Brighton and Sussex University Hospitals NHS Trust

Meeting of the Board of Directors

10.30-13.15 on Wednesday 27 November 2019
Level 6 Boardroom, Trust HQ, Royal Sussex County Hospital, Brighton

AGENDA – MEETING IN PUBLIC

1.	10.30	**Welcome and Apologies for Absence** To note	Verbal	Chair
2.	10.30	**Declarations of Interests** To note	Verbal	All
3.	10.30	**Minutes of Board Meeting held on 25 September 2019** To approve	Enclosure	Chair
4.	10.35	**Matters Arising from the Minutes** To note	Enclosure	Chair
5.	10.40	**Report from Chief Executive** To receive and note overview of the Trust's activities	Enclosure	Marianne Griffiths
		INTEGRATED PERFORMANCE REPORT		
6.	10.55	**Introduction from Chief Executive** To receive and note overview of the Trust's activities	Enclosure	Marianne Griffiths
7.	11.00	**Quality Improvement** To receive and agree any necessary actions *After this section the Chair of Quality Assurance Committee will be invited to provide their report included at item 11* To receive assurance from Committee and recommendations from the Committee	Enclosure	George Findlay
8.	11.20	**Systems and Partnerships** To receive and agree any necessary actions	Enclosure	Jayne Black
9.	11.30	**Sustainability** To receive and agree any necessary actions	Enclosure	Karen Geoghegan
		After these two sections the Committee Chairs will be invited to provide their report included at item 12-14 To receive assurance from Committee and recommendations from the Committee		
10.	11.45	**Our People** To receive and agree any necessary actions *At this point the Committee Chairs will be invited to provide any additional assurance from the work of their committees.*	Enclosure	Helen Weatherill
		ASSURANCE REPORTS FROM COMMITTEES		

11.	-	**Report from Quality Assurance Committee Chair** - **from the meeting on 26 November** To receive assurance from Committee and recommendations from the Committee	Verbal	Mike Rymer
11.	-	**Reports from Finance and Performance Chair** - **from the meeting on the 26 November** To receive assurance from Committee and recommendations from the Committee - **from the meeting on the 29 October**	Verbal Enclosure	Patrick Boyle
11.	-	**Reports from the Audit Committee Chair** - **from the meeting on the 1 October** To receive assurance from Committee and recommendations from the Committee	Verbal	Lizzie Peers
12.	11.55	**Board Assurance Framework** To approve for publication on the website	Enclosure	Glen Palethorpe
		SERVICE PRESENTATION		
13.	12.00	**End of Life Care (Service Presentation)** To receive assurance over application of patient first processes	Presentation	Clare Williams
		OUR PEOPLE		
14.	12.20	**National Approach to Flu Vaccinations** To receive and agree any necessary actions	Enclosure	Carolyn Morrice
		WELL LED & COMPLIANCE		
15.	12.30	**Annual Winter Plan** To receive and note	Presentation (To Follow)	Jayne Black
16.	13.00	**Company Secretary Report** **Appendices:** - **Learning from Deaths Report** - **H&S annual report** To note	Enclosure	Glen Palethorpe
		OTHER		
17.	13.10	**Any Other Business** To receive and action	Verbal	Chair
18.	13.15	**Questions from the public** To receive and respond to questions submitted by the public	Verbal	Glen Palethorpe
19.	13.15	**Date and time of next meeting:** The next meeting in private 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**	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

Brighton and Sussex University Hospitals NHS Trust

Minutes

Minutes of the Board of Directors (Public) meeting held at 10:30 on Wednesday 25 September 2019 in the Lecture Theatre 1, Euan Keat Education Centre, Princess Royal Hospital, Haywards Heath

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
	Jon Furmston	Non-Executive Director
	George Findlay	Chief Medical Officer
	Karen Geoghegan	Chief Financial officer
	Pete Landstrom	Chief Delivery & Strategy Officer
	Denise Farmer	Chief Workforce & Organisational Development Officer
	Clare Williams	Interim Chief Nurse
In attendance:	Glen Palethorpe	Group Company Secretary
	Tamsin James	Board and Committee Administrator
	Helen Weatherill	HR Director
	Malcolm McKenzie	Consultant ED & Clinical Lead (Item 14)
	Renee van Der Most	Clinical Lead Organ Donation/ICU consultant (Item 15)
	Babs Harrison	Head of Inclusion (Item 16)
	Amanda Walker	Head of Nursing for Infection Prevention (Item 18)

B/09/19/1 WELCOME AND APOLOGIES **Action**

1.1 The Chair welcomed those present to the meeting. The Chair formally welcomed Jackie Cassell to the Board as Non-Executive Director from October 2019, replacing Dr Malcolm Reed.

1.2 Dr Malcolm Reed, although not in attendance, was thanked for his time with the Trust.

1.3 Apologies of absence were received from Joanne Crane, Kirstin Baker, Jayne Black, Clare Stafford & Rob Haigh

1.4 The Board was confirmed as quorate.

B/09/19/2 DECLARATIONS OF INTEREST

2.1 There were no declarations of interest.

B/09/19/3 MINUTES FROM THE PREVIOUS MEETING HELD ON 24 JULY 2019

3.1 The minutes of the meeting held on 24 July 2019 were **APPROVED** as a correct record.

B/09/19/4 MATTERS ARISING

4.1 The Committee **NOTED** that the matters arising each had a narrative which explained their resolution and **AGREED** to close the completed actions.

B/09/19/5 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 August & September.

Headlines

5.2 The Brighton Pride event was a beautiful day and Marianne expressed her gratitude at the Trust's staff involvement with PRIDE, a clear statement about the value the Trust puts on inclusion, diversity and equality. Marianne thanked all those who attended the celebration with special recognition to Nick and the team for organising the float.

5.3 HSJ Shortlisted the Trust for Acute or Specialist Trust of the Year: Marianne expressed her delight at being shortlisted for this prestigious award.

5.4 BSUH is proud to be one of 100 employers recognised by Defence Minister Ben Wallace for outstanding support for the Armed Forces community by being awarded an Employer Recognition Scheme Gold Award. This award represents the highest badge of honour available to those that employ and support those who serve, veterans, and their families. A celebration event is to be held in October.

5.5 The #BelongHere campaign featured 14 colleagues from across the Trust as the faces of this special campaign. It was fantastic to see the campaign on the streets of Brighton and it really helps to tell the story of the diverse, inclusive and welcome culture in the Trust, we should all be very proud.

5.6 Congratulations were given to Wave 6 teams from the Princess Royal Hospital who have just completed their Patient First Improvement System (PFIS) training,. Sixty teams have now completed this 4 month intensive training programme and 10 more teams have just started their PFIS journey at RSCH.

5.7 Staff and supporters of The Trevor Mann Baby Unit (TMBU) at The County Hospital celebrated the completion of refurbishment work and the opening of a new quiet room for families earlier this month. The improvements, which cost more than £350k, were paid for by supporters of BSUH Charity and the Early Birth Association (EBA). The changes have created a more comfortable space for parents and allows the Trust to offer them more privacy than had been possible on the main wards.

5.8 **Diary Highlights**

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

5.9 **Looking ahead**

Marianne confirmed the Annual Staff Survey is due to launch in early October as a chance for BSUH staff to have their say. There will be a lot of activity to promote the survey to beat the 2018 59% response rate.

5.10 The annual Flu season is fast approaching, from October the Trust will be taking part in the national flu vaccination campaign supporting the Trust's patients, their families and staff remain healthy

5.11 The Board **NOTED** the report.

B/09/19/6 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/09/19/7 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 May 19 has reduced for a further period. The in-month HSMR was 86.76. In the 12 months to May 2019 the HSMR was 90.42, just falling short of the objective to be in the Top 20 quintile of the Trust in the UK.

7.3 The rate of inpatient falls for the past 12 months is 3.32 falls per 1000 bed stay days; equating to 841 falls in the past year compared to 855 in the previous year. The National Falls rate is 6.63 falls per 1000 bed days.

7.4 Following a challenging month operationally there were 62 mixed sex accommodation breaches reported in August. Whilst a disappointing month, over the past 12 months the trend has been decreasing.

7.5 The rate of harm free care was 94.56% in August, 0.44% below the Trust target of 95%. The harm-free care score for the past 12 months was 94.94% against the target of 95%. Alan McCarthy emphasised the significance of this good quality performance for the Trust's patients which supported the views he had heard that patients once being seen by the Trust receive a great service and outcomes.

7.6 The pressure ulcer rate for the past 12 is months 1.17 incidents per 1000 bed stay days. A data cleanse and a review of the current process of reporting is in progress. A new standard operating procedure (SOP) has been written that incudes specific criteria for sign off for Grade 2, 3 and 4 and a monthly validation meeting from September 2019. Following the introduction of national changes to the grading of Pressure Ulcers a Training Needs Assessment has been updated with an implementation plan of cross-wide training.

7.7 The current rate of Friends & Family recommended rates for August were reported for Inpatients this achieved 93.6%, in A&E this recorded 86% and for Outpatients the rate was recorded as 93.3%.

7.8 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, Safeguarding and External Visits reporting. Mike confirmed that at the conclusion of the meeting the Committee were assured over the quality of care being provided to the Trust's patients.

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

7.10 The Committee **NOTED** the report.

B/07/19/8 SYSTEMS AND PARTNERSHIPS

8.1 Pete Landstrom updated the Board in respect of a range of performance indicators.

8.2 Pete informed the Board that for August the A&E performance was 82%, compared to a national average of 86.3%.

8.3 The Trust's 62 day cancer performance for GP referral to treatment reduced by 6.1% to 57.9% in July-19 compared to June-19. This reduction was expected as part of the recovery actions that was put in place to reduce the waiting list size and the concentration on dealing with patients waiting for the longest time. National average performance (July-19) was 77.6%.

8.4 The Trust's RTT Performance decreased slightly by 0.6% in August-19 to 64.8%, with the waiting list reduced by 219 patients since June-19. There were thirty four 52 week breaches in the month this was an increase of 21 on the prior month. National average performance (July-19) was 85.8%.

8.5 Pete confirmed that the Trust has implemented its robust plans to improve both RTT and Cancer wait times and expects this will see improvements in the reported performance in the near future.

8.6 The Trust's Diagnostics performance improved by 5% to 21.1% in August-19 compared to June-19. Significant improvements have been made in Non-obstetric Ultrasound. National average performance (July-19) was 3.5%.

8.7 Pete drew the section to a close by confirming that there have been challenges but a number of extra measures have been implemented to reduce the wait time for patients and confirmed that Cancer, Endoscopy and Diagnostics are still working hard to deliver their trajectory.

