the training and development they need to fulfil their roles. We will rarely accept risks that would limit our ability to achieve this objective and the Trust's overall risk appetite for workforce related risks is **low**. Specifically:

We have a **low** appetite for risks related to the recruitment, retention and training of staff to deliver safe, high quality services and good patient experience.

We have **no** appetite for risks associated with unprofessional conduct, bullying, or an individual's competence to perform roles or tasks safely nor any incidents or circumstances which may compromise the safety of any staff members and patients or contradict our values.

We have a **moderate** appetite for risks associated with the implementation of non-NHS standard terms and conditions of employment, innovative resourcing, and staff development models where these enhance or improve patient safety, care quality, service delivery or financial sustainability.

We have **no** appetite for any risk that could result in staff being non-compliant with legislation, or any frameworks provided by professional bodies.

We have **no** appetite for any risk that could result in us being in breach of our contractual or statutory responsibilities in relation to our staff or in a breach of our staff's employment rights.

Systems and Partnerships: We will collaborate with commissioners, local authorities, our other partners and other care providers to prevent ill health, plan and deliver services that meet the needs of our local population and deliver operational and NHS constitutional standards. Overall we have a **moderate** appetite for risks to the achievement of this objective. Specifically:

We have a **moderate** appetite for risk where this results in improvements in the design or delivery of healthcare services for our patients or the population we serve. Our appetite for risk in this area recognises that the Trust operates in a complex environment and is subject to very challenging economic conditions and changing demographics with intense scrutiny. We consider the risks associated with innovation, creativity and clinical research to be an essential part of the Trust's risk profile. We increase our appetite for risk in this area to **significant** in order to maximise the opportunities to improve patient outcomes and the Trust's sustainability. . A decision to take this level of risk would be based on a rigorous risk assessment and a review of the robustness of the controls and would require support of the Board.

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

BSUH PUBLIC BOARD

ITEM 13

IM&T UPDATE PRESENTATION

A COPY OF THE PRESENTATION WILL BE AVAILABLE ON THE DAY

Agenda Item:	14	Meeting:	BSUH Public Board	Meeting Date:	29/01/19
Report Title:	Equality Annual Report 2019				
Sponsoring Executive Director:	Helen Weatherill, Director of Human Resources				
Author(s):	Equality, Diversity and Inclusion Team.				
Report previously considered by and date:	Diversity Matters Steering Group December 2019				
Purpose of the report:					
Information	<input checked="" type="checkbox"/>	Assurance	<input checked="" type="checkbox"/>		
Review and Discussion	<input checked="" type="checkbox"/>	Approval / Agreement	<input checked="" type="checkbox"/>		
Reason for submission to Trust Board in Private only (where relevant):					
Commercial confidentiality	<input type="checkbox"/>	Staff confidentiality	<input type="checkbox"/>		
Patient confidentiality	<input type="checkbox"/>	Other exceptional circumstances	<input type="checkbox"/>		
Link to Trust Strategic Themes:					
Patient Care	<input checked="" type="checkbox"/>	Sustainability	<input type="checkbox"/>		
Our People	<input checked="" type="checkbox"/>	Quality	<input type="checkbox"/>		
Systems and Partnerships	<input type="checkbox"/>				
Any implications for:					
Quality					
Financial					
Workforce	There are strong links between discrimination and poor patient experience. Also there are clear links between equality, inclusion and staff wellbeing.				
Link to CQC Domains:					
Safe	<input type="checkbox"/>	Effective	<input type="checkbox"/>		
Caring	<input type="checkbox"/>	Responsive	<input type="checkbox"/>		
Well-led	<input checked="" type="checkbox"/>	Use of Resources	<input type="checkbox"/>		
Communication and Consultation:					
This report has been shared with the WRES Working Group and the Diversity Matters Steering Group (with a recommendation for the report to be approved by the Board).					
Executive Summary:					
<p>The report is required to be produced on an annual basis.</p> <p>The information contained demonstrates our demographic awareness of patients and workforce, and where there are discrepancies in outcome due to protected characteristics, the processes in place to rectify them.</p>					
Key Recommendation(s):					
This report has been submitted to the Board for approval – submission Equality Annual Report must be uploaded onto our web-site by 31 st January 2020. .					



Annual Equality Report 2019

January 2020

The Inclusion Team



Contents

Introduction.....	2
Who benefits from this report.....	3
Vision statement.....	4
What is the Trust doing to further the inclusion agenda?.....	5
Research from the LGBTQ+ Network.....	19
Brighton and Sussex University Hospitals NHS Trust Equality Objectives	21
Who are the local communities the trust serves?.....	23
Who are the Trust's workforce?.....	27
Quick facts about management staff (excluding medical staff).....	39
Results from the NHS Staff Survey 2018.....	40
Information about staff that have left the Trust during 2018/19.....	53
The Trust's recruitment processes data.....	63
The Trust's employment policies and practices data.....	68
Training and development opportunities.....	72
What does the data tell us about our staff?.....	75
Who are the Trust's patients?.....	90



Introduction

Brighton and Sussex University Hospitals NHS Trust recognises that its workforce and patients are core to achieving its business and social responsibilities. The aim of this report is to help demonstrate progress in delivering the best possible inclusive healthcare services. The report will also help to demonstrate that the Trust has a workforce which is valued, reflective of and meeting the needs of the communities that the Trust serves.

As one of the largest employers in the area and a major public sector service provider, the Trust is duty bound by legislation to ensure everyone receives a fair and equitable service, in effect promote a culture of active inclusion. The Equality Act 2010 specifically states that people should not be treated unfavourably because of:

- their age
- any disabilities they may have
- their ethnic background or race
- their gender (sex as defined in the act)
- their gender identity (gender reassignment as defined in the act)
- their marital status
- if they are pregnant or recently had a baby
- any religion or beliefs they may have
- their sexual orientation

These nine attributes are known as the protected characteristics.

The contents of this report will help to demonstrate how compliant the Trust is with a number of national, legislative, NHS specific and regulatory drivers that include:

- BSUH Equality Objectives (in this report) – a requirement set by the Equality Act 2010, Public Sector Equality Duty
- Care Quality Commission – The Fundamental Standards (Health and Social Care Act 2008 (Regulated Activities) Regulations 2014)
- Equality Act 2010 – including the Public Sector Equality Duties
- Equality and Human Rights Commission – Codes of Practice
- Human Rights Act 1998
- NHS Constitution
- The Trust's Patient First Programme – This is a programme to deliver improvements for both patients and staff

Brighton and Sussex University Hospitals NHS Trust is an acute hospital based across two main sites: the Royal Sussex County Hospital in Brighton and the Princess Royal Hospital in Haywards Heath. The Brighton campus includes the Royal Alexandra Children's Hospital and the Sussex Eye Hospital. The Haywards Heath campus includes Hurstwood Park Regional Centre for Neurosciences and the Sussex Orthopaedic Centre. The Trust also provides services in: Brighton General Hospital, Lewes Victoria Hospital, Bexhill Renal Satellite Unit, Hove Polyclinic, Park Centre Breast Care, Goodcourt Medical Centre and Worthing Hospital.

This report provides a summary of activity and a snapshot of demographical data covering 1st April 2018 to 31st March 2019. As a public sector organisation extra care is taken to monitor decisions that could unfairly affect any particular protected characteristic of staff, carers, volunteers, patients and their families.



Who benefits from this report?

Those with an interest in our services

Collecting and analysing data allows the Trust to see if it is meeting both corporate and equality objectives. The data helps demonstrate if services are being delivered are safe, effective and of high quality. The data can also highlight areas where the Trust needs to improve and opens the door to inclusive engagement with relevant stakeholders.

This report can also be used by those who interact with our services, local charities and commissioners to review any barriers to access or outcomes. Publishing this report is an important part of demonstrating transparency, acting as an enabler to communicate how we are tackling inequity and it also acts as a lever to improve quality.

Those who work within the Trust

Attracting, developing and retaining a diverse and reflective workforce are essential to delivering responsive and inclusive services. Having such a workforce encourages the Trust to develop and deliver services that understand the complex needs of the diverse communities it serves. National research suggests that the degree to which organisational demography is representative of community demography drives positive effects in terms of patient experience. (Why Organisational and Community Diversity Matter: Representativeness and the Emergence of Inclusivity and Organisational Performance, King et al., 2011).



Vision statement

Equality, Diversity and Inclusion at the Brighton and Sussex University Hospitals NHS Trust

Our vision is for equality, diversity and inclusion to be a 'golden thread' running through, and central to, how we work together to provide sustainable high quality patient-centred care for all people we serve.

Our vision is intended to provide a focus and vision for the delivery and development of all our services.

Our patients and service users:

- 1) Have confidence their individual needs and beliefs are taken seriously and they are treated with dignity and respect.
- 2) Know their individual life chances and well-being are enhanced by the Trust's commitment to equality, diversity and inclusion.
- 3) Are happy to choose to use and recommend the organisation.

Our staff:

- 1) Feel valued and fairly treated in an organisation that really cares.
- 2) Knows the Trust as an organisation that people want to come and work for, stay with and thrive in, because of its commitment to equality, diversity and inclusion.
- 3) Are proud to work in an open and inclusive organisation.

Our communities:

- 1) Assured the Trust engages with the diverse communities based on mutual interest and respect.
- 2) Confident the Trust is active in tackling inequality, making services accessible, solving problems, delivering solutions and willing to learn.
- 3) The Trust is responsive to the challenges faced by people in relation to diverse needs and communicates appropriately.

Our organisation:

- 1) Lives its values consistently across all sites.
- 2) Demonstrates long-term, consistent commitment to equality, diversity and inclusion for the people it serves.
- 3) Is a positive, innovative and 'can do' place to be.



What is the Trust doing to further the inclusion agenda?

The Trust undertakes a wide range of work, projects and activities to support the inclusion agenda to benefit patients and the workforce. Below is a summary of some of the key highlights that occurred during 2018/19.

Diversity Matters Steering Group (DMSG)

The steering group is co-chaired by the Chief Executive and the Chief Workforce and Organisational Development Officer. The group provides a valuable forum to discuss issues that impact equality and inclusion in the Trust for both staff and patients.

DMSG also provides governance for action plans (such as the NHS equality standards, which are Workforce Race Equality Standard, Workforce Disability Equality Standard and the Stonewall Workplace Equality Index) and relevant policies and guidelines. The steering group reports up to the Trust Executive Committee and the Trust Board.

Leadership, Culture and Workforce (LCW)

The Board demonstrating their commitment to address the longstanding equality and inclusion issues within BSUH, created a Leadership, Culture and Work (LCW) Programme, which has Executive ownership and leadership.

There are work streams which covers a range of activities that impact our staff – this is led by our Chief Executive, Dame Marianne Griffiths.

The work streams are:

1. Corporate Structures
2. Leadership Development
3. Communications
4. Equality and Diversity
5. Recruitment and Retention
6. Violence and Aggression
7. Medical Engagement
8. Staff Engagement
9. Appraisals
10. Health and Wellbeing

11. Integrated Education
12. Statutory and Mandatory Training (STAM)
13. National Guardian's Office Recommendations (Freedom to Speak Up)

The overall aim of the programme is to deliver sustainable improvements within the culture of the organisation and to improve staff experience and engagement.

Gender Pay Gap Reporting

All large employers are required to publish the pay and comparison of differences in pay for men and women. This helps to demonstrate on an organisational level if there are disparities or inequalities.

The report highlighted that the main issue for the Trust was the number of female doctors putting themselves forward for the Clinical Excellence Award (CEA). A working group has been formed to look at the issues surrounding this and have developed an action plan.

To see the 2018 report and action plan, please go to:

<https://gender-pay-gap.service.gov.uk/Employer/QqOrRsA6>

NHS England Equality Standards

The Trust has participated in the Workforce Race Equality Standard (WRES) since 2015. The WRES looks at a number of factors that help to demonstrate race equality within Trust processes and services for staff. The areas that are looked at in the standard include:

- Representation in the general workforce
- Recruitment
- Entry into the disciplinary process
- Access to non-mandatory and CPD training
- Experiencing bullying, harassment or abuse
- Provision of equal opportunities and career progression and development
- Representation in the Board

Data is taken from the NHS Staff survey, Electronic Staff Records and local employee relations and recruitment databases.

<https://www.bsuh.nhs.uk/about-us/equality-diversity-and-human-rights/edi/>

The Workforce Disability Equality Standard (WDES) was mandated in the NHS Standard contract in April 2018 with implementation in April 2019. The reporting period for the standard covered 2018/19. The aim of the standard is demonstrating

fairness within services using standardised data available to all NHS Trusts, the standard will also highlight areas for improvement. This standardisation of data allows NHS Trusts to compare the experiences of disabled and non-disabled staff in a range of areas that impact staff. A specific working group (formed of Trust staff) has been formed to look at issues raised within the standard.

The areas that the standard looks at include:

- Workforce representation
- Recruitment
- Entrance into formal capability processes
- Experiences of discrimination, harassment and abuse
- Provision of equal opportunities and career progression and development
- Feeling pressured to come into work when not feeling well enough to perform duties
- Satisfaction of staff in terms of valuing work and contribution
- Reasonable adjustments
- Engagement of disabled staff
- Representation of disabled staff in the Board.

If you would like to see the report and action plan, please go to:

<https://www.bsuh.nhs.uk/about-us/equality-diversity-and-human-rights/edi/>

NHS England has released the Sexual Orientation Monitoring Standard, the standard will look at sexual orientation monitoring for patients. This standard has been implemented with the Trust and ensures there are appropriate standardised ways of recording the sexual orientation of patients/service users (over 16 year of age) in NHS services and some elements of social care.

Further information about the standard can be found by going to:

<https://www.england.nhs.uk/about/equality/equality-hub/sexual-orientation-monitoring-information-standard/>

Stonewall Workplace Equality Index

In 2018/19 the Trust entered the annual Stonewall Work Equality Index. This index allows organisations to identify how equitable they are to LGBT staff. The Trust ranked at 143 out of 445 organisations, which was a good achievement as there has been a gap since the last entrance into the index.

The index looks at a number of key areas that include:

- Policies and benefits
- The employee lifecycle

- LGBT employee network group
- Allies and role models
- Senior leadership
- Monitoring
- Procurement
- Community engagement
- Clients, customers and service users
- Any additional work
- Employee feedback

The Trust is preparing for the next submission and has assembled a project team to manage the 2019/20 submission. It is an ambition that the Trust works to be recognised as a 'Stonewall Top 100 Employer'.

The Inclusion Team

The Trust continues to have a dedicated Inclusion team, comprised of a Head of Inclusion (key areas of responsibility include Race and WRES), Deputy Head of Inclusion (key areas of responsibility include service improvement, disability, and the Workforce Disability Equality Standard) and Inclusion Advisor (key area of responsibility is training). This enables the organisation to benefit from their expert advice for both staff and patients. Our Head of Inclusion participated in the Workforce Race Equality Standard (WRES) Experts Programme and completed Cohort 1 in October 2018, thus ensuring that the Trust benefits from their knowledge.

Due Regard Assessments

This is a process where policies and practices (and anything else that would affect our workforce, patients or service delivery) are reviewed. The review makes sure they will not unfairly impact on groups protected by the Equality Act 2010. The assessments also ensure any opportunity to promote equality is taken.

During 2018/19 the Inclusion team supported more than 30 assessments.

Freedom of Information Request

The Freedom of Information Act 2000 was introduced to promote transparency within public services. The Inclusion team completed 4 such requests between 2018/19; mainly dealing with the use of interpretation and translation within the Trust.

Staff Conferences

The Trust held three staff conferences in 2018/19, they were as follows:.

The first conference took place in May 2018 and this was our Race Equality Conference. This reviewed our 2017 Workforce Race Equality Data, and with the support of our Chief Executive, Chief Workforce and Organisational Development Director, Yvonne Coghill OBE and the NHS WRES Team – staff were asked to provide a commentary on the report and to help suggest methods of the inequality that were found.

The second conference was held in July 2018, it was called ‘Race and Culture; Next Steps’ and this conference looked not only at Race, and helped solidify the work that had been undertaken since the Conference in May, it also looked at wider equality issues – particularly in the context of Sexual Orientation and how we can help change the narrative when needed, with regards to potentially unacceptable language that might still be used.

The third conference was held in July 2018, this conference was aimed at senior managers and looked at intersecting issues affecting equality and leadership.

2019 LGBTQ+ Inclusion Conference

On 26th February 2019, the Network supported the Trust’s first LGBTQ+ Inclusion Conference. Our Chief Executive, Dame Marianne Griffiths, opened the conference, which brought together over 230 Trust staff, healthcare partners and third sector organisations. Presentations from Stonewall set our work in a national context, which was then followed by in-depth exploration of local data. (from our 2018 LGBTQ+ Staff Survey, and analysis of the NHS Staff Survey by Sexual Orientation).

During the event, delegates played a bespoke board game (‘Journey To True North: Follow The Yellow Brick Road’). The game was designed to tackle stereotypes and encourage creative ways of providing new answers to longstanding challenges.

Players called it “fantastic”, “amazing” and “a great way to develop ideas”. It is now played throughout the Trust, and a shortened ‘travel version’ is in development.

Staff Networks

LGBTQ+ Network

The LGBTQ+ Network has expanded and developed significantly during this year, supporting a wide range of events and initiatives to improve LGBTQ+ staff and patient experience. Monthly newsletter subscriptions and our social media following (www.twitter.com/bsuh_lgbtq) have also grown.



Inclusion Employer of Choice

There has been a significant increase in the proportion of staff employed who identify as LGB+ from 1st April 2018 to 31st March 2019. The proportion of LGB+ staff who 'prefer not to say' what their Sexual Orientation is has also fallen from 1 Apr 2018 to 31 March 2019. Together, these data suggest that BSUH is building its reputation as an inclusion employer of choice, and that more colleagues feel confident being their authentic selves at work. Research shows that when people are able to be themselves, they are able to give even better care to patients. Helping colleagues to feel included and equal is at the heart of achieving our Patient First ambitions.

Stonewall 2019 Workplace Equality Index

The Network supported the Trust's application for the Stonewall 2019 Workplace Equality Index (WEI). This is an external benchmark of our progress towards equity for LGBTQ+ staff, and also covers LGBTQ+ patient experience.

During the first LGBTQ+ Inclusion Conference (see staff conferences section), it was exclusively revealed that the Trust reached 143rd out of 445 entrants in the 2019 WEI. This was a remarkable achievement, and we are building on this for the 2020 WEI assessment.

Supported by Allies

The Network is fortunate to have continuing high level of support from non-LGBTQ+ people (Allies). These people may wear a rainbow pin/lanyard, and can be counted on to stand up for the rights and freedoms of their LGBTQ+ colleagues. Allyship within the wider LGBTQ+ umbrella has also been promoted.

Allies are involved with the full spectrum of Network activity. In this year, new allies have been welcomed from:

- The Trust Board
- The Nursing Directorate (including the Nurse Director)
- The Medical School
- The HR and the Recruitment Teams
- The 3Ts team
- The Chaplaincy
- Clinical Governance, and many more.

Events

The Network hosted a wide range of social and sporting events throughout the year. There was a specific focus on widening participation, Health & Wellbeing, and moving away from traditional 'down the pub' settings.

Events included theatre trips, bingo, countryside walks, yoga, Zumba and our 2nd Annual Volleyball Tournament and Sunset beach Picnic. The Network has also supported international/national initiatives such as Lesbian Visibility Day or the International Day Against Homophobia, Biphobia, Intersexism and Transphobia.

BSUH Disabled Staff Network

In February 2019, staff launched the BSUH Disabled Staff Network (DSN) and Marce Quinn leads the network. The BSUH DSN provides staff with a safe space to discuss issues that are affecting staff who have a disability or long term health condition. The network also provides a forum to discuss improvements that could be made to improve the standards for disabled staff.



Marce is a member of the WDES Working Group and has helped to contribute to the action plan.

Workforce Race Equality Working Group

As a consequence of the May 2018 Race Equality Conference, an initially small (10) group of staff responded to the 'call to action' from our Chief Executive to help us improve the data surrounding WRES. The working group was formed in June 2018 and has met monthly, devised a Partnership and Engagement Plan 2018 – 2021 which has been fully supported by the Trust Board, and this is in part our WRES Action Plan. The main areas of focus are:-

- Recruitment
- Communication
- Education and Training

Members of the working group felt that by concentrating on these issues – it would have the greatest positive impact on our BME workforce.

Information to support the workforce and patients

The Inclusion team has produced or made available a wide range of information that promotes good practice to assist staff and patients. The team are also happy to discuss issues or concerns that staff or patients may have about inclusion issues in the Trust.

The EDI team have worked with our Critical Care and Emergency Departments to improve the quality of information that was available to patients, carers and relatives

that do not communicate in English. This was highlighted in the latest Care Quality Commission regulatory inspection report (published 8th January 2019) as being beneficial to patients, carers and their relatives.

Examples of such information can be found on the Trust's website or by contacting the team on 01273 696955 ext. 64685 or emailing bsuh.equality@nhs.net.

The Trust is currently reviewing its recruitment processes to ensure that fairness and equity is leveraged throughout. An initial way will be to utilise picture cards representing a full range of diverse people/needs – which will require candidate feedback and bring to the fore any potential unconscious biases.

Training

The Inclusion team have facilitated a number of general and specialised training sessions. Training helps ensure the workforce are aware of their responsibilities under equality legislation, and to be able to meet a wide range of needs. General equality awareness training can be completed either by face-to-face or e-learning. This approach makes sure a wide range of learning styles and working patterns can be accommodated.

The Inclusion team provide training on the Trust's Corporate Induction and Statutory and Mandatory Training programmes.

Staff have been offered targeted training on issues relating to gender and sexual diversity.

The Audiology department run regular deafness and hearing impairment awareness workshops. The workshops provide staff a further insight into the issues faced by communities with hearing issues. The workshop also looks at methods of communication.

Service Improvements and other initiatives

NHS Accessible Information Standard

The standard was launched in July 2016, however in the lead up, the Inclusion team provided information and support to the workforce to ensure they can consistently meet the requirements in the standard. The standard was introduced to ensure patients who have additional communication needs (which have been caused by a disability) are consistently met by NHS Trusts. For more information about the standard please visit: <https://www.england.nhs.uk/ourwork/accessibleinfo/>.

The workforce has access to a range of interpretation and translation services, hospital communication books and a Learning Disabilities Liaison Team. The

Inclusion team have also provided support by: purchasing and distributing Sonido Personal Listening Devices to a number of wards and departments, providing hospital communication books (this provides a pictorial way of communicating) to wards and departments, and purchasing the 'Recite Me' system which has helped to improve accessibility of the Trust's website.

Recite Me (website accessibility tool)

The Trust had contracted the 'Browsealoud' web screen reading system to increase the accessibility of the external website. The contract came to an end during 2017/18, after evaluating all the options, the Trust has signed a new 2-year contract for the 'Recite Me' system. The new system has all the same functionality of the previous system, but also adds some important additional functions. These functions not only benefit people with sensory impairments, but also benefits people with learning disabilities/difficulties and overseas language speakers. This service went live in June 2018, during 2018/19 ReciteMe has been used by over 3,000 individual people.



Overseas and Communication Support Services

The Trust undertook a 9 month procurement process with other NHS partners in the local area. The NHS partners procured a range of overseas and communication support services that will meet the needs of the local population. Undertaking this process as a group, enables the Trust to secure high quality services and solutions whilst enjoying the benefits of economy of scale.

The contracts went live in July 2018, the providers under this citywide agreement are:

- Action Deafness – British Sign Language and all other communication Support
- Language Line – Telephone Interpreting and all translation support
- Sussex Interpreting Services – Face-to-face overseas interpreting
- Vandu Language Services – Face-to-face overseas interpreting

In the coming year, the Trust will be looking to expand their interpreting services to improve access to patients who use British Sign Language.

The Inclusion team has undertaken some targeted engagement work with clinical divisions, to provide ward/department based solutions to meeting their patient's needs. This includes the production of patient information, graphical tools and equipment to aid clear communication.

Signage and Wayfinding

The Inclusion team are also assisting the Clinical Director of Facilities and Estates to redesign the signage and way finding at the Brighton Site. Careful thought has been given to disability accessibility including physical wayfinding and the appearance of the signage. The signage has been designed to meet the widest range of accessible needs.

Engagement with Patient Experience

The Trust has taken a number of steps to engage with patients and their experience. The Trust has a Patient Experience and Engagement Group, a disabled patient and user group and many departments undertake their own engagement exercises e.g. maternity services attended Trans-Pride 2019 for trans and non-binary people and worked alongside local trans support groups.

The Learning Disability Liaison Team (LDLT)

The LDLT provide specialist nursing guidance and advice to people with a learning disability, as well as their families and staff. The team help with planned and emergency admissions, outpatient appointments and hospital discharge.

The team work with hospital staff to ensure that the healthcare that they deliver is person centred by:

- aiding and teaching communication skills using specialist techniques or tools
- help staff understand the patient's needs and preferences
- looking at reasonable adjustments that can be made to the environment, treatment plans or timing of appointments
- for patients that have capacity, the team ensure the patient understands planned treatment, expectations of them for their treatment/care plan and consent
- advocate for patients and their family or carers
- help co-ordinate treatment and ongoing care
- provide reassurance to the patient and their family or carers
- promote the use of the 'Hospital Passport' and 'Hospital Communication Book' where appropriate.

In addition to ward based work, the LDLT can also provide education for staff to help raise the standards for patients with learning disabilities in Trust premises.

During 2018/19 the team received 251 referrals for patients receiving healthcare in the Brighton campus and 64 referrals in the Haywards Heath campus.

Current work the team are undertaking to provide better services for patients with Learning Disabilities include:

- Working with the Outpatient Booking Centre to introduce Easy Read appointment letters for patients that would benefit from this form of communication.
- Working with the Library Services Team to turn the LDLT page on the Trust website into Easy Read.
- Identifying areas where there is a low referral rate to the LDLT and putting in measures to deliver improvements.

The LDLT can be contacted by telephoning 01273 664975 or by email LDLTreferral@sussexpartnership.nhs.uk.

Freedom to Speak Up Guardian

Caroline Owen, The Freedom to Speak Up Guardian is here to provide support and advice to staff, if they are worried about something they think may affect the quality or safety of patient care or is a risk to our Trust. Caroline provides advice on how to raise concerns effectively and guidance on how the Raising Concerns Policy and process works.



Caroline works alongside trust leadership teams to support the organisation in becoming a more open and transparent place to work, where all staff are actively encouraged and enabled to speak up safely.

HELP Service – Health, Employee, Learning and Psychotherapy

The service provides staff with confidential support, counselling and psychotherapy for a range of issues. Issues ranging from work related concerns, from stress management to relational issues, employment difficulties or following critical/traumatic events, to personal issues that may be affecting the individual.

HELP also provides specialist EMDR (Eye Movement Desensitisation and Reprocessing) trauma therapy for staff who have had stressful or traumatic experiences.

During 2018/19 the service undertook the following activities to help support staff:

- Supporting staff including 1-2-1 support with staff
- 20 debriefs around the Trust – a debrief is a way of providing emotional and psychological support to staff in a group setting, shortly after a traumatic or major incident.
- 2 hot debrief training sessions – this is training gives teams tools to perform a debrief when there is a traumatic or major incident.
- 13 workshops - stress management and mindfulness workshops.



Donna Butler who is the HELP Service Manager, is the lead for mental health wellbeing for the Trust. There is a specific work stream which is aligned with the Mental Health Core Standards (Thriving at Work - Stevenson and Farmer) which forms part of the Leadership, Culture and Workforce programme. Some of the items the service will be delivering for this work stream include:

- Developing Mental Health Awareness training to improve knowledge and reduce stigma. The first pilot of this training has been completed, and a second pilot is planned. This training will be available to all managers.
- The HELP Service has involvement and engagement with Workforce Disability/Race Equality Standards, Learning and Development and the LGBTQ+ Network and acts as organisational allies for these protected characteristics.,
- HELP service recruitment and expansion has diversity awareness at the forefront.
- Video logging going live in November to further improve understanding of mental health/ well -being in the workplace.
- HELP are promoting equality and diversity and inclusion, in its hosting and training honorary psychotherapists from University (on placement).
- Mindfulness workshops delivered to teams within the Trust.
- The service has developed a number of resources for staff including managing anxiety, depression, grief and trauma.
- Developed a community resource, with contact numbers, for staff who want to access BME/ BAME/ LGBTQ + and disability groups.

Donna is currently co-authoring a book on wellbeing and mental health in the workplace. The book has case studies highlighting the importance of inclusivity.

The service is collecting demographic data for service use which will be available to report in the next annual equality report.

Occupational Health Services

The Trust has an in-house occupational health (OH) service, they provide advice and support to BSUH NHS Trust employees and to some external organisations.

OH is concerned with the effect of work on health and ensuring employees are fit for the work they do. One aim of the service is to provide a quality professional OH service and promote the provision of a safe and healthy working environment.

OH has Safe, Effective, Quality Occupational Health Service (SEQOHS) accreditation which means those using the service have assurance, through independent validation, that the services provided satisfies the SEQOHS standards for safety, effectiveness and quality as a minimum.

OH offers a wide range of services that include:

- Advice on fitness to work
- Health clearance and screening for employment
- Vaccination and blood testing
- Physiotherapy
- Ergonomic assessments
- Manual handling training and advice
- Assessment and advice following sharps and splash incidents
- Health surveillance

OH has recently started to collect demographic data on service use which will be available in the next annual equality report.

Rainbow Lanyard and Pin Badges Scheme

During 2018/19 the Trust launched the rainbow lanyard and badges scheme, which has been made available on a voluntary basis to all staff and volunteers. The scheme allows staff and volunteers to show their support for LGBTQ+ patients, carers, visitors and colleagues.

The lanyards and badges also provide a subtle signifier that the wearer is a 'safe listen ear' for LGBTQ+ patients, colleagues, volunteers and students. This has been a hugely successful scheme with over 3,000 lanyards and badges being distributed around the Trust.

Interpreting and Translation Services for Patients

(Overseas and Communications Support Services)

During 2018/19 a total of 5,958 interpreting sessions happened throughout the Trust. The total cost for this was £455,011.55 and this was for 2,135 individual patients.

This can be further broken down:

BSL / Communication Support	Overseas Language (Face-to-Face)	Overseas Language (Telephone)
654 sessions £75,600	5,146 sessions £377,441.13	158 sessions £1,970.42

There were also 1,080 sessions that qualified as a late cancellation, this cost the Trust £50,321.39 and this was for 752 individual patients.

The top ten languages that needed assistance from an interpreter are:

- | | |
|---|------------------------------|
| 1. Arabic (1,790 sessions) | 6.) Mandarin (249 sessions) |
| 2. British Sign Language (652 sessions) | 7. Portuguese (217 Sessions) |
| 3. Polish (404 sessions) | 8. Cantonese (208 sessions) |
| 4. Bengali (375 sessions) | 9. Romanian (206 session) |
| 5. Farsi (309 sessions) | 10 Turkish (199 sessions) |

The clinical divisional spend for interpretation:

Division	Number of Sessions	Cost
Central Clinical Services	1,324	£84,636.67
Children and Women's	1,937	£142,217.42
Medicine	509	£43,870.02
Specialist Services	594	£54,139.14
Surgery	1,559	£128,950.54

There were 54 translations jobs completed in this reporting period, which cost £14,572.63.

This can be further broken down into:

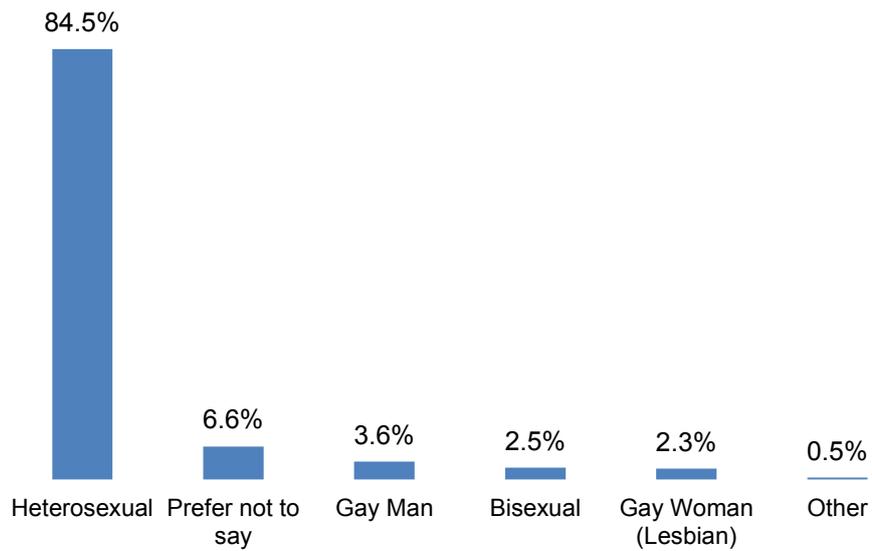
Braille and other communication support	Overseas Languages
13 Translated documents £1,241.63	41 Translated documents £13,331.00



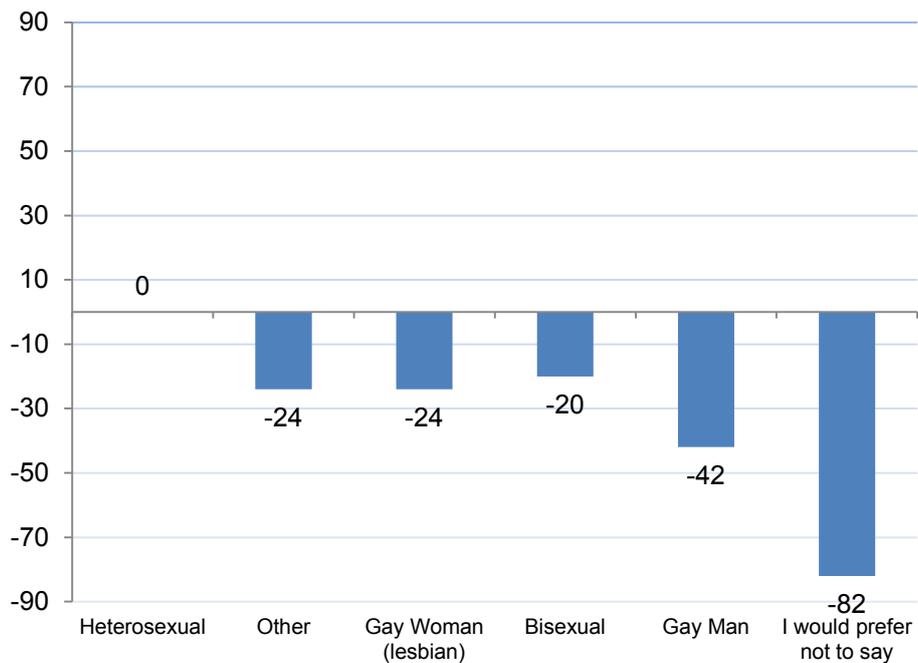
Research from the LGBTQ+ Network

NHS Staff Survey 2018

Demographic of staff completing the survey

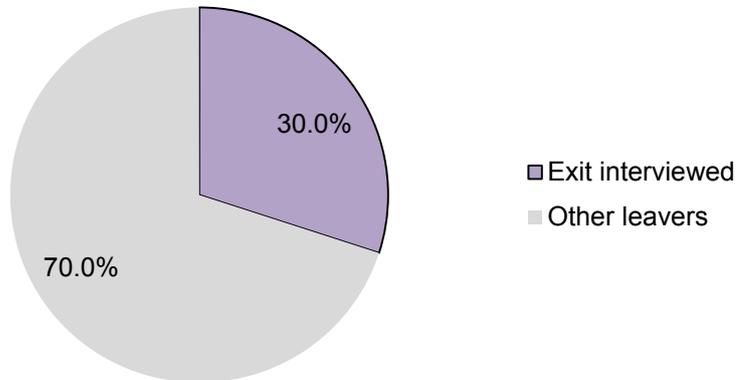


NHS Staff Survey 2018: Net Higher / Lower Scores vs Heterosexual

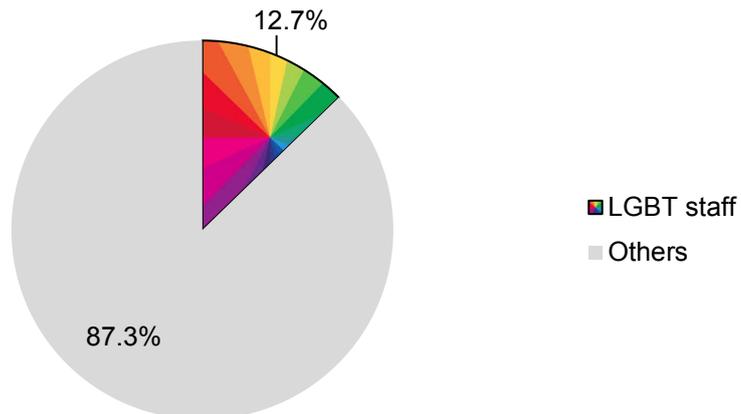


Trust Exit Survey data

Exit questionnaire filled out (SNAP)

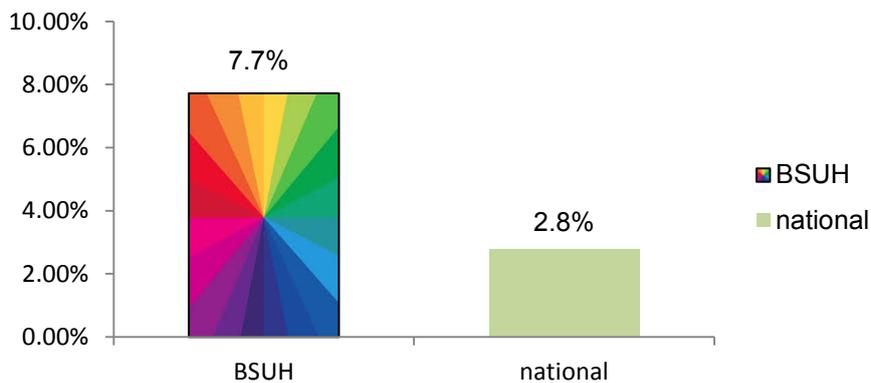


**From those who filled out the questionnaire
not include Prefer not to say (%) and undefined/blanks**



LGBT staff Benchmarking againts national NHS data

does not include Prefer not to say (%) and undefined/blanks





Brighton and Sussex University Hospital NHS Trust Equality Objectives

The Equality Act 2010 places specific duties on public sector organisations. Part of the specific duties is to set some measurable objectives and goals which demonstrate how the organisation is meeting needs or taking steps to improve equality.