8.8 The Committee **NOTED** the report.

B/07/19/9 SUSTAINABILITY

9.1 Karen Geoghegan reported to the Board the Trust financial performance, reporting that for August, the Trust is reporting a deficit of £3.8m which is slightly better than plan.

9.2 At the end of M5, the Trust has delivered a deficit of £25.9m, in line with the plan, so has earned £7.97m of PSF and FRF income. In addition the Trust has also received confirmation of £0.6m of 2018/19 as a national post accounts reallocation of PSF.

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 will require close management of elective and non-elective activity and control of the Trust's cost base, particularly in relation to medical pay, which is a break-through objective for 2019/20.

9.5 The Trust's Finance and Use of Resources Risk Rating for August is 3, and the individual rating components are in line with plan.

9.6 The Efficiency and Transformation Programme is forecasting full delivery of the £27m requirement.

9.7 There is less spend to date on Capital the Trust's capital programme due to delays within the 3Ts programme. Purchases of medical equipment and estates infrastructure continues to progress as planned.

9.8 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. Both Patrick and Marianne stated they were confident of reaching the required trajectories in Cancer, Diagnostics and Endoscopy by December in line with the Trust's plan.

9.9 Lizzie Peers requested assurance over the long wait times and the potential impact on patients in Cancer and Diagnostics is monitored. It was confirmed efforts are in place to keep patients fully informed along their journey and the impact of any long waits is subject to detailed reviews the outcome of which has been reported to the Quality Assurance Committee.

9.10 The Committee **NOTED** the report.

B/09/19/10 OUR PEOPLE

10.1 Helen Weatherill presented the Board with an update on workforce developments and emphasised the positive outcome from 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 Helen 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 7.1 out of 10. The 2018 National NHS staff acute trust average was 7 out of 10 and we were slightly below this at 6.9. The best Acute Trust scored 7.6 out of 10. Our ambition is to be above average in 2019 National Staff Survey.

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 July 2019 to 'I would recommend the organisation as a place to work.' Focused staff input has created a developed plan of actions. The measurable goal is to increase the NHS staff survey score of 'I would recommend the Trust as a place to work' to above the National Acute Trust average score by the 2020 Staff Survey. In 2018 we were slightly below average compared to other Acute Trusts.

10.4 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.

10.5 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 opens on 3rd October for 8 weeks until 30th November 2019. Initial results will be available between December 2019 and January 2020, with

National results being available in February 2020. BSUH will run a mixed mode survey for the 8000 staff, split between paper and electronic surveys. 50 Staff Survey Champions have been identified by each division who will distribute paper surveys and assist with promotional campaigns, with bi-weekly meetings scheduled to monitor uptake and impact throughout the survey period.

10.6 Helen drew the Board's attention to the fact that there has been an improvement to staff turnover of rates reducing to 12.5% which is now in line with the Trust set target.

10.7 The Board **NOTED the** information received from the Integrated Performance Report.

B/09/19/11 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 Committee were **ASSURED** following the update of the report.

B/09/19/12 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.

12.2 The Committee **NOTED** the update.

B/09/19/13 BOARD ASSURANCE FRAMEWORK

13.1 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 no changes were required to the scores.

13.2 The Board **APPROVED** the Board Assurance Framework.

B/09/19/14 URGENT & EMERGENCY CARE SERVICE PRESENTATION

14.1 Malcolm McKenzie presented the Board with an overview of the Urgent & Emergency Care Service at both the Royal Sussex County and Princess Royal sites. The presentation commenced with informing the Board on the areas of improvement made by the service, these being:

14.2 We are one of few Trusts providing Consultant Delivered Services which include 24/7 consultant cover ensuring patients are seen and reviewed at all times. This forms part of the improvements regarding timely and senior assessment/treatment, from Arrive to Triage in under 15minutes – 92% of the time; Arrival to Assessment in under 1hour – 97% of the time; Arrival to Specialist Referral – 96minutes; and Arrival to Senior Specialty review – 4hours.

14.3 The introduction of single clerking ensures the patient sees the most appropriate clinical senior decision maker as early in their attendance as possible, cutting the wait time by over 5hours, which has been core to development of the acute medical model and allows focus on patient best practice.

14.4 A successful recruitment campaign includes the expansion of consultant numbers providing 24/7 cover and a review of nursing templates fully established at both BSUH and PRH sites.

14.5 There has been a successful rebuild in the Princess Royal Emergency department that includes an improved resuscitation room; a dedicated ambulance handover area; an expansion of Majors trolley area for safety; while continuing to work closely with the CCG for Improved Access and Primary Care for patients in the local area.

14.6 There has been an improvement in ambulatory care a Royal Sussex County Hospital which includes extended opening hours to 22:30; and enhanced ambulatory handover processes.

14.7 Patrick Boyle asked for further information in relation to primary care engagement with the Urgent and Emergency Care pathway with Malcolm confirming there is a IC24 funded GP service at Royal Sussex from 9-11pm and an employed GP at Princess Royal from 2pm-10pm daily, there is a trial in place currently to offer extended hours at PRH, this offers the opportunity to stream patients away from unnecessary acute care.

14.8 Alan McCarthy questioned how Mental Health patients was impacting A&E departments, Malcolm confirmed this area was supported well at Royal Sussex County through a 24/7 liaison service; and PRH is supported by a shift based Mental Health Nurse and a dedicated psychiatric liaison suite.

14.9 The Board thanked Malcolm McKenzie and **NOTED** the presentation.

B/09/19/15 ANNUAL ORGAN DONATION REPORT

15.1 The Board welcomed Renee Van Der Most, Clinical Lead for Organ Donation and ICU consultant to present the Annual Organ Donation Activity Report and highlighted the following key points:

- In 2018/19, 16 patients proceeded to organ donation, a slight increase from 15 the previous year. This increase is in donation after circulatory death.
- BSUH is increasingly referring patients who meet the relevant criteria to the SNOD (Specialist Nurse in Organ Donation).
- Improvements are being seen in Organ Donation due to increase in awareness
- Future recruitment campaign to on-board a further 2 specialist nurses.

15.2 George added that the Organ Donation team work well with others in the Trust and are all committed to supporting families with the process of donation. Ideally, George would like to see the numbers of donors after circulatory death increasing. The new specialist nurse appointments will be key in aiming to increase the numbers to ensure that no potential donors are missed.

15.3 The Board thanked Renee for the presentation and **NOTED** the report.

B/09/19/16 ANNUAL WORKFORCE RACE EQUALITY STANDARD SUBMISSION

16.1 Denise Farmer introduced Barbara Harris (Babs), the Trust's Head of Equality, Diversity and Inclusion, who presented the Comparative WRES Data Plan.

16.2 There are eight WRES Indicators and it was noted that figures for reducing

harassment, bullying and discrimination of BME staff are making steady progress. 2019 has seen the highest percentage of BME staff believing there is a relative likelihood of BME staff entering a formal disciplinary process. However, abuse from patients has been decreasing. She added good progress is being made and we are in a privileged position to commission an inclusion programme and are working closely with South East Coast Ambulance Trust to deliver this.

16.3 The Board thanked Babs for the huge amount of effort put in to the WRES work and emphasised the importance of getting this into the core of the organisation to educate the leaders.

16.4 The Board **NOTED** the update.

B/09/19/17 NURSE STAFFING CAPACITY REPORT

17.1 Clare Williams presented the Nursing Staffing Capacity report, and highlighted the following:

17.2 The national picture shows that vacancies are over 41,000 across the Country. At BSUH the rolling 12 month turnover (% FTE) of registered nurses, as of July 2019, is 11.7%. Registered Nurse (RN) vacancies are showing a downward trend, currently at 12% in July 2019 (down from 12.5% in May 2019) and RN turnover is down to 11.7% (in comparison to the region average which is 12.4%.)

17.3 Following a recruitment drive BSUH has 137 RNs in the pipeline to start on wards from October. A number of Band 3s are due to start on wards to provide some added support to HCAs where the Trust has seen turnover higher than the Trust would like Sickness rates are higher within Nursing Assistants staff than Registered Nurses the rate has increased from 5.9% to 6.16%. The Trust has commenced focused work in this area to redress this difference.

17.4 October 2019 will see the introduction of HealthRoster (Allocate) as part of a Trust wide e-rostering implementation project across all staff groups. Due to high Workforce costs in BSUH it is imperative that services are provided with modern, dynamic systems that can support rosters and people management. Our current e-rostering system in nursing and midwifery does not provide this, therefore the proposal has been agreed to roll out one workforce system, across the Trust to manage rotas, absence management, job planning and temporary staffing.

17.5 The Board **NOTED** the Report.

B/09/19/18 2018/19 INFECTION PREVENTION AND CONTROL ANNUAL REPORT & PRESENTATION

18.1 Clare Williams welcomed Amanda Walker, Head of Nursing for Infection Prevention, to present the Trust's annual report and summarised the key information contained within the report.

18.2 Amanda reported that there had been two MRSA cases for the period 1April 2018 to 31March 2019 and the Trust's rate of C. Diff cases was slightly higher than the target set for the Trust of 45 cases. There were 23 cases of MSSA BSI during this period.

18.3 Hand hygiene compliance is monitored every week in practice by departments

who facilitate and undertake their own audits.

18.4 There have been changes and improvements to the team to allow ongoing infection prevention surveillance supported with daily team visits to high risk areas.

18.5 The Trust achieved its target for the CQUIN influenza vaccination across the Trust.

18.6 The Board acknowledged the complex work that the Infection Control team do and the improvements that have been made and received assurance that more robust processes are being implemented.

18.7 The Board thanked Amanda and **NOTED** the report.

B/09/19/19 ANY OTHER BUSINESS

19.1 There was no other business discussed.

B/07/19/20 QUESTIONS FROM THE PUBLIC

20.1 Two members of the public had previously submitted questions to the Board relating to the Community Beds Action Plan, shortage of community step down beds and complex care discharges.

20.2 Pete Landstrom responded by confirming that a community bed mobilisation plan has been launched in response to the overall deficit and closures in certain areas. An action plan is in place over the coming months to increase beds in Newhaven and Lindbridge.

20.3 Pete confirmed in relation to the complex discharges the Trust was achieving on average 25 per day, with additional support from the Red Cross it will be possible to increase the target to at least 30-40 per day. The complexity in this area needs to be streamlined by inclusion at regular CCG meetings (daily and weekly) and working with partners and reviewing winter planning and increasing bed capacity at both Newhaven and Lindbridge.

There were no further questions.

Tamsin James
Board and Committee Administrator
September 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

November 2019

Content

- Headlines
- Diary highlights
- Looking ahead

Headlines

Flu campaign – Time to get your annual flu jab

We are six weeks into the Trust's annual flu campaign and over 52% of frontline staff have already been vaccinated. The Jab will still be available until early 2020 however we are encouraging staff to get vaccinated within the first two months to ensure they are protected before the flu season sets in.

There are many ways staff can get the jab; either by 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.

HSJ Awards: Acute or Specialist Trust of the Year Finalists

Nine colleagues from BSUH attended the HSJ Awards in London on Thursday evening (6th November).

Clare Williams, Nurse Director; Alan McCarthy, Chairman; Karen Geoghegan, Chief Financial Officer; Melanie Lyons, Personal Assistant; Ash Hicks, Nursing Auxillary; Kimberly O'hara, Chief Nurse of Surgical Division; Fadairo Farzai, Biomedical Scientist; Ann Gibbins, Head of Nursing Medicine Division; and Adam Shields, Assistant Director of Financial Planning represented the Trust which was nominated for Acute or Specialist Trust of the Year in the prestigious awards.

Although we did not win this time, we were recognised for the outstanding improvements that have been made across our hospitals over the last year. Thanks to everyone who took part in demonstrating to the HSJ during the judging process just how fantastic we are!

Headlines

Patient First Open Day

Last week we welcomed more than 50 executive and senior management team members from across Europe and the UK to a Patient First open day. Hosted at Worthing Hospital, our visitors gained an exclusive insight into the journey 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.

Clinical Improvement Scholars underway

Colleagues from across the Trust have joined a collaborative programme with Western Sussex giving them the opportunity to develop their research skills and help bring research evidence into their practice.

The Clinical Improvement Scholarship is part of the Clinical Academic Programme, designed to help with the national drive for non-medical staff to pursue academic qualifications, particularly at Masters and PhD level. With funding from Health Education England, Kent, Surrey & Sussex (HEKSS) four BSUH colleagues joined the 2019/20 cohort

Clinical Scientist wins BAA Audiologist of the Year

Sam Blakemore, a clinical Scientist in Audiology at BSUH has been awarded Audiologist of the Year Award by the British Academy of Audiology (BAA).

Sam *(pictured right)* was nominated by the mother of a service user who has received audiology care from Sam and her team for over 14 years

Headlines

Dementia Conference

A fantastic day was had by all who attended the Annual BSUH Dementia Conference in October. Colleagues from BSUH were joined by neighbouring trusts, dementia specialists and partner charity organisations who came together to share their experiences and encourage an improved understanding of care for patients with dementia.

The Conference was also 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.

Workforce Race Equality Conference (WRES) 2019

Representatives from Sussex Health and Care Partnership (BSUH, WSHT, SPFT, SCFT, ESHT and QVH) came together on Thursday (14 November) to discuss and develop ways we can work together to achieve sustained change for our Black and Minority Ethnic Staff. The event was facilitated by the National WRES Implementation Team, NHS England and Yvonne Coghill, CBE, OBE Director of the National Team, along with other members of her team who presented collective and individual data on all of the respective organisations. Others in attendance included Chief Executives of the Trusts, HR Directors, Inclusion Leads and other staff who are working on the race agenda.

The purpose of the conference was to look at how we can work more collectively to address the issues that are not moving forward as quickly as we would like, with regards to achieving race equality within the local STP.

Headlines

Long Service Awards - Thank you for your contribution!

Celebrating the fantastic hard work and commitment of 128 members of staff was the order of the day on Wednesday (6th November) at our BSUH long service awards. Between them this great group of outstanding staff have worked at the Trust for an incredible 3,237 years

Remarkably, 12 of these long serving staff all moved to England together from the Philippines 20 years ago. Over a special afternoon tea the Cardiac team also took the opportunity to celebrate the opening of Cardiac Surgery 20 years ago.

Recognising our neighbour's success

Congratulations to our colleagues at Western Sussex Hospitals on becoming the first non-specialist acute trust in the country to be rated 'Outstanding' in all the key inspection areas assessed by the Care Quality Commission (CQC), improving upon the trust's first 'Outstanding' rating from four years ago. The government's health watchdog awarded the highest possible rating for services at Worthing, St Richard's and Southlands hospitals, following a rigorous inspection process which took place from June to August this year.

Diary highlights

- Sussex Workforce Race Equality Conference
- Meetings with partner organisations
- Lean Transformation Summit
- Acute Network
- NHS Providers Annual Conference
- University of Chichester Graduation
- Consultant engagement briefings
- Women’s Leaders Network Annual Conference

Looking ahead

NHS Staff Survey

We are in the final two weeks of the NHS Staff Survey period and over 4400 members of staff have taken part.

There has been lots of activity to promote the survey among staff groups and we hope to gain an increase of responses on last year's survey which saw 59% of staff take part. An increased response will help us to get an updated understanding of the issues affecting our staff and establish the key focus areas over the next year for staff wellbeing.

So far, 54% of staff have completed their survey – can we beat our target by the end of November?

Planning for the future

After nearly three years of the management contract between Brighton & Sussex University Hospitals and Western Sussex, we have decided to further develop the relationship between the two trusts, under the leadership of a single board and executive team. 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.

Integrated Performance Report

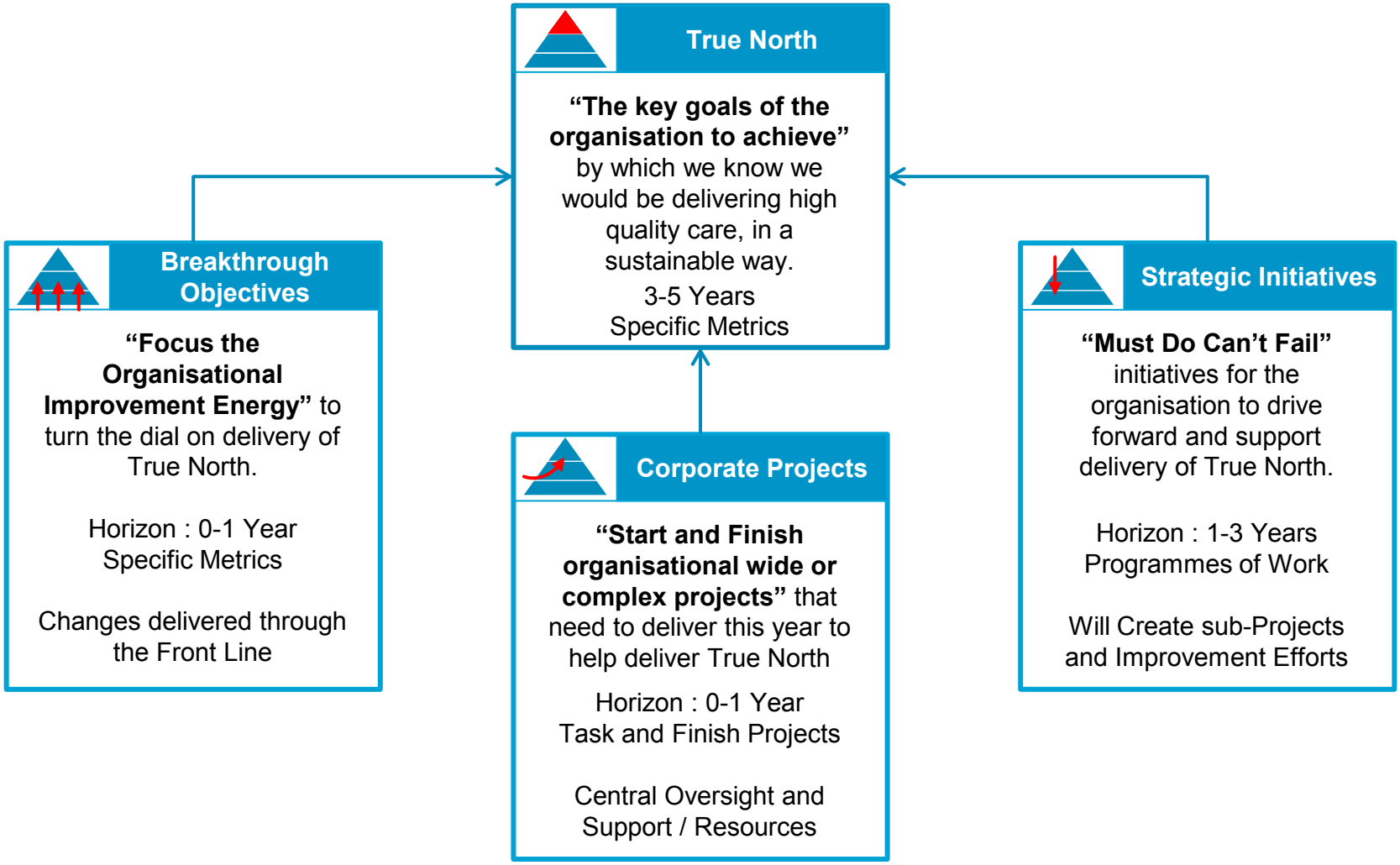
November 2019

Brighton and Sussex University Hospitals NHS Trust

Contents

Structure of the report

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

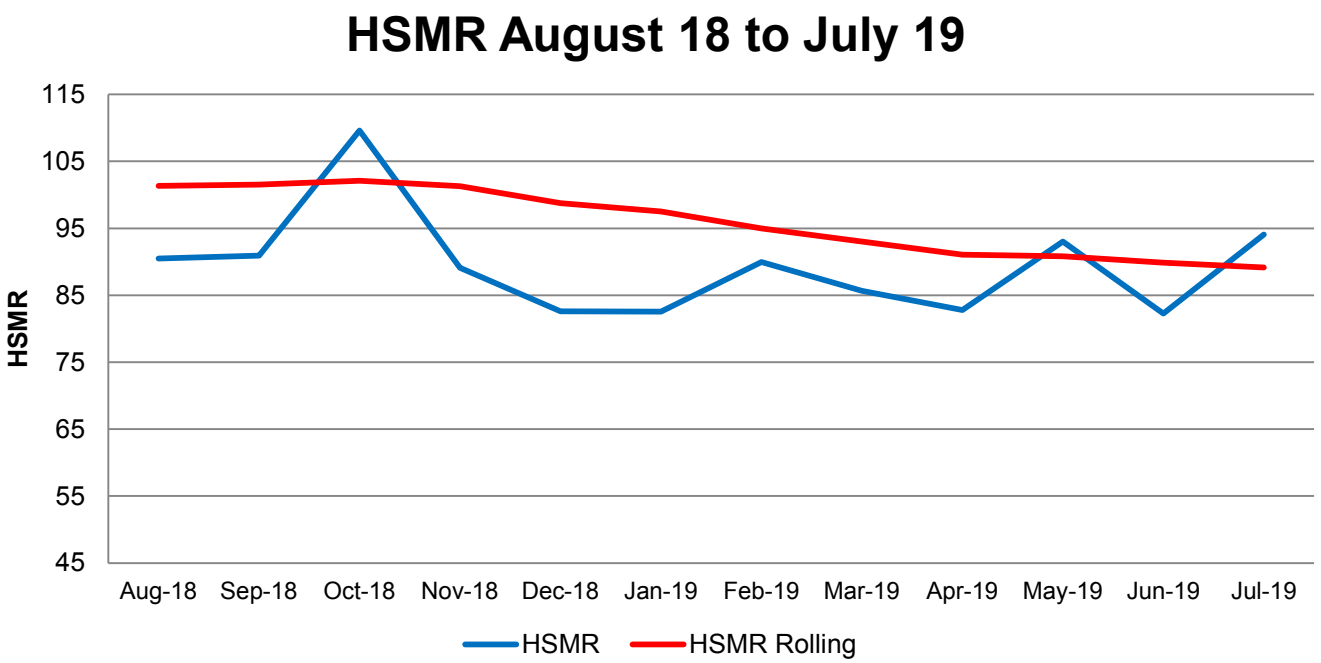
Quality

Preventable Mortality

Target: HSMR Top 20% in the Country

Avoidable Harm

Target: Patient Safety Thermometer 95% Harm Free Care



HSMR is available up until July 19 when 79 patients died against an expected number of 84. In the 12 months to July 2019 the HSMR was 89.16
BSUH is currently ranked 25th out of 132 organisations (19%). The last time that the Trusts had a HSMR below 90 was in in May 2016.