The Trust's first set of objectives and goals which were live from 2019 to 2022. Below is a summary of the objectives and relevant actions.

The following objectives will be undertaken jointly with Western Sussex Hospitals Foundation NHS Trust:

1. Aim to have the workforce's declared equality monitoring data as a minimum of 90% across the board.
 - As of March 2019 the current rates staff declaring their diversity data (including 'prefer not to say'): Age (100%), Disability (93.0%), Gender (100%), Marriage and Civil Partnership (96.0%), Race and Ethnicity (97.0%), Religion or Belief (86.1%) and Sexual Orientation (88.6%).
2. Review the disparity of experiences from the NHS Staff Survey.
 - This is currently being reviewed under the Leadership, Culture and Workforce work stream (see page 5), work is also being undertaken as part of WRES and WDES (see page 6) with respective action plans that will address the issues highlighted
3. Review recruitment and selection process and training to identify areas of practice and unconscious bias.

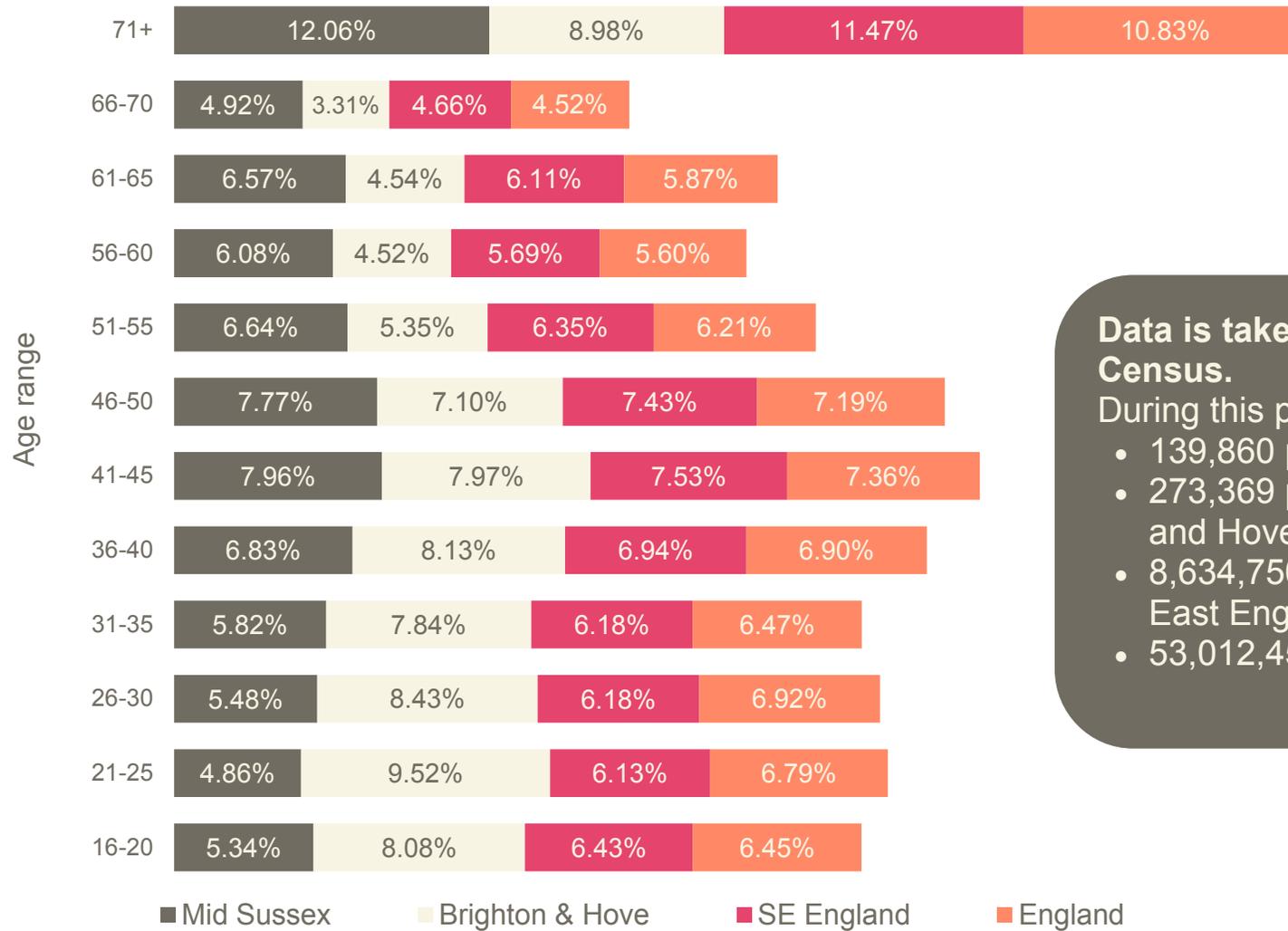
The following objectives are specific to Brighton & Sussex University Hospitals NHS Trust:

4. Engage with Trans and Black, Asian and Minority Ethnic communities to understand why they appear to have a worse experience to other groups (relating to the Friends and Family Test score).
5. Engage with patients to encourage greater trust with patient monitoring exercises.
6. Adult services to receive Trans, Non Binary and Gender Fluidity awareness.

- It is expected that 20% of the (untrained) workforce will undergo this training per annum.



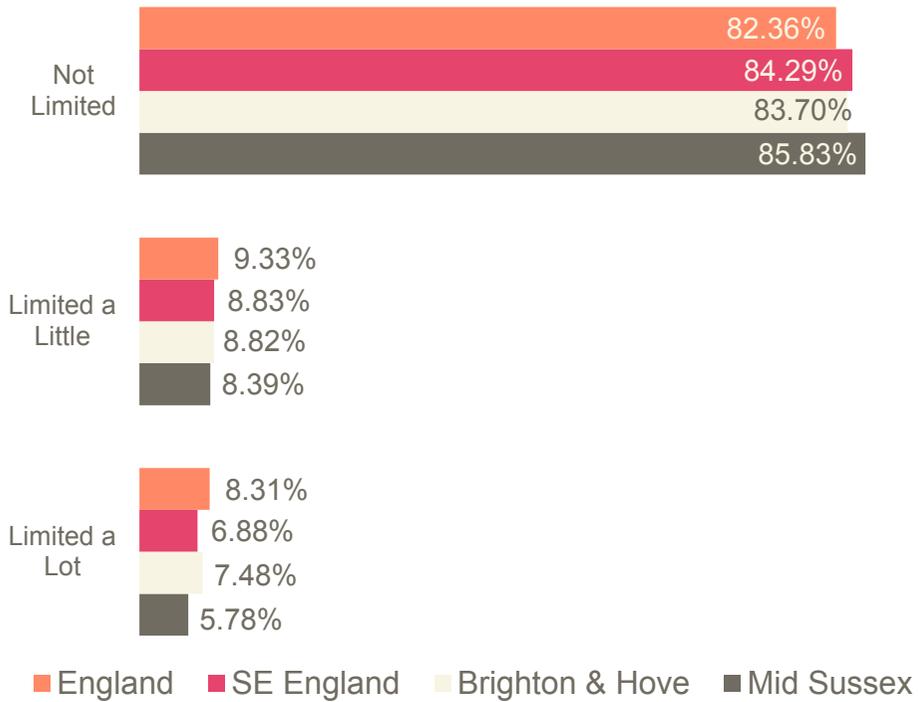
Who are the local communities the trust serves?



Data is taken from the 2011 Census.

During this period there were:

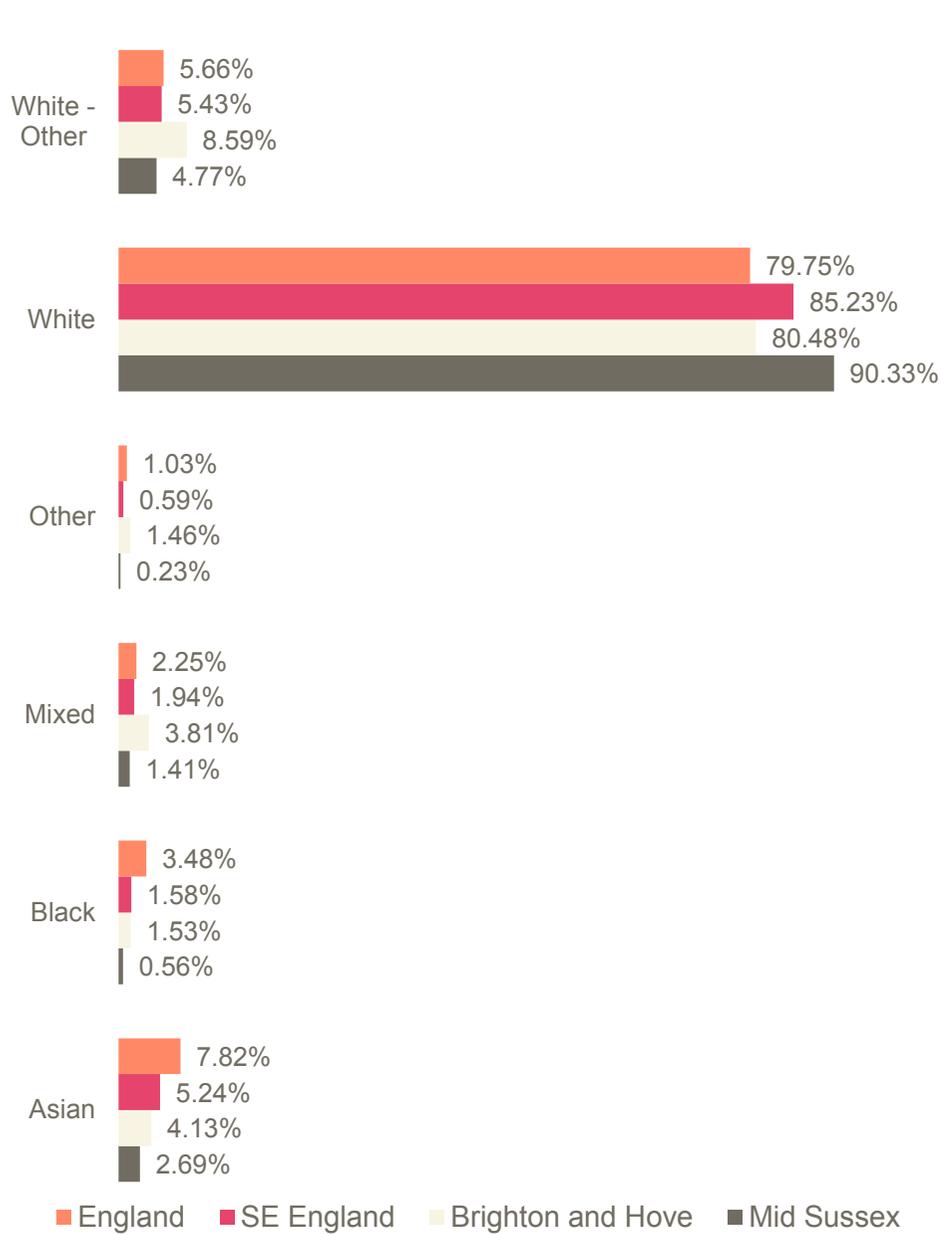
- 139,860 people in Mid Sussex
- 273,369 people in Brighton and Hove
- 8,634,750 people in South East England
- 53,012,456 people in England



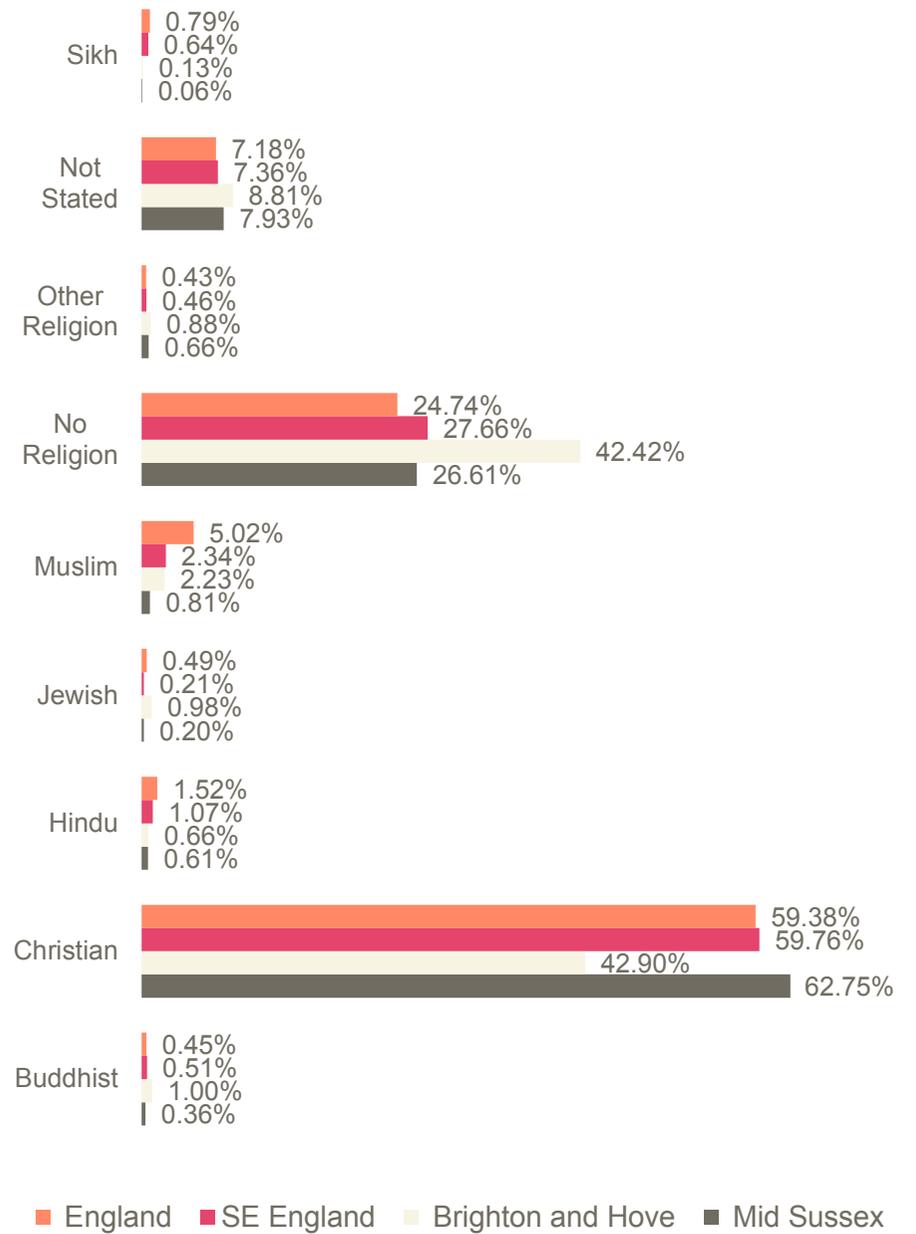
The 2011 Census asks 'Are your day-to-day activities limited because of a health problem or disability which has lasted, or is expected to last, at least 12 months?'

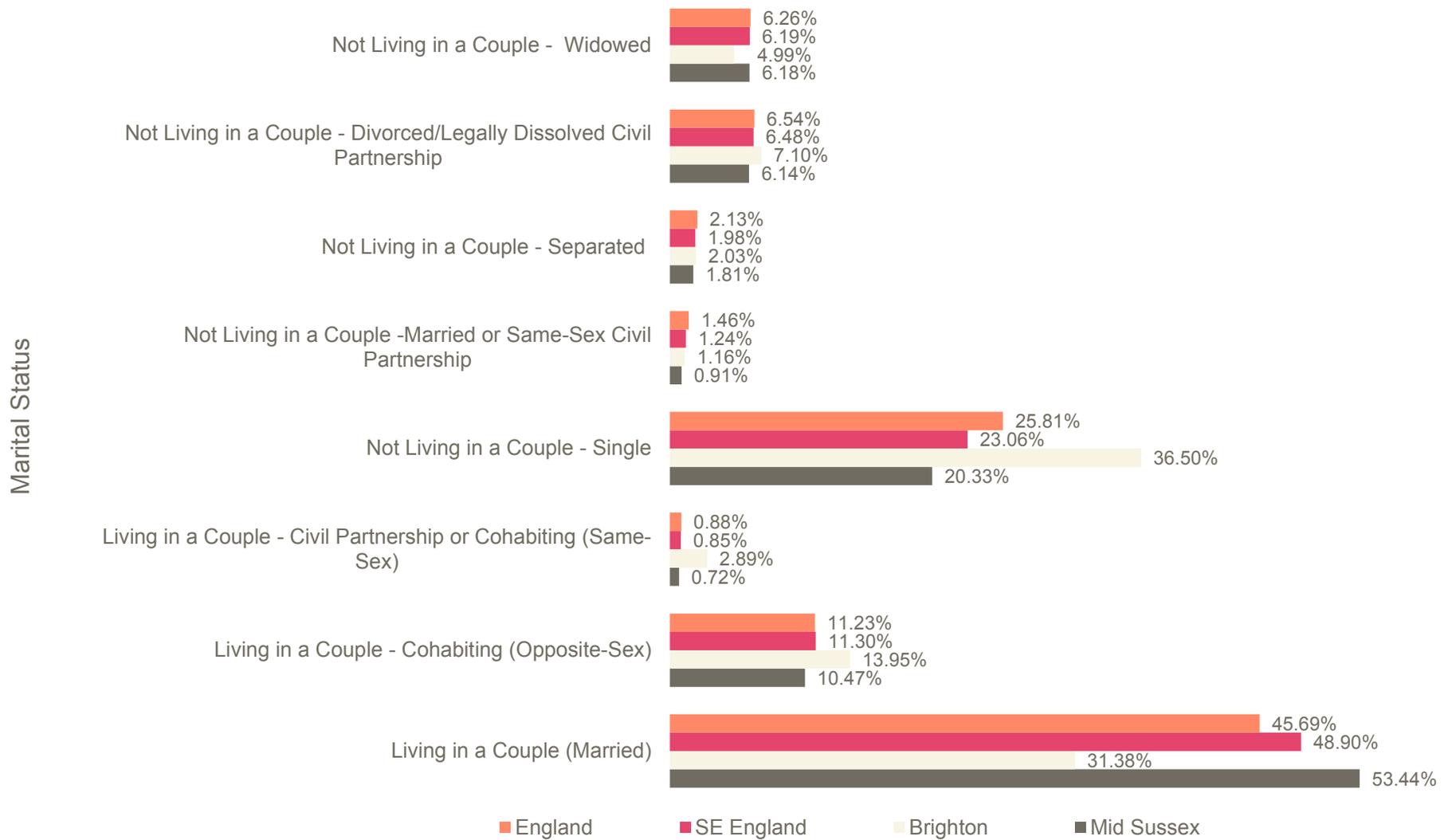


Ethnic Background



Religion or Belief

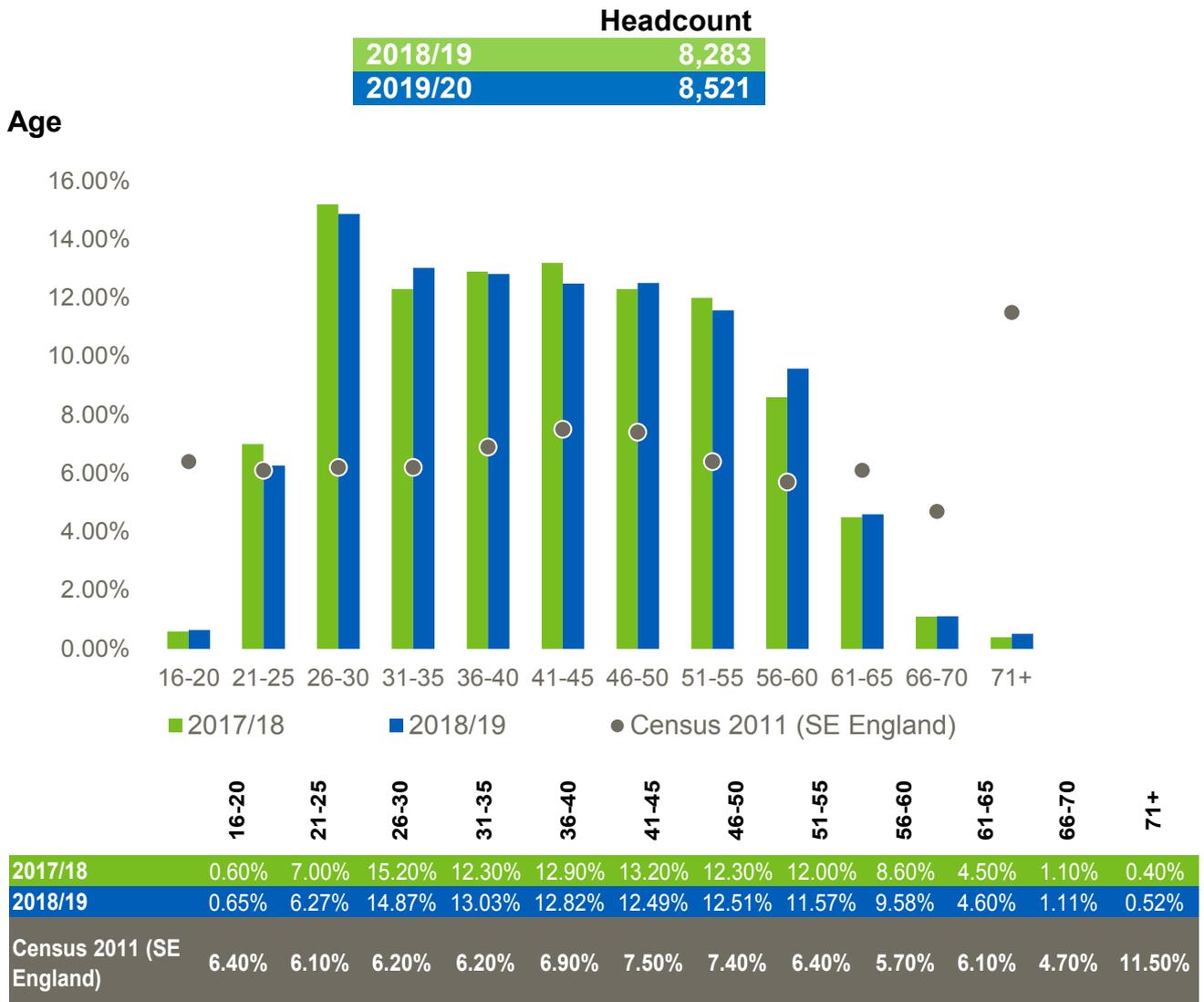






Who are the Trust's workforce?

The information is taken from the Trust's Electronic Staff Records system and provides a wide range of demographical data.



Gender Identity

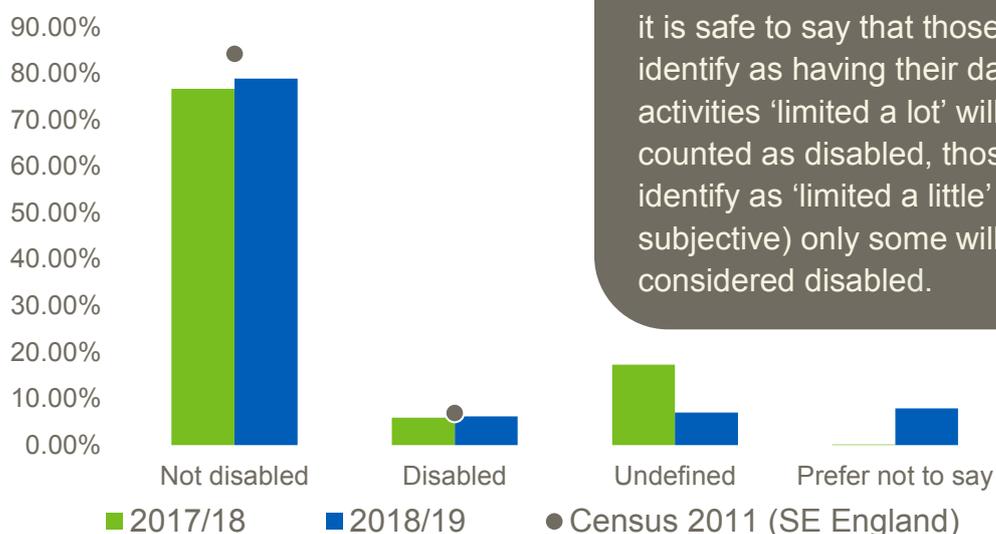
At present the Electronic Staff Records system does not support collecting data that would allow monitoring of gender identity, this is a national issue.



Maternity and Pregnancy

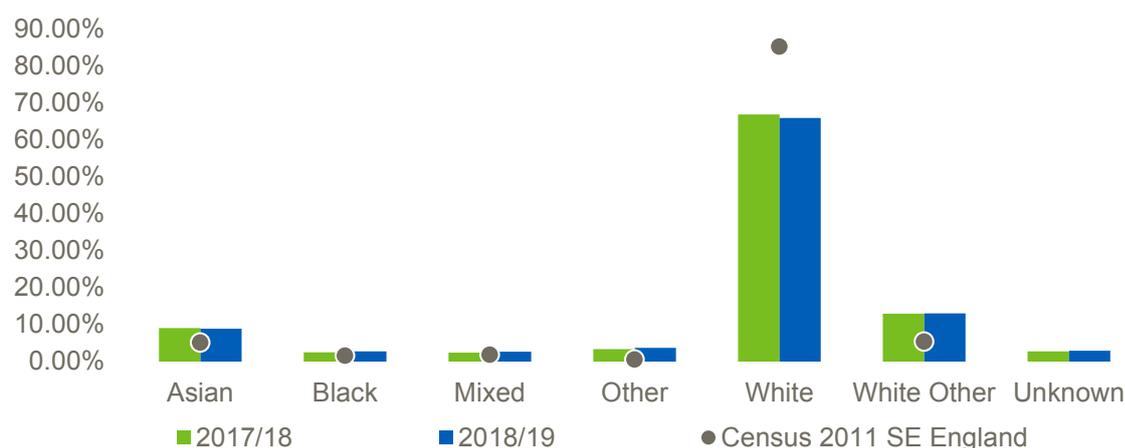
During 2018/19 there were 197 members of staff on maternity leave.

Disability



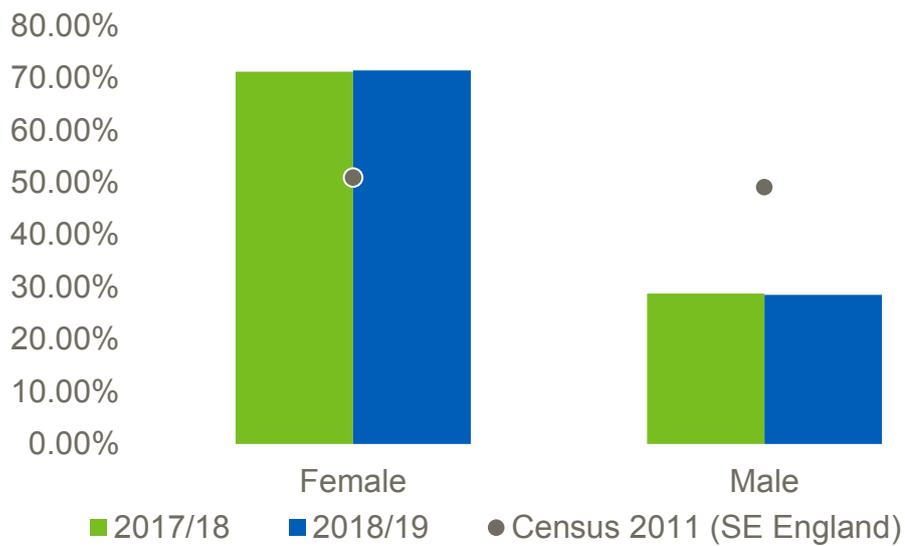
	Not disabled	Disabled	Undefined	Prefer not to say
2017/18	76.72%	5.88%	17.29%	0.11%
2018/19	78.97%	6.16%	6.97%	7.90%
Census 2011 (SE England)	84.29%	6.88%		

Ethnic Background



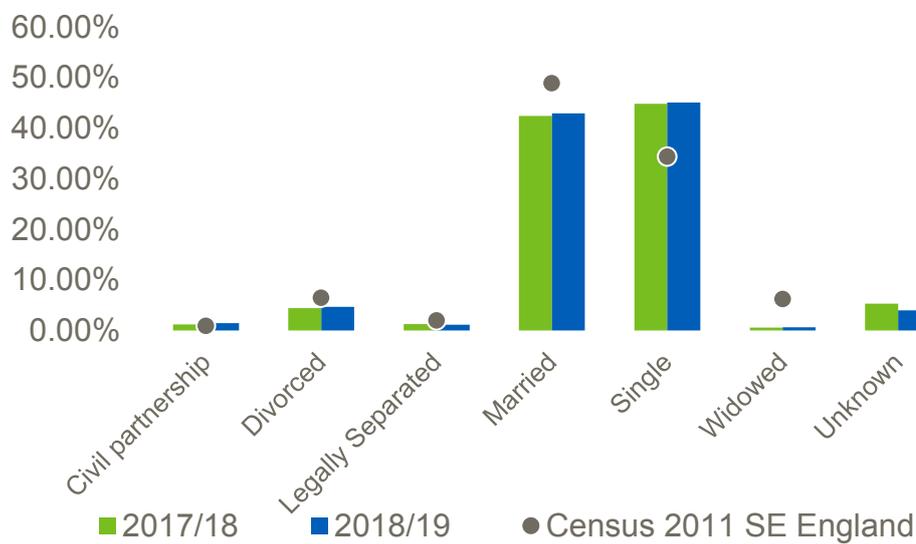
	Asian	Black	Mixed	Other	White	White Other	Unknown
2017/18	9.10%	2.50%	2.40%	3.40%	66.80%	13.00%	2.80%
2018/19	8.91%	2.78%	2.69%	3.74%	65.85%	13.07%	2.96%
Census 2011 SE England	5.20%	1.60%	1.90%	0.60%	85.20%	5.40%	

Gender



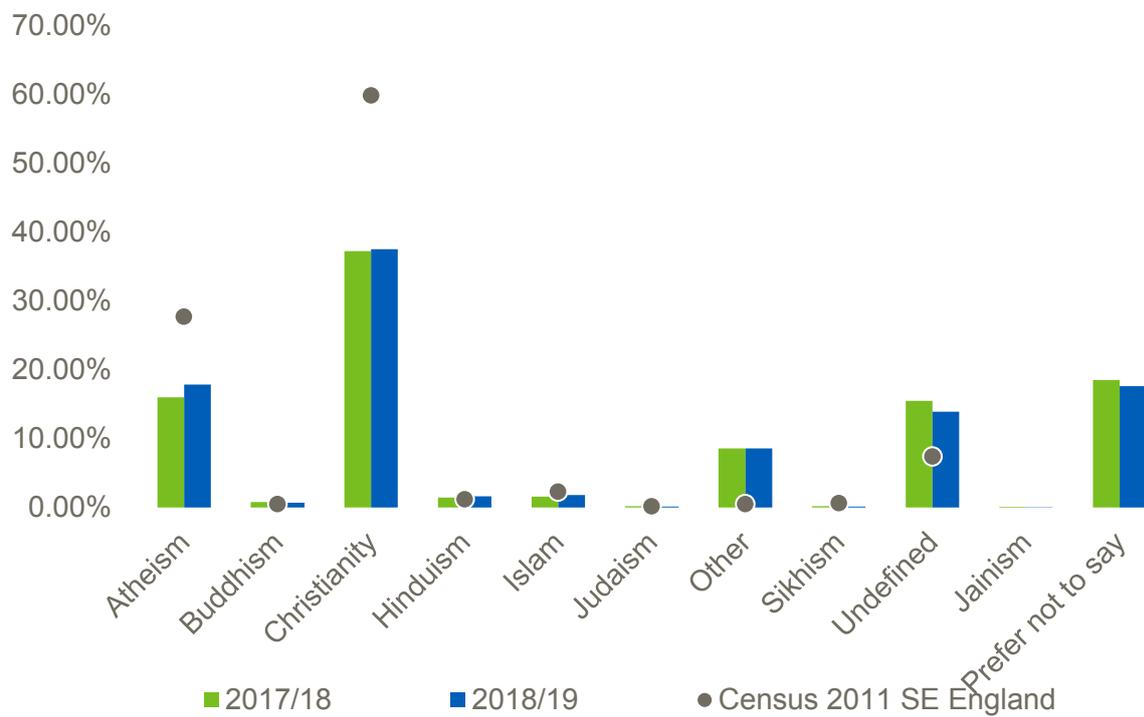
	Female	Male
2017/18	71.20%	28.80%
2018/19	71.47%	28.53%
Census 2011 (SE England)	50.90%	49.10%

Marital Status



	Civil partnership	Divorced	Legally Separated	Married	Single	Widowed	Unknown
2017/18	1.20%	4.40%	1.30%	42.40%	44.80%	0.60%	5.30%
2018/19	1.49%	4.68%	1.17%	42.94%	45.08%	0.66%	3.98%
Census 2011 SE England	0.90%	6.50%	2.00%	48.90%	34.40%	6.20%	

Religion or Belief



	Atheism	Buddhism	Christianity	Hinduism	Islam	Judaism	Other	Sikhism	Undefined	Jainism	Prefer not to say
2017/18	16.00%	0.80%	37.20%	1.47%	1.60%	0.20%	8.60%	0.20%	15.50%	0.10%	18.50%
2018/19	17.84%	0.70%	37.51%	1.62%	1.82%	0.16%	8.60%	0.16%	13.92%	0.04%	17.63%
Census 2011 SE England	27.70%	0.50%	59.80%	1.20%	2.30%	0.20%	0.50%	0.64%	7.40%		

As there are a high number of 'prefer not to say' and 'undefined' categories, sometimes it is useful to represent the data as a percentage of the workforce that have declared their religion or belief. Should these categories be excluded the workforce representation looks like:

	Atheism	Buddhism	Christianity	Hinduism	Islam	Judaism	Other	Sikhism	Jainism
2017/18	24.19%	1.19%	56.35%	2.23%	2.49%	0.24%	12.98%	0.24%	0.09%
2018/19	26.06%	1.03%	54.79%	2.37%	2.66%	0.24%	12.57%	0.24%	0.05%

Sexual Orientation



	Bisexual	Gay or Lesbian	Heterosexual	Prefer not to say	Not Stated
2017/18	1.19%	3.93%	67.23%	15.03%	12.61%
2018/19	1.34%	4.22%	69.11%	13.97%	11.36%

Sexual orientation is not asked in the 2011 Census. It is therefore not possible to make an accurate comparison of the workforce against the local demographics.