The harm-free care score for the past 12 months was 94.98% against the target of 95%. The national average is 94.2%.

Quality Performance

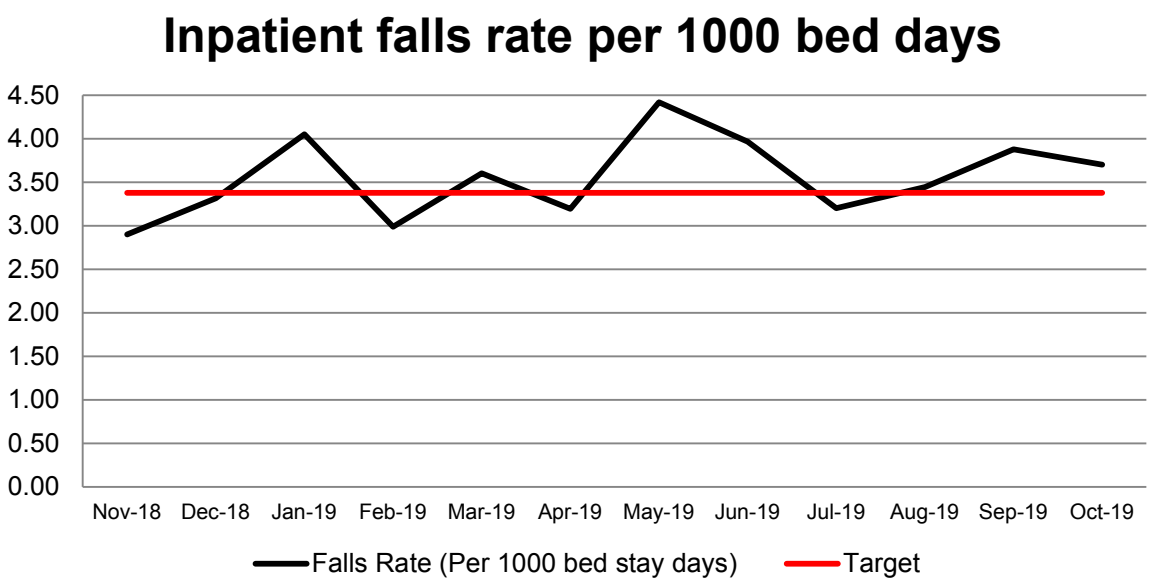
Quality

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



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

This data will form part of the quality and safety dashboard that will be presented at the Monthly Chief Nurse business meeting. This meeting will ensure ongoing monitoring, lessons learnt and action plans are competed.

Quality Performance

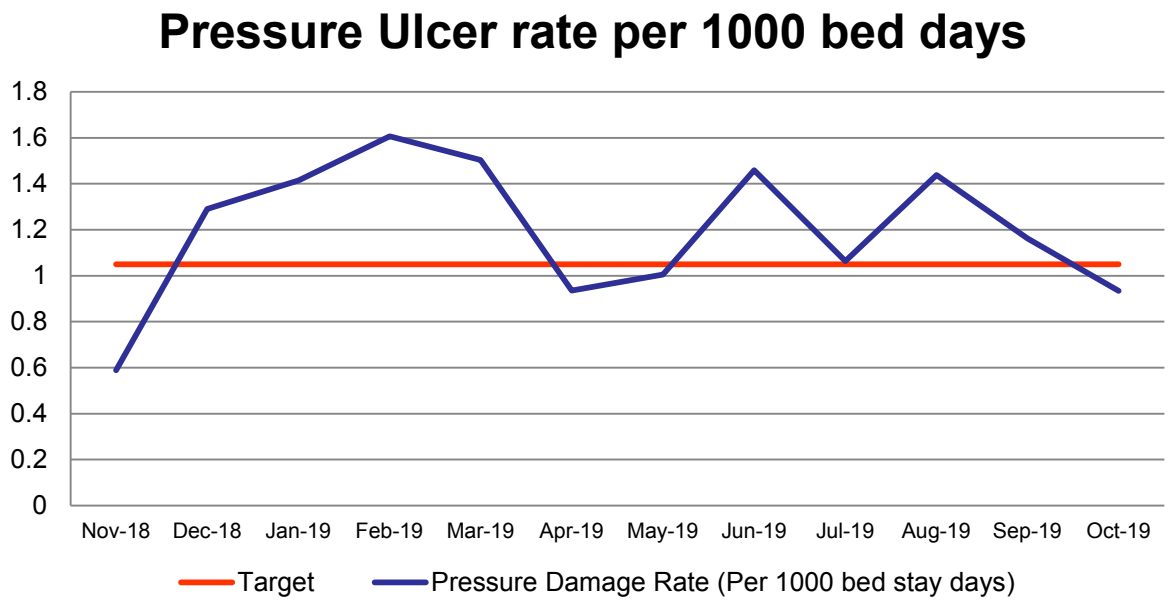
Quality

Inpatient Falls

Target: 3.38 falls per 1000 bed stay days

Pressure Ulcers

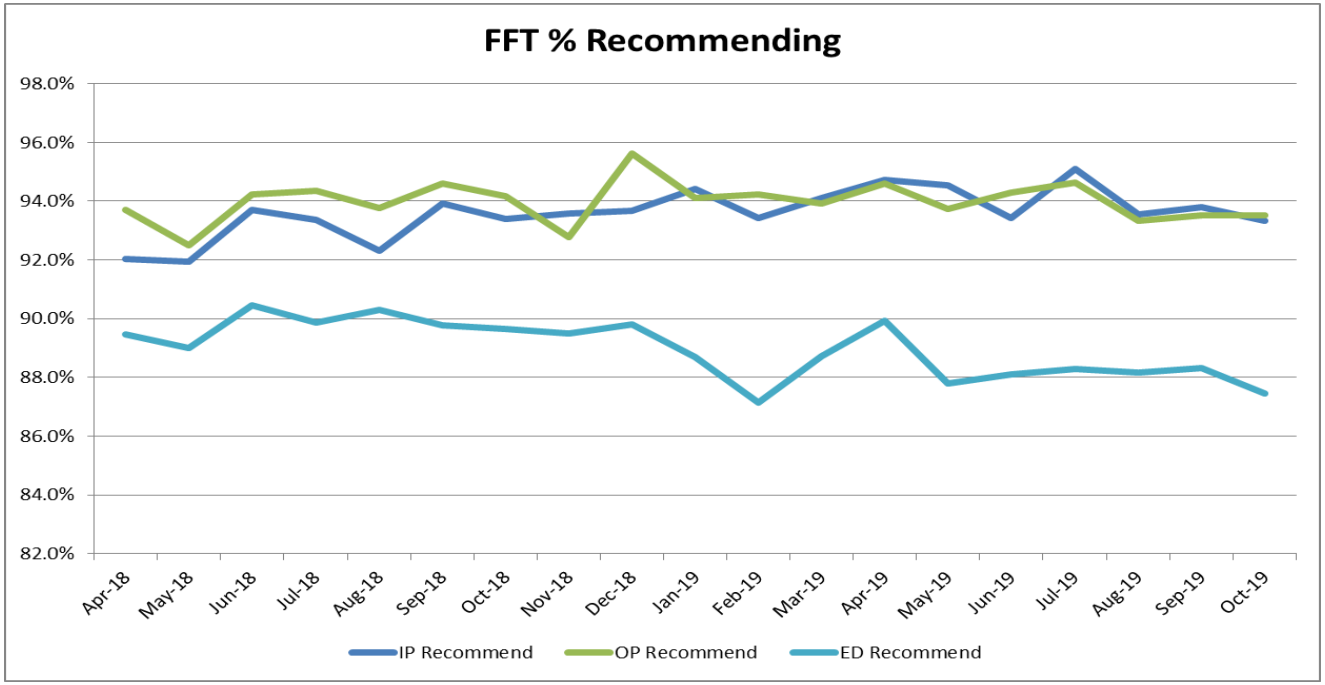
Target: 1.05 rate of acquired pressure ulcers per 1000 bed stay days



The pressure ulcer rate for the past 12 months was 1.20 incidents per 1000 bed stay days.

This data will form part of the quality and safety dashboard that will be presented at the Monthly Chief Nurse business meeting. This meeting will ensure ongoing monitoring, lessons learnt and action plans are competed.

Quality Performance



Our current recommend rates for October 2019 are;

Area	Recommend %	Target %
Inpatient	93.32%	96%
A&E	87.4%	90%
Outpatients	93.5%	94%

Quality

Friends and Family Test

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

Systems and Partnerships – Summary

Systems & Partnerships
Non Elective Care
Target: A&E 95% <4hrs
Elective Care
Target: RTT 92% <18wks

- A&E Performance deteriorated to 82.6% (acute footprint) in October-19 compared to the national performance of 83.6%.

- 62 day cancer performance for GP referral to treatment improved by 10.4% to 73.8%% in September -19 compared to August -19. National average performance (September -19) was 76.9%.

- RTT Performance improved by 0.6% in October -19 to 67.2%. The waiting list reduced by 691 patients compared to Sept -19. There were 67 52 week breaches in the month this is an increase of 20 on the prior month. National average performance (September-19) was 84.8%.

- 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 and improvements have begin for endoscopy. National average performance (September -19) was 3.8%.

Systems and Partnerships – Cancer

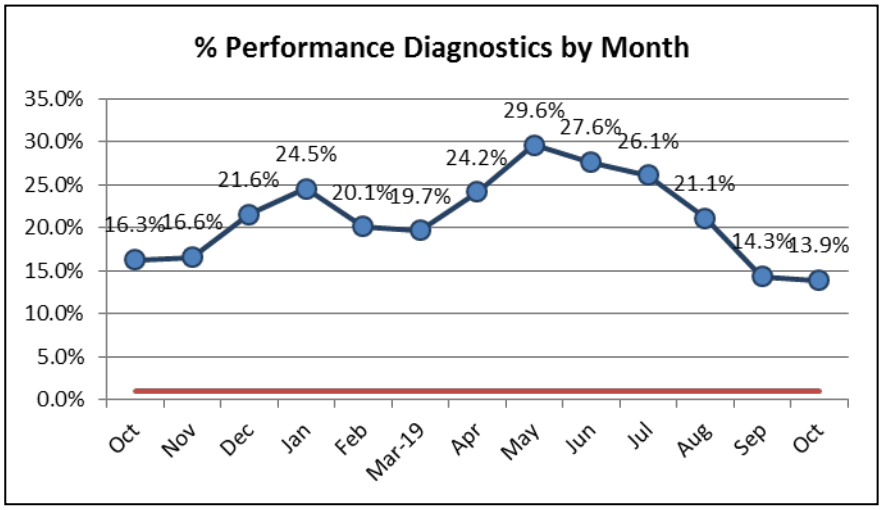
	2019/20		Var-18/19		
	Sep	YTD	Sep	YTD	Target
2 week GP ref to 1st OP	93.9%	85.9%	13.1%	-1.6%	93%
2 week GP ref to 1st OP - breast symptoms	90.1%	79.8%	-4.3%	-12.1%	93%
31 day 2nd or subs trtmnt - surgery	96.4%	94.4%	0.3%	-3.8%	94%
31 day 2nd or subs trtmnt - drug	100.0%	99.8%	0.0%	-0.1%	94%
Cancer: 31 day second or subsequent treatment - radiotherapy	100.0%	99.9%	0.0%	0.7%	94%
31 day diag to trtmnt all cancers	97.3%	93.5%	-0.2%	-4.2%	96%
62 day ref to trtmnt: screening	90.0%	60.5%	14.2%	-7.8%	90%
62 day ref to trtmnt : upgrade	95.7%	76.6%	19.7%	-4.0%	85%
62 days urgent GP ref to trtmnt : all cancers	73.8%	62.4%	-0.4%	-8.7%	85%

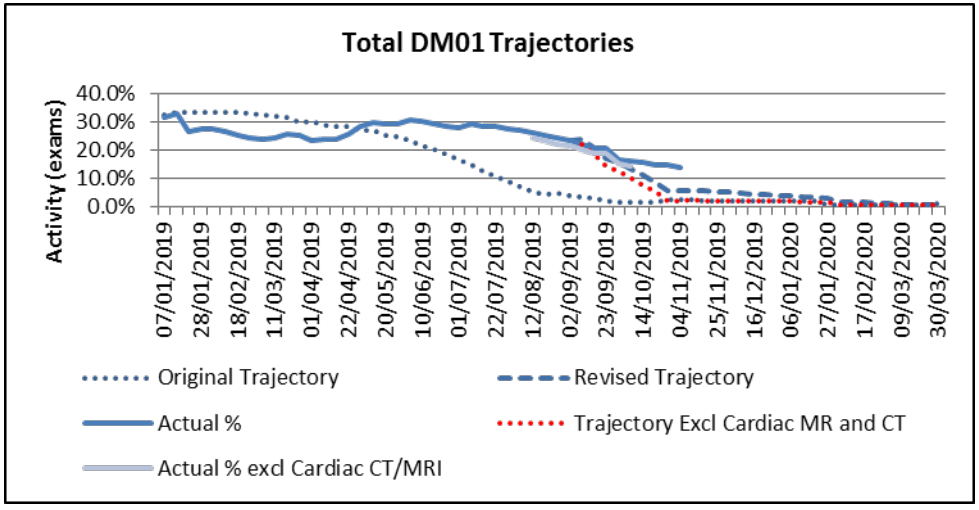
- The Trust was compliant in 6 of 8 reportable cancer metrics in September - 19.
- 2ww was compliant in September – 19
- The Trust was non-compliant against the 62 day urgent referral to treatment target of 85%, with 73.8% of patients commencing treatment within 62 days. This is a 10.3% improvement on the previous month.
- 31 patients were treated past the 62 day breach target out of a total of 120 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 18 as at 13th November.

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



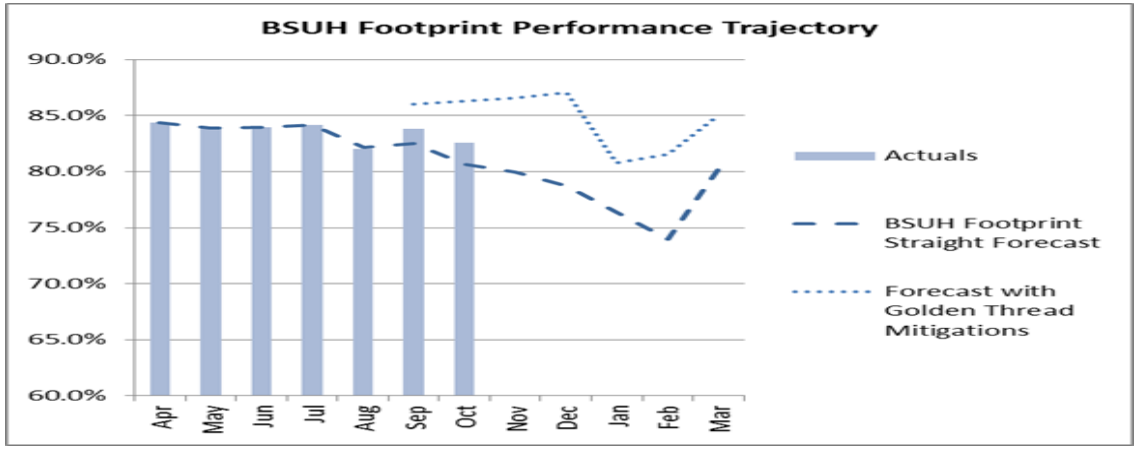


- Trust diagnostics performance improved by 0.43% in October-19 compared to the previous month.
- The overall diagnostic waiting list has reduced by 2,333 since April 2019.
- The diagnostic backlog of patients waiting over 6 weeks has decrease by 1,373 since April 2019.
- Non Obstetric Ultrasound is now compliant against the 1% standard.
- The backlog in endoscopy modalities has begin to see a slow improvement in recent weeks.

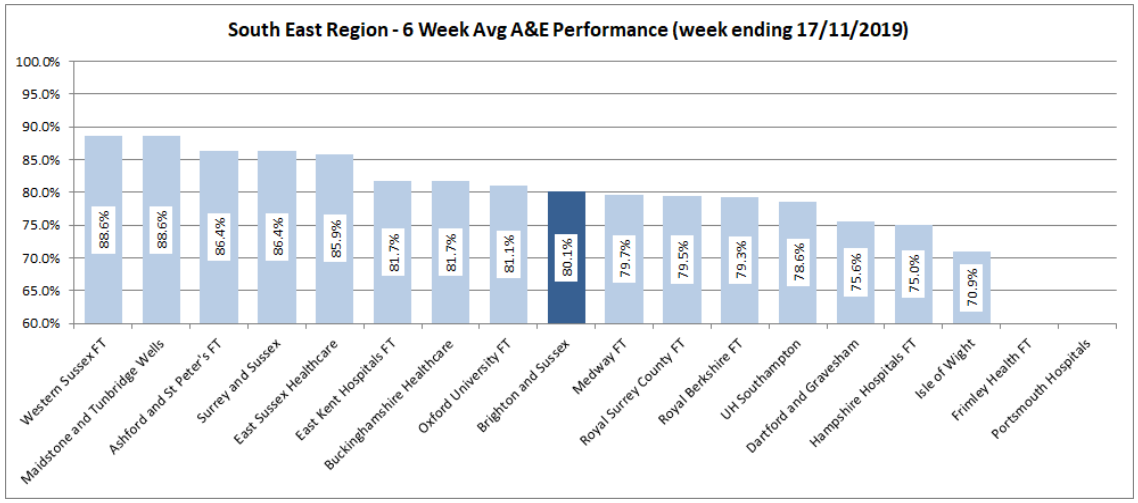
Improvement Focus:

- 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 Nov 19).
- Endoscopy recovery plan approved and mobilised including outsourcing some endoscopy activity in the short term .

Systems and Partnerships – True North Metrics



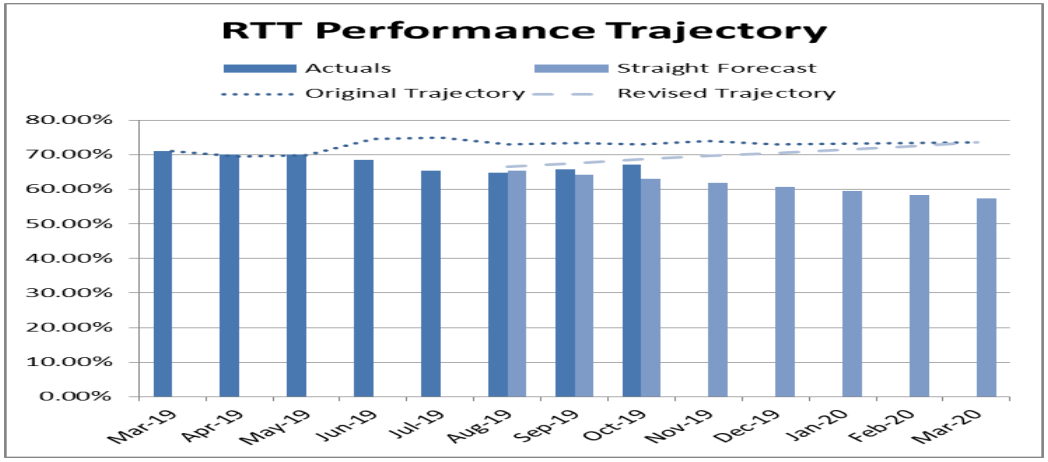
- Trust A&E Performance for Oct -19 was 82.6% including the NHSE allocated type 3.
- This is 1.2% lower than Sept - 19. The performance is behind the agreed trajectory by 3.7%.
- The trust had 3346 4 hour A&E breaches which was 469(14%) more than the same month last year.
- The trust was below the national average performance of 83.6% in Oct -19.



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 will be implemented w/c 2nd December.