However, there are some national figures/estimates:

- Approximately 3% of the NHS workforce identify as Lesbian, Gay or Bisexual.
- The Office for National Statistics estimate in 2017 that 1.3% of the population identify as a gay man or lesbian, 0.3% as bisexual and 0.6% as an 'other' orientation.

As there are a high number of 'prefer not to say' and 'not stated' categories, sometimes it is useful to represent the data as a percentage of the workforce that have declared their sexual orientation. Should these categories be excluded the workforce representation looks like:

	Bisexual	Gay or Lesbian	Heterosexual
2017/18	1.65%	5.44%	92.91%
2018/19	1.79%	5.66%	92.55%

Pay Banding – in this section the data and information will show the composition of the pay band by the protected characteristic

Text highlighted in green indicate that there is a higher than expected representation of that group compared to the general workforce.

Age Range

	16-20	21-25	26-30	31-35	36-40	41-45	46-50	51-55	56-60	61-65	66-70	71 & above
Band 1	1.01%	4.04%	7.07%	13.13%	14.14%	11.87%	14.14%	11.11%	10.35%	9.09%	2.78%	1.26%
Band 2	2.82%	9.00%	11.66%	12.68%	11.58%	10.49%	10.33%	11.42%	11.19%	5.56%	1.72%	1.56%
Band 3	1.35%	7.52%	11.00%	10.55%	11.00%	10.66%	12.12%	12.79%	12.46%	7.86%	1.91%	0.79%
Band 4	0.51%	4.90%	12.67%	9.80%	10.30%	9.63%	10.98%	14.53%	14.70%	9.12%	2.03%	0.84%
Band 5	0.00%	11.95%	26.04%	13.25%	10.13%	9.16%	9.81%	8.31%	7.40%	3.12%	0.65%	0.19%
Band 6	0.00%	4.06%	13.18%	14.27%	14.63%	16.15%	14.34%	11.80%	7.53%	3.19%	0.80%	0.07%
Band 7	0.00%	0.38%	6.63%	12.00%	15.50%	16.63%	17.50%	15.63%	11.13%	4.13%	0.50%	0.00%
Band 8a	0.00%	0.43%	2.60%	5.19%	15.58%	17.32%	24.24%	19.05%	9.96%	4.76%	0.87%	0.00%
Band 8b	0.00%	0.00%	1.79%	4.46%	15.18%	13.39%	21.43%	23.21%	15.18%	5.36%	0.00%	0.00%
Band 8c	0.00%	0.00%	0.00%	8.33%	11.11%	16.67%	11.11%	27.78%	25.00%	0.00%	0.00%	0.00%
Band 8d	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	31.58%	31.58%	21.05%	10.53%	0.00%	5.26%
Band 9	0.00%	0.00%	0.00%	10.00%	20.00%	0.00%	30.00%	20.00%	20.00%	0.00%	0.00%	0.00%
Consultant	0.00%	0.00%	0.00%	2.19%	17.72%	26.04%	20.79%	16.85%	11.82%	3.06%	1.09%	0.44%
Middle	0.00%	0.00%	0.00%	5.56%	14.81%	22.22%	14.81%	14.81%	22.22%	3.70%	1.85%	0.00%
Training	0.00%	8.90%	38.56%	29.94%	13.98%	5.65%	1.98%	0.56%	0.28%	0.14%	0.00%	0.00%
Local Contract	0.00%	0.00%	0.00%	100.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Directors	0.00%	0.00%	0.00%	0.00%	0.00%	13.33%	40.00%	20.00%	26.67%	0.00%	0.00%	0.00%
Overall age group in workforce	0.65%	6.27%	14.87%	13.03%	12.82%	12.49%	12.51%	11.57%	9.58%	4.60%	1.11%	0.52%

Disability Status

	Disabled	Not disabled	Prefer not to say	Unknown
Band 1	11.87%	85.10%	0.25%	2.78%
Band 2	6.96%	81.77%	6.65%	4.62%
Band 3	9.65%	77.44%	8.87%	4.04%
Band 4	6.93%	80.24%	9.46%	3.38%
Band 5	6.04%	82.86%	7.47%	3.64%
Band 6	4.49%	76.90%	13.40%	5.21%
Band 7	4.88%	77.88%	11.88%	5.38%
Band 8a	5.63%	81.82%	9.09%	3.46%
Band 8b	9.82%	79.46%	7.14%	3.57%
Band 8c	2.78%	80.56%	5.56%	11.11%
Band 8d	0.00%	73.68%	15.79%	10.53%
Band 9	20.00%	60.00%	10.00%	10.00%
Consultant	1.31%	70.90%	1.09%	26.70%
Middle	1.85%	59.26%	1.85%	37.04%
Training	4.80%	74.58%	1.98%	18.64%
Local Contract	0.00%	100.00%	0.00%	0.00%
Directors	0.00%	60.00%	13.33%	26.67%
Overall disability status in workforce	6.16%	78.97%	7.90%	6.97%

Ethnic Background

	Asian	Black	Mixed	Other	White	White Other	Unknown
Band 1	7.83%	6.31%	4.29%	4.80%	30.30%	40.66%	5.81%
Band 2	9.31%	2.50%	2.82%	4.46%	62.91%	14.63%	3.36%
Band 3	6.51%	2.36%	2.02%	2.81%	73.74%	10.33%	2.24%
Band 4	4.73%	1.69%	1.86%	1.69%	81.42%	6.76%	1.86%
Band 5	10.39%	3.57%	2.14%	6.23%	55.26%	19.29%	3.12%
Band 6	6.15%	1.96%	2.03%	3.55%	73.28%	9.85%	3.19%
Band 7	3.25%	2.00%	2.25%	2.00%	82.38%	4.88%	3.25%
Band 8a	2.60%	1.73%	2.16%	0.87%	86.15%	3.03%	3.46%
Band 8b	1.79%	2.68%	0.00%	0.00%	87.50%	6.25%	1.79%
Band 8c	0.00%	2.78%	2.78%	0.00%	83.33%	11.11%	0.00%
Band 8d	0.00%	0.00%	0.00%	0.00%	94.74%	0.00%	5.26%
Band 9	0.00%	10.00%	0.00%	0.00%	80.00%	0.00%	10.00%
Consultant	19.91%	1.97%	3.72%	2.84%	56.89%	12.47%	2.19%
Middle	27.78%	3.70%	9.26%	11.11%	27.78%	18.52%	1.85%
Training	19.21%	4.38%	5.65%	3.67%	54.52%	10.88%	1.69%
Local Contract	0.00%	0.00%	0.00%	0.00%	100.00%	0.00%	0.00%
Directors	13.33%	0.00%	0.00%	0.00%	73.33%	0.00%	13.33%
Overall ethnic category in workforce	8.91%	2.78%	2.69%	3.74%	65.85%	13.07%	2.96%

Gender

	Female	Male
Band 1	54.29%	45.71%
Band 2	70.34%	29.66%
Band 3	74.41%	25.59%
Band 4	77.70%	22.30%
Band 5	78.51%	21.49%
Band 6	81.90%	18.10%
Band 7	77.50%	22.50%
Band 8a	73.16%	26.84%
Band 8b	65.18%	34.82%
Band 8c	66.67%	33.33%
Band 8d	42.11%	57.89%
Band 9	30.00%	70.00%
Consultant	40.92%	59.08%
Middle	40.74%	59.26%
Training	56.21%	43.79%
Local Contract	0.00%	100.00%
Directors	60.00%	40.00%
Overall gender in workforce	71.47%	28.53%

Marital Status

	Civil Partnership	Divorced	Legally Separated	Married	Not Stated	Single	Unknown	Widowed
Band 1	2.27%	6.31%	1.52%	36.11%	0.25%	40.66%	11.11%	1.77%
Band 2	2.13%	5.83%	1.42%	38.53%	1.81%	45.07%	3.94%	1.26%
Band 3	2.02%	6.38%	1.46%	43.23%	1.01%	41.99%	3.02%	0.90%
Band 4	0.85%	9.49%	1.53%	43.05%	0.51%	41.19%	2.37%	1.02%
Band 5	1.04%	3.84%	1.50%	33.49%	1.04%	56.57%	2.02%	0.52%
Band 6	1.30%	4.04%	1.52%	46.28%	1.16%	43.54%	1.95%	0.22%
Band 7	1.88%	4.75%	0.50%	52.00%	1.00%	37.50%	2.13%	0.25%
Band 8a	0.87%	5.19%	1.30%	55.84%	0.43%	32.03%	2.60%	1.73%
Band 8b	0.89%	4.46%	0.89%	56.25%	1.79%	31.25%	3.57%	0.89%
Band 8c	0.00%	5.71%	0.00%	48.57%	2.86%	37.14%	5.71%	0.00%
Band 8d	5.26%	0.00%	0.00%	68.42%	0.00%	15.79%	10.53%	0.00%
Band 9	0.00%	20.00%	0.00%	40.00%	0.00%	30.00%	10.00%	0.00%
Consultant	1.92%	1.92%	0.00%	69.87%	2.56%	22.44%	1.07%	0.21%
Middle	0.00%	3.77%	0.00%	62.26%	1.89%	28.30%	3.77%	0.00%
Training	0.85%	0.28%	0.28%	31.26%	0.99%	65.49%	0.85%	0.00%
Local Contract	0.00%	0.00%	0.00%	0.00%	0.00%	100.00%	0.00%	0.00%
Directors	0.00%	0.00%	0.00%	57.14%	7.14%	35.71%	0.00%	0.00%
Overall marital status category in workplace	1.49%	4.68%	1.17%	42.94%	1.19%	45.08%	2.79%	0.66%

Religion or Belief

	Atheism	Buddhism	Christianity	Hinduism	Prefer not to say	Islam	Jainism	Judaism	Not Stated	Other	Sikhism
Band 1	8.59%	1.52%	49.75%	1.26%	20.96%	6.82%	0.00%	0.00%	0.25%	10.86%	0.00%
Band 2	16.35%	0.55%	44.37%	1.64%	12.75%	1.88%	0.00%	0.23%	9.86%	12.28%	0.08%
Band 3	14.03%	0.90%	39.96%	0.67%	13.58%	1.46%	0.00%	0.00%	18.74%	10.44%	0.22%
Band 4	16.39%	0.68%	36.32%	1.01%	13.34%	0.51%	0.00%	0.34%	21.11%	10.30%	0.00%
Band 5	19.74%	0.71%	43.18%	1.10%	13.77%	0.78%	0.00%	0.06%	12.73%	7.86%	0.06%
Band 6	19.84%	0.51%	37.00%	0.65%	13.47%	0.72%	0.00%	0.14%	19.48%	8.18%	0.00%
Band 7	20.13%	0.50%	32.50%	0.75%	15.38%	0.38%	0.00%	0.00%	23.00%	7.25%	0.13%
Band 8a	14.72%	0.43%	31.17%	2.16%	15.58%	0.87%	0.00%	0.00%	28.57%	6.49%	0.00%
Band 8b	22.32%	0.00%	26.79%	0.89%	16.96%	0.89%	0.00%	0.00%	20.54%	11.61%	0.00%
Band 8c	19.44%	2.78%	33.33%	0.00%	16.67%	0.00%	0.00%	0.00%	22.22%	5.56%	0.00%
Band 8d	31.58%	0.00%	26.32%	0.00%	5.26%	0.00%	0.00%	0.00%	31.58%	5.26%	0.00%
Band 9	10.00%	0.00%	40.00%	0.00%	10.00%	0.00%	0.00%	0.00%	30.00%	10.00%	0.00%
Consultant	12.69%	0.66%	27.35%	6.35%	44.20%	2.19%	0.22%	0.44%	0.44%	5.03%	0.44%
Middle	7.41%	0.00%	25.93%	0.00%	57.41%	3.70%	1.85%	0.00%	1.85%	1.85%	0.00%
Training	25.14%	1.13%	22.74%	4.66%	32.77%	6.78%	0.14%	0.56%	0.99%	4.10%	0.99%
Local Contract	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	100.00%	0.00%
Directors	20.00%	0.00%	13.33%	0.00%	46.67%	0.00%	0.00%	0.00%	13.33%	6.67%	0.00%
Total Religion or Belief in workforce	17.84%	0.70%	37.51%	1.62%	17.63%	1.82%	0.04%	0.16%	13.92%	8.60%	0.16%

Sexual Orientation

	Bisexual	Gay or Lesbian	Heterosexual	Prefer not to say	Not Stated
Band 1	1.77%	2.53%	71.46%	23.99%	0.25%
Band 2	1.64%	3.91%	76.45%	8.84%	9.15%
Band 3	0.79%	5.05%	69.92%	8.87%	15.38%
Band 4	1.01%	3.55%	69.59%	8.95%	16.89%
Band 5	2.01%	3.96%	72.14%	11.17%	10.71%
Band 6	1.30%	5.00%	67.99%	10.07%	15.64%
Band 7	0.75%	4.75%	66.00%	11.25%	17.25%
Band 8a	0.43%	5.63%	64.50%	5.63%	23.81%
Band 8b	0.00%	3.57%	65.18%	16.96%	14.29%
Band 8c	0.00%	5.56%	69.44%	11.11%	13.89%
Band 8d	0.00%	10.53%	63.16%	5.26%	21.05%
Band 9	0.00%	20.00%	60.00%	10.00%	10.00%
Consultant	0.88%	3.72%	56.24%	38.51%	0.66%
Middle	1.85%	1.85%	44.44%	50.00%	1.85%
Training	1.69%	3.53%	65.40%	28.39%	0.99%
Local Contract	0.00%	0.00%	0.00%	100.00%	0.00%
Directors	0.00%	0.00%	46.67%	40.00%	13.33%
Overall sexual orientation in workforce	1.34%	4.22%	69.11%	13.97%	11.36%



Quick facts about management staff (excluding medical staff)

6.4% have a disability

80.0% do not have a disability

4.9% would prefer not to say

8.7% is unknown

**65.4 %
Female**

**34.6%
Male**

**65.4%
Heterosexual**

**9.6% Prefer
not to say**

**18.9%
Unknown
Orientation**

**5.8%
Gay or
Lesbian**

**0.3%
Bisexual**

90.5% are white

80.9% - White, British
4.9% - White, Irish
4.4% - White, Other
0.3% - Old white codes

**6.3% are Black, Asian
and Minority Ethnic**

1.8% - Asian
1.5% - Mixed race
2.3% - Black
0.7% - Other



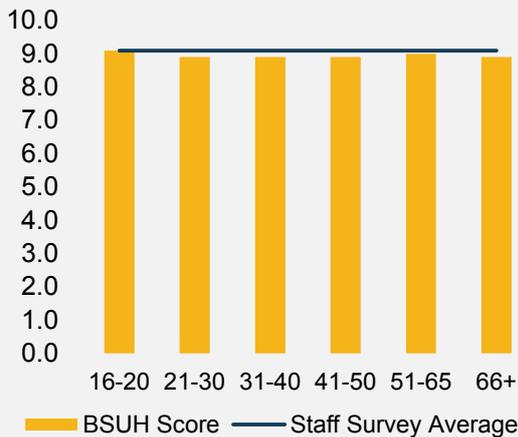
Results from the NHS staff survey 2018

4,739 staff completed the annual NHS Staff Survey from Brighton and Sussex University Hospitals NHS Trust – this gives the Trust an overall response rate of 59%. The average response rate for acute trusts is 44%.

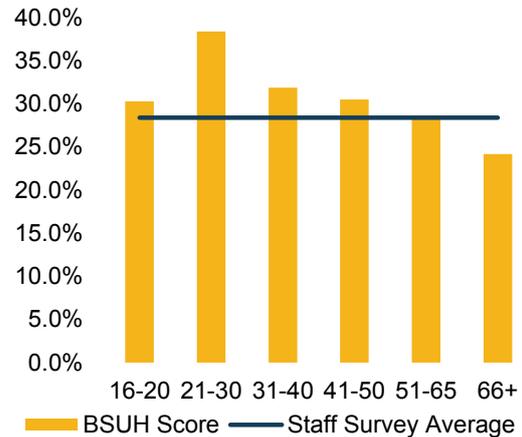
Below are some of the results to some key questions relating to equality, diversity and inclusion.

Results broken down by age:

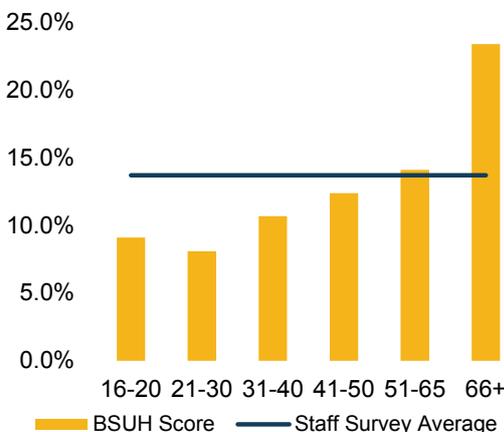
Overall equality and diversity theme



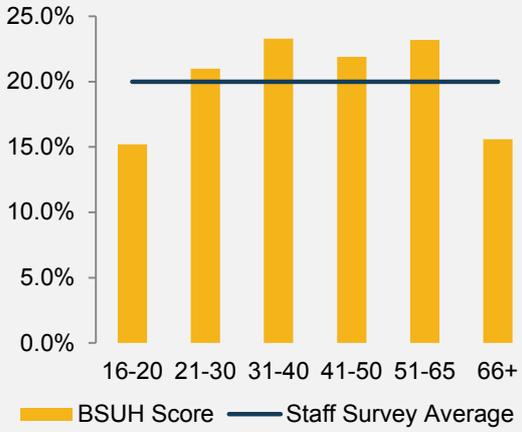
Q.13a - Staff experiencing bullying, harassment or abuse in the last 12 months from patients, service users or the public



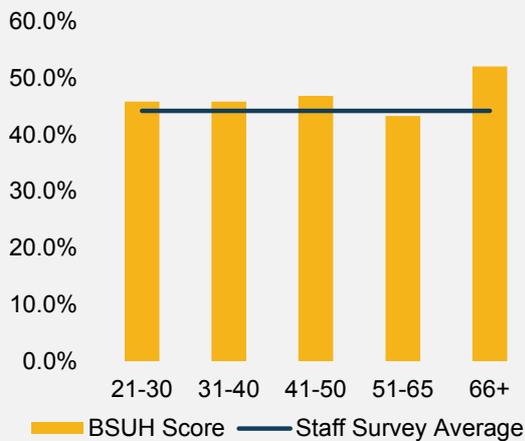
Q.13b - Staff experiencing bullying, harassment or abuse in the last 12 months from their line manager



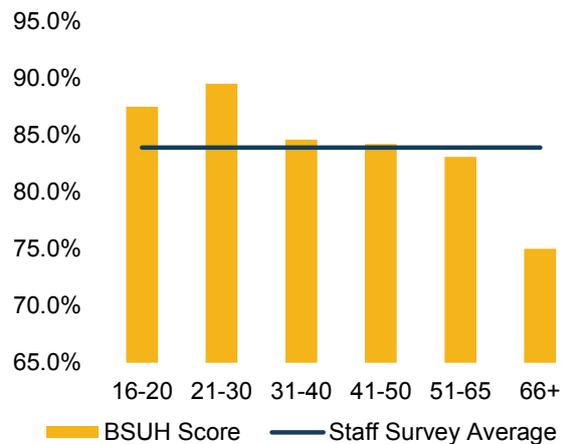
Q.13c - Staff experiencing bullying, harassment or abuse in the last 12 months from other colleagues



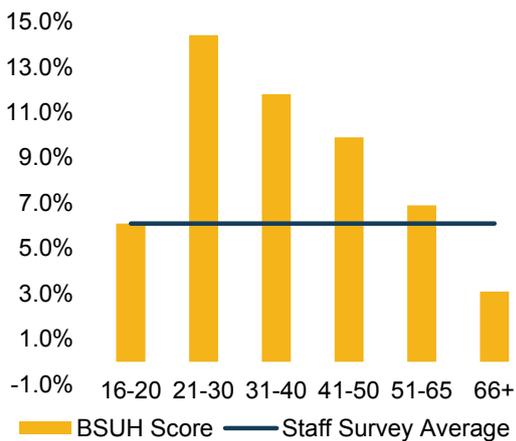
Q.13d- Staff that experienced bullying, harassment or abuse in the last 12 months did they report it?



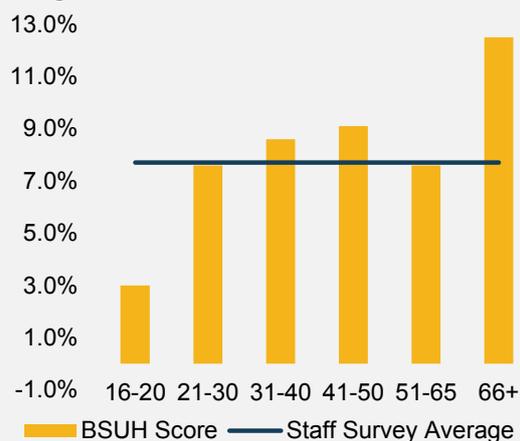
Q.14 Does the organisation act fairly in relation to progression/promotion regardless of protected characteristic?



Q.15a Staff that have experienced discrimination in the last 12 months from patients, service users, relatives or the public



Q.15b Staff that have experienced discrimination in the last 12 months from their manager, team leader or other colleagues



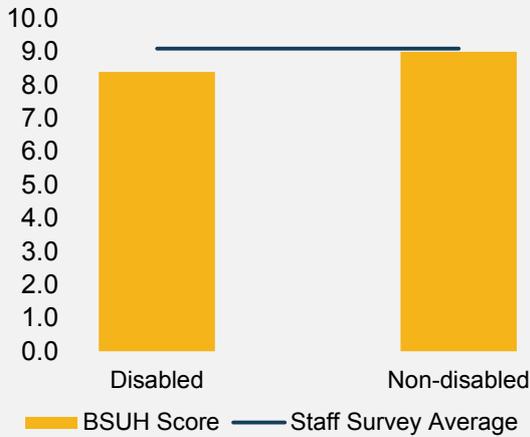
For answers in Q.15a and b, respondents were asked to identify why they feel they have been discriminated against:

	21-30	31-40	41-50	51-65	Staff Survey Average
Age	30.0%	7.1%	5.8%	22.4%	18.2%
Disability	3.3%	9.8%	4.2%	7.7%	6.9%
Ethnic background	57.3%	52.5%	57.1%	42.7%	42.4%
Gender	29.3%	21.3%	17.8%	18.9%	18.8%
Other reasons	13.3%	22.4%	24.1%	25.9%	32.1%
Religion or Belief	0.7%	3.8%	2.6%	2.8%	3.7%
Sexual Orientation	6.7%	7.1%	6.3%	8.4%	3.1%

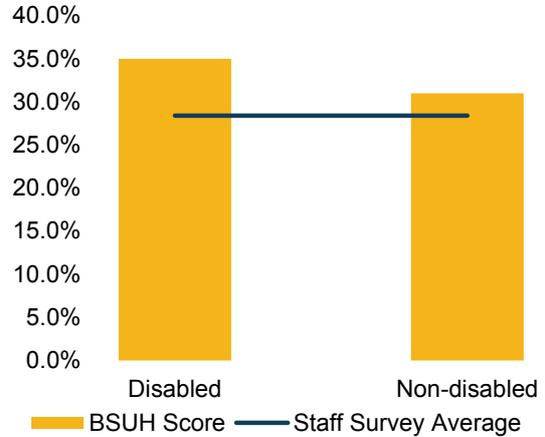
(Please note there was no data for the age group 66+)

Results broken down by disability status:

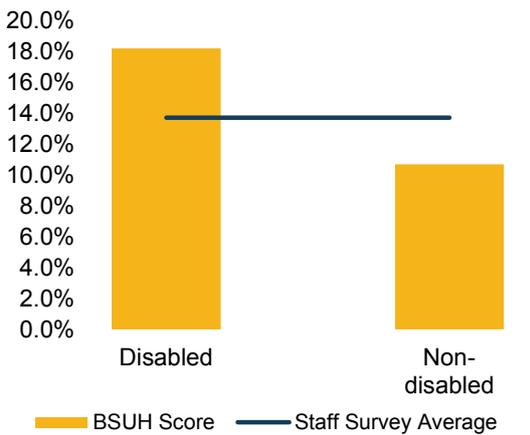
Overall equality and diversity theme



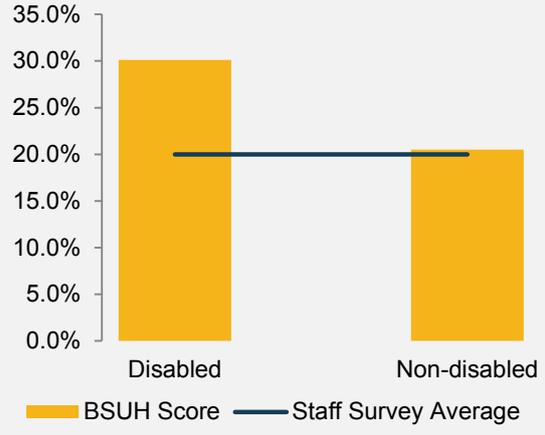
Q.13a - Staff experiencing bullying, harassment or abuse in the last 12 months from patients, service users or the public



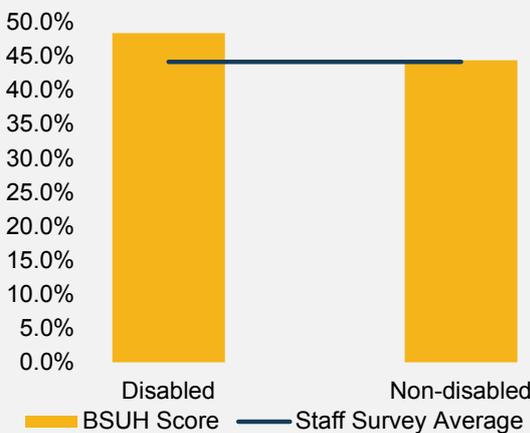
Q.13b - Staff experiencing bullying, harassment or abuse in the last 12 months from their line manager



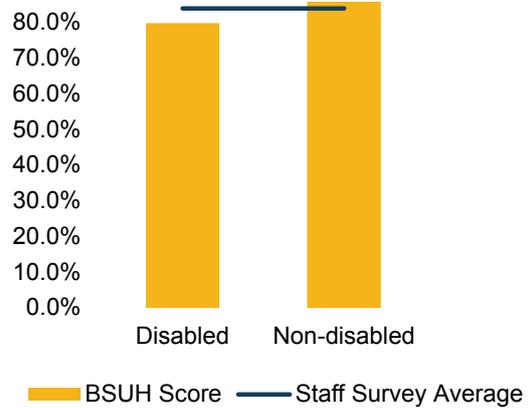
Q.13c - Staff experiencing bullying, harassment or abuse in the last 12 months from other colleagues



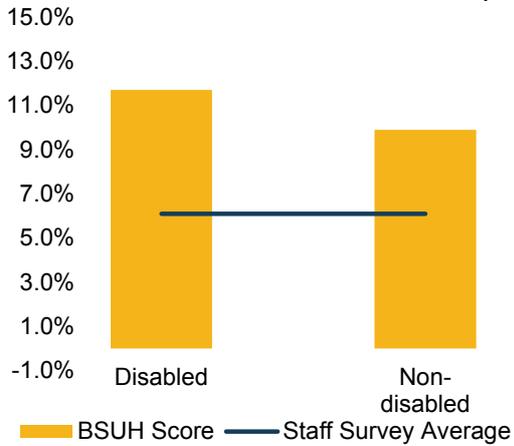
Q.13d- Staff that experienced bullying, harassment or abuse in the last 12 months did they report it?



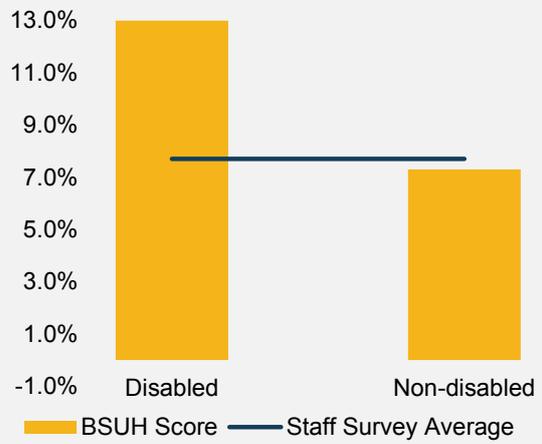
Q.14 Does the organisation act fairly in relation to progression/promotion regardless of protected characteristic?



Q.15a Staff that have experienced discrimination in the last 12 months from patients, service users, relatives or the public



Q.15b Staff that have experienced discrimination in the last 12 months from their manager, team leader or other colleagues

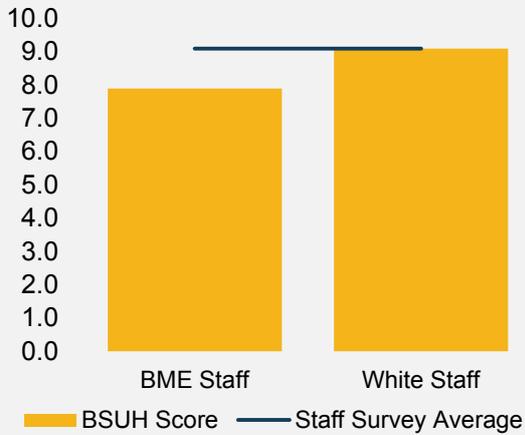


For answers in Q.15a and b, respondents were ask to identify why they feel they have been discriminated against:

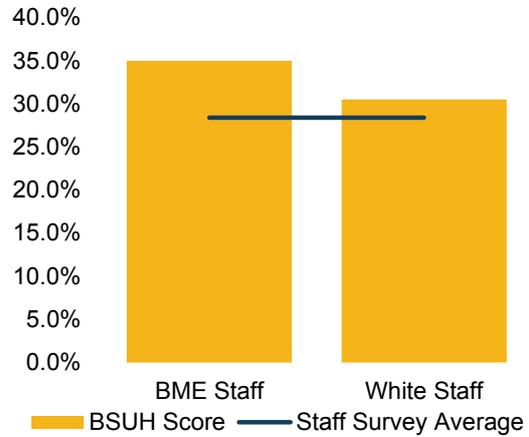
		Disabled	Non-disabled	Staff Survey Average
Experienced discrimination because of	Age	19.0%	14.5%	18.2%
	Disability	22.8%	1.5%	6.9%
	Ethnic background	28.5%	58.7%	42.4%
	Gender	25.9%	19.9%	18.8%
	Other reasons	23.4%	21.4%	32.1%
	Religion or Belief	3.2%	3.1%	3.7%
	Sexual Orientation	11.4%	5.5%	3.1%

Results broken down by ethnic background:

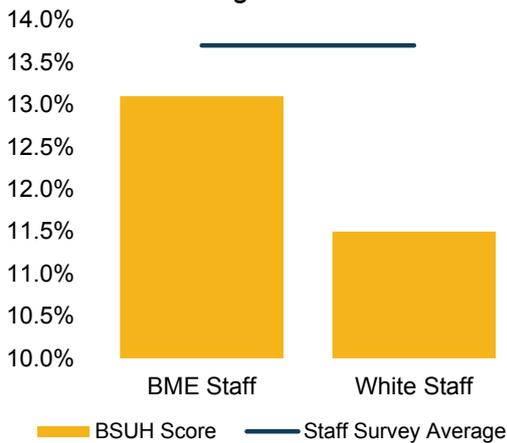
Overall equality and diversity theme



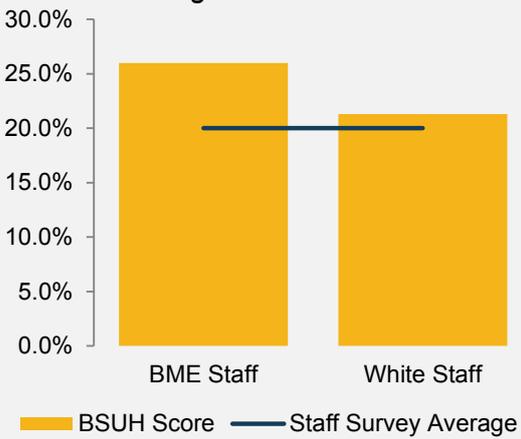
Q.13a - Staff experiencing bullying, harassment or abuse in the last 12 months from patients, service users or the public



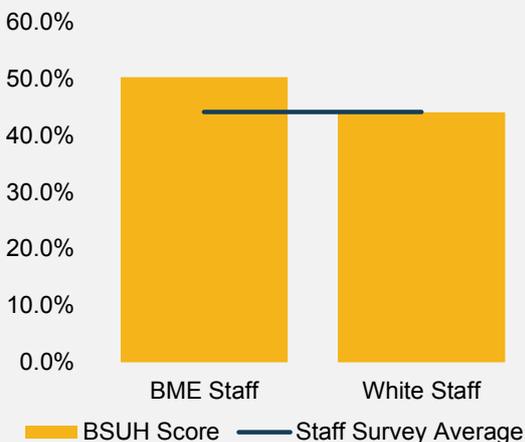
Q.13b - Staff experiencing bullying, harassment or abuse in the last 12 months from their line manager



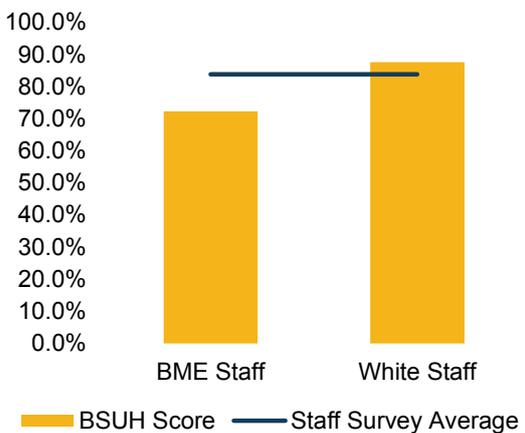
Q.13c - Staff experiencing bullying, harassment or abuse in the last 12 months from other colleagues



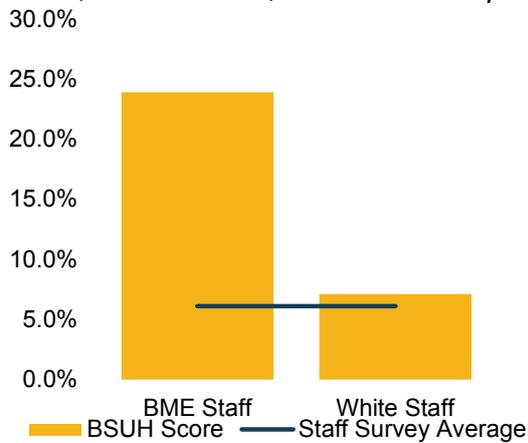
Q.13d - Staff that experienced bullying, harassment or abuse in the last 12 months did they report it?