Systems and Partnerships – True North Metrics



- Trust performance for RTT in October - 19 was 67.2% for all specialties, an improvement of 0.6% compared to Sept - 19.
- There were 67 52 week waiters at end Oct - 19. This was an increase of 20 compared to the previous month.
- The RTT incomplete Waiting List fell by 691 waiters in October - 19 compared to September -19.
- The overall backlog of patients waiting over 18 weeks reduced by 882 compared to the previous month. 12 of 17 specialities had a reduction in backlog.

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

Financial Performance - Summary

Sustainability

Financial Management

Target: Break Even

- For October, the Trust is reporting a deficit of £3.8m which is in line with plan.

- At the end of M7, the Trust has delivered the planned deficit of £33.9m and as a result has earned £11.4m of additional income from the Provider Sustainability Fund (PSF) and Financial Recovery Fund (FRF). In addition the Trust has also received an additional £0.6m of income; part of a 2018/19 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 is challenging particularly given the impact of operational pressures; which will increase further as we move into winter. Ensuring delivery of elective and non-elective activity and control of the cost base, particularly in relation to medical pay, will require close management.

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 October 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 £1.99m.

Control Total (Surplus) / Deficit £k — G

	Plan	Actual / Forecast	Variance
Year-to-date exc PSF/FRF/MRET	33,952	33,912	40
Year-end Forecast exc PSF/FRF/MRET	52,996	52,964	32
Year-to-date	21,444	20,794	650
Year-end Forecast	25,747	25,105	642

The Trust deficit in Month 7, 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 (£12.51m 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	12,122	11,594	(528)
Year-end Forecast	27,070	27,070	0

In Month 7, £2.57m of savings have been delivered against a plan of £2.70m. Year-to-date the Trust has delivered £11.59m against a plan of £12.12m and the Trust is forecasting full delivery of the £27.07m requirement.

Capital £k — A

	Plan	Actual / Forecast	Variance
Year-to-date	82,019	48,998	33,021
Year-end Forecast	152,840	112,648	40,192

Strategic Capital: expenditure of £44.4m; which is £31.8m behind plan due to slippage on the 3Ts project. The main contractor is currently in the process of finalising their latest programme for the 3Ts project.

Operational Capital: expenditure of £4.6m; which is £1.2m behind plan. Schemes are progressing through the capital investment group.

Financial Performance – Key Metrics

Income £k — **R**

	Plan	Actual / Forecast	Variance
Year-to-date	(366,112)	(361,133)	(4,979)
Year-end Forecast	(634,855)	(626,072)	(8,783)

Income was below plan by £2.45m in-month giving a year-to-date adverse variance of £4.98m. Of this total, £4.56m relates to Patient Care Activities income and £0.42m to Other Operating Income.

Operating Costs £k — **G**

	Plan	Actual / Forecast	Variance
Year-to-date	375,079	371,005	4,075
Year-end Forecast	649,701	641,242	8,459

In October, operating costs were £1.17m below plan, mainly due to non-pay inflation and a growth allocation, which have been phased in accordance with the submitted plan. Pay expenditure year-to-date is overspent by £0.93m, the key driver being medical workforce which is £2.96m above budget.

Agency Ceiling £k — **R**

	Ceiling	Actual / Forecast	Variance
Year-to-date	6,949	8,437	(1,488)
Year-end Forecast	11,783	13,769	(1,986)

Agency expenditure in October was £1.12m, exceeding the agency ceiling target by £0.15m in-month (£1.49m year-to-date). The Trust is forecasting to exceed the target at year-end by an estimated £1.99m.

Cash £k — **G**

	Plan	Actual / Forecast	Variance
Year-to-date	3,004	15,846	12,842
Year-end Forecast	3,004	3,605	601

At the end of October the consolidated cash balance was £15.8m against a plan of £3.0m. This is higher than planned following receipt of 2018/19 PSF incentive and bonus totalling £10.3m. This funding has been ring fenced to part repay high interest bearing loans in November.

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. 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

The monthly pulse survey 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 2018 National NHS staff acute trust average was 7 out of 10 and we were slightly below this at 6.9. The best Acute Trust scored 7.6 out of 10. Our ambition is to be above average in 2019 National Staff Survey.

STAFF ENGAGEMENT SCORECARD - BSUH

Year Month		Trust Staff Engagement Staff Survey 2018	2018 National Average	Scorecard Average 18/19	Trust Target	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Trend
	Number of Responses	4739 (number of staff)		42876		4029	4279	5302	5251	5023	4838	4634	5268	3727	
Question															
Advocacy	I would recommend my organisation as a place to work.	59.1%	62.1%	64.2%		69.8%	68.8%	66.5%	70.2%	66.8%	69.8%	69.5%	72.2%	66.4%	
Advocacy	If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation.	67.9%	71.1%	73.2%		79.5%	75.9%	78.6%	77.3%	74.5%	76.8%	76.1%	77.8%	69.3%	
Advocacy	Care of patients/service users is my organisation's top priority.	76.9%	76.6%	71.7%		70.8%	72.6%	71.3%	66.8%	68.6%	72.7%	77.4%	71.7%	74.0%	
Motivation	I look forward to going to work.	56.0%	58.8%	59.4%		64.3%	58.8%	56.9%	64.6%	60.6%	62.3%	66.2%	66.2%	62.5%	
Motivation	I am enthusiastic about my job.	72.4%	74.4%	75.8%		78.3%	77.9%	74.1%	78.4%	74.9%	74.8%	78.9%	78.2%	77.3%	
Motivation	Time passes quickly when I am working.	74.4%	76.5%	72.4%		73.8%	73.5%	67.5%	74.8%	73.0%	74.2%	74.1%	72.9%	78.0%	
Improvement	There are frequent opportunities for me to show initiative in my role.	72.4%	72.8%	71.1%		70.0%	72.7%	69.6%	72.1%	72.0%	74.1%	75.1%	73.1%	71.4%	
Improvement	I am able to make suggestions to improve the work of my team/department.	75.3%	74.0%	74.5%		74.0%	75.8%	74.0%	74.1%	75.1%	78.5%	75.4%	72.6%	71.4%	
Improvement	I am able to make improvements happen in my area of work.	56.2%	55.8%	61.6%		59.8%	62.7%	59.8%	63.1%	62.3%	67.2%	62.4%	60.1%	59.1%	
	Overall Staff Engagement Score	6.9	7.0	7.0		7.0	7.0	6.9	7.0	7.0	7.1	7.1	7.0	7.0	
	Do you believe BSUH takes positive action on Health and Wellbeing	23.4%	28.2%	n/a		n/a	n/a	n/a	n/a	n/a	21.7%	24.2%	26.5%	20.9%	
	I have clear work objectives definitely agreed during my appraisal	33.3%	35.0%	n/a		n/a	n/a	n/a	n/a	n/a	21.6%	29.9%	3.6%	28.5%	

Key highlights:

- 5 out of the 9 engagement questions are above the 2018 National Staff Survey Average, these are “I would recommend my organisation as a place to work”, “I look forward to going to work”, “I am enthusiastic about my job”, “Time passes quickly when I am working”, and “I am able to make improvements happen in my area of work”.
- “Time passes quickly when I am working” has seen the biggest increase this month, this is the first time that this question has been above the 2018 National Average since February 2019.
- Overall the results show a decrease in a number of areas which will be reviewed again next month to determine if a trend is developing so we can take the appropriate action.

Our People - Improving Staff Engagement (continued)

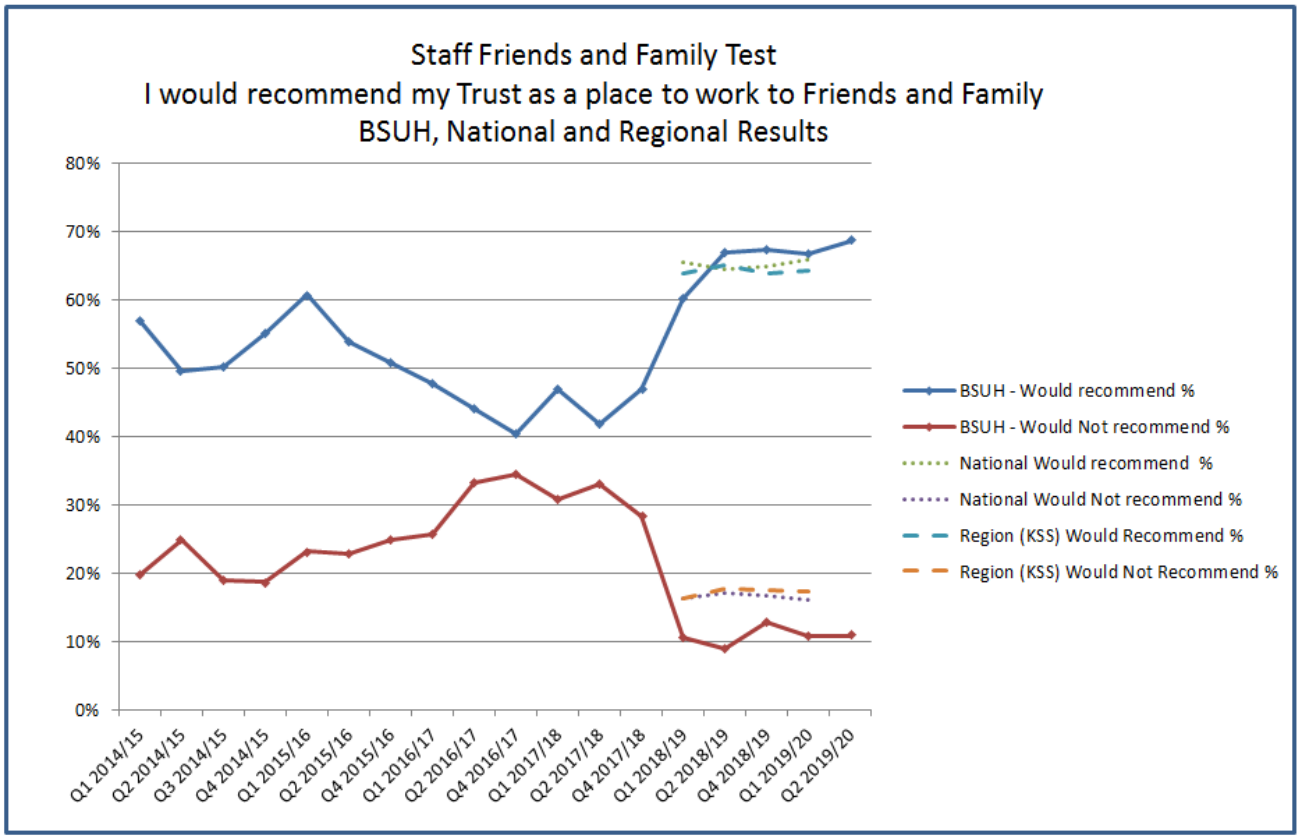
People

Staff Engagement
Target: Top 20% Engagement Score

Breakthrough Objective

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 changed in July 2019 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 target.