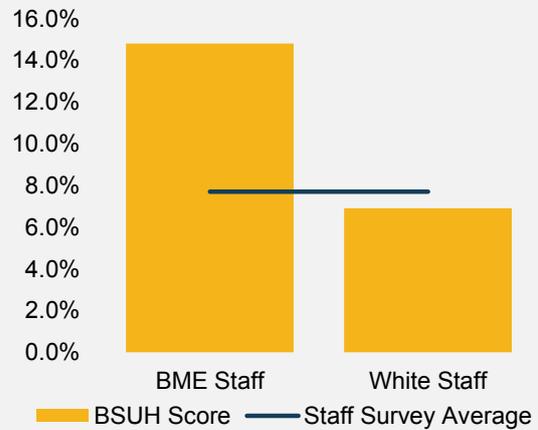
Q.14 Does the organisation act fairly in relation to progression/promotion regardless of protected characteristic?



Q.15a Staff that have experienced discrimination in the last 12 months from patients, service users, relatives or the public



Q.15b Staff that have experienced discrimination in the last 12 months from their manager, team leader or other colleagues

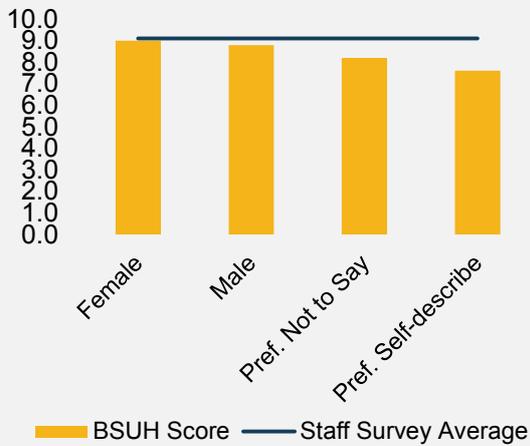


For answers in Q.15a and b, respondents were ask to identify why they feel they have been discriminated against:

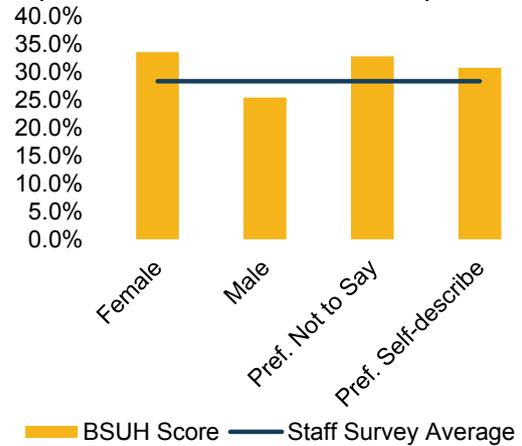
Experienced discrimination because of	BME Staff	White Staff	Staff Survey Average
	Age	9.1%	19.4%
Disability	3.5%	8.4%	6.9%
Ethnic background	80.5%	35.2%	42.4%
Gender	12.6%	26.9%	18.8%
Other reasons	13.0%	26.5%	32.1%
Religion or Belief	3.5%	2.7%	3.7%
Sexual Orientation	2.6%	9.8%	3.1%

Results broken down by gender:

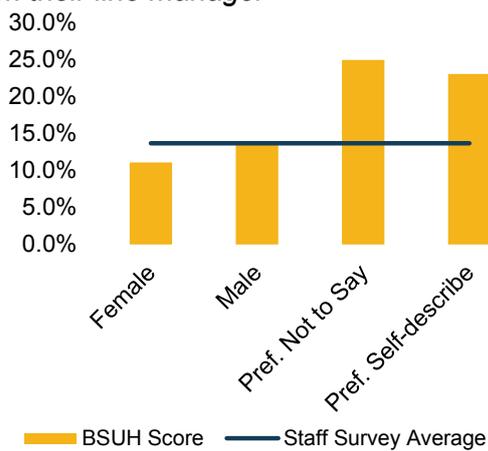
Overall equality and diversity theme



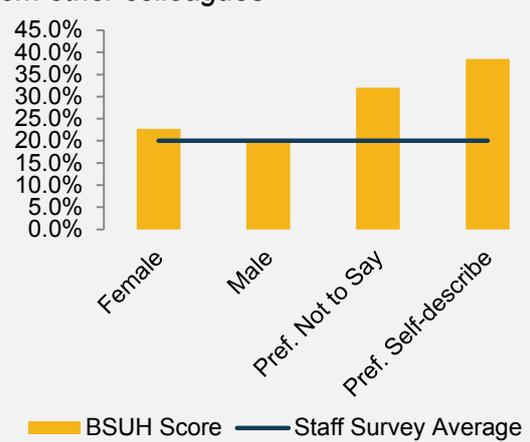
Q.13a - Staff experiencing bullying, harassment or abuse in the last 12 months from patients, service users or the public



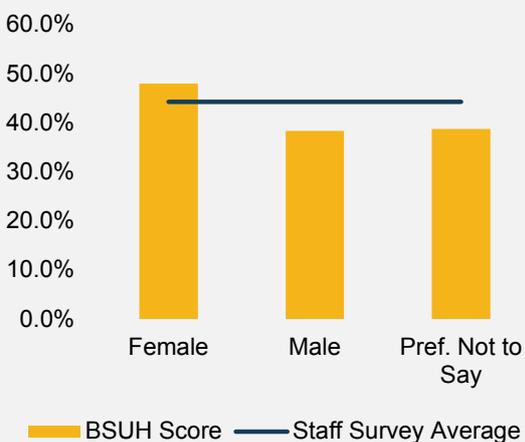
Q.13b - Staff experiencing bullying, harassment or abuse in the last 12 months from their line manager



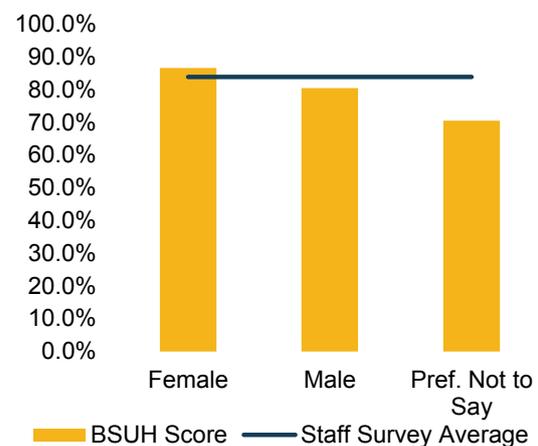
Q.13c - Staff experiencing bullying, harassment or abuse in the last 12 months from other colleagues



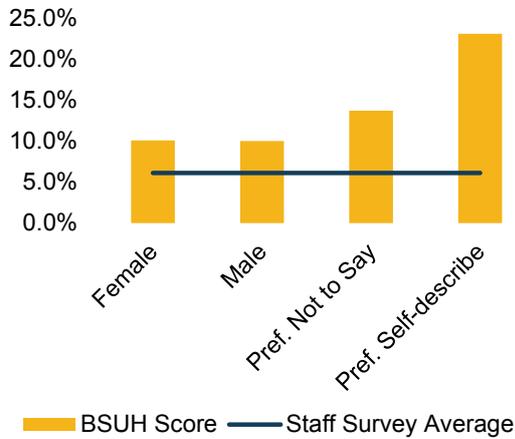
Q.13d - Staff that experienced bullying, harassment or abuse in the last 12 months did they report it?



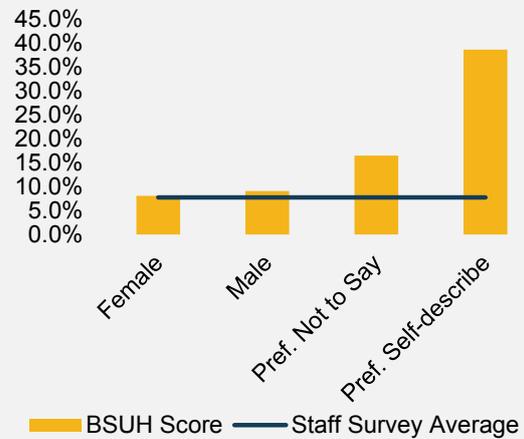
Q.14 Does the organisation act fairly in relation to progression/promotion regardless of protected characteristic?



Q.15a Staff that have experienced discrimination in the last 12 months from patients, service users, relatives or the public



Q.15b Staff that have experienced discrimination in the last 12 months from their manager, team leader or other colleagues

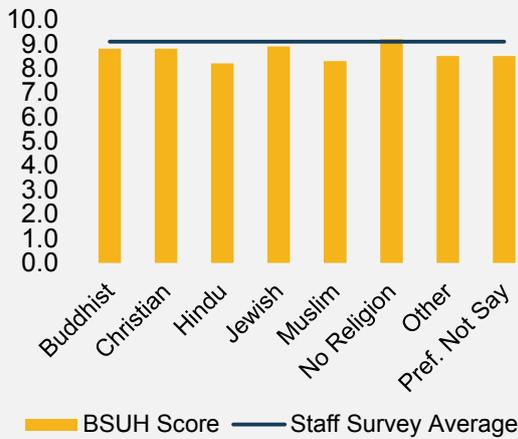


For answers in Q.15a and b, respondents were ask to identify why they feel they have been discriminated against:

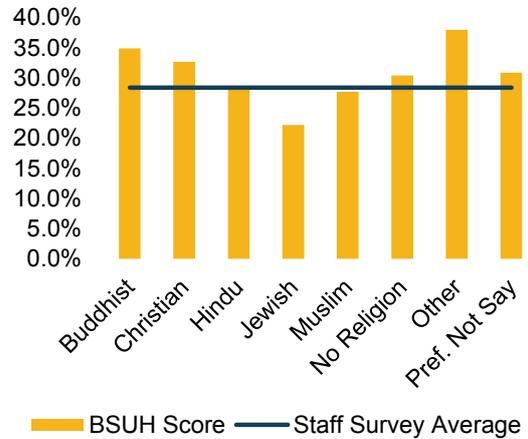
Experienced discrimination because of	Female	Male	Prefer not to say	Staff Survey Average
	Age	16.6%	13.6%	23.5%
Disability	7.0%	4.0%	11.8%	6.9%
Ethnic background	49.6%	57.6%	35.3%	42.4%
Gender	24.2%	15.8%	17.6%	18.8%
Other reasons	23.2%	16.9%	29.4%	32.1%
Religion or Belief	2.7%	4.0%	0.0%	3.7%
Sexual Orientation	3.9%	15.3%	11.8%	3.1%

Results broken down by religion or belief:

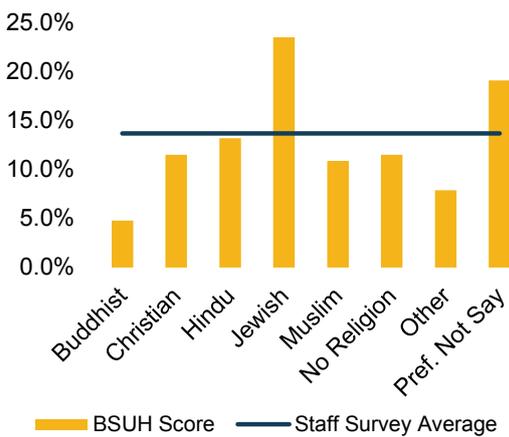
Overall equality and diversity theme



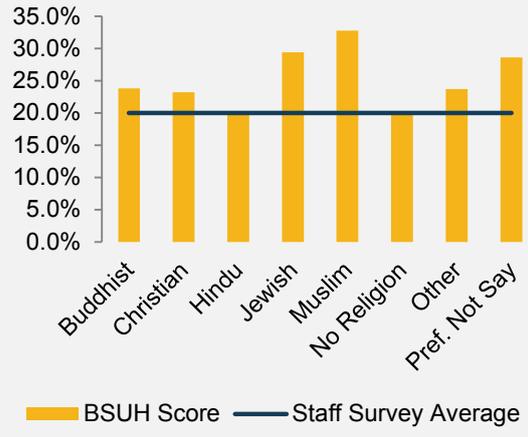
Q.13a - Staff experiencing bullying, harassment or abuse in the last 12 months from patients, service users or the public



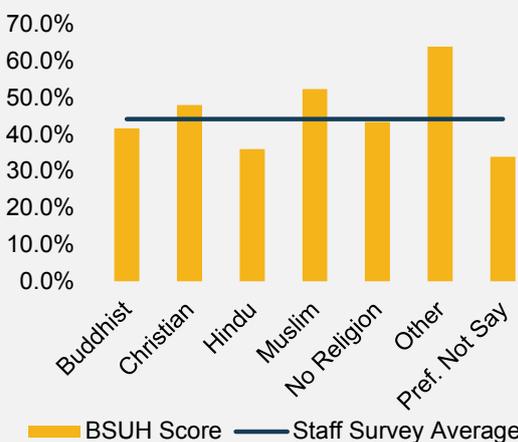
Q.13b - Staff experiencing bullying, harassment or abuse in the last 12 months from their line manager



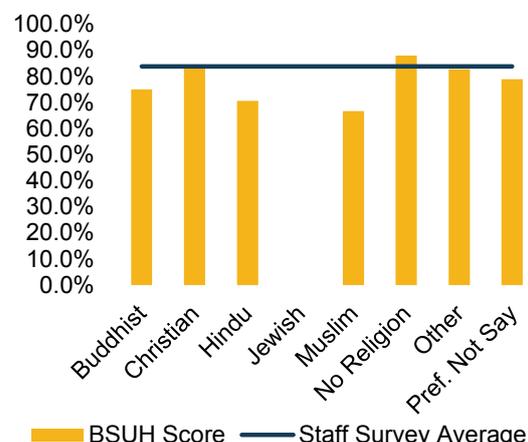
Q.13c - Staff experiencing bullying, harassment or abuse in the last 12 months from other colleagues



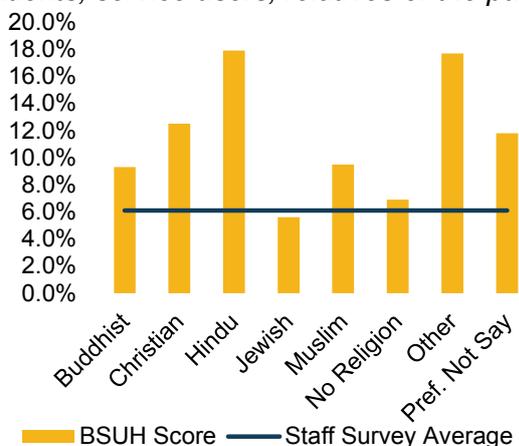
Q.13d - Staff that experienced bullying, harassment or abuse in the last 12 months did they report it?



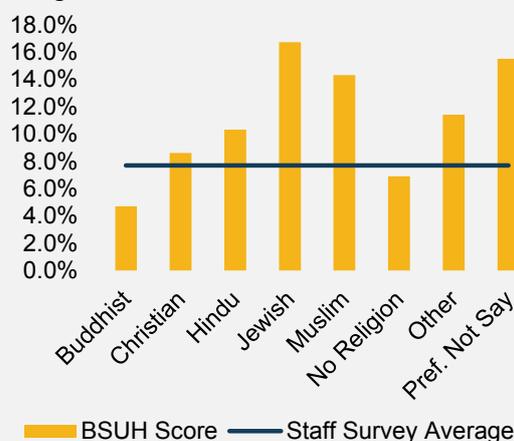
Q.14 Does the organisation act fairly in relation to progression/promotion regardless of protected characteristic?



Q.15a Staff that have experienced discrimination in the last 12 months from patients, service users, relatives or the public



Q.15b Staff that have experienced discrimination in the last 12 months from their manager, team leader or other colleagues

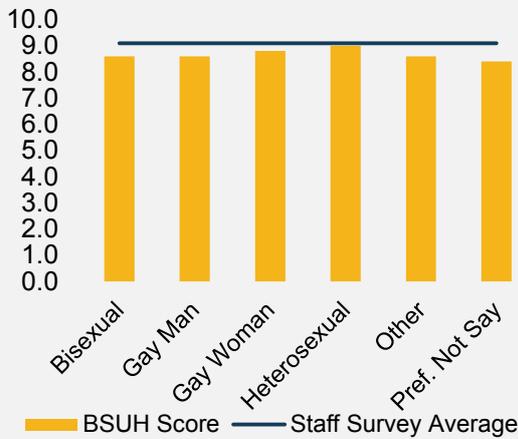


For answers in Q.15a and b, respondents were asked to identify why they feel they have been discriminated against:

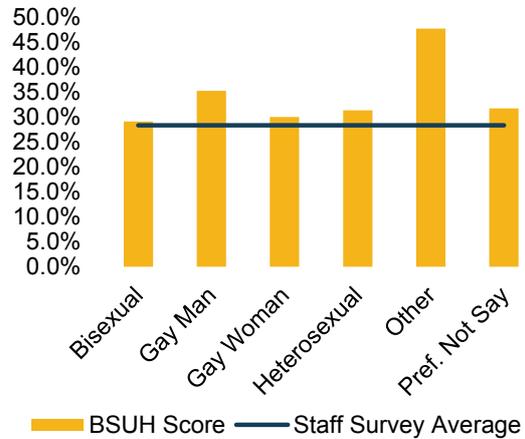
	Christian	Hindu	Muslim	No Religion	Other	Pref. Not Say	Staff Survey Average
Age	13.2%	16.7%	7.7%	20.5%	5.0%	14.8%	18.2%
Disability	5.2%	11.1%	0.0%	7.4%	15.0%	8.2%	6.9%
Ethnic background	62.9%	72.2%	61.5%	31.9%	55.0%	50.8%	42.4%
Gender	13.2%	16.7%	30.8%	34.5%	10.0%	24.6%	18.8%
Other reasons	18.4%	5.6%	23.1%	25.8%	30.0%	24.6%	32.1%
Religion or Belief	3.4%	0.0%	23.1%	1.7%	0.0%	3.3%	3.7%
Sexual Orientation	4.9%	0.0%	0.0%	10.5%	0.0%	8.2%	3.1%

Results broken down by sexual orientation:

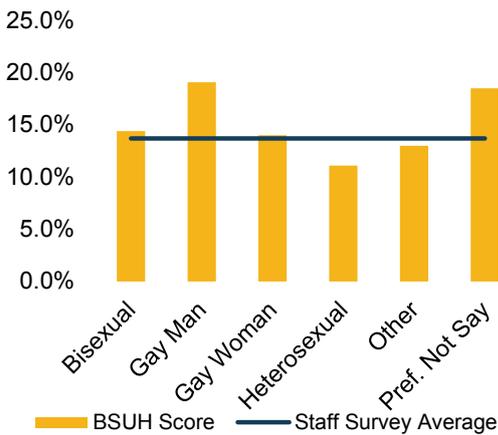
Overall equality and diversity theme



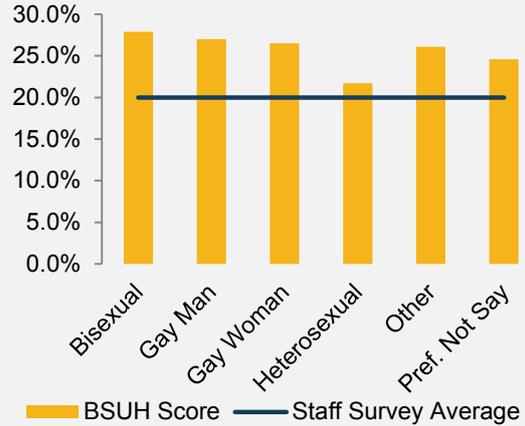
Q.13a - Staff experiencing bullying, harassment or abuse in the last 12 months from patients, service users or the public



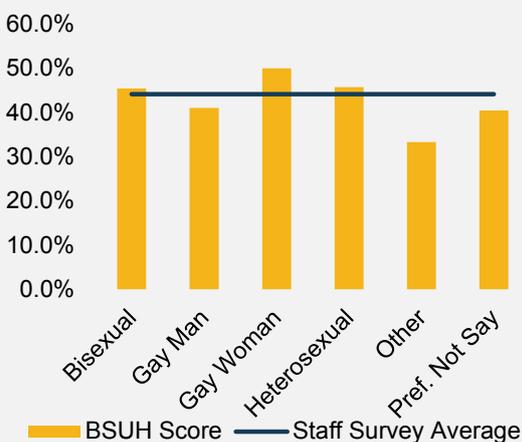
Q.13b - Staff experiencing bullying, harassment or abuse in the last 12 months from their line manager



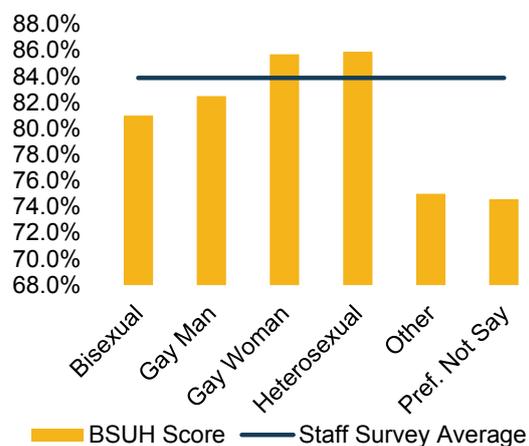
Q.13c - Staff experiencing bullying, harassment or abuse in the last 12 months from other colleagues



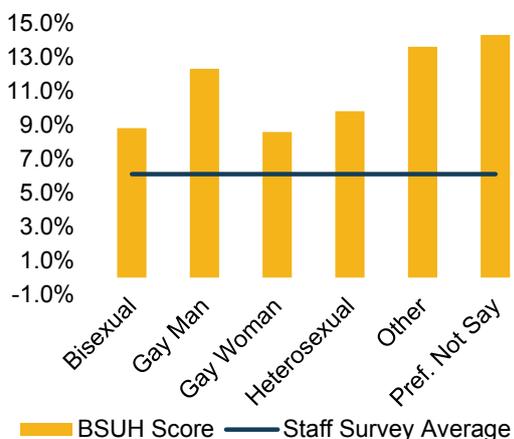
Q.13d - Staff that experienced bullying, harassment or abuse in the last 12 months did they report it?



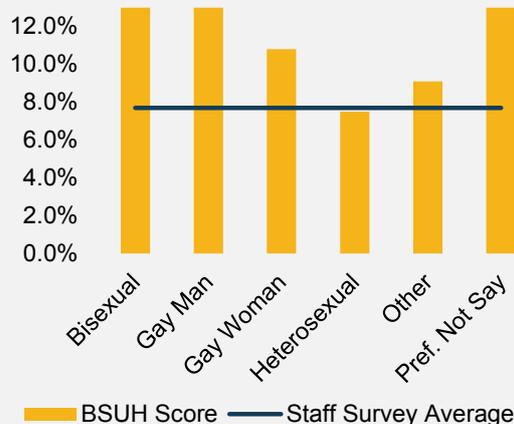
Q.14 Does the organisation act fairly in relation to progression/promotion regardless of protected characteristic?



Q.15a Staff that have experienced discrimination in the last 12 months from patients, service users, relatives or the public



Q.15b Staff that have experienced discrimination in the last 12 months from their manager, team leader or other colleagues

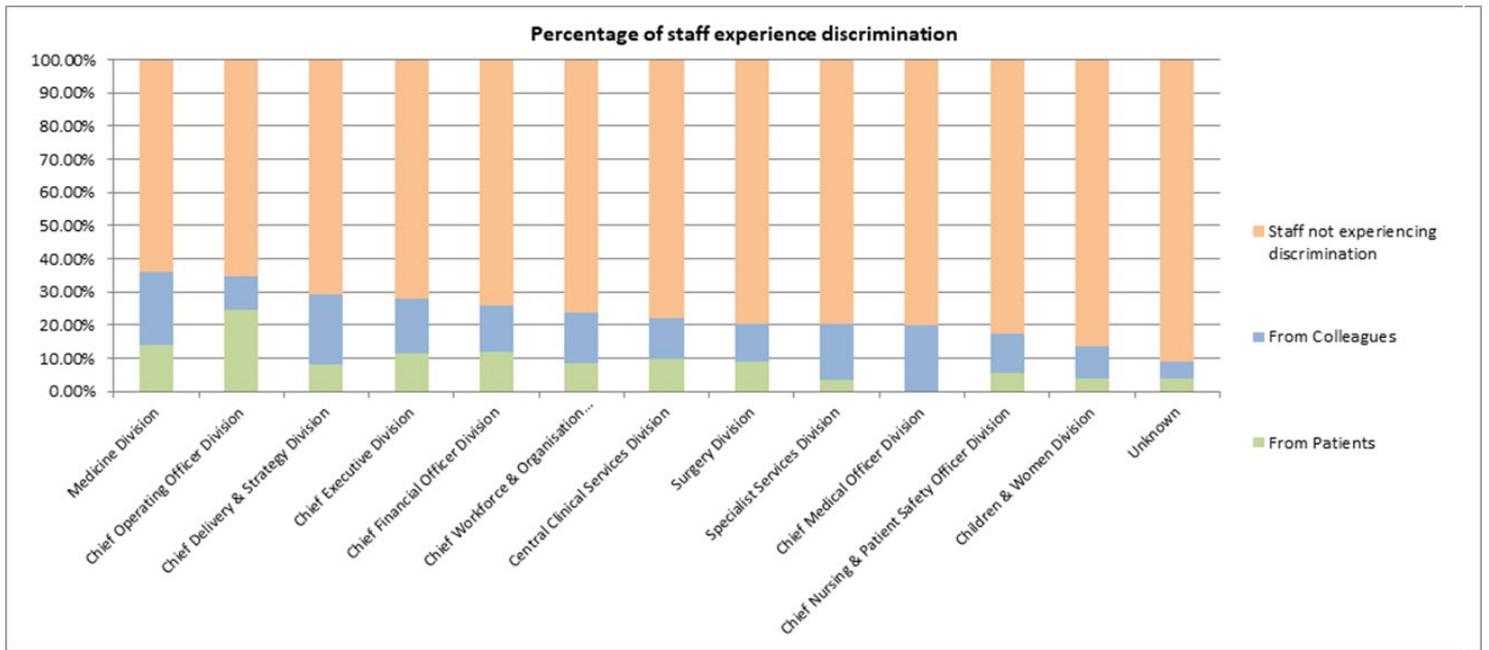


For answers in Q.15a and b, respondents were asked to identify why they feel they have been discriminated against:

		Bisexual	Gay Man	Gay Women	Heterosexual	Pref. Not Say	Staff Survey Average
Experienced discrimination because of	Age	14.3%	16.7%	22.2%	16.1%	10.9%	18.2%
	Disability	9.5%	2.8%	11.1%	6.0%	10.9%	6.9%
	Ethnic background	28.6%	38.9%	38.9%	54.4%	46.9%	42.4%
	Gender	33.3%	19.4%	50.0%	20.1%	21.9%	18.8%
	Other reasons	23.8%	5.6%	11.1%	22.5%	26.6%	32.1%
	Religion or Belief	4.8%	2.8%	0.0%	3.1%	3.1%	3.7%
	Sexual Orientation	14.3%	55.6%	33.3%	2.7%	1.6%	3.1%

The Trust also uses opportunities to collect information from staff outside of the NHS Staff Survey. This data is collected when staff complete their statutory and mandatory training, and provides information which gives a 'real-time temperature gauge' of staff experiences.

The following chart will look at if staff have experienced discrimination from colleagues or patients in the last 12 months broken down into the organisation's divisional structure.

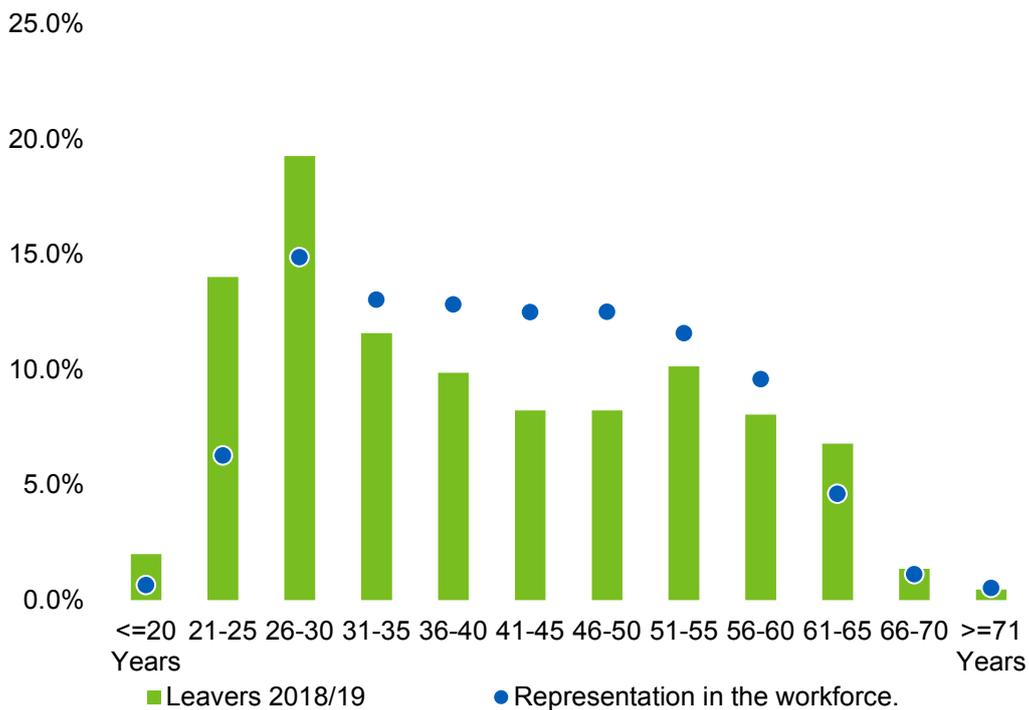




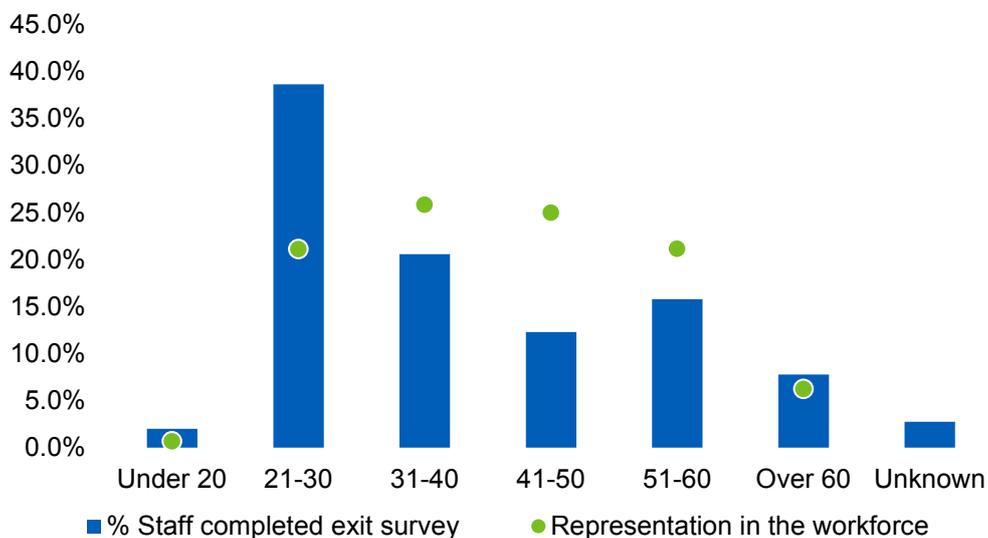
Information about staff that have left the Trust during 2018/19

During the reporting period a total of 1,105 staff left the Trust, a total of 398 staff completed an exit interview.