The Staff Friends and Family Test takes place on a quarterly basis using data from the BSUH monthly pulse survey and Annual NHS Staff Survey. The latest data shows the following results.



- The graph shows a positive upward trend in number of BSUH staff recommending the Trust as place to work and a positive downward trend in staff not recommending the BSUH as a place to work.
- Latest results submitted for the period June – September 2019 shows the highest recorded number of staff recommending the Trust as a place to work.
- Data show BSUH scoring more positively on both recommending and not recommending the Trust when compared to available national and regional results.

Our People - Improving Staff Engagement (continued)

People

Staff Engagement
Target: Top 20% Engagement Score

2019 Staff Survey

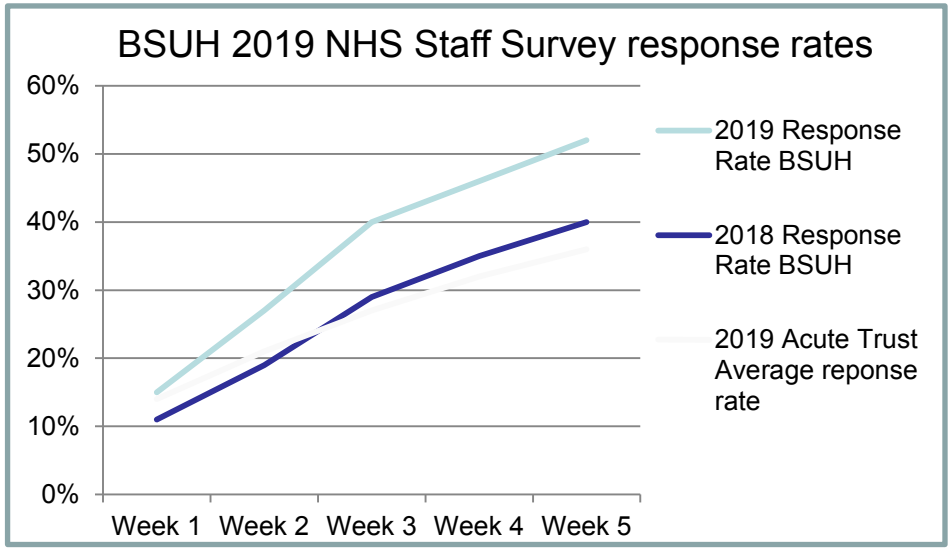
The Trust has run the NHS Staff Survey for all Trust employees since 2016 (previous only a sample of staff were surveyed). Participation has increased from under 40% in 2016 to 59.1% in 2018.

The NHS staff survey opened on 3rd October for 8 weeks until 30th November 2019. Initial results will be available between December 2019 and January 2020, with National results being available in February 2020, exact dates to be confirmed by the Survey coordination centre shortly.

BSUH have chosen a mixed mode survey for the 8400 staff, split between paper and electronic surveys. A total of 50 Staff Survey Champions have been identified by Divisions to coordinate roll out for their areas with support from Divisional leads and HR Business Partners.

Participation updates are communicated weekly to Trust and Divisional Leads and Champions. Response rates to date indicate higher a participation rate week on week compared to last year. The Trust is consistently above the average acute Trust participation score.

A comprehensive communication plan started September 2019 with key messages delivered by the Trust Brief, via Workplace, BUZZ and Chief Executives Message, with Trust and Divisional achievement stories communicated along the way.



Our People

People
Staff Engagement Target: Top 20% Engagement Score

Key Actions

- **Leadership Culture and Workforce programme**
- **Extensive Health and Well being initiatives**
- **Fortnightly recruitment campaigns**
- **Inclusion programme**
- **Improved communication including Workplace**
- **New leadership development Programmes**

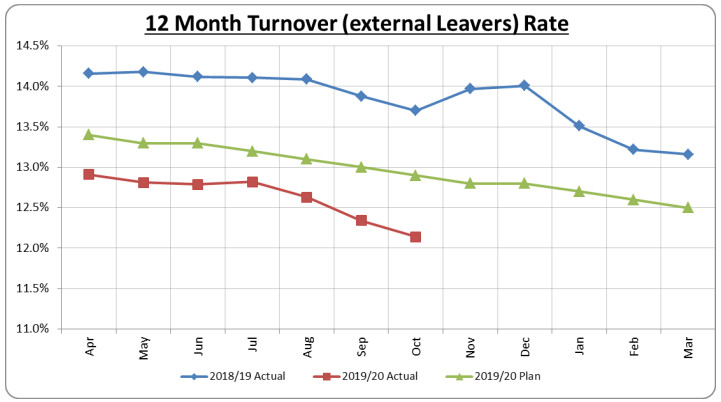
Our People - Capacity and Capability

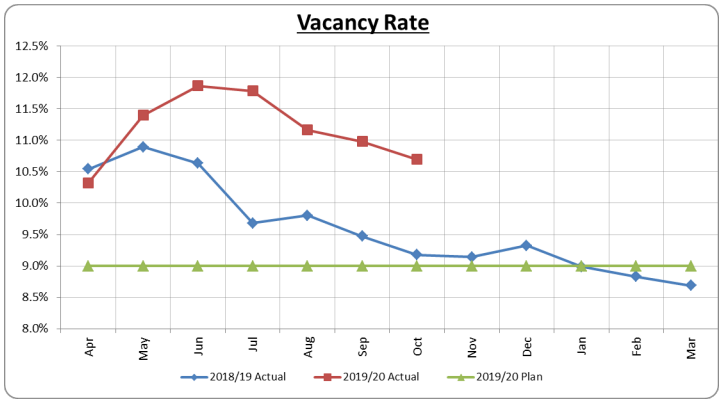
In M7, overall workforce spend was £33.35m against a plan of £33.11m,Year To Date workforce spend is overspent by £994k against a plan of £233.4m. Medical is the key driver of this YTD position with an overspend of £2.96m. The YTD position is partially mitigated by underspends in other staff groups.

		Last Month	This Month	Variance
Worked	wte	8,157	8,243	↑
% Worked to Budget (WTE)	%	95.51	96.30	↑
Temporary Workforce	%	10.16	9.36	↓
Agency	%	4.76	3.35	↓
Bank	%	5.40	6.01	↑

Agency expenditure in October was £1.12m (3.4% of the total pay bill) , exceeding the agency ceiling target by £0.15m in-month (£1.49m year-to-date). The Trust is forecasting to exceed the target at year-end by an estimated £2.0m.

Our People – Key Metrics





Turnover: In October the Trust's Turnover (external leavers) rate continued the reductions seen since December 2018 and now stands at 12.1%, the lowest level achieved since February 2015. Turnover is also favourable to the 12.5% target set within the 2019/20 Operational Plan.

Vacancies: In October the Trust's overall vacancy rate stood at 10.7%, down from the recent high of 11.9% in June 2019, but still unfavourable to the 9.0% Trust Target. The Trust's Establishment WTE grew by another 20 WTE over the past month, and is now 276 WTE higher than it was in October 2018.

- **Improvement Focus:**

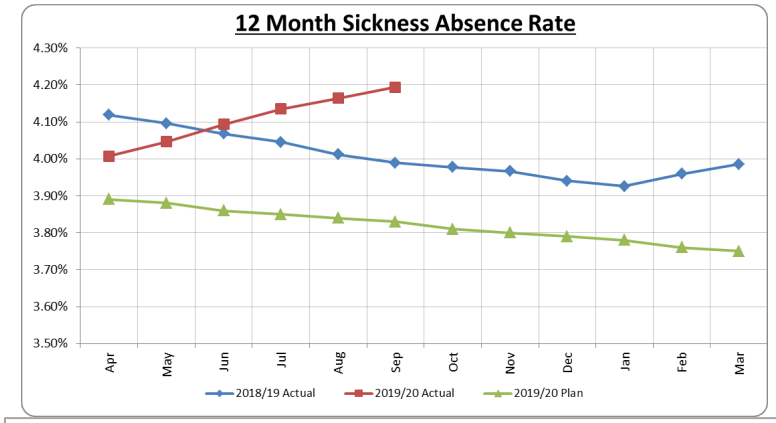
Divisions continue to review in detail their hot spot areas. Internal surveys, face to face exit interviews and engagement sessions have taken place or are planned to gather further intelligence. The output from these will be used to develop further improvement action plans. For example, the Surgery Division have a high number of Health Care Assistants who leave the Digestive Diseases ward and have held staff focus groups to identify the specific issues that need to be addressed. The A&E Department has reduced turnover by 2% by actions including providing additional educational support, review of rotas & amending night shift patterns, introducing an enhanced bank rate and an improved, supportive focus on sickness absence management.

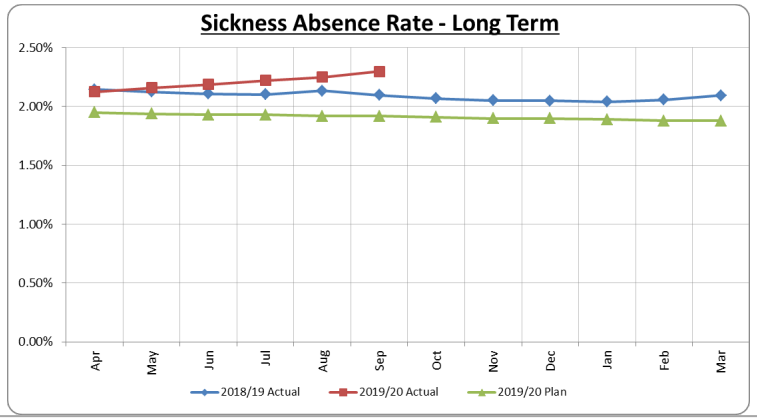
- **Improvement Focus:**

Rotas in all Clinical Divisions have been reviewed to identify opportunities to recruit a flexible nursing workforce at all levels. The Divisions continue to run rolling recruitment days to attract nursing staff. An internal transfer process is being introduced to make it easier for nurses to move from one area to another.

The Surgery Division have advertised for specialist Gastrointestinal Nurses to encourage additional interest and the Medicine Division continue to look at alternative ways to attract nurses to A&E such as recruiting from the armed forces.

Our People – Key Metrics





Sickness: The Trust's 12 month sickness absence rate continues the upwards trend seen in recent months, and now stands at 4.19% (Sep 19). When absence is split short term / long term it can clearly be seen that growth across 2019 is due to an increase in long term sickness absence, which has grown from 2.09% in September 2018 to the current 2.30%.