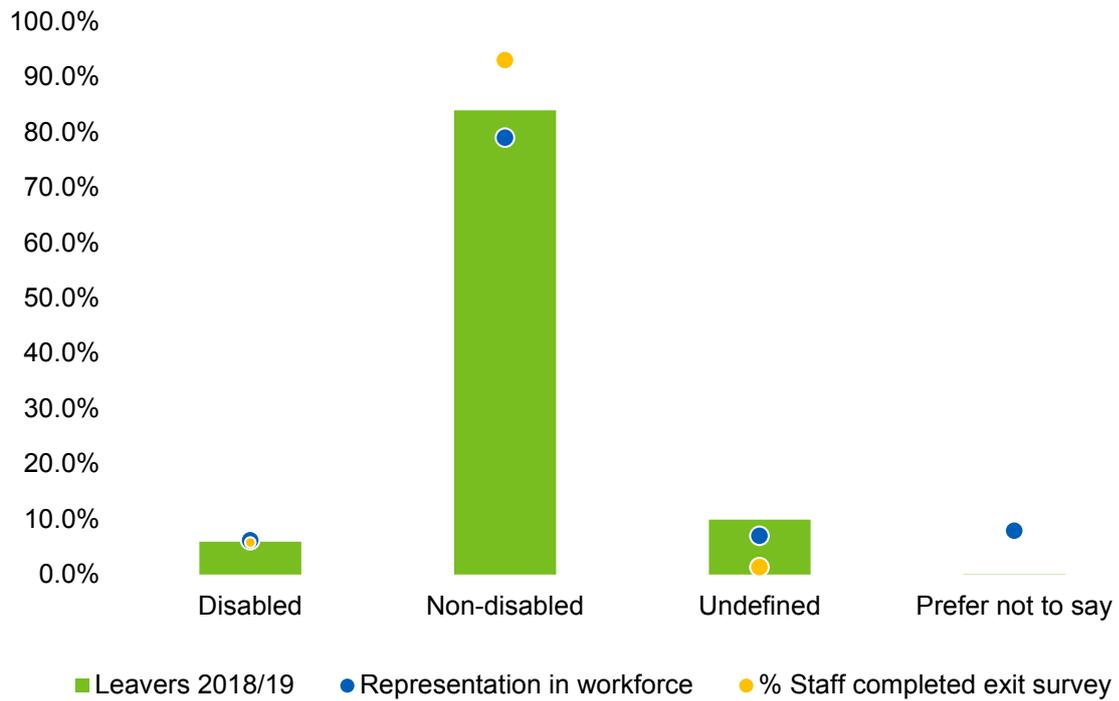
Leavers by age



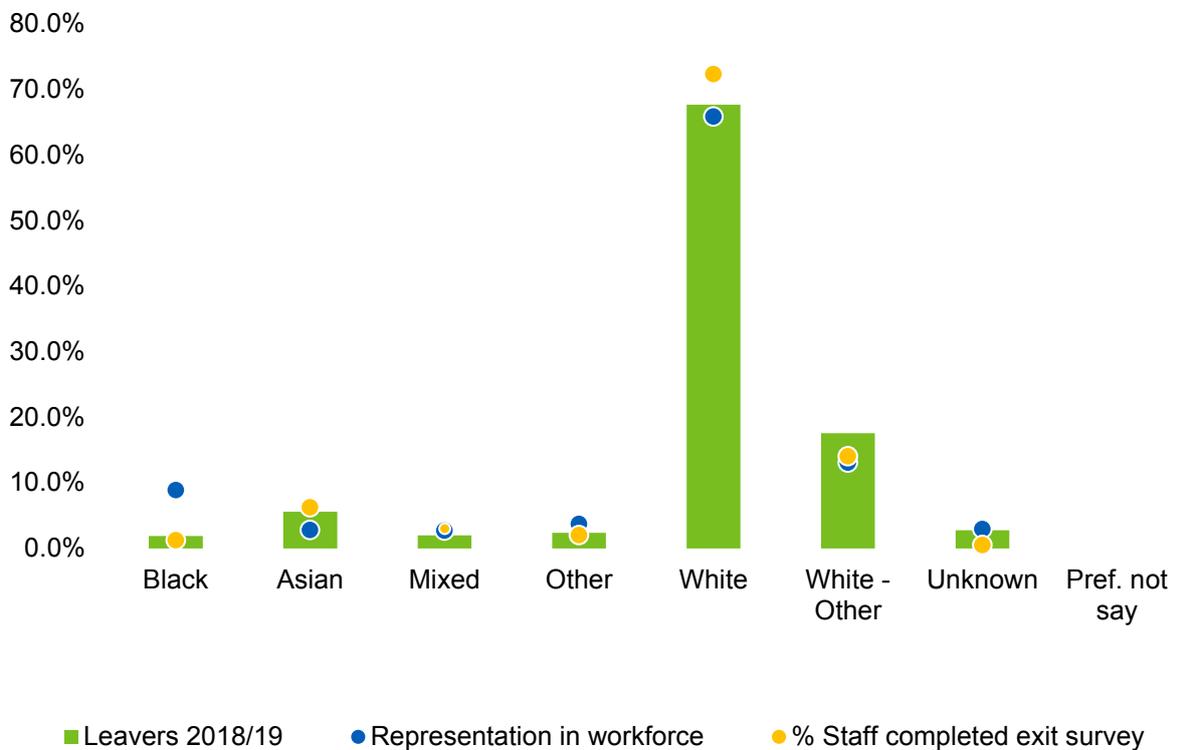
Number of exit interviews by age



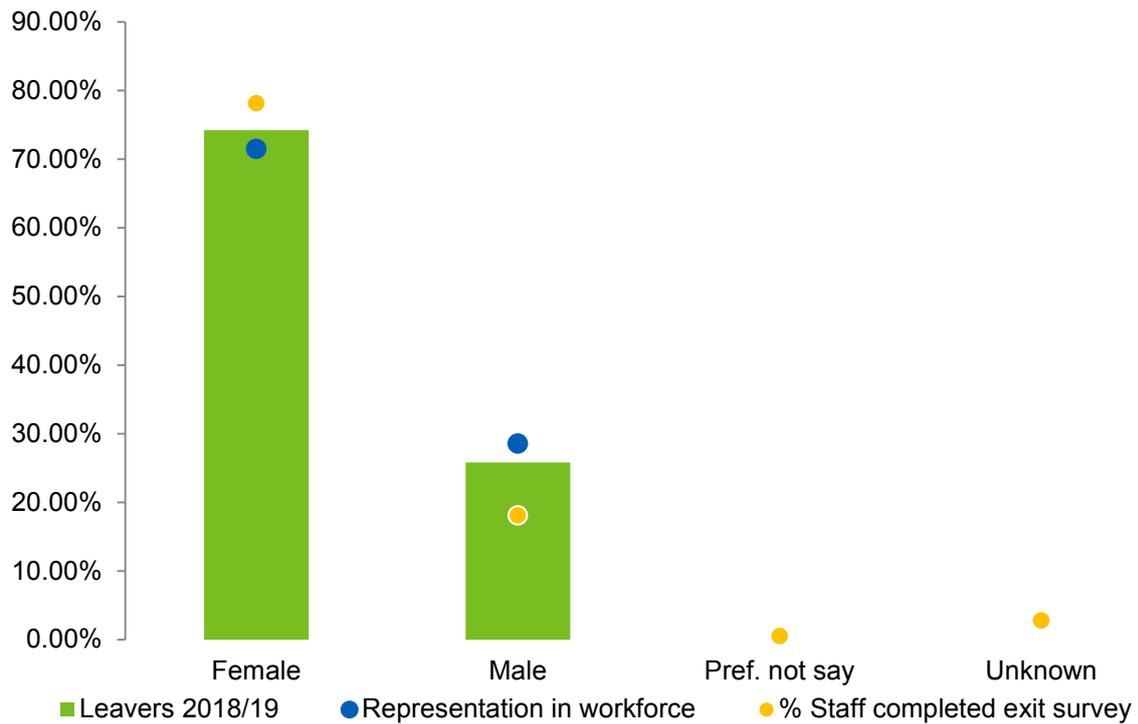
Leavers by disability



Leavers by ethnic background



Leavers by gender

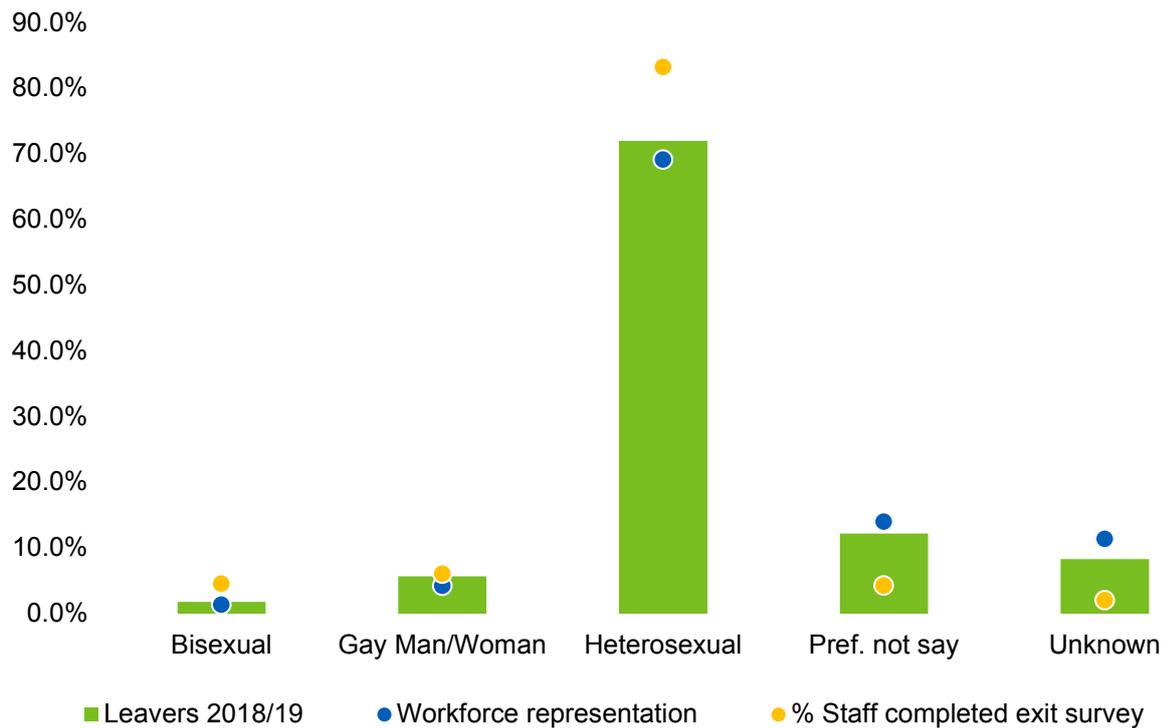


In this section – 0.5% of respondents have identified themselves as being transgender.

Leavers by religion or belief



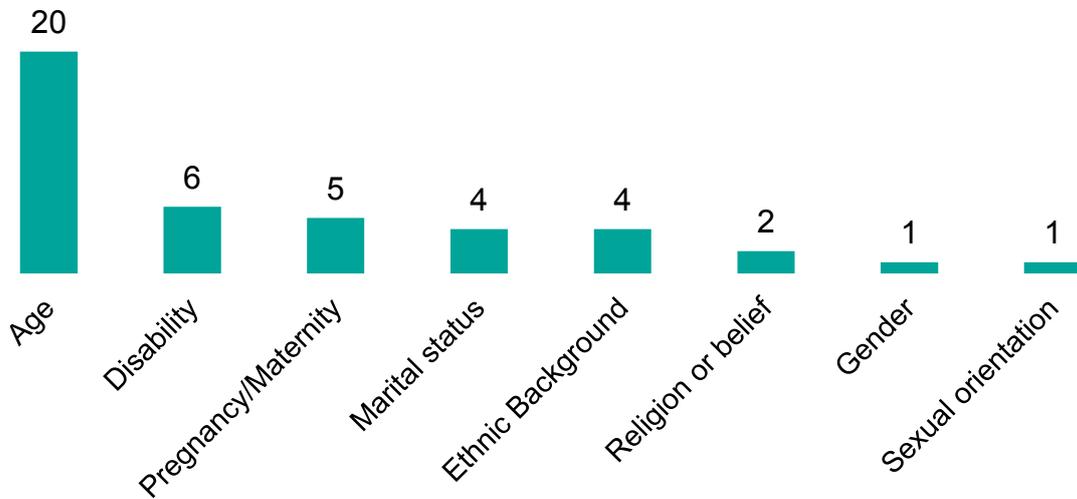
Leavers by sexual orientation



In exit surveys/interviews staff are asked to provide reasons for leaving, staff are able to select more than one reason.

Reason for leaving	Number of staff
Lack of promotion or career opportunities	94
Relocation	86
Better pay or reward	79
Other reasons	72
Work related stress	70
Change of carer	62
Lack of training opportunities	58
Travel	56
Retirement	47
Lack of flexible working arrangements	40
Relationship with manager	38
Family issues	37
Personal health reasons	30
Suffered bullying or harassment or ill treatment from managers or colleagues	24
Relationship with colleagues	19
Suffered bullying or harassment or ill treatment from patients or patient's relatives	5
Redundancy/MARS/TUPE	1

Staff were also asked if they feel if their protected characteristics was a factor for their reason to leave

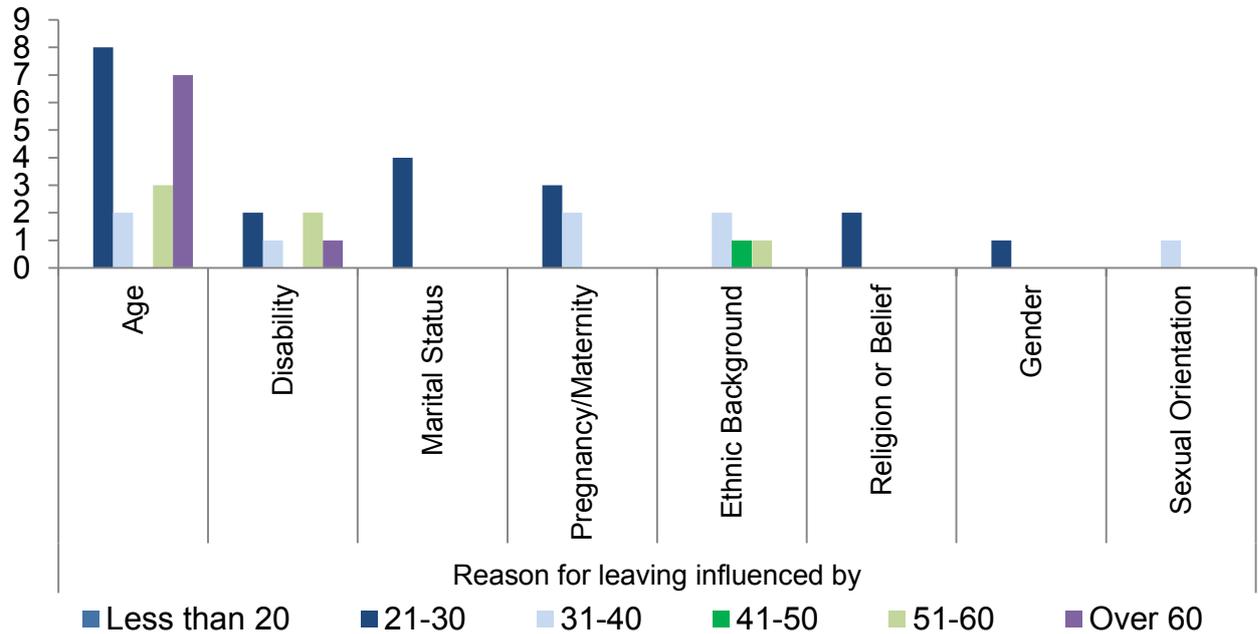


Breakdown of responses by age

Here are the top 3 reasons for leaving broken down by age group.

Less than 20	Change of career (3)	Other reasons, Work related stress and Travel (2)	Lack of promotion or career opportunities and Suffered bullying or harassment or ill treatment from managers or colleagues (1)
21-30	Relocation (44)	Better pay or reward (43)	Lack of promotion or career opportunities (42)
31-40	Relocation (25)	Lack of promotion or career opportunities (23)	Better pay or reward (21)
41-50	Lack of promotion or career opportunities (16)	Relocation (11)	Change of career (9)
51-60	Retirement (19)	Lack of promotion or career opportunities and (10)	Other reasons (9)
Over 60	Retirement (24)	Other reasons (4)	Family issues and Personal health reasons (3)

The following chart shows the people that responded that their reason for leaving was influenced by a protected characteristic broken down by age groups.

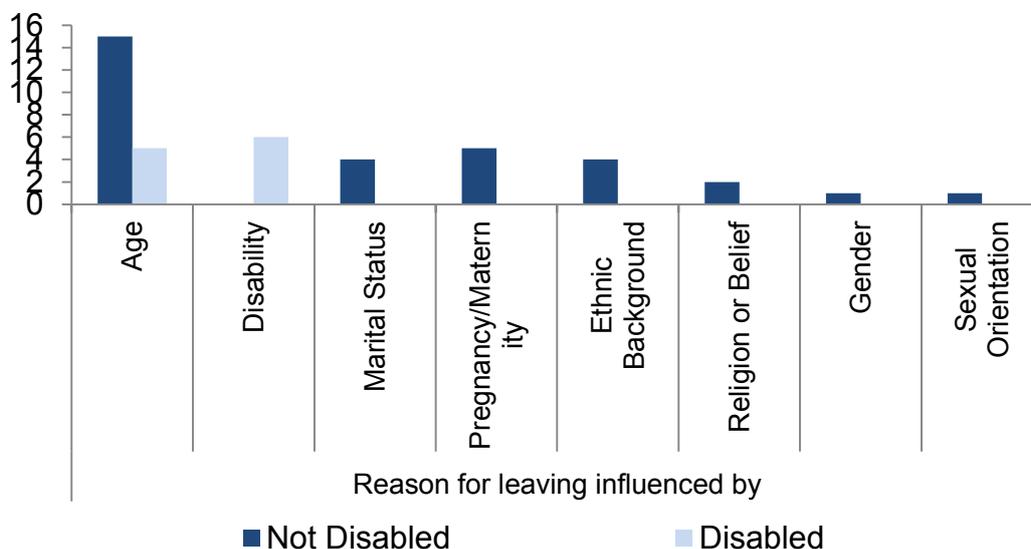


Breakdown of responses by disability status

Here are the top 3 reasons for leaving broken down by disability status.

Disabled	Lack of promotion or career opportunities (9)	Work related stress and Retirement (7)	Lack of training opportunities and Change of career (6)
Non-disabled	Relocation (85)	Lack of promotion or career opportunities (83)	Better pay or reward (75)

The following chart shows the people that responded that their reason for leaving was influenced by a protected characteristic broken down by disability status.

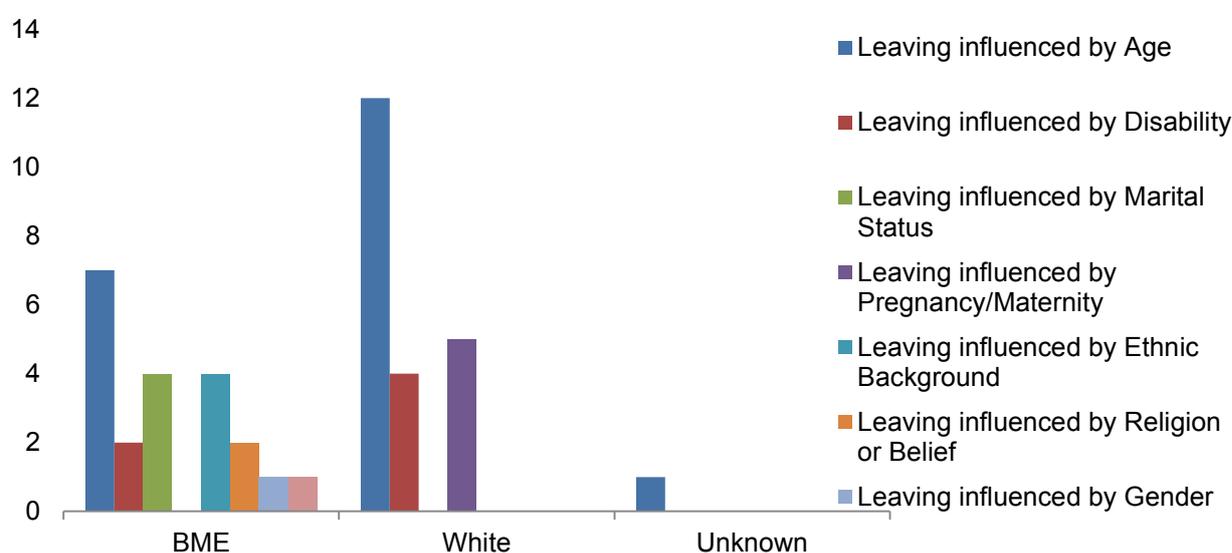


Breakdown of responses by ethnic background

Here are the top 3 reasons for leaving broken down by ethnic background.

BME	Work related stress and relocation (28)	Lack of promotion or career opportunities and Better pay or reward (25)	Other reason (21)
White	Lack of promotion or career opportunities (67)	Relocation (58)	Better pay or reward (53)

The following chart shows the people that responded that their reason for leaving was influenced by a protected characteristic broken down by ethnic background groups.

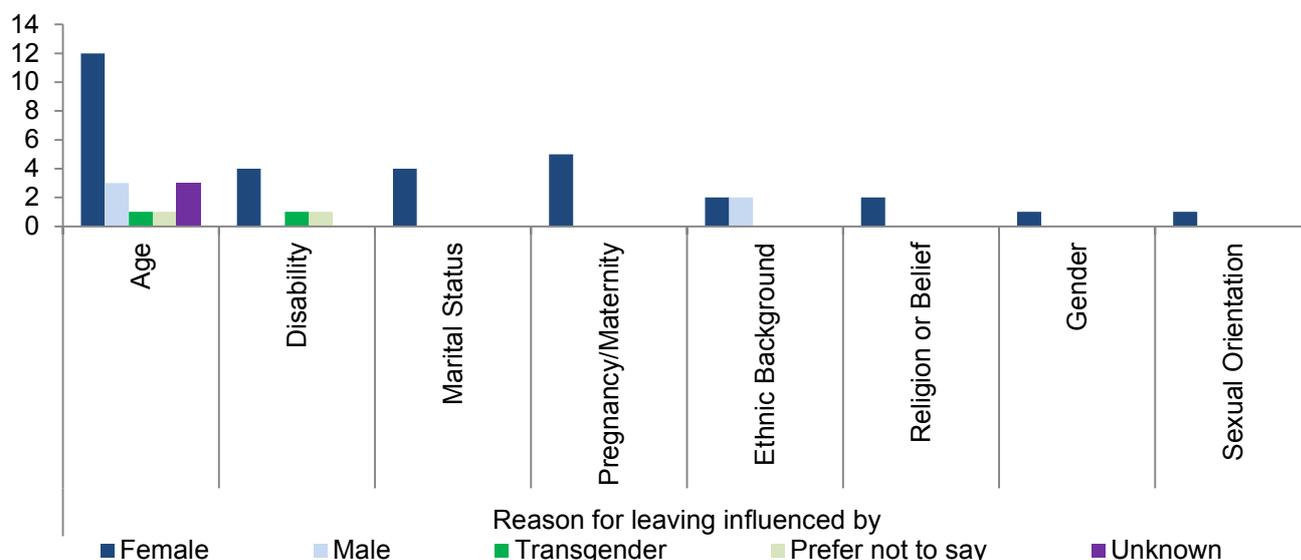


Breakdown of responses by gender

Here are the top 3 reasons for leaving broken down by gender.

Female	Lack of promotion or career opportunities and Relocation (73)	Better pay or reward (61)	Other reasons (51)
Male	Other reasons and Work related stress (19)	Better pay or reward (16)	Lack of promotion or career opportunities (15)
Transgender	Family issues (2)	Work related stress, Lack of promotion or career opportunities and Relocation (1)	

The following chart shows the people that responded that their reason for leaving was influenced by a protected characteristic broken down by gender groups.



It is recognised that transgender is not a gender, but the data reflects the exit interview questionnaire at the time.

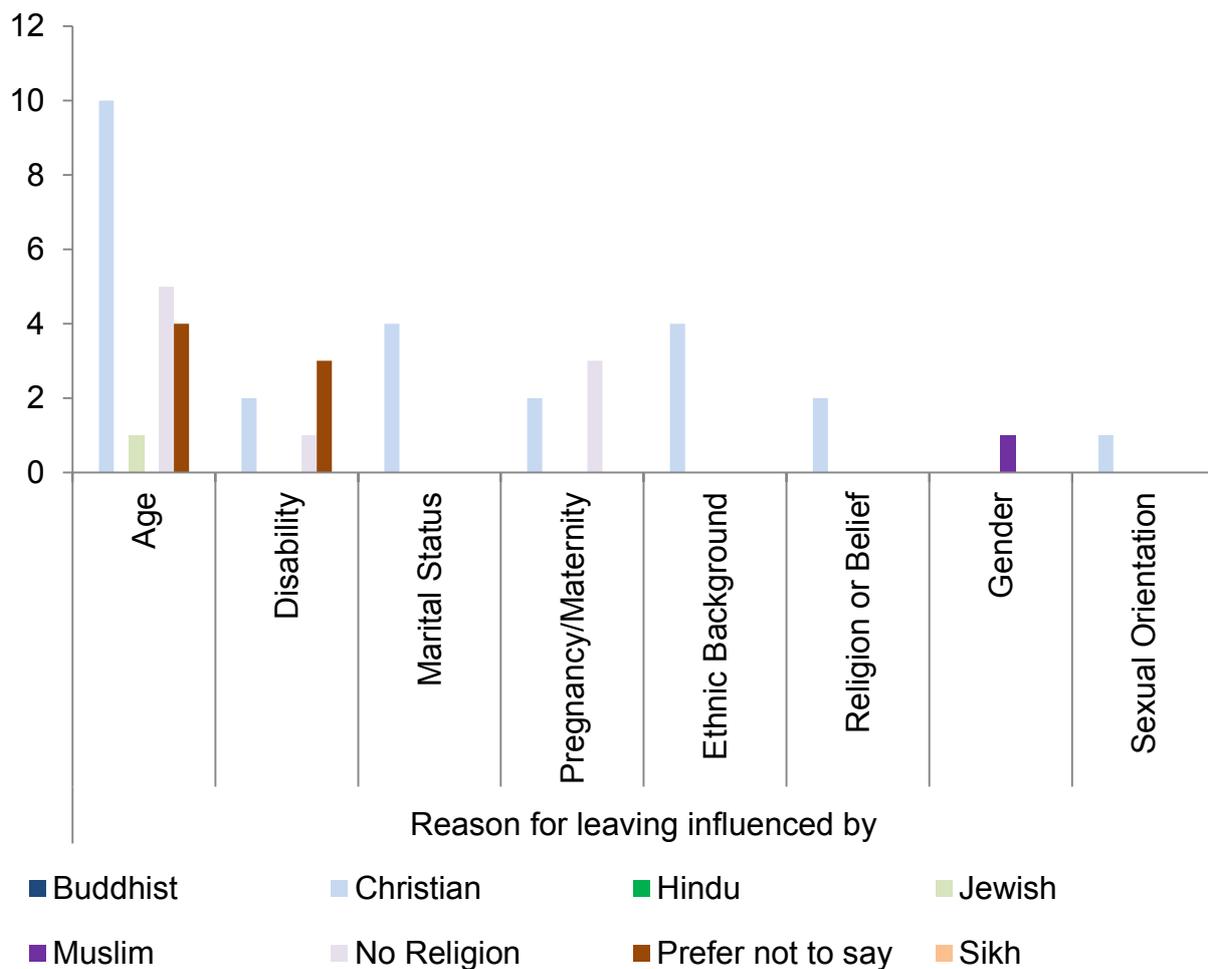
Breakdown of responses by religion or belief

A number of the religious groups were too small to draw meaningful top list of reason for leaving, so this has been ordered by all reasons with a breakdown by religion.

	Buddhist	Christian	Hindu	Jewish	Muslim	No Religion	Prefer not to say	Sikh	Unknown	Total
Lack of promotion or career opportunities	1	42		1		37	8		5	94
Relocation		43			1	36	2		5	87
Better pay or reward	2	35			2	31	4		5	79
Other reasons		32			1	32	6		1	72
Work related stress	1	27			2	31	9			70
Change of career		20	1		1	32	6		2	62
Lack of training opportunities	1	27		1		24	4		1	58
Travel	1	25	1		1	25	1		2	56
Retire		28		1		14	1		3	47
Lack of flexible working arrangements	1	17				19	1		2	40
Relationship with manager	1	15			1	13	7		1	38
Family issues		27				8	1		1	37

	Buddhist	Christian	Hindu	Jewish	Muslim	No Religion	Prefer not to say	Sikh	Unknown	Total
Personal health reasons	1	14	1			10	2	1	1	30
Suffered bullying or harassment or ill treatment from managers or colleagues		8			1	7	6		2	24
Relationship with colleagues		8				8	1		2	19
Suffered bullying or harassment or ill treatment from patients or patient's relatives		3				1	1			5
Redundancy/MARS/TUPE							1			1

The following chart shows the people that responded that their reason for leaving was influenced by a protected characteristic broken down by religion or belief groups.

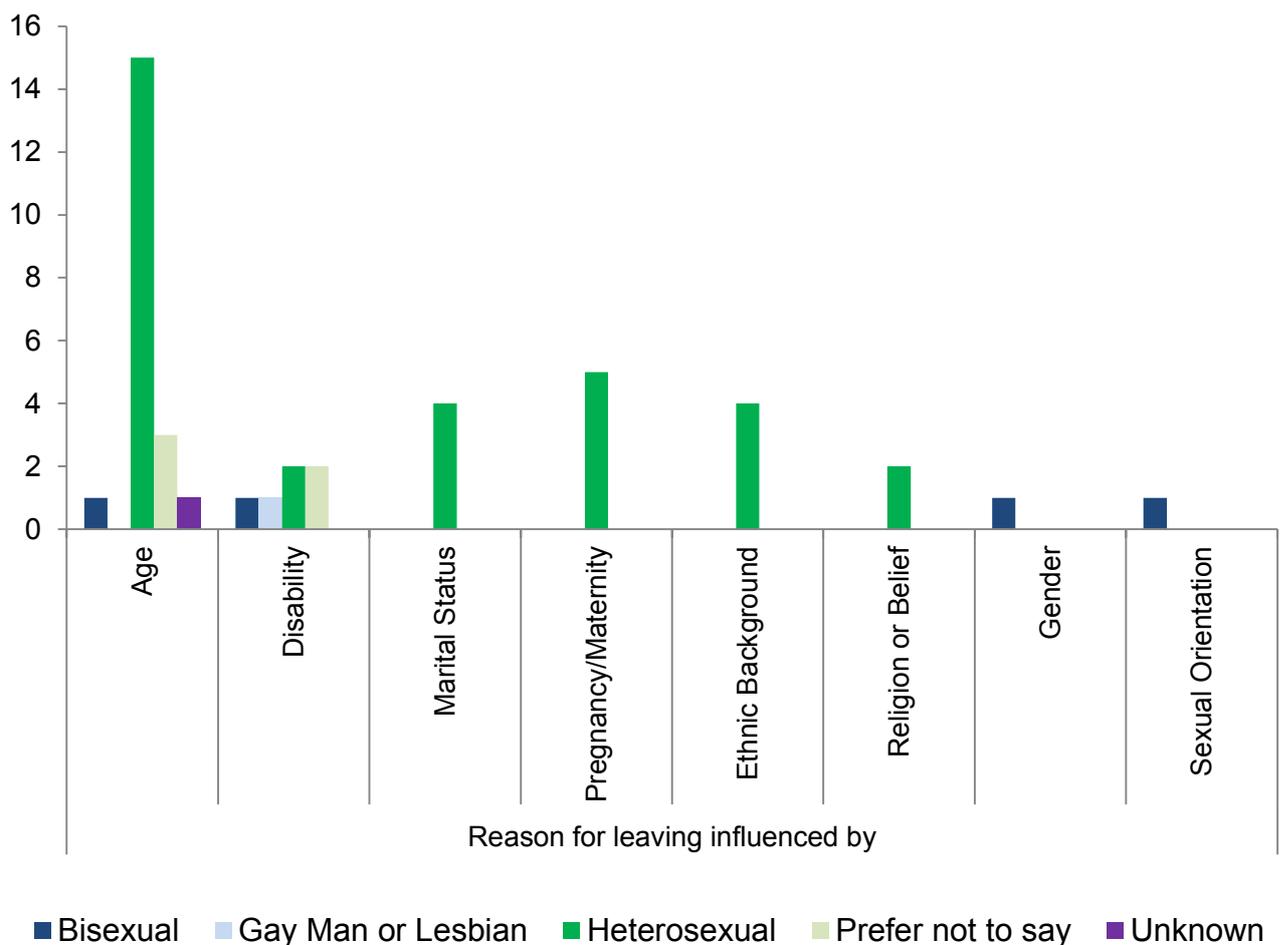


Breakdown of responses by sexual orientation

Here are the top 3 reasons for leaving broken down by sexual orientation.

Bisexual	Work related stress and relocation (8)	Lack of promotion or career opportunities (7)	Lack of training opportunities (5)
Gay Man or Lesbian	Relocation (7)	Lack of promotion or career opportunities (6)	Work related stress and Other reasons (5)
Heterosexual	Lack of promotion or career opportunities (72)	Relocation (70)	Better pay or reward (69)
Prefer not to say	Lack of promotion or career opportunities (7)	Lack of training opportunities (5)	Relationship with manager (4)

The following chart shows the people that responded that their reason for leaving was influenced by a protected characteristic broken down by sexual orientation.





The Trust's recruitment processes data

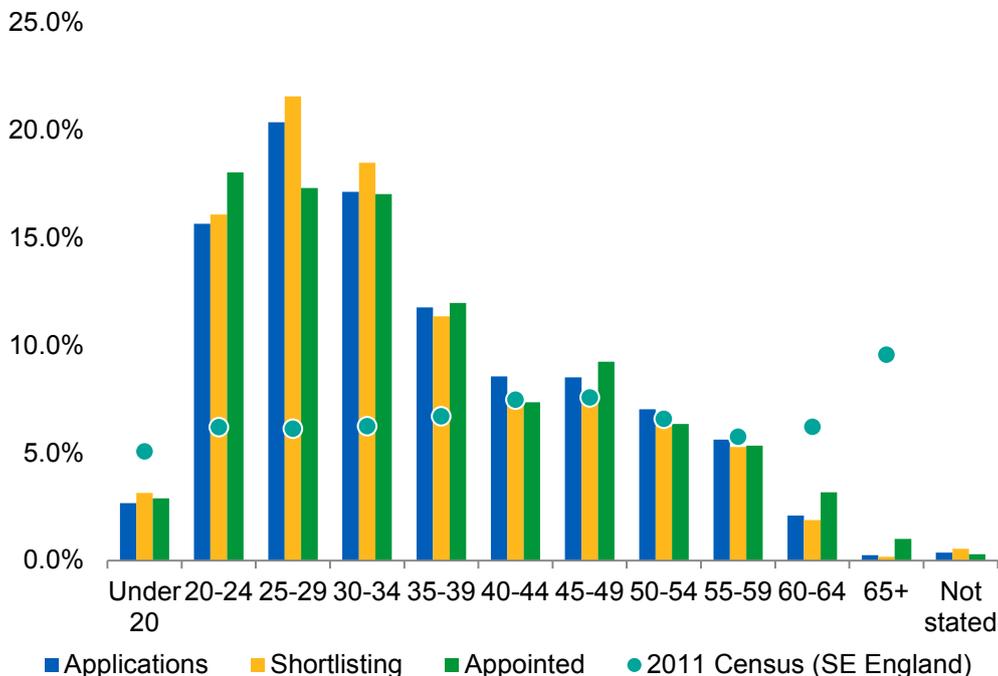
The charts show the breakdown of demographic of the representation through the three stages of recruitment: application, shortlisting and appointment. It is desirable to see a proportional consistency as each group progresses through the different stages.

Given that the Trust is open to recruitment from applicants internationally, it would be unrealistic to expect the demographic of applicants to exactly mirror the profile of the 2011 Census. This could have an impact on the representation of applicants through all three stages of recruitment.

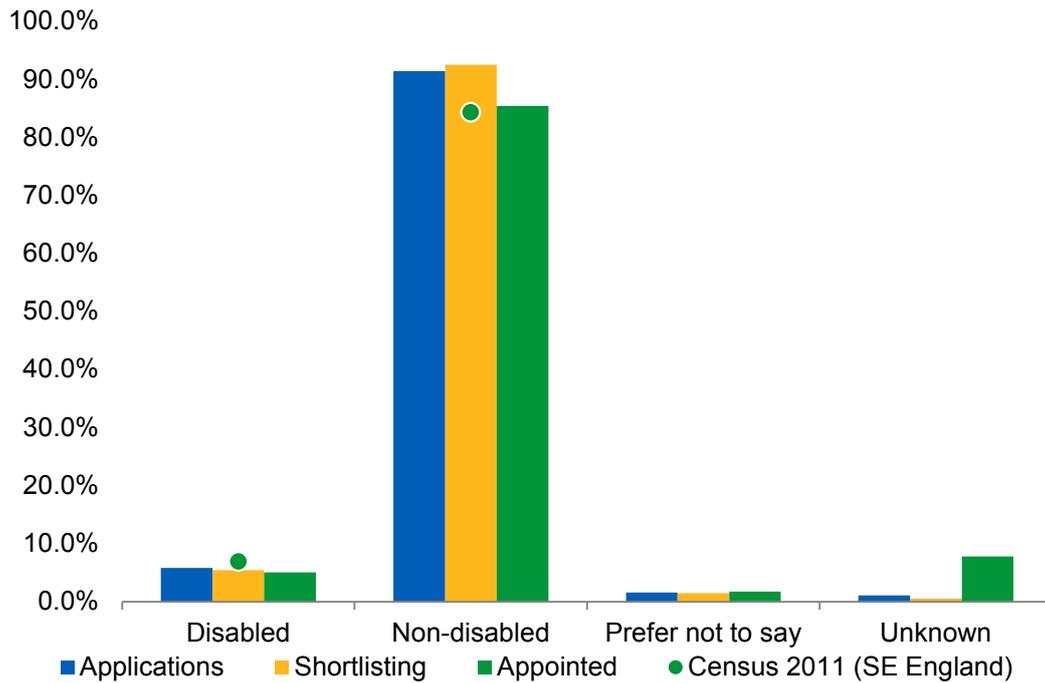
During 2017/18 there were:
 Applications received: 12,397
 Applicants Shortlisted: 6,618
 Applicants Appointed: 423

During 2018/19: there were:
 Applications received: 19,742
 Applicants Shortlisted: 11,356
 Applicants Appointed: 693

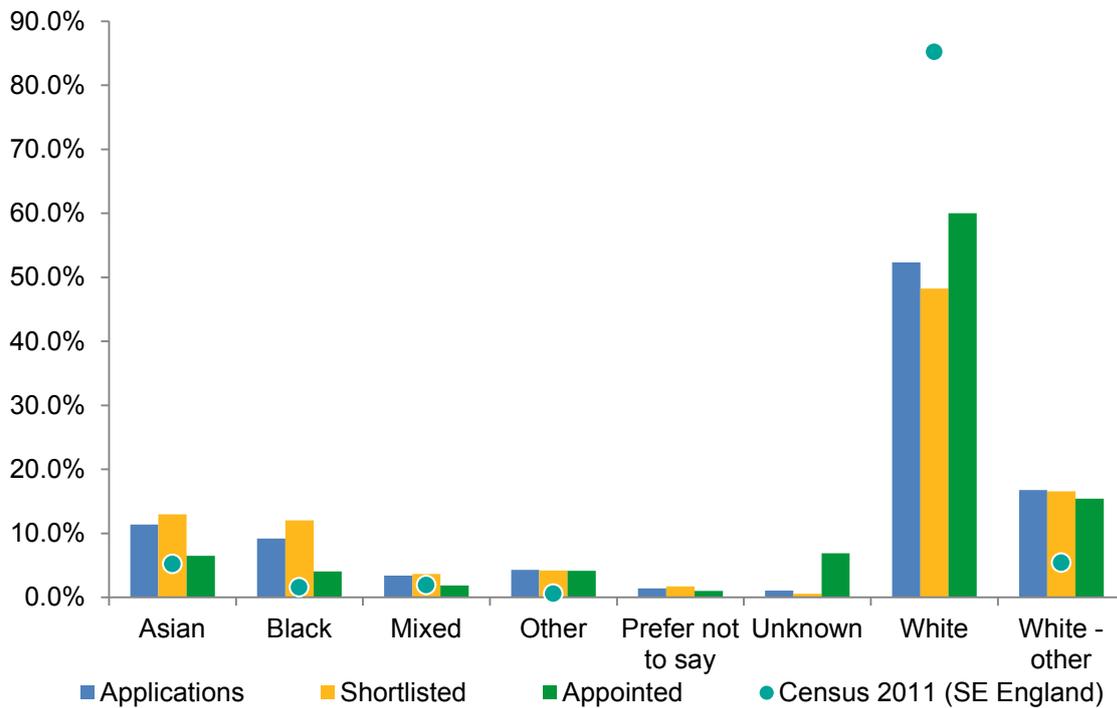
By age



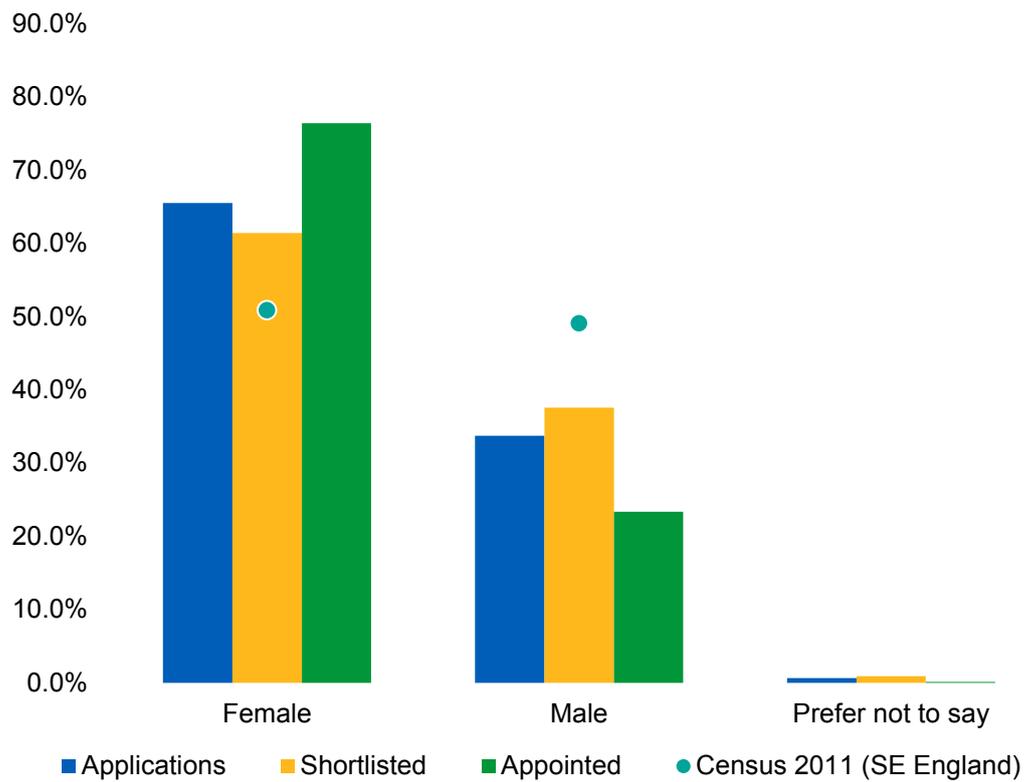
By disability



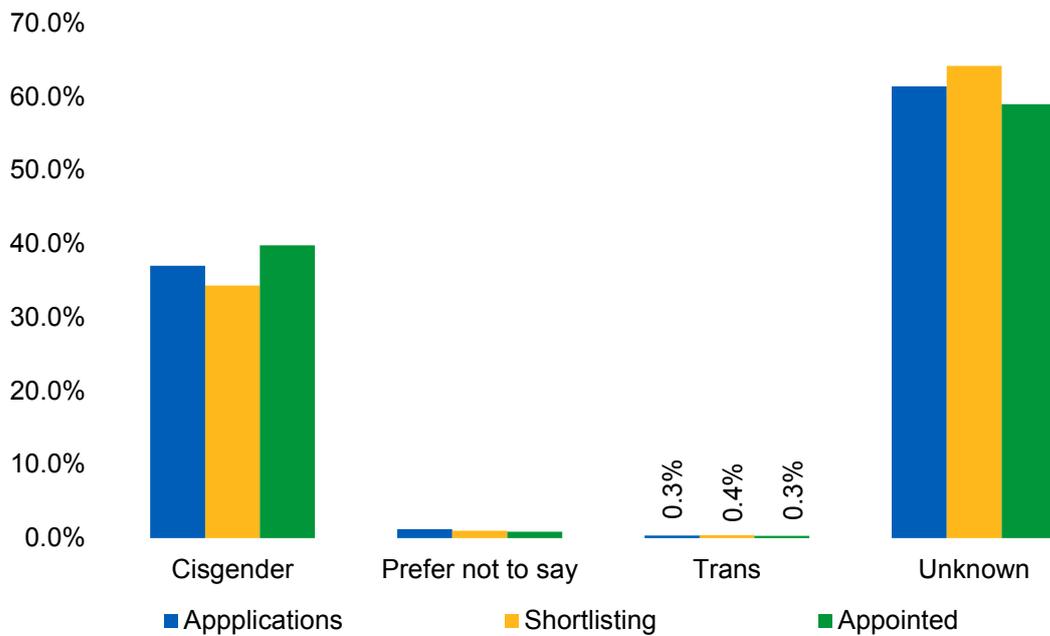
By ethnic background



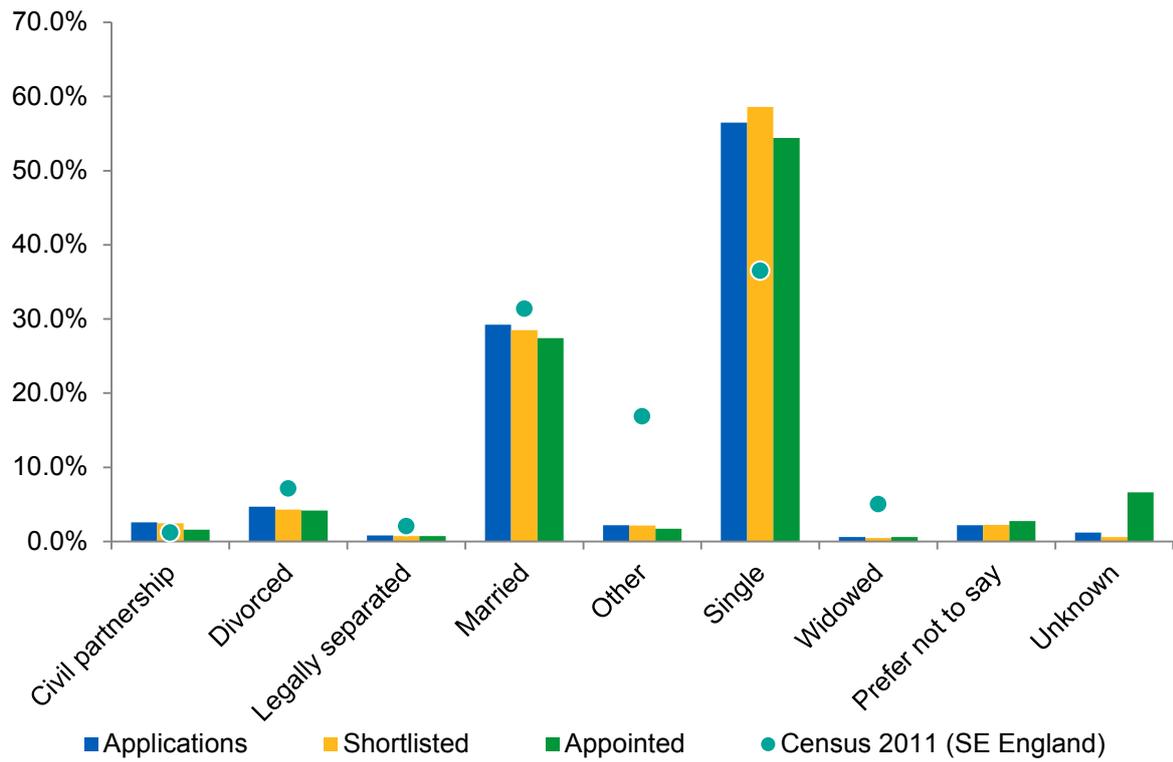
By gender



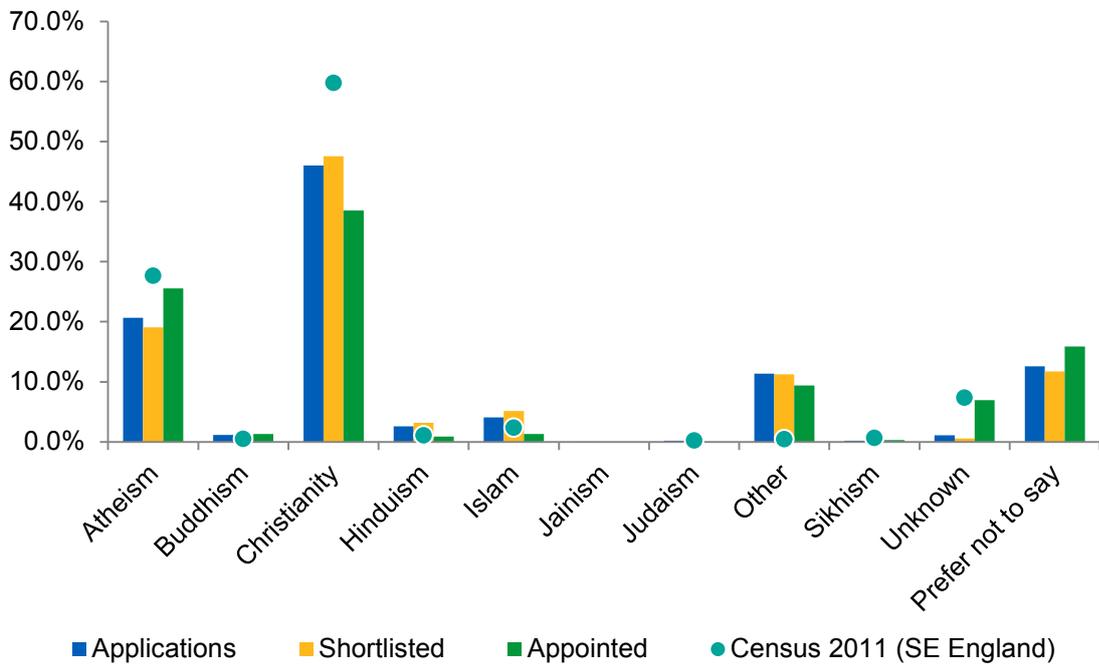
By gender identity



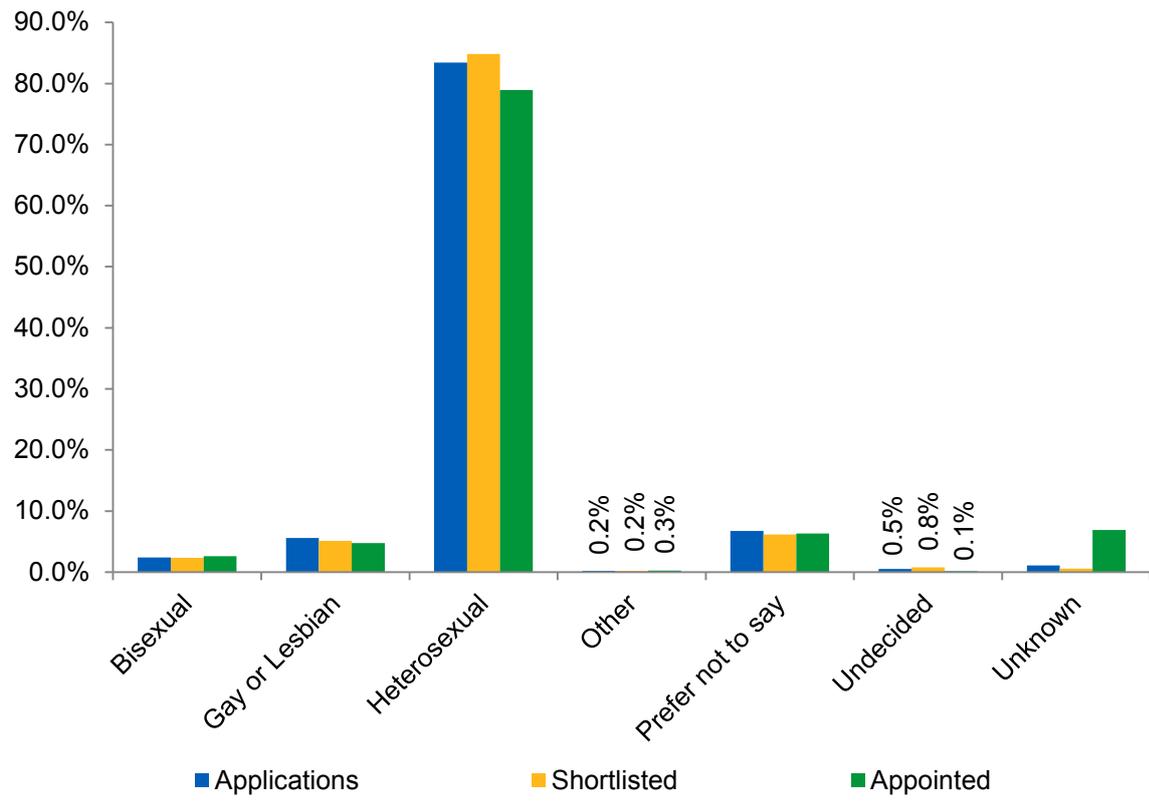
By marriage and civil partnership status



By religion or belief



By sexual orientation





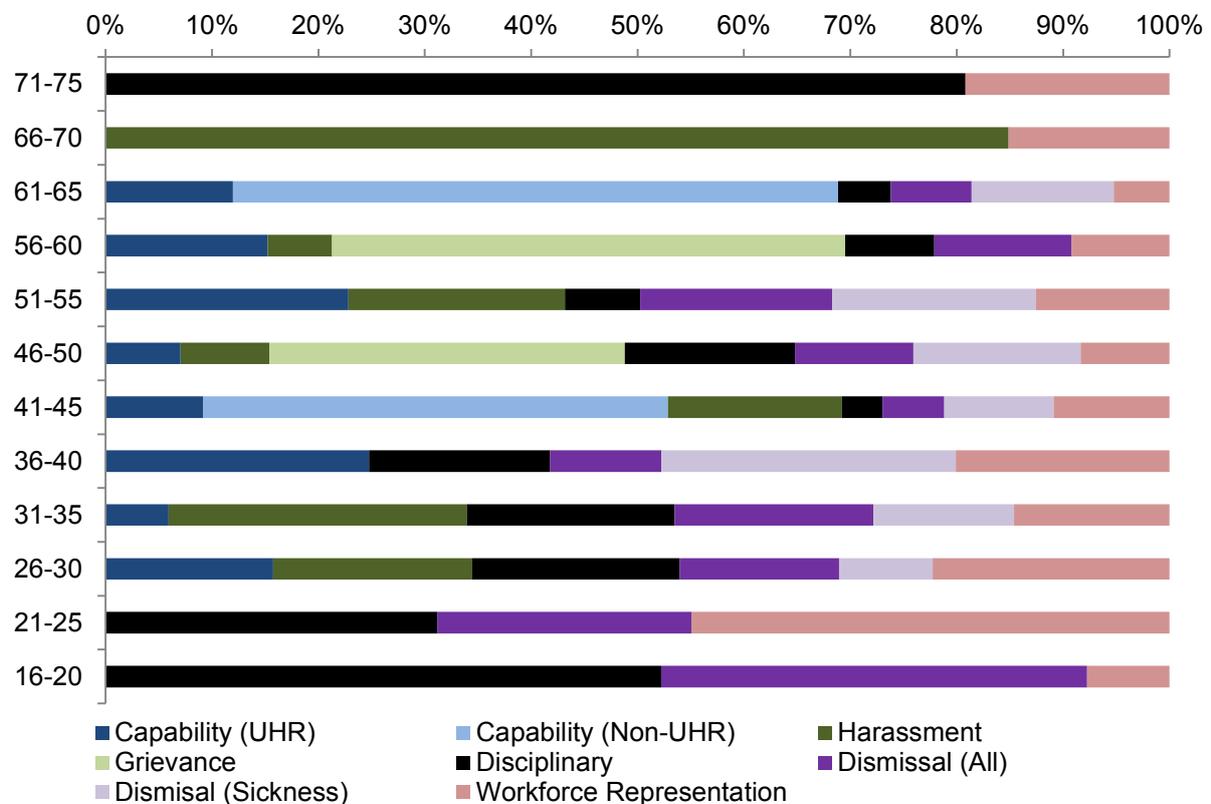
The Trust's employment policies and practices data

One way of demonstrating how fair employment practices and policies are is to see if there are any groups who have been disproportionately impacted. In this section the data will demonstrate which groups have been affected by, or raised concerns under specific policies and practices.

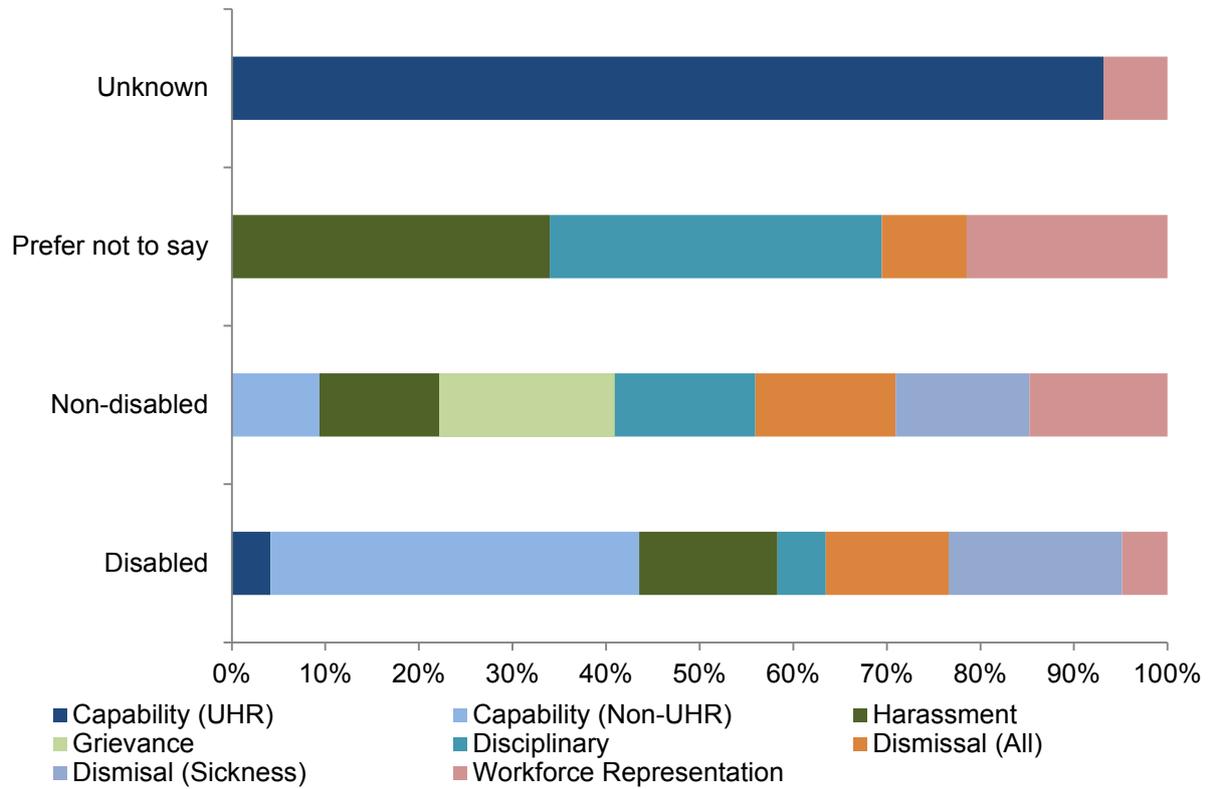
During 2018/19 there were:

- 19 Capability cases (underlying health reason)
- 2 Capability cases (no underlying health reason)
- 16 Harassment cases
- 2 Grievances
- 46 Disciplinary cases
- 30 Dismissals
 - of which 17 dismissals related to sickness

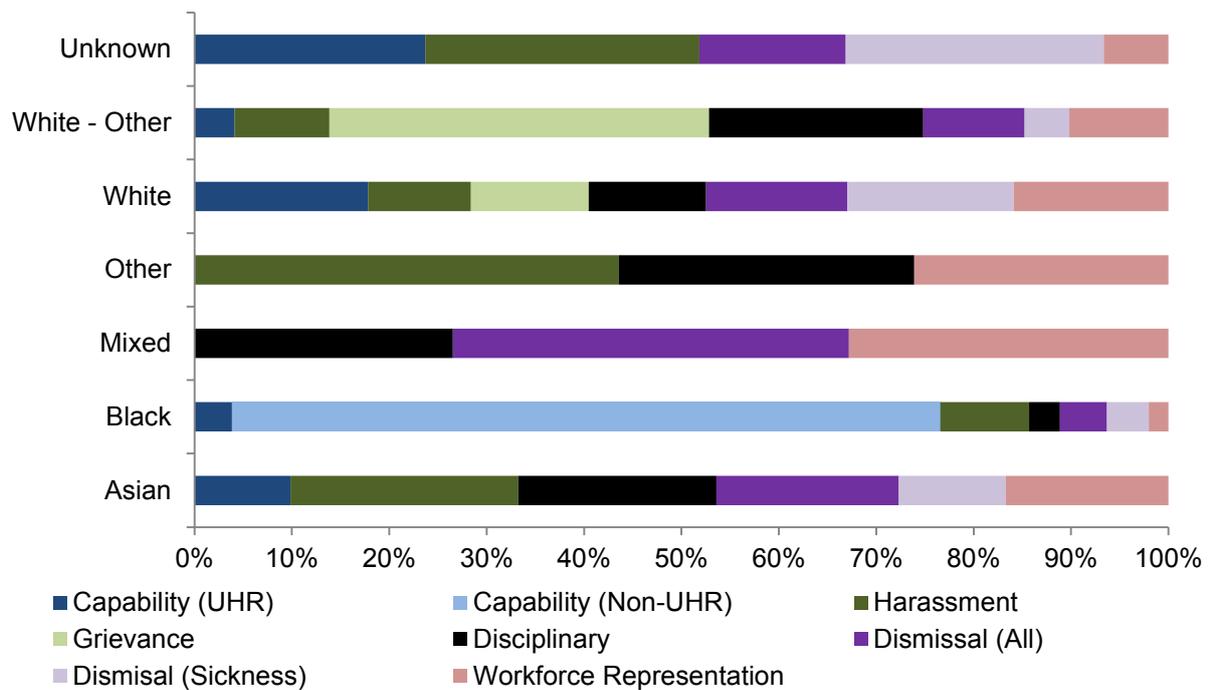
Breakdown of cases by age



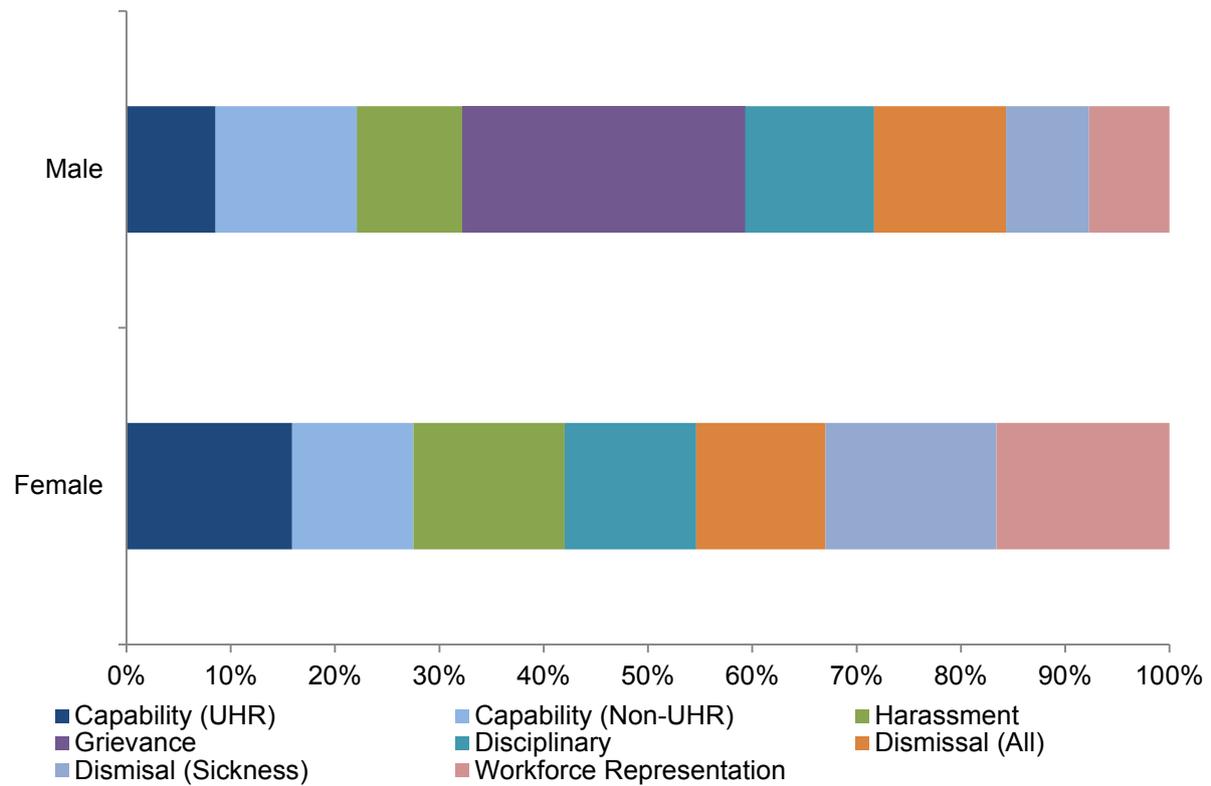
Breakdown of cases by disability status



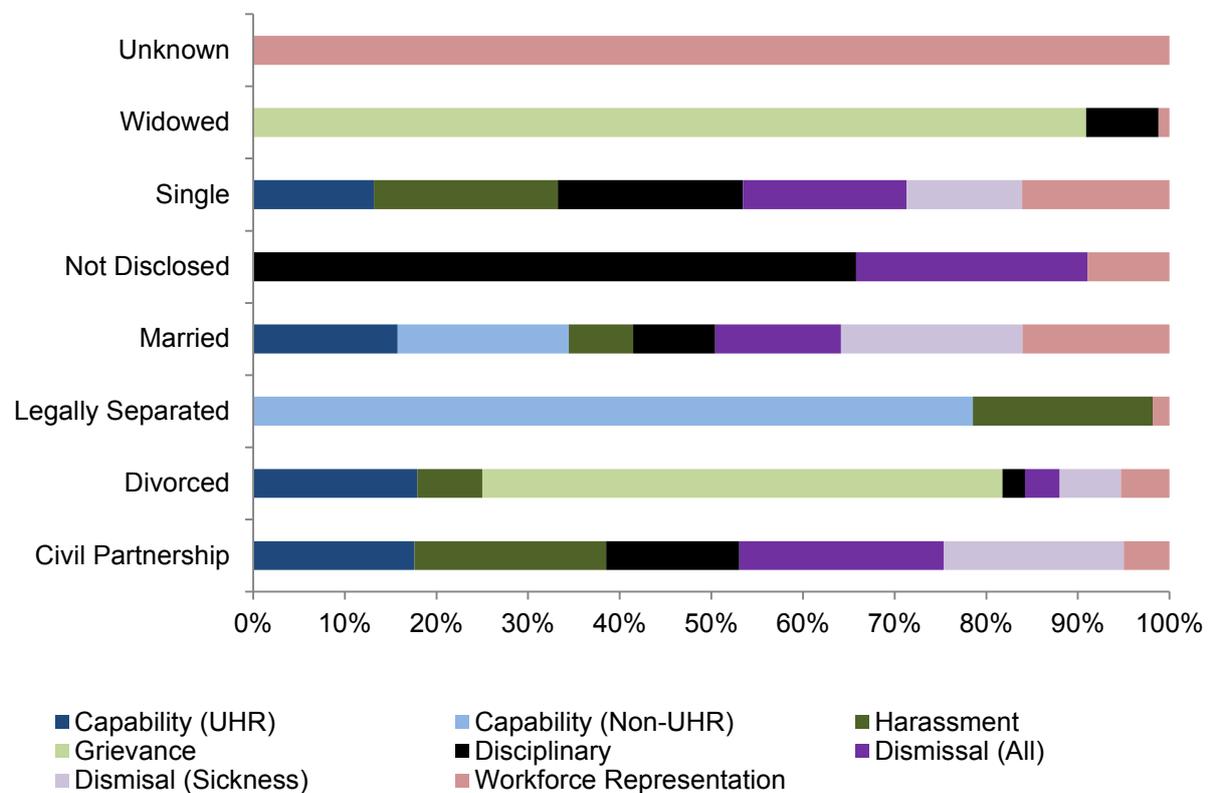
Breakdown of cases by ethnic background



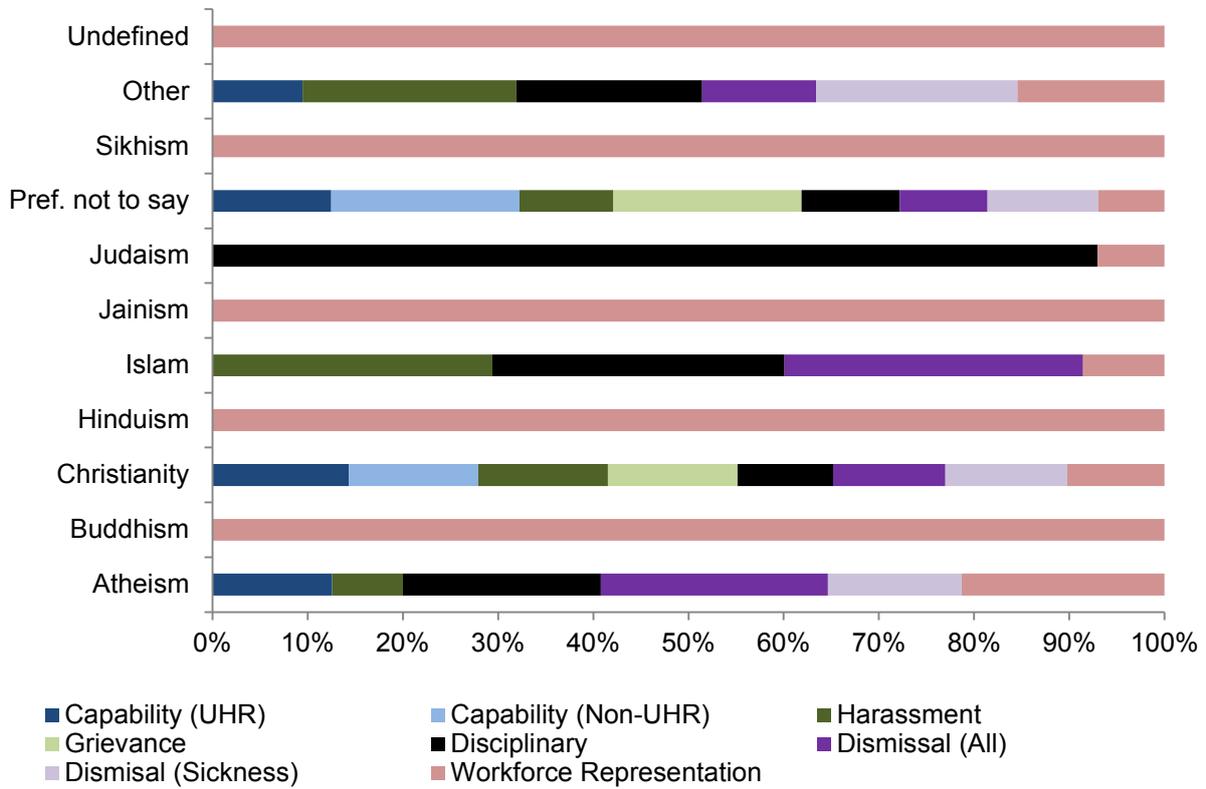
Case breakdown by gender



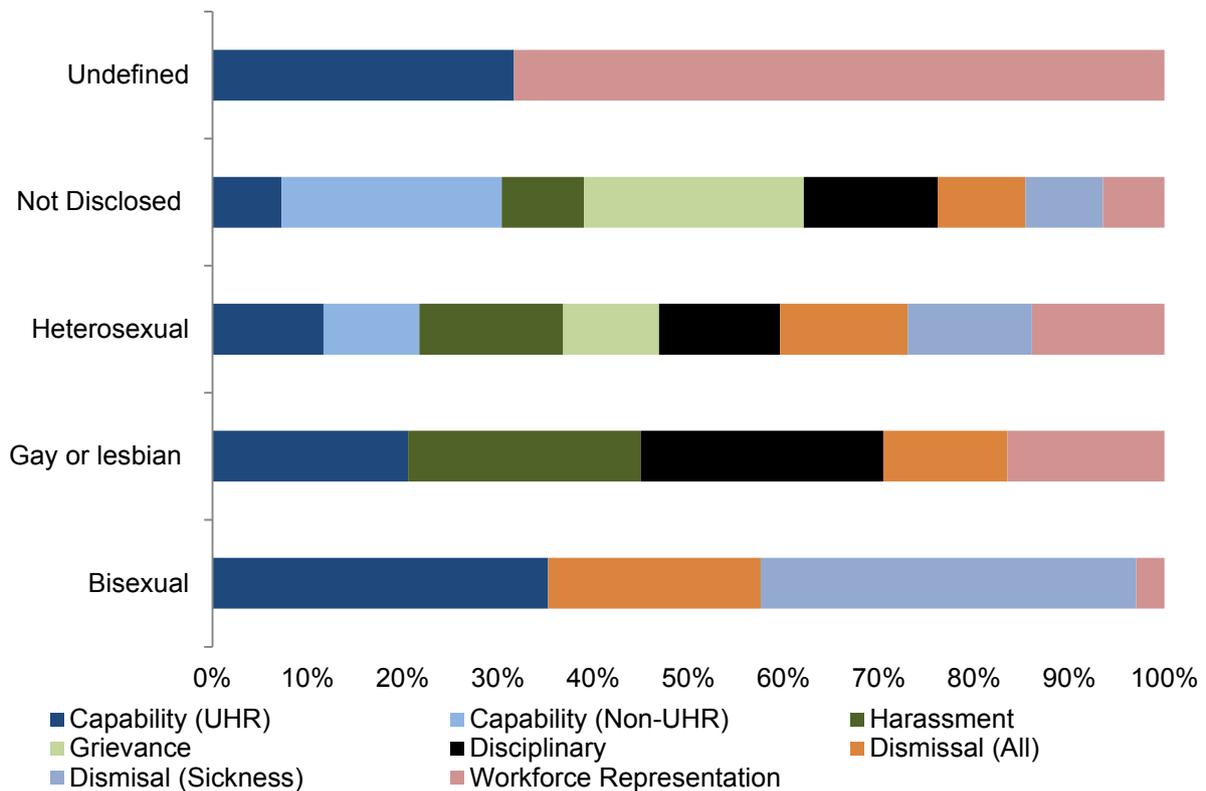
Breakdown of cases by marital status



Breakdown of cases by religion or belief



Breakdown of cases by sexual orientation





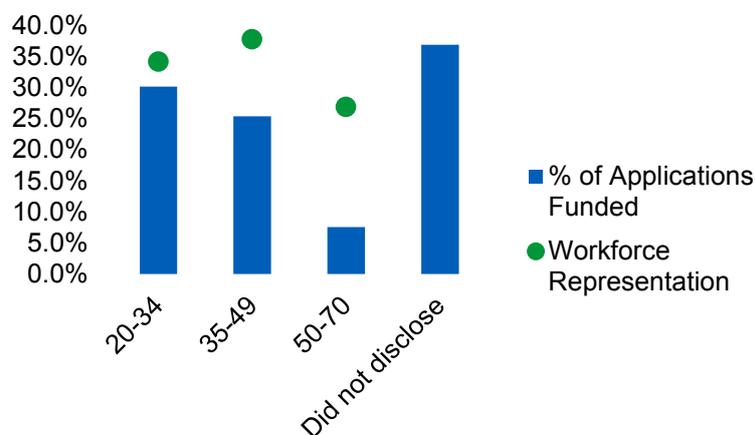
Training and development opportunities

The following data looks at training and development opportunities which our workforce have applied and been accepted to attend. The types of training and development opportunities relate to continuing professional development, as such excludes training that is considered statutory or mandatory.

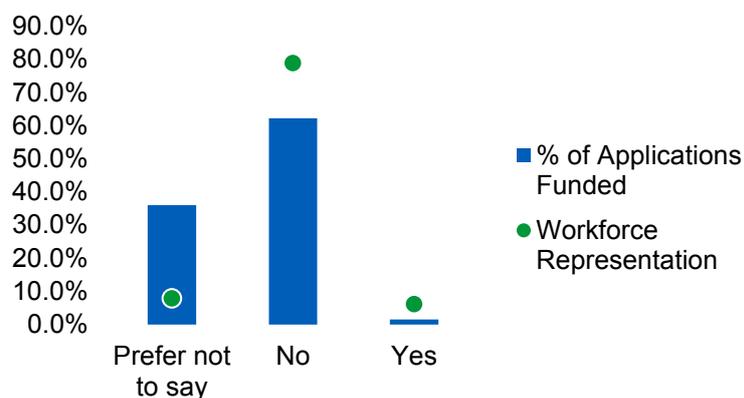
The following tables relates to applications/acceptance from Allied Health Professionals (e.g. Occupational Health Therapists, Operating Department Practitioners, Physiotherapists, Radiographers and Speech and language Therapists), nursing and administrative staff.

During 2018/19, 252 applications were approved. The monitoring process for applications has changed – as applicants are now not advised to apply without first having secured funding.

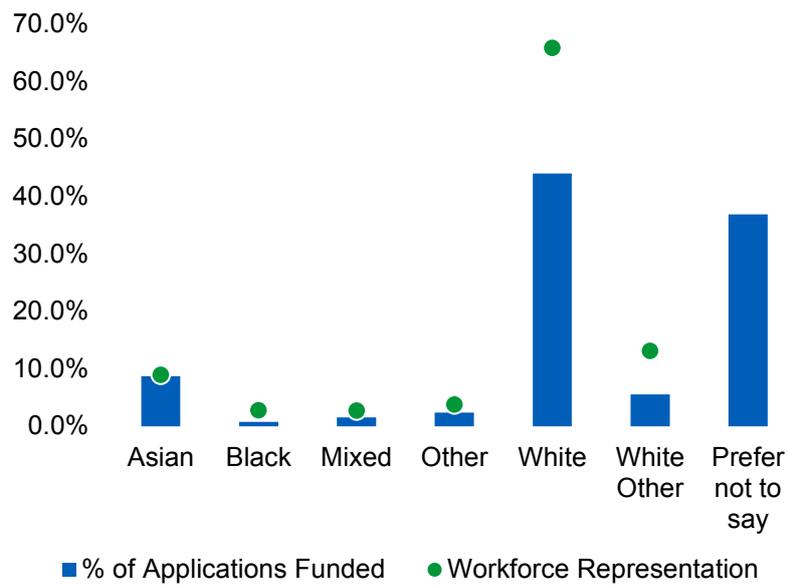
Age



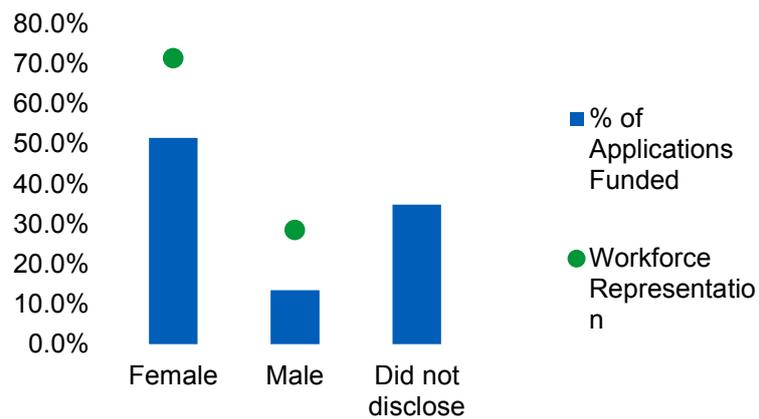
Disability



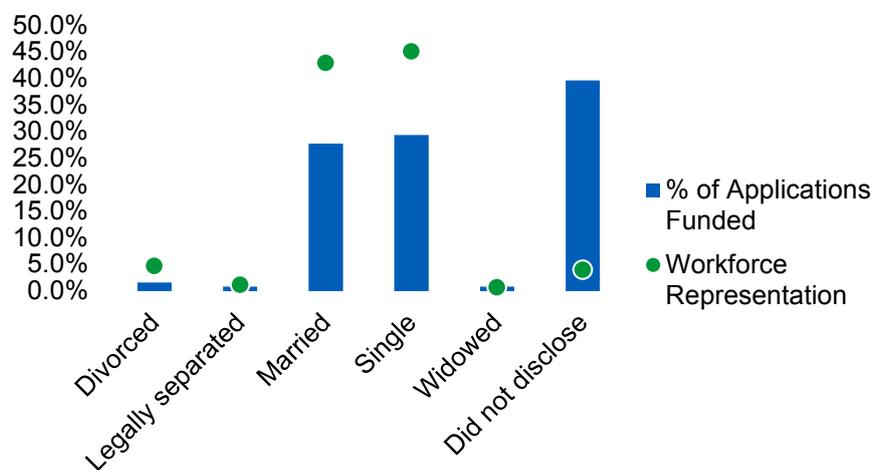
Ethnic background



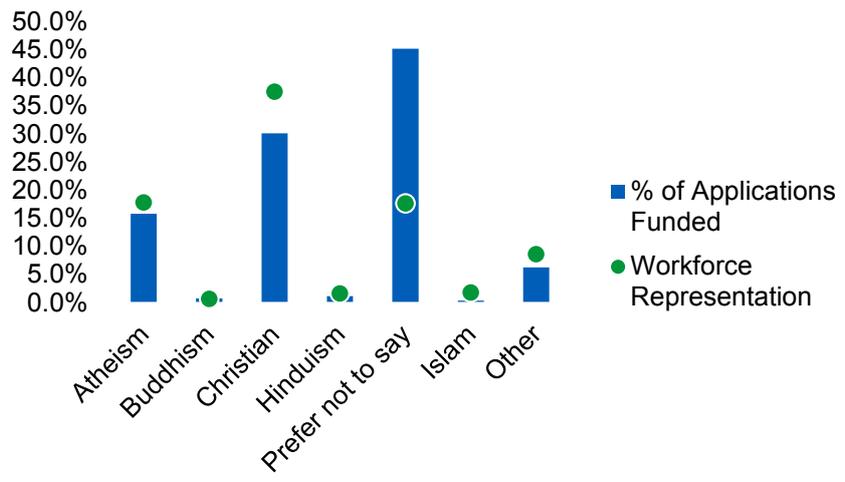
Gender



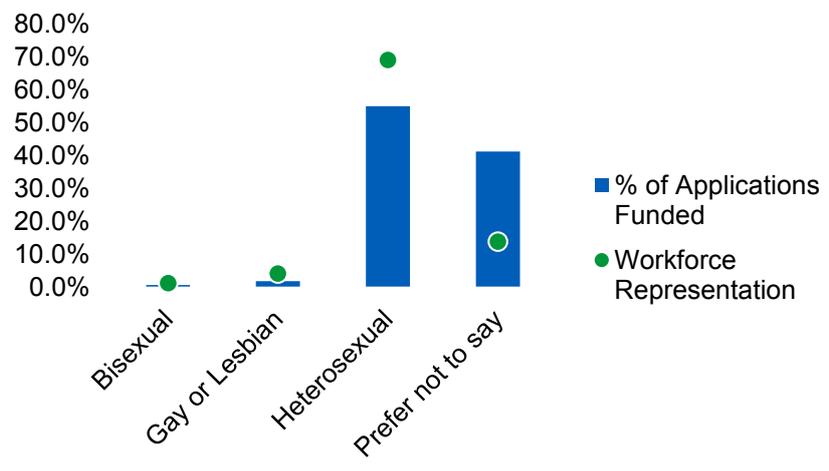
Marital and Civil Partnership Status



Religion or Belief



Sexual Orientation





What does the data tell us about our staff?

2011 Census data refers to South East England – this region covers areas within the Trust catchment area.

Age

Workforce representation (including pay bands) – when comparing the 2017/18 and 2018/19 workforce age demographic data, the base profile of the age profile of staff has not significantly changed from the two reporting periods. There is some correlation from a number of age groups (especially between 21-60 years of age); the workforce generally represents the trend (not exact representation) of 2011 Census data.

There are variations in representation at ages 16-20 and 61+. Given that the vast majority of the roles in the Trust are clinical requiring professional registration (and associated training implications) it is not surprising to see the impact on younger workers. However, given new routes to training i.e. apprenticeships and associate nursing roles; may improve the range of roles available to younger workers.

We are still living with the legacy of the ‘default retirement age’, whilst this not something this Trust has enforced; however, the principle of retiring at the age of 65 remains engrained in society. This could help to explain the curtailing of staff 60 onwards, on top of other issues such as ill health, caring responsibilities and factors relating to their work (Fuller Working Lives – Background Evidence, DWP - June 2014).

Research has shown that older workers are now thinking of working past the state pension age for a number of reasons (How people think about older age and pensions, Citizens Advice Bureau - March 2015), this can be seen that the number of older workers in the workforce is increasing both nationally and to a smaller extent in the Trust’s workforce.

Consideration will need to be given on what needs and cultural/workplace changes are needed to remain a competitive employer.

Specifically looking at representation in pay bands:

- There is a higher representation of younger and older workers in lower bands specifically 1-3.
- Directors within the Trust within the categories 41-60.
- The majority representation in medical grades ‘middle’ and ‘consultant’ are aged between 36-60. For training graded doctors the majority representation is 21-40.

- Representation in AfC in higher pay bands progressively increases from the categories between 16-60, and then sharply tapers off from 61+.

Results from the staff survey – all age groups answered questions related to equality and diversity which were broadly in line with the staff survey average score of 9.1. This ranges from 0-10, 10 being a good score.

The age group 51-65 were more likely to have issues relating to bullying, harassment from staff, however they were least like to report incidents of bullying, harassment or abuse.

The experience of discrimination from both staff and patients was broadly similar for almost all age groups.

Staff aged 51+ were most likely to have issues with their line manager, and least likely to think that the Trust acts fairly with regard to progression or promotion regardless of protected characteristics.

All age groups highlighted that they felt their ethnic background or sexual orientation was contributory factors to the discrimination they had experienced in the last 12 months (both above the national average). However, staff in age groups between 31-50, were least like to feel that their age was contributory factor to the discrimination they experienced in the last 12 months.

Leavers – from the leavers data it is notable that a large number of staff left the Trust during 2018/19: under 20, 21-25, 26-30, 61-65 and 66-70 years of age. The following groups completed an exit survey which was higher (that workforce representation): under 20, 21-30 and over 60 years of age.

For a number of staff under 50 there were recurrent themes of leaving due to a lack of promotion and development opportunities, which could also explain those leaving for relocation and better pay and reward. Those over 50 retirement and other reasons as well as a lack of promotion and development opportunities was cited main reason for leaving

Age was cited as the largest protected characteristic influencing factor for staff leaving the Trust.

Recruitment – when comparing against the demographic profile through recruitment stages to 2011 Census data, it is notable that only applicants aged between 40-59 broadly match the Census findings. Whilst applicants in age groups: under 20 and those 60+ there is a lower proportion of applicants (when compared to the workforce representation for these groups. For applicants aged 20-39 there were more than expected number of applicants from these groups.

For applicants under 20, 30-34 and not stated, they follow a similar pattern, from application to shortlisting stage there is an increase in representation and then

progressing to appointment it drops but is broadly in line with the application representation.

For applicants 40-44 and 50-59, they follow a similar pattern, the rate of representation drops slightly from application to shortlisting stages and from shortlisting to appointment the representation is broadly consistent.

For applicants aged 35-39, 45-49 and 60-64, they follow a similar pattern from application to shortlisting there is an initial drop in representation and then a rise when progressing to appointment. The rate of representation in appointment for these groups are slightly higher than at application.

For group 20-24 and 65+ we can see the overall representation in appointment is greater than the representation through the two preceding stages. Whereas with the 25-29 group, there is an initial increase when comparing application to shortlisting and then a drop when progressing to appointment. The overall representation at appointment is lower than the representation at application.

Overall, the recruitment data would suggest that there is a broad consistency in outcomes, there are some groups which appear to benefit progressing through the stages e.g. applicant aged 20-24 and 60+. However, it would be useful to understand why age group 25-29 appears to experience a notable disadvantage when progressing from shortlisting to appointment.

It is not possible to accurately compare the representation of the recruitment process to the workforce composition, as the categorisation of age bands are different.

Employee relations data – the only categories that do not appear to be proportionally represented in the Trust's employee relations procedures are 21-25 and 26-30.

41-65 would initially appear to be overrepresented in grievance and capability (no underlying health reason) by there was only two of each type of case so this must be taken into account.

Staff between the ages 16-40 and 46-50 appear to be mostly impacted by disciplinary and dismissals (all). Staff aged 36-40 and 51-65 appear to be mostly impacted by capability (UHR) and dismissals. Staff aged 66-70 appear to be overrepresented in harassment cases. The Trust will need to review this data to understand the reasons behind this.

Access to training – applications for CPD training for all age groups is proportionally below the workforce representation. However the largest groups of staff that undertook CPD did not disclose their age.

Disability

Workforce representation (including pay bands) – comparing the 2017/18 and 2018/19 workforce disability profile, we can see that there is an overall increase in the number of staff that have declared a disability. We can also see that there has been an approximate 10% decrease in staff (in the workforce demographic) with an ‘undefined’ category which could be attributed to a combination of people choosing to declare disability status data and those leaving (10% of leavers had an ‘undefined’ category according to their Electronic Staff Record file, but interestingly 7.8% of new starters have also a ‘undefined’ category).

There has also be an increase of 7.79% of the workforce who would ‘prefer not say’ what their disability status is (only 1.7% of new starters selected this status).

The overall representation of disabled staff is slightly below (-0.72%) the Census 2011 data (day-to-day activities are limited a lot), however, given that nearly 7% of the workforce disability status is ‘undefined’ and nearly 8% have elected not to provide a status – it is likely that a number of staff that could be disabled that are within these groups. It would also be fair to say that some disabled staff may have also selected ‘not disabled’ either through choice or acquiring a disability after they last completed a declaration.

We can see in senior management grades (excluding medical posts) that the overall representation of disabled staff increases slightly to 6.4% however, with 4.9% ‘prefer not to say’ and 8.7% whose status is unknown, it is likely there could be more for this category of staff group.

Specifically looking at representation in pay bands:

- There is lower representation of disabled staff in medical grades – however, there is a higher proportion of medical staff where their disability status is unknown.
- 60% of directors do not have stated they have a disability.
- There is higher representation of disabled staff in bands 1-4, 8b and 9. But there is a lower representation in bands 5-8a, 8c and 8d.

Results from the staff survey – disabled staff answered questions related to equality and diversity with a collaborative score of 8.4, which is below the staff survey average score of 9.1. This ranges from 0-10, 10 being a good score.

Overall disabled staff are more likely to have a worse experience relating to bullying, harassment, abuse and discrimination than non-disabled staff (all questions are below the national average). However, disabled staff are more likely to report incidents of bullying, harassment and abuse than non-disabled staff.

There is a higher proportion of disabled staff that have experienced bullying, harassment, abuse and discrimination issues with other staff than the non-disabled workforce.

Disabled staff have cited that their disability, gender and sexual orientation are reasons for experiencing discrimination.

Leavers – there were no staff groups that left the Trust during 2018/19 that was above the baseline representation of that group within the workforce. A greater proportion of non-disabled staff completed an exit survey.

For disabled staff there was a common sense of a lack of development opportunities, retirement and work related stress. For non-disabled staff there was a large number of people stating they left due to the lack of development opportunities which could have led them to relocating to enable them to gain a new post with better pay or reward.

Disability status was the second largest protected characteristic influencing factor for staff leaving the Trust.

Recruitment – the Trust operates within the Disability Confident Scheme, part of this is when an applicant identifies themselves as being disabled, providing they meet the minimum criteria they are guaranteed an interview.

When comparing the recruitment data to the 2011 Census, there is proportionally less disabled applicants. However, it is fair to say that there will be proportion of applicants that would be disabled that may select a 'prefer not to say' or may leave the field blank (therefore unknown). The rate of decrease while progressing through the stages of recruitment is 0.4%, which the Trust will need to review. The NHS Workforce Disability Equality Standard will look into this further.

Whilst non-disabled applicants experience an initial advantage whilst progressing through to shortlisting, the representation drops below application at the appointment stage.

The representation of disabled people in the recruitment process is below the overall representation in the Trust's workforce the opposite could be said for non-disabled applicants.

Employee relations data – only a small proportion of disabled staff are impacted by capability (underlying health reason), however, an over representation in dismissals and specifically those related to sickness can be seen. There is an overrepresentation in capability (no UHR) but given that there were only 2 cases in the reporting period this should be taken into account. Harassment is the other process which sees an overrepresentation of disabled staff. The Trust will need to review this data to understand the reasons behind this..

The main notable overrepresentation for non-disabled staff is grievances, and capability (UHR) for unknown; as there were only two of each case during the reporting period, this should be taken into account. The Trust will need to review this data to understand the reasons behind this.

Access to training – staff that declared their disability status and attended CPD training are below workforce representation. The number of 'prefer not to say' was above the workforce representation.

Ethnic Background

Workforce representation (including pay bands) – from 2017/18 to 2018/19 we can see that the profile of the ethnic background of the staff has remained broadly similar. When comparing this year's data to the Census, there is a higher representation of all BME groups in the workforce – given a number of clinical roles within the Trust that historically attracts a wide BME application base and a number of overseas recruitment drives; this is to be expected.

When looking at senior management posts (excluding medical roles), the overall representation drops for all categories. Work is being undertaken by the Workforce Race Equality Standard to review and address this.

Specifically looking at representation in pay bands:

- The majority of BME staff on the Agenda for Change pay scale are in bands 1-5.
- BME staff are generally represented well across all medical grades
- White staff have a lower than expected representation across all medical grades
- 70% of directors are white, 13% are Asian and 13% are of unknown ethnic background

Results from the staff survey – BME staff answered questions related to equality and diversity with a collaborative score of 7.9, which is below the staff survey average score of 9.1. This ranges from 0-10, 10 being a good score.

Overall BME staff are more likely to have poorer experiences than white staff in relation to bullying, harassment, abuse and discrimination. BME staff are more likely to report their experiences of bullying, harassment and abuse than white staff.

When compared to the staff survey average, BME staff are nearly 4 times more likely to experience discrimination from patients and 3 times more likely to experience discrimination from staff. BME staff highlighted that the main contributory factor to the discrimination they have faced is their ethnic background.

White staff have highlighted that their age and gender as being their main contributory factor to discrimination. But proportionally sexual orientation should also be highlighted as staff's responses were over 3 times more than the staff survey average.

Leavers – a higher proportion of Asian, White and White Other staff left the Trust during the reporting period. A high proportion of Asian and White staff completed exit forms.

The majority of BME staff highlighted job related reasons for leaving e.g. work related stress, relocation, lack of promotion opportunities as well as other reasons. White staff had a focus of promotional opportunities which could have led them to relocate to an area with a role offering better pay and reward.

Recruitment – It is notable that a higher than expected number of BME applicants apply for roles, whilst the number of white applicants is much lower.

BME candidates (except 'Other' which is consistent throughout) all appear to experience a detriment when progressing through the stages i.e. when progressing to shortlisting it is either consistent or above the application rate, then drops at appointment which is generally lower than the number at application. However, it should be noted that for most BME groups the representation at appointment is either above or in line with 2011 Census data. Work under the NHS Workforce Race Equality Standard will look into this issue further.

White candidates appear to favour well in recruitment process, after an initial reduction when progressing to shortlisting, there is a rise in appointments (above that at application stage).

The overall representation of applicants compared to the Trust's workforce is greater for Black, Other, White Other and Unknown applicants – the remaining are less.

Employee relations data – it would appear that BME staff are impacted more by the Trust's employee relations processes the Trust will need to review this data to understand the reasons behind this. There is specific work under the NHS Workforce Race Equality Standard looking at employee relations for BME staff.

Access to training – for all staff groups the number of staff undertaken training was below the workforce representation. However, over a third of staff that had undertaken training opted not to declare their ethnicity.

Gender

Workforce representation (including pay bands) – when comparing 2017/18 to 2018/19 the gender profile is broadly the same, but comparing to census data we can see the workforce has more female staff. This is broadly in line with the national [NHS workforce representation](#) statistics of 77% female and 23% male.

Looking at Agenda for Change pay bands, women have a higher than expected representation in bands 3-8a.

When looking at senior management roles we can see that there is a higher than expected representation of male staff, with a notable lower than expected representation of female staff in bands 8b-9.

Most junior doctors are female, however the majority of middle grade and consultants are male.

60% of the Trust's directors are female, which is good compared to general NHS board structures but it is still below the 71.47% representation of women in the Trust's workforce.

Results from the Staff Survey – staff that completed the survey answered a series of questions that linked to an equality and diversity theme, the average staff survey response for this theme was 9.1 (0-10, 10 being the best). Female staff averaged as 9.0, Male 8.8, those who stated they would prefer not to say 8.2 and those who prefer to self-describe their gender 7.6.

Staff who selected the category 'prefer not to say' and 'prefer to self-describe' (where data was available) would appear to have the worst experience for gender groups in terms of experience of bullying, harassment, abuse and discrimination. In terms of the staff average the 'prefer not to say group' were twice as likely to experience discrimination from staff and patients. Whilst those who would 'prefer to self-describe' staff: x2 and patients: x5 more likely than the staff average for this question.

Men and staff who selected 'prefer not to say' were less likely than women to report incidents of bully, harassment and abuse, the same can be said for the question relating to feeling that the Trust acts fairly in relation to progression and promotion regardless of protected characteristic. Female staff are more likely to experience bullying, harassment and abuse and from patient and other colleagues than their line managers.

All groups experienced discrimination (from both staff and patients) which was greater than the survey average.

Areas for contributory factors to the discrimination they experienced include: sexual orientation, ethnic background and disability (for 'prefer not say').

Leavers – more female staff left the organisation and completed exit surveys than expected, the reverse is true for male staff. Interestingly there were more staff who completed the exit survey who stated they would ‘prefer not say’ or their gender was ‘unknown’ – exit survey and Electronic Staff Records and two independent processes, as the Trust manages the exit survey process with a level of flexibility that has been built in declaration which does not exist in Electronic Staff Records.

Female staff had a focus of promotional opportunities which could have led them to relocate to an area with a role offering better pay and reward. Male staff followed a similar pattern with work related stress included. Trans staff cited family issues, work related stress, lack of promotion or career opportunities and relocation – but this is a much smaller sample set (as to be expected).

Recruitment – When comparing to the 2011 Census data it is obvious that neither female nor male staff follow the trend set by the Census. When comparing to NHS data there are more male applicants at application and shortlisting stage. It is not until appointment that the ratio of female and male applicants mirrors NHS data.

Overall female applicants are shortlisted in a slightly smaller proportion to applications, but appointed at a much higher proportion. The opposite is true for male applicants. The process itself would indicate that the overall outcome favour female applicants, but the overall outcome is in line with national NHS and Trust (broadly) representation data.

Employee relations data – male staff are disproportionately represented in almost all processes. The Trust will need to review this data to understand the reasons behind this.

Female staff representation is either level or under for all processes.

Access to training – for both male and female staff the number of staff that undertook CPD training was below the workforce representation. However, over a third of staff that undertook training elected not to disclose their gender or did not identify with the categories provided.

Gender Identity

Workforce representation (including pay bands) – nationally there is no way to record the gender identity of staff; therefore, data is not available.

Marital Status

Workforce representation (including pay bands) – when comparing 2017/18 to 2018/19 data, the marital status demographic profile of staff is broadly the same but we can see a small decrease (1.32%) of ‘unknown’ status.

When comparing 2018/19 to the 2011 Census data, those in the married and widowed categories are represented by a lower than expected amount. However, the ‘single’ category is higher than expected. All other groups broadly follow the trend in the representation trend of the 2011 Census.

When specifically looking at representation in pay bands:

- Bands 1-3 are generally represented well across all marital status categories
- Married staff have a high representation in most groups (especially senior management grades).
- Staff in a civil partnership have a lower representation in most grades except bands 1-3, 7, 8d and medical consultants.
- Staff that are legally separated and widowed are generally well represented in Agenda for change bands up to senior management levels and underrepresented in medical grade

Recruitment – overall with the exception of civil partnership, there have been less applicants applied from other groups when comparing to 2011 Census data.

From the three stages of recruitment, a number of groups have a small decline per stage. Main groups that do not follow this trend are single where proportionally more applicants are shortlisted than applied, ‘prefer not to say’ and ‘unknown’ where proportionally more applicants are appointed than applied.

In terms of comparing the outcome of recruitment processes, it is notable that with the exception of single and civil partnership all other categories are below the workforce representation. Of particular note married applicants that have been appointed is well below the workforce representation (-15.5%) and single above (nearly 10%).

Employee relations data – staff in a civil partnership appear to be overrepresented in a range of employee relations issues. Divorced (capability (UHR) and harassment grievance), legally separated (capability both no UHR and UHR), married (capability (no UHR) and dismissal (sickness)), single (harassment, disciplinary and dismissals) and widowed (grievance and disciplinary) staff also appear to be overrepresented in a number of processes. The Trust will need to review this data to understand the reasons behind this.

Access to training – for all groups (except widows which was in line) there was an underrepresentation of staff undertaking training compared to workforce

representation. Near 40% of staff who undertook training declined to provide their marital status.

Pregnancy and Maternity

Workforce representation (including pay bands) – due to limitations within Electronic Staff Records, there is no way to accurately extract data about staff that are either pregnant or on maternity leave. However during the reporting period 197 staff was on maternity leave.

Religion or Belief

Workforce representation (including pay bands) – when comparing 2017/18 to 2018/19 workforce demographic data, the religion or belief profile is broadly similar. However, there has been a slight decrease in the categories ‘prefer not to say’ and ‘undefined’.

When comparing the 2018/19 workforce data to the 2011 census we can see there is a higher than expected representation in the following groups: Buddhists, Other (religion) and undefined. However, there is also a lower than expected representation in the following groups: atheist, Christian, Islam and Sikhs.

When specifically looking at representation in pay bands:

- Minority groups are not generally well represented in Agenda for Change pay bands, however are generally well represented in medical grades.
- There is a very high proportion of medical staff who have a ‘prefer not to say’ category
- Atheists have a good representation in most grades, but a notable lower than expected representation in the middle and consultant medical grades
- Christians have generally have good representation across all Agenda for Change pay bands, but there is a notable underrepresentation within the medical grades (especially training and middle)
- The majority of directors have selected ‘prefer not to say’ or is a ‘not stated’ category.

Results from the Staff Survey – staff that completed the survey answered a series of questions that linked to an equality and diversity theme, the average staff survey response for this theme was 9.1 (0-10, 10 being the best). A number of the groups responded to the questions with a score broadly in line with the average, the groups that did not were: Hindu: 8.2, Islam (Muslim): 8.3, Other and prefer not to say: 8.5.

Overall, the staff that selected 'prefer not to say' appear to have the worst experience in terms of bullying, harassment, abuse and discrimination. It should also be noted that these groups are least likely to report incidents of bullying, harassment and abuse.

Jewish and Muslim staff seem to have a higher likelihood of experiencing staff-on-staff issues. Muslim and Other (religion) are the most likely to report incidents of bullying, harassment and abuse.

Staff that identified as Hindu and Other were nearly 3 times more likely to receive discrimination from patients compared to the survey average for that question.

Ethnic origin and sexual orientation (proportionately) appear to be key issues across most religion or belief groups as a contributory factor for the discrimination that they experienced. Only Muslim staff that their religion or belief was a factor for the discrimination they experienced.

Leavers – only those with an 'Other' religious/belief affiliation left the Trust during the reporting period that was higher than the workforce representation rate. A high representation of Atheists, Christians and Hindus completed an exit questionnaire.

The common issues leading to the reason for leaving, revolved around the member of staff's role and organisation.

Recruitment – most of the groups we can see a higher than expected number of applicants applying for vacancies with the exception of atheists and Christians (which are also the majority groups within the Trust workforce).

For minority groups the data suggests that in terms of overall outcome there are proportionally less applicants being appointed than applied and shortlisted. This is also true for Christians. This could suggest that they are not necessarily favouring well through the recruitment process. The exception to this is with Buddhist and Sikhs where their representation across the three stages is relatively consistent.

In terms of comparing recruitment outcome to the workforce representation, there are greater proportional representation from: Atheist, Buddhist, Christians, Other, Sikhs, Unknown and prefer not to say. Jewish applicants are consistent. Hindus, Muslims and Jains are below.

Employee relations data – staff that are Christian, Muslim, Jewish, other (religion) appear to be over represented in harassment, disciplinary and dismissals. The Trust will need to review this data to understand the reasons behind this

Access to training – for all groups (except Buddhists which was in line) there was an underrepresentation of staff undertaking training compared to workforce representation. Over 45% of staff who undertook training declined to provide their religion or belief.

Sexual Orientation

Workforce representation (including pay bands) – From 2017/18 to 2018/19 there has been an increase in lesbian, gay and bisexual staff and a decrease of staff with a 'prefer not to say' or 'not stated' category.

There is no accurate Census data that captures sexual orientation, however when comparing the workforce representation of 2018/19 to either NHS national data (approximately 3% of NHS staff are L, G or B) or The Office for National Statistics (1.3% of the population are lesbian or gay, 0.3% are bisexual and 0.6% are 'other') there is a significantly higher than expected representation of lesbian, gay and bisexual staff. Naturally, if we are to exclude all categories that do not provide indication of an actual sexual orientation – the workforce representation is even higher.

When specifically looking at representation in pay bands:

- Gay and Lesbian staff are generally well represented in Agenda for Change pay bands, there is also a higher representation within senior management pay bands.
- Bisexual staff are generally not well represented in Agenda for Change pay bands (with the exception of 1-2 and 5). There is no representation from senior management band 8b-9.
- In medical grades there is a fair representation of lesbian and gay staff in training and consultant roles, but all grades are lower than expected. There is a higher representation of bisexual staff in training and middle grades, but a lower than expected representation in consultant roles.
- There are more than expected staff where their sexual orientation is 'not stated' in Agenda for Change bands, whilst there is a higher than expected number of staff who have selected 'prefer not to say' in medical grades and directors.
- 46.7% of directors that have declared their sexual orientation are heterosexual.

Results from the Staff Survey – staff that completed the survey answered a series of questions that linked to an equality and diversity theme, the average staff survey response for this theme was 9.1 (0-10, 10 being the best). Both gay women and heterosexual staff were broadly in line with the staff survey average for this question, but the 'other' group rated lower with an average score of 8.6, prefer not to say was 8.4.

Overall all minority groups had a poorer experience in relation to bullying, harassment, abuse and discrimination compared to heterosexual staff. Gay men, other (sexual orientation) and prefer not to say experienced the worst discrimination from patients and bisexual, gay men and prefer not to say groups experienced the worst discrimination from staff.

Gay men, other and prefer not to say were least likely to report incidents of bullying, harassment and abuse.

Gay women and heterosexual reported highest in feeling that the Trust acts fairly in relation to progression and promotion regardless of protected characteristics.

All categories highlighted (above the survey average) that their gender was a contributory factor to the discrimination they received. Heterosexuals and prefer not to say specifically said their ethnic background and bisexuals (1.4 times), gay men (nearly 18 times) and gay women (10.7 times) compared to the survey average said their sexual orientations was a causation factor.

Leavers – there was a higher proportion of staff from declared groups completing exit surveys during 2018/19.

With LGB staff there was a sense of dissatisfaction with their role because of the lack opportunities and work related stress. Heterosexual staff had a focus on promotional opportunities which could have led them to relocate to an area with a role offering better pay and reward. Those who selected 'prefer not to say' would appear to have left because a level of dissatisfaction because of lack of opportunities for promotion and development along with a problematical relationship with their line manager.

Recruitment – when comparing recruitment data to national NHS and ONS data, it is notable that the number of LGB applicants is significantly higher.

Bisexual applicants are overrepresented in recruitment processes, Gay or lesbian appear to be slightly underrepresented in progressing through the stages of recruitment, whilst those who identify as 'other' have a relatively small overrepresentation once progressing to appointment. Heterosexual applicants have a small underrepresentation progressing to shortlisting and then a relatively small disadvantage when it comes to appointment.

Overall minority groups in this category do not appear to be disadvantaged by the Trust recruitment processes.

Comparing to workforce representation, LGB and heterosexual applicants have a higher representation in recruitment process than in the general workforce. Those electing to select 'prefer not to say' or where the status is unknown is lower than the workforce representation (which may demonstrate why there is a decrease in the same fields in the workforce population from 2017/18 to 2018/19).

Employee relations data – L,G, (capability, harassment, disciplinary) B (but particularly bisexual in capability and dismissals) staff appear to be overly represented in the Trust's employee relations processes. The Trust will need to review this data to understand the reasons behind this.

Access to training – for all groups there was an underrepresentation of staff undertaking training compared to workforce representation. Over 41% of staff who undertook training declined to provide their sexual orientation.



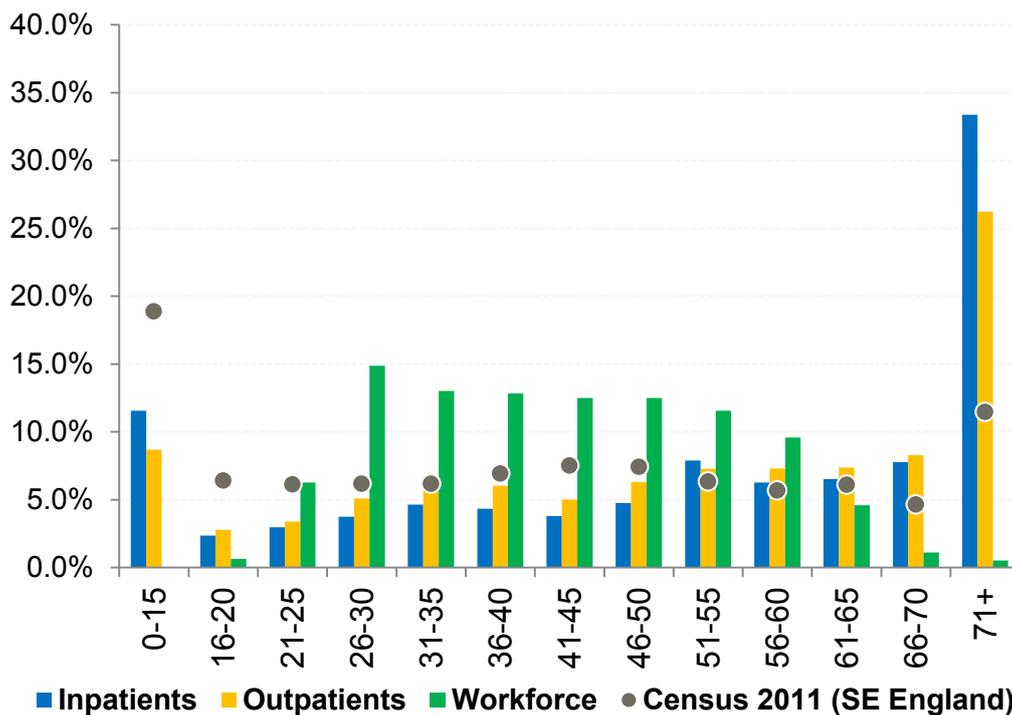
Who are the Trust's patients?

During 2018/19 the Trust saw nearly 750,000 patients attending its services, which included:

- 142,566 inpatient admissions
- 603,937 outpatient appointments

A crucial part of delivering person centred care is in understanding the communities that are served. The following data helps the Trust to recognise the different people accessing services, which gives an idea of the types of additional support that should be offered to ensure the Trust is accessible.

Age



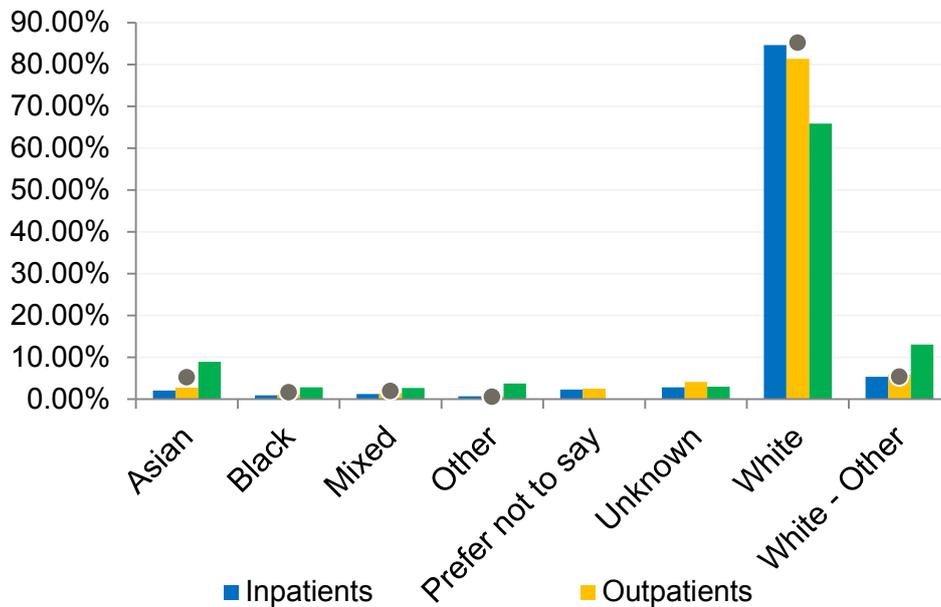
The census data acts as a good indicator for both inpatient and outpatient attendance, but from age 56 onwards there is a higher representation in attendances. This is to be expected given the probability of developing long term health conditions later in life and comorbidity.

Workforce – there is generally a greater rate of representation of staff than patients from 26-60 (21-25 is roughly in line), however, this dramatically decreases after 61 years of age.

Disability

Due to a change of patient administration system in 2018/19, calculating the disability status of patients is currently being worked on. This report will be updated once the data is available.

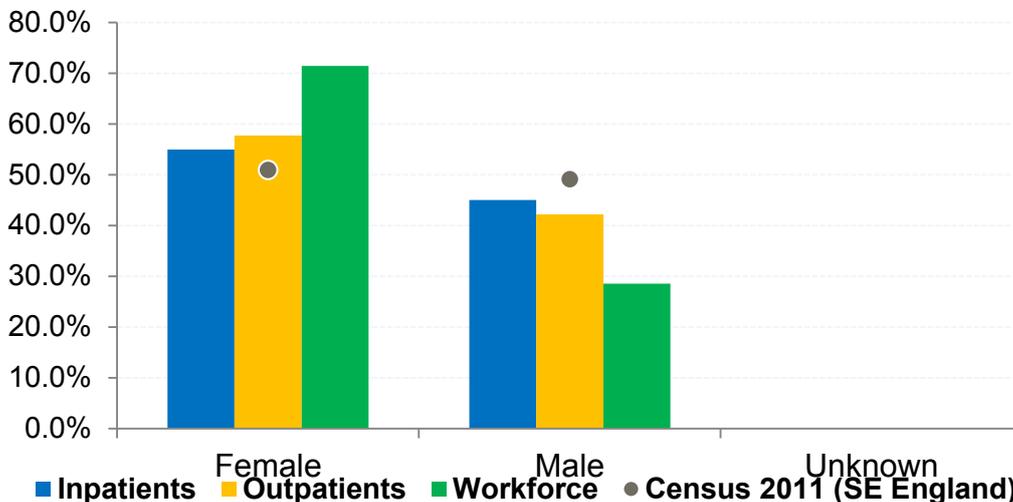
Ethnic Background



For Asian, Black and Mixed patients there is a lower proportion of patients/service users attending when compared to census data. There is a higher proportion of Other and about the same for White and White – Other.

Workforce – For almost all categories (except white which is lower) there is a greater representation of staff compared to patients and service users.

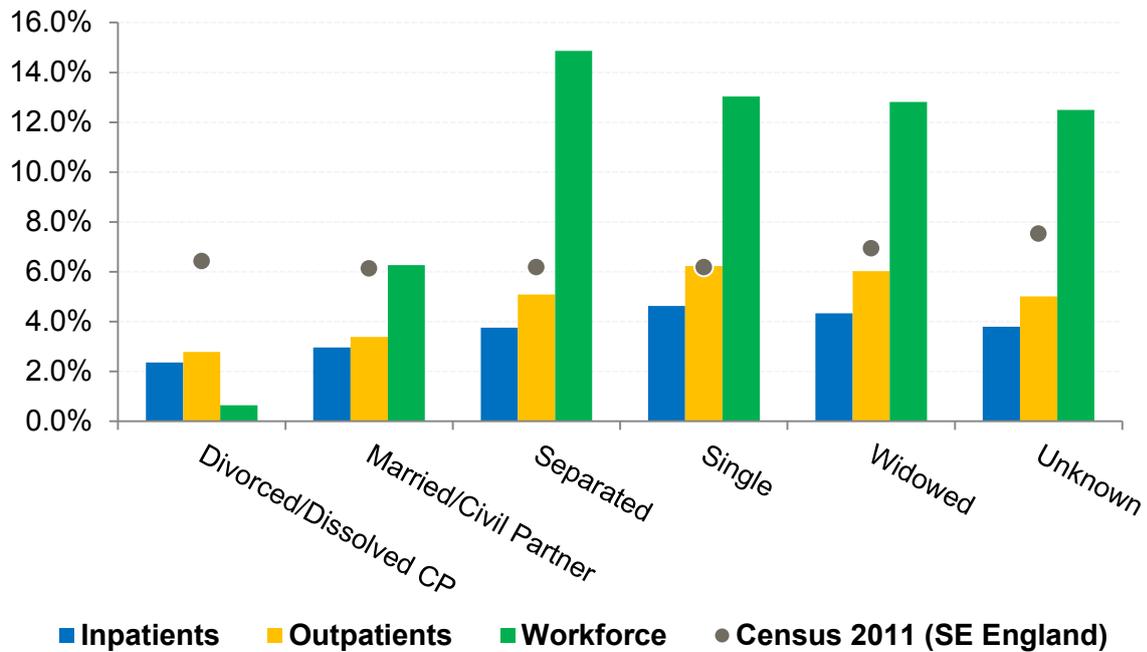
Gender



Proportionally more women than men attend the Trust as patients and service users. Given a margin of 5% it is roughly in line with the census data.

Workforce – there is a much higher proportion of female staff when compared to patients, the opposite is true about male staff.

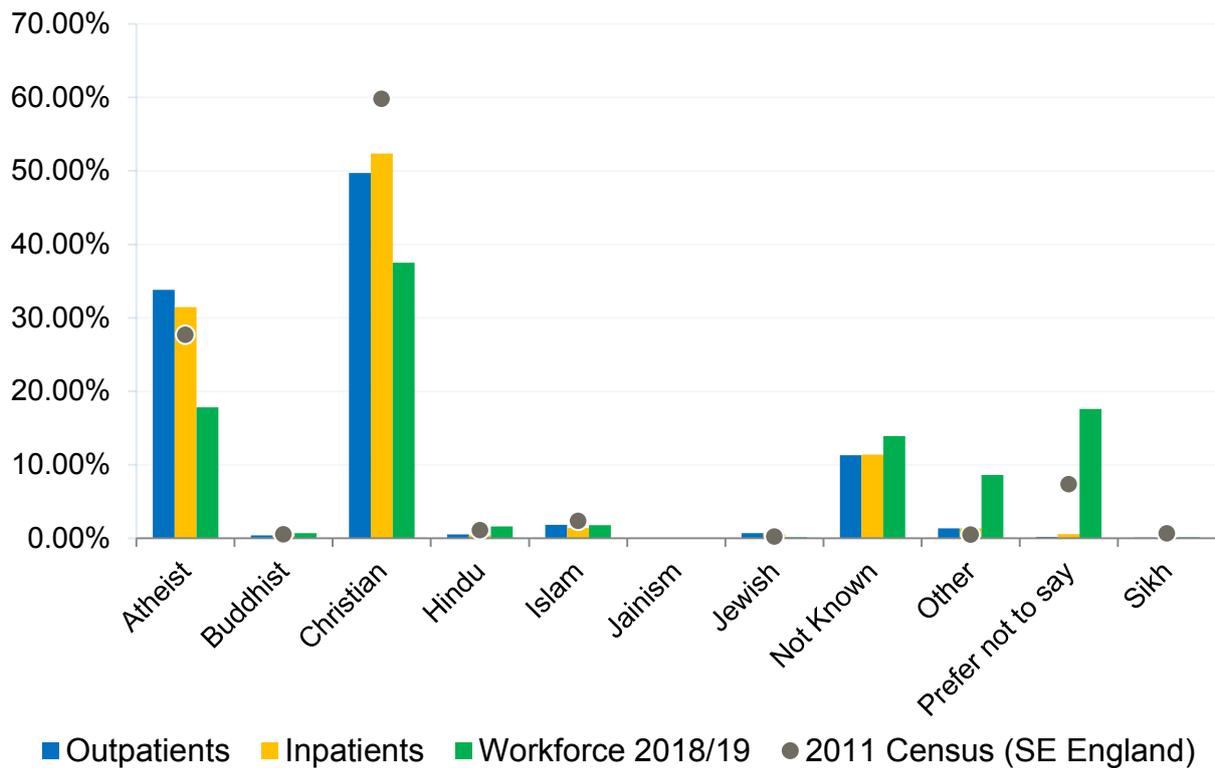
Marriage / Civil Partnership



In all categories (except single outpatients which is equal) there is a lower proportion of patients/service users attending when compared to census data.

Workforce – in all categories (except divorced/dissolved civil partnership) there is a greater representation of staff compared to patients and service users.

Religion or Belief



In all categories (except Atheist, Jewish and Other which is higher) there is a lower proportion of patients/service users attending when compared to census data.

Workforce – in relation to Buddhist, Hindu, Other and those who have selected 'prefer not to say' there is a greater representation of staff compared to patients and service users. For all other groups there is a lower representation.

Agenda Item:	16	Meeting:	Public Board	Meeting Date:	29 Jan 2020
Report Title:	Company Secretary Report				
Sponsoring Executive Director:	Glen Palethorpe, Group Company Secretary				
Author(s):	Glen Palethorpe, Group Company Secretary				
Report previously considered by and date:					
Purpose of the report:					
Information	<input type="checkbox"/>	Assurance	<input checked="" type="checkbox"/>		
Review and Discussion	<input checked="" type="checkbox"/>	Approval / Agreement	<input checked="" type="checkbox"/>		
Reason for submission to Trust Board in Private only (where relevant):					
Commercial confidentiality	<input type="checkbox"/>	Staff confidentiality	<input type="checkbox"/>		
Patient confidentiality	<input type="checkbox"/>	Other exceptional circumstances	<input type="checkbox"/>		
Link to Trust Strategic Themes:					
Patient Care	<input checked="" type="checkbox"/>	Sustainability	<input checked="" type="checkbox"/>		
Our People	<input checked="" type="checkbox"/>	Quality	<input checked="" type="checkbox"/>		
Systems and Partnerships	<input checked="" type="checkbox"/>				
Any implications for:					
Quality					
Financial					
Workforce					
Link to CQC Domains:					
Safe	<input checked="" type="checkbox"/>	Effective	<input checked="" type="checkbox"/>		
Caring	<input checked="" type="checkbox"/>	Responsive	<input checked="" type="checkbox"/>		
Well-led	<input checked="" type="checkbox"/>	Use of Resources	<input checked="" type="checkbox"/>		
Communication and Consultation:					
Executive Summary:					
<p>This report provides the Board with an update, including matters for which the Trust has complied with a NHS I or other regularly requirements. This report does not seek to duplicate matters that are subject to separate agenda items at today's board meeting.</p> <p>Learning from Deaths report Q3– Appendix 1</p> <p>The Trust is required to receive reports on learning from deaths. The Board is reminded that the detail of this report is scrutinised by the Quality Assurance Committee especially in respect of the Trust's processes for learning from the review of deaths. The focus for learning is to improve the Trust's processes. The outcome of this learning manifests itself in the Trust's mortality indices; these are tracked within the routine report to the Board as part of the Integrated Performance Report.</p> <p>Schedule of meetings for 2020/21</p> <p>We have continued to have Public Board meetings taking place across both the Trust's sites.</p> <p><u>Schedule of Board meetings</u></p> <p>The Board meetings remain bi monthly on a Thursday, but with them moving to be a week behind the supporting Committee meetings they most now fall in the first few days of the Month.</p>					

	Jun-20	Aug-20	Sept-20	Dec-20	Feb-21	Mar-21
Board of Directors	Tues 2 nd Jun 10.00-13.30 PRH	Tues 4th Aug 10.00-13.30 RSCH	Tues 29 th Sept 10.00-13.30 PRH	Tues 1st Dec 10.00-13.30 RSCH	Tues 2nd Feb 10.00-13.30 PRH	Tues 30th Mar 10.00-13.30 RSCH

Annual General Members Meeting

The Trust is provisionally targeting the Tuesday 28th July 2020 for its AGM with it being held at Brighton this year.

Quoracy Update

The Trust has looked at the quoracy of its Board Sub Committees and the Committees have made the following changes. These changes were made to ensure the Committees continue to function effectively. The Board members agreed these changes in between the Board meeting in November and this meeting.

Finance and Performance Committee. Changes to the quoracy of this Committee have been made to reflect the enhanced role of the Deputy Chief Executive

Revised quoracy is *two NEDs plus two executives (one of the executives will be drawn from Deputy CEO, Chief Financial Officer and COO).*

Quality Assurance Committee. The quoracy has been amended to reflect the enhanced role of the Trust's Medical Director.

Revised quoracy is *two NEDs plus one executive and if this executive is NOT the Chief Nurse then the Trust Medical Director must be in attendance.*

Charitable Funds Committee. The quoracy has been revised to require at least one other director to attend alongside the NEDs.

Revised quoracy is *one NED and either one Executive or the Trust Finance Director.*

Key Recommendation(s):

The Board is recommended to

NOTE the Trust's learning from deaths report and note the learning identified from the structured judgement review process, recognising the detail of this work is subject to scrutiny and oversight at the Quality Assurance Committee.

NOTE the dates of the public Board meetings and the proposed date for the AGM. The Board meeting dates will be publicised on our web site as will the AGM date once agreed.

NOTE the agreed changes to the Board Committees quoracy made in December 2019.

Agenda Item:	16	Meeting:	Quality Assurance Committee	Meeting Date:	28 Jan 2020
Report Title:	Learning from Deaths Report Q3 2019/20				
Sponsoring Executive Director:	Dr George Findlay - Chief Medical Officer, Rob Haigh - Medical Director				
Author(s):	Rob Haigh – Medical Director, Della Morris - Safety & Quality Lead				
Report previously considered by and date:					
Purpose of the report:					
Information	<input checked="" type="checkbox"/>	Assurance	<input checked="" type="checkbox"/>		
Review and Discussion	<input type="checkbox"/>	Approval / Agreement	<input type="checkbox"/>		
Reason for submission to Trust Board in Private only (where relevant):					
Commercial confidentiality	<input type="checkbox"/>	Staff confidentiality	<input type="checkbox"/>		
Patient confidentiality	<input type="checkbox"/>	Other exceptional circumstances	<input type="checkbox"/>		
Link to Trust Strategic Themes:					
Patient Care	<input checked="" type="checkbox"/>	Sustainability	<input type="checkbox"/>		
Our People	<input type="checkbox"/>	Quality	<input checked="" type="checkbox"/>		
Systems and Partnerships	<input type="checkbox"/>				
Any implications for:					
Quality	The Trust's True North Objective is for the mortality rates (HSMR) to be in the lowest 20% of Trusts.				
Financial					
Workforce	Human Resource Implications: There are training and protected time requirements for clinical staff undertaking SJR's.				
Link to CQC Domains:					
Safe	<input type="checkbox"/>	Effective	<input type="checkbox"/>		
Caring	<input type="checkbox"/>	Responsive	<input type="checkbox"/>		
Well-led	<input type="checkbox"/>	Use of Resources	<input type="checkbox"/>		
Communication and Consultation:					
Not applicable					
Executive Summary:					
This report is produced in line with National Guidance on Learning from Deaths, and provides the Trust Board with information relating to local implementation of the guidance; recent Structured Judgment Review activity; and the themes and learning that are emerging from this work.					
Key Recommendation(s):					
The Board is asked to NOTE the report.					

1. Purpose

- 1.1 Approximately 1800 deaths occur at BSUH every year. For many people death under NHS care is an inevitable outcome and they experience excellent care. However, some patients experience poor care resulting from a variety of factors. The purpose of a structured death review is to identify and learn from any problems that may have contributed to death to prevent a recurrence.
- 1.2 This paper updates the board on the implementation of the Learning from Deaths Policy at BSUH. Data is included on rates of review, mortality statistics and outcomes of reviews of mortality statistic data alerts.

2. Background

- 2.1 The CQC report 'Learning, Candour and Accountability' published in December 2016 outlines the importance of mortality review as a source of learning and improvement. In March 2017, the National Quality Board published guidance for Trusts on mortality review processes and Learning from Deaths.
- 2.1.1 BSUH's Learning from Deaths Policy was ratified in 2017 and data has been collected quarterly since Q1 17/18 using the National Learning from Deaths Dashboard.

3. Governance

- 3.1 The BSUH Medical Director is the Board lead with responsibility for delivering the Learning from Deaths Agenda
- 3.2 The Medical Director chairs the Trust Mortality Review Group (TMRG) ensuring the committee appropriately discharges its functions including the implementation of the Learning from Deaths Policy.
- 3.3 The TMRG reports to the Patient Safety Committee, which escalates on an exception basis to the Quality Governance Steering Group.

4. Process

- 4.1 Deaths requiring review are identified and triangulated through feedback from the Serious Incident Review Group (SIRG), Complaints, Medical Examiners, Medico-legal Department, Learning Disabilities Team, or in response to risk adjusted mortality statistics.
- 4.2 Cases are allocated to a trained reviewer to complete a Structured Judgment Review (SJR) and share the findings with the care team for the patient.
- 4.3 Any deaths identified as potentially resulting from failures in care are recorded on the DATIX reporting system and reviewed at SIRG where they are considered for Serious Incident Investigation.
- 4.4 An SJR electronic form (within PANDA) facilitates data collection and analysis. All Consultants have been given access to submit and review SJRS.
- 4.5 Deaths of all patients with Learning Disabilities (LD) are referred to the Leder Programme for independent care pathway review but also undergo local SJR, to ensure timely scrutiny and learning.
- 4.6 National Guidance on Learning from Deaths for the Ambulance Service has recently been published and requires the Trust to ensure arrangements are in place to notify Ambulance Trusts of any deaths of patients previously in the care of the Ambulance Trust where a review maybe warranted. Relationships with Ambulance Trust colleagues are already in place and there are no concerns regarding the implementation of this guidance.

5. SJR Training

- 5.1 The Palliative Care Team provides face-to-face training on request and have released a short training video on the IRIS system.

6. Involving Families / Carers

- 6.1 All deaths at the RSCH are reviewed by a Medical Examiner (ME) who speaks with the family/carers of the deceased to ascertain any concerns regarding care. If concerns are raised either by family or ME review, the ME automatically refers the case for SJR.

7. Mortality Review Outcomes

- 7.1 A best practice recommended dashboard is used to illustrate SJR activity at BSUH (see attachment).

7.2 The table below shows the last 4 quarters data for BSUH (LD refers to deaths of patients with learning disabilities).

	Q4 18/19	Q1 19/20	Q2 19/20	Q3 19/20	Total
Total Deaths (adult inpatients not LD)	460	349	322	440	1571
Total deaths reviewed using SJR (adult inpatients not LD)	43	21	7	3	74
Deaths more likely than not a result of problems in care (adult inpatients not LD)	1	0	0	0	1
LD Deaths	4	3	0	3	10
LD deaths reviewed using SJR	4	1	0	0	5
LD deaths more likely than not a result of problems in care	0	0	0	0	0
Deaths in the Emergency Department					158
Total % of adult deaths reviewed	10.1%	6.25%	2.17%	0.68%	4.8%

7.3 All deaths that have been recorded as 'more likely than not a result of problems in care' have been fully investigated in line with Trust policy. The death in quarter 4 18/19 related to the neonatal death of a twin, the investigation has been shared with the family in line with national requirements for duty of candour. There are two ongoing investigations into deaths in quarter 2 19/20.

7.4 The percentage of deaths reviewed from the most recent quarter is inevitably lower due to delays accessing patient records and allocating reviews. However, overall there has been a fall in the percentage of deaths reviewed since April 18 with a further decline in 2019 following the loss of the Deputy Director for Safety & Quality. (Figure 1). Following completion of the restructure of the Safety & Quality function, the Divisional teams will be targeted to improve representation and participation in SJRs and to address the backlog of SJRs.

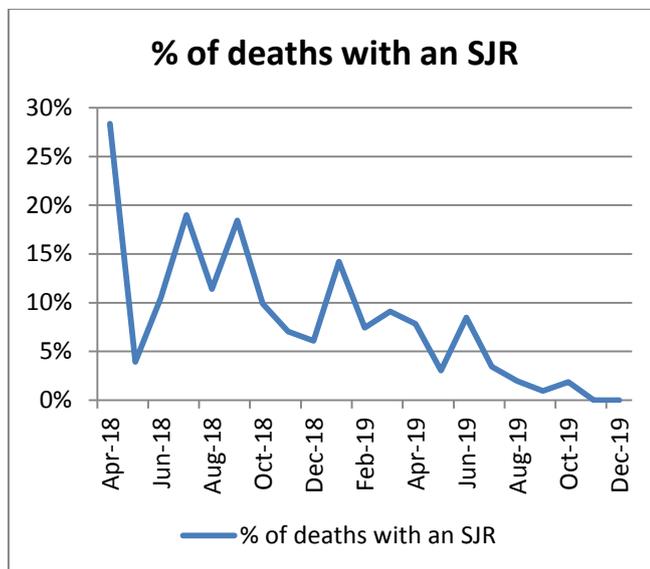


Figure 1

7.5 All SJRs review 6 discreet areas of care. Figure 2 shows the level of care received by patients in the last 4 quarters¹.

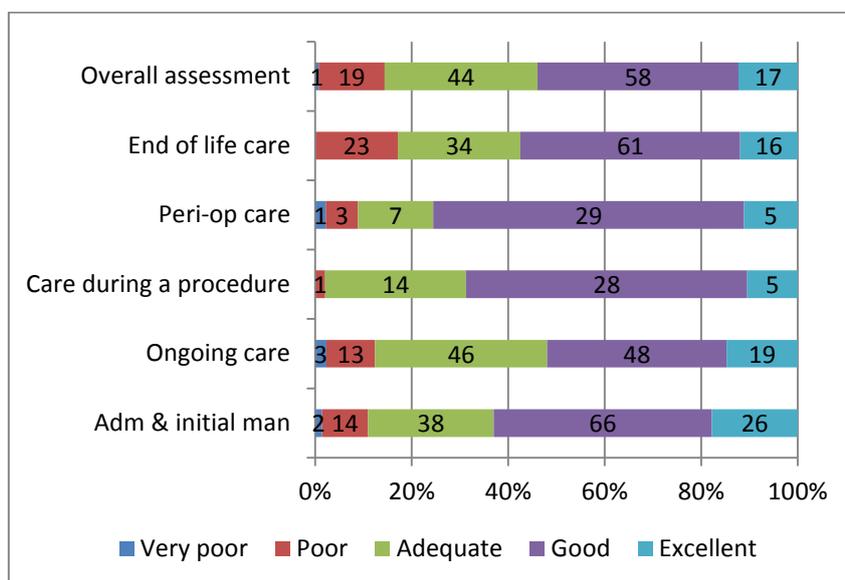


Figure 2

7.6 The Deteriorating Patient Steering group continues to focus on the Trust breakthrough objective 'improvement in recognition and management of deteriorating patients' by analysing the contributing factors to MET calls and sharing the learning locally to improve practice. The majority of the SJRs are undertaken by or supported by the Palliative Care Team; this is another factor that has impacted on the number of SJRs undertaken as the Palliative Care Team have been focusing on the implementation of the internal rolling End of Life Care Audit.

7.7 The 'assessment of problems in healthcare' section of the SJR records quantitative data on the nature of the problem type and whether this resulted in harm to the patient. Figure 3 shows the number of SJRs in the last 4 quarters where a problem in care was identified as causing or probably causing harm to the patient.

¹ Q4 18/19 & Q1 & Q2 19/20, Q3 19/20

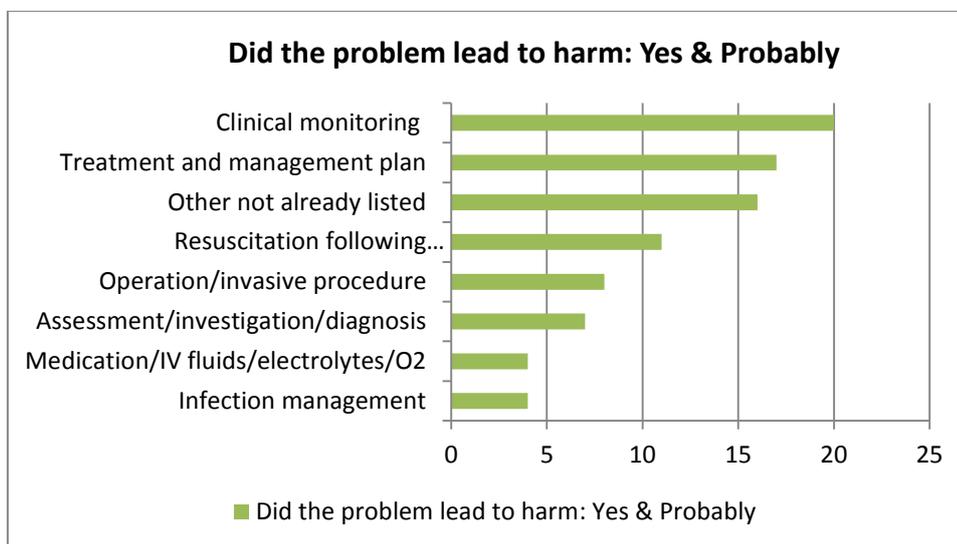


Figure 3

- 7.8 As in quarter 2, the most common 'problem' area remains 'clinical monitoring' which includes 'failure to plan, to undertake or to recognise and respond to changes. The roll-out of Patientrack (electronic observation system) continues within the Trust and a new CQUIN project has been published 'Recording of NEWS2 score, escalation time and response time for unplanned critical care admissions'.
- 7.9 The TMRG continue to promote use of the SJR tool within PANDA and have added a third tab for use by clinical teams in their M&M meetings. This will allow SJR data to be linked to M&M data. Development of this remains at an early stage and will be piloted before roll out across the Trust.
- 7.10 Work to embed ME activity into PANDA actively paused in 2019 to enable a National ME IT system to be developed. However, the requirement to submit all coronial referrals electronically is now being worked up. The ME's and IT department are developing a new ME form on PANDA which will work in tandem with the existing SJR form to provide a fuller picture of the number of deaths that are reviewed in the Trust.
- 7.11 NHS digital escalated concerns from the National Bowel Cancer Audit in 2020 '*The Audit has found that your trust had a higher than expected rate of 2-year mortality after major resection.*' The outlier alert was investigated in detail and inaccurate data submitted in 15/16 and was identified as causing 3 separate outlier alerts. Accurate historic data was resubmitted with the Safety & Quality and Digestive Diseases Teams reviewing all 300 cases that had been uploaded to the audit (105 surgeries and 195 non surgeries). This identified that 48 cases had not been previously submitted. The main causes for concern (which affects the 'expected' no of deaths) were: TNM², ASA³ and admission type. Having re analysed the corrected data, the National Team have re-classified BSUH as no longer an outlier. Work is ongoing between the divisions of Surgery and Central Clinical Services to ensure data accuracy for all current and future submissions.

8. SHMI⁴ & HSMR⁵

- 8.1 SHMI data available is for the 12 months to August 2019; the SHMI for BSUH is 98.8.⁶
- 8.2 The trend in SHMI for in month and rolling data is shown in Figure 4

² The TNM Classification of Malignant Tumors is a globally recognised standard for classifying the extent of spread of cancer

³ The ASA physical status classification system is a system for assessing the fitness of patients before surgery

⁴ SHMI is the ratio of observed to expected in-hospital deaths and deaths within 30 days of discharge for all patient diagnosis groups with limited case mix adjustment

⁵ HSMR is the ratio of observed to expected in-hospital deaths for a basket of 56 diagnosis groups. Data is adjusted for case mix

⁶ National average is 100

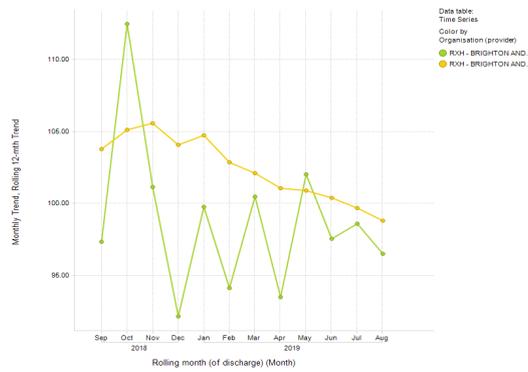


Figure 4

8.3 HSMR data available is for the 12 months to September 2019. HSMR for BSUH is 88.10.⁷

8.4 The trends for in month and rolling HSMR is shown in figure 5

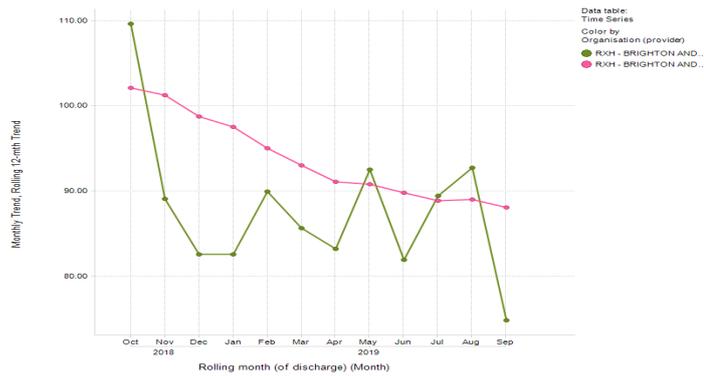


Figure 5

8.5 BSUH organisational priorities are summarised into 4 strategic themes including that ‘We aim to be in the best 20% of Trusts in the country for the Hospital Standardised Mortality Rate (HSMR)’. In Quarter 3 the Trust were ranked 18th out of 132 Trust’s putting them in the top 15% of performing Trusts. This is an improvement of the quarter 2 position where the Trust were ranked 24th. The decrease in HSMR is aligned to ongoing improvements in the accuracy of palliative care coding, work led by the Palliative Care Team. (figure 6)

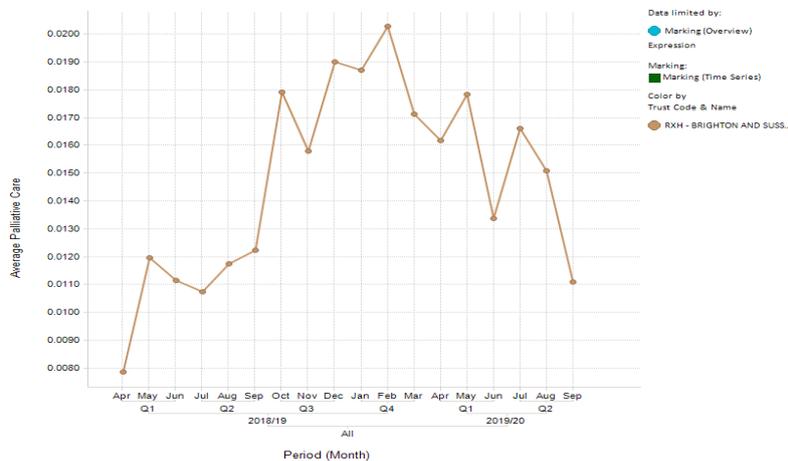


Figure 6

8.6 A detailed investigation into a mortality alert for ‘other fractures’ was reviewed by the TMRG in October 2019, led by the by the Trauma and Orthopaedics team. The investigation found that such fractures were the result of falls and RTCs in elderly patients. The mean ISS severity score was 13 (scores >15 are considered very serious). Most of the patients died of pneumonia. The RSCH Trauma ward is now open and options to appoint a Trauma Geriatrician are being explored. Ventilation was found to be an issue as this is managed more effectively on the ITU than a ward environment. Younger patients might recover more easily but this is not the case with the older population. Overall it was felt that the pathway would benefit from review with a Trauma Geriatrician.

⁷ National average is 100

- 8.7 A review of the themes from SJRS, following deaths after elective admission found no new learning and it was felt that thematic review following M&M would be more useful. The pilot of the M&M tab on PANDA will review this.
- 8.8 Detailed data reviews are underway for the diagnostic group 'Complication of device; implant or graft' and 'Coronary atherosclerosis and other heart disease' are in progress as the HSMRs are above 100 (i.e. above national average).
- 9. Summary**
- 9.1 In accordance with the requirements of National Guidance on Learning from Deaths, BSUH have published the specified data on deaths.
- 9.2 Overall there is a fall in the rate of deaths being reviewed following secondment of the Deputy Director of Safety & Quality. However completion of the restructure of the Safety & Quality function will improve representation and participation in SJRs at Divisional Level.
- 9.3 Clinical monitoring remains the most commonly reported problem in care. Patientrak improves patient monitoring; the quality of care to patients and will support the newly published 'Recording of NEWS2 score, escalation time and response time for unplanned critical care admissions' CQUIN.
- 9.4 The data submitted the National Bowel Cancer Audit has been corrected, BSUH are no longer Bowel Cancer outcome outlier.
- 9.5 BSUH are currently in the top 15% of Trusts for HSMR.
- 9.6 A thematic review of deaths following elective admission has identified no concerns in the quality and safety of care.
- 9.7 A deep dive review of an alert for 'other fractures' has identified the value of a Trauma Geriatrician to provide a holistic approach for older patients with trauma.
- 10. Recommendation**
- 10.1 The QAC is asked to receive and discuss the implementation of the Learning from Deaths Policy and the learning from the outcomes of the mortality reviews.

Dr Rob Haigh
BSUH Medical Director
21.01.2020