Improvement Focus:

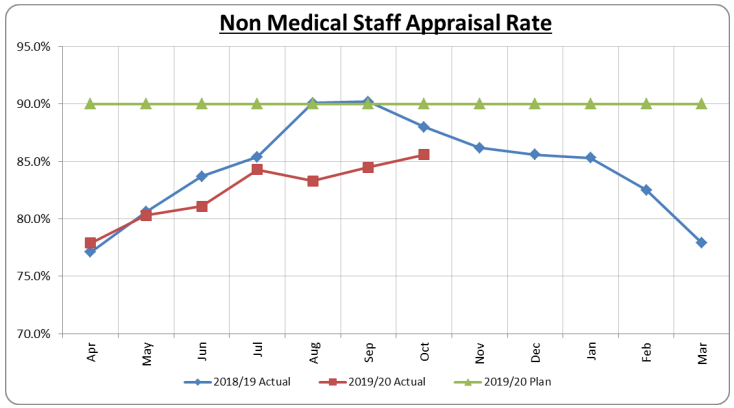
Forensic analysis of the data and hotspots is undertaken to triangulate information and reviewed monthly to understand the underlying causes of sickness by care centre and identify any actions which could be taken. Influencing factors include areas with high vacancy rates, reviews of working patterns due to on call requirements as well as preventative actions for MSK and manual handling issues.

220 managers have attended the workshops providing information and guidance on the new Health, Wellbeing and Attendance Policy since its implementation in July 2019. The frequency of the Health, Wellbeing and Attendance workshops has been increased across both sites for the rest of the year to meet demand and to ensure that managers feel confident in managing the sickness absence of their staff in line with the new policy.

Managers across the Trust continue to be supported by members of the Employee Relations team in analysing and reviewing the management of the sickness absence in their teams, considering additional health and wellbeing initiatives that may be of assistance and ensuring plans are in place for all individuals in line with Trust policy.

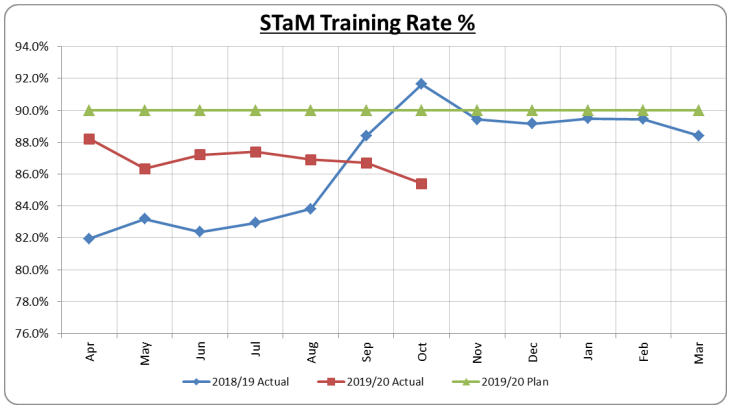
There is a drive to improve the accuracy in reporting the reason for sickness absence and reduce the amount of sickness absence recorded as "Unknown causes /not specified" across the Trust so that more focused initiatives can be implemented to support departments.

Our People – Key Metrics



The Trust's Appraisal rate increased to 85.6% in October, the highest rate achieved since November 2018. While still below the target rate of 90% and below October 2018 when the Appraisal rate stood at 88.0%, the current rate is still the fourth best since records began

Improvement Focus - Appraisal:
The new Appraisal and Pay Progression Policies have been launched, together with an updated appraisal form and guidance. Launch sessions are being held during November and December to provide managers and staff with an overview of the changes and the link between the annual appraisal and pay progression.
Improving the quality of appraisals remains a key focus as part of the Staff Survey Engagement Action Plans developed from last year's Annual Staff Survey Results, as well as ongoing work to increase the number of appraisals completed to reach the Trust target of 90%. A targeted approach led to two Divisions (Medicine and Facilities and Estates) showing significant improvement to 89% in October (3% and 6% increases respectively).



The Statutory and Mandatory (STAM) compliance rate for October is 85.4%. This figure is down 1.3% from September 2019 and 6.2% below October 2018.

Improvement Focus - STAM:
The Divisions receive detailed reports each month to identify the topics and the staff who need to be trained. Managers are responsible for checking that all training is up to date as part of the appraisal process, and for releasing staff to attend face to face sessions or given time to complete online modules where appropriate.
STAM compliance is discussed at Safety Huddles, team meetings and Divisional management meetings as well as Trust Performance Reviews with the Executive Team.
Managers are asked for detailed plans to reach the required compliance level of 90% on a monthly basis.

Brighton and Sussex University Hospitals NHS Trust

Agenda Item:	12	**Meeting:**	Board	**Meeting Date:**	27 Nov 2019
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 –Q3 scheduled to be presented on the 3 December 2019 QAC – 26 November 2019 F&P – 26 November 2019				

Purpose of the report:			
Information	☐	Assurance	✓
Review and Discussion	☐	Approval / Agreement	✓
Reason for submission to Trust Board in Private only (where relevant):			
Commercial confidentiality	✓	Staff confidentiality	☐
Patient confidentiality	☐	Other exceptional circumstances	☐
Link to Trust Strategic Themes:			
Patient Care	✓	Sustainability	✓
Our People	✓	Quality	✓
Systems and Partnerships	✓		

Any implications for:	
Quality	Quality related strategic risks
Financial	Finance related strategic risks
Workforce	Workforce related strategic risks

Link to CQC Domains:			
Safe	✓	Effective	✓
Caring	✓	Responsive	✓
Well-led	✓	Use of Resources	✓

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

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.

For quarter 3 at 17 November there have been two changes from the Q2 assessed scores. These changes have seen risk 2.2 increase and risk 5.1 reduce to its target score.

BAF SUMMARY

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.

The table also shows pictorially the movement in risk between the current score for Q3 and that recorded for Q1. (⟷ No change, ↑ an increase in risk and ↓ 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** ⟷	3	3	**9** ⟷	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** ⟷	4	4	**16** ⟷	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** ⟷	4	4	**16** ↑	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** ⟷	4	3	**12** ⟷	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** ⟷	4	3	**12** ⟷	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** ⟷	4	3	**12** ⟷	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** ⟷	4	3	**12** ⟷	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** ⟷	3	4	**12** ⟷	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** ↔	3	3	**9** ↓	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	3	**12** ↔	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 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 however, did recognise the increase in demand as a pressure on risks 2.1, 2.2 and 5.3 in relation to the Trust's ability to flex its resources and meet it strategic and operational plans alongside the delivery of the Trust's operational targets. The Committee also recognised the need for the recovery plans to deliver the agreed performance improvement before the risk should be reduced. The Committee did refer to the Quality Assurance Committee the review of waits on the quality risks and received as stated above assurance that the long waits were not increasing the quality risks.

The Committee has also recognised the pressure within the wider system which could increase the risk in relation to strategic risk 5.1.

The BAF reflects an increase in the current risk score for 2.2. In respect of risk 2.2 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 for October and November and include information on planned mitigations and the delivery of which will be tracked within the routine reports to Finance and Performance Committee. .

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, 3.2 and 3.3 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.

Trust Executive Committee

The Trust Executive Committee considers the BAF alongside the highly scored divisional / corporate risks. The Committee has not identified any increasing divisional / corporate 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.

NHS
Brighton and Sussex University Hospitals
NHS Trust

Agenda Item:	13	**Meeting:**	Trust Public Board	**Meeting Date:**	27/11/19
Report Title:	Palliative & End of Life Care				
Sponsoring Executive Director:		Carolyn Morrice, Chief Nurse			
Author(s):		Claire Williams			
Report previously considered by and date:					
Purpose of the report:					
Information		✓	Assurance		✓
Review and Discussion		✓	Approval / Agreement		☐
Reason for submission to Trust Board in Private only (where relevant):					
Commercial confidentiality		☐	Staff confidentiality		☐
Patient confidentiality		☐	Other exceptional circumstances		☐
Link to Trust Strategic Themes:					
Patient Care		✓	Sustainability		☐
Our People		☐	Quality		✓
Systems and Partnerships		☐			
Any implications for:					
Quality					
Financial					
Workforce					
Link to CQC Domains:					
Safe		☐	Effective		☐
Caring		☐	Responsive		☐
Well-led		☐	Use of Resources		☐
Communication and Consultation:					
Executive Summary:					
To review and receive assurance of the Palliative & End of Life Care Service.					
Key Recommendation(s):					
To receive assurance over application of patient first processes.					

Brighton and Sussex University Hospitals NHS Trust

Palliative & End of Life Care

Welcome to our services

Dr Ollie Minton
Lead Clinician Palliative Medicine

Steve Bass
Lead Clinical Nurse Palliative & EOLC

Aligned to CCS Division

Who we are:

The core members of the Specialist Palliative CareTeam [SPCT] are:

- Lead Nurse Palliative and EOLC
- 4 Consultants in Palliative Medicine (1.85 Whole Time Equivalent [WTE])
- 5 Clinical Nurse Specialists (total 4.6 WTE)
- 2 Palliative Care Support Workers (2 WTE)
- 2 Palliative Care Occupational Therapists (1.8 WTE)
- Clinical Fellow
- Core Medical Trainee

The strategic management for the SPCT across the BSUH and liaison with the local health economy is provided by the Lead Clinician and Lead Nurse (supported by the Trust Lead Cancer Nurse).

Background

- The Specialist Palliative Care Team Operational Policy:

  Our ambition is to improve the quality of living and dying of patients with advanced cancer and other advanced life limiting diseases and their carers through the provision of multi-disciplinary:

  - Specialist assessments and advice on the management of complex physical symptoms, psychological distress, spiritual issues, family and carer distress, social, and financial issues
  - Advice to health care staff in Brighton and Sussex University Hospitals NHS Trust
  - Formal and informal education

- We have established an integrated service model for palliative and end of life care across BSUH.

Palliative & End of Life Care 2017: GOOD

- **The specialist palliative care team is not funded to provide the recommended 7 day service. This limits 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.**
- **We our pursuing plans to scope and develop an Enhanced Supportive Care Team to work alongside the Acute Floor.**

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Good	Good	Inadequate	Requires improvement	Requires improvement
Medical care	Inadequate	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Surgery	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement
Critical care	Inadequate	Requires improvement	Good	Requires improvement	Inadequate	Inadequate
Maternity and gynaecology	Requires improvement	Good	Good	Good	Good	Good
Services for children and young people	Good	☆ Outstanding	☆ Outstanding	Good	Good	☆ Outstanding
End of life care	Good	Requires improvement	Good	Good	Good	Good
Outpatients and diagnostic imaging	Requires improvement	N/A	Good	Requires improvement	Requires improvement	Requires improvement
Overall	Inadequate	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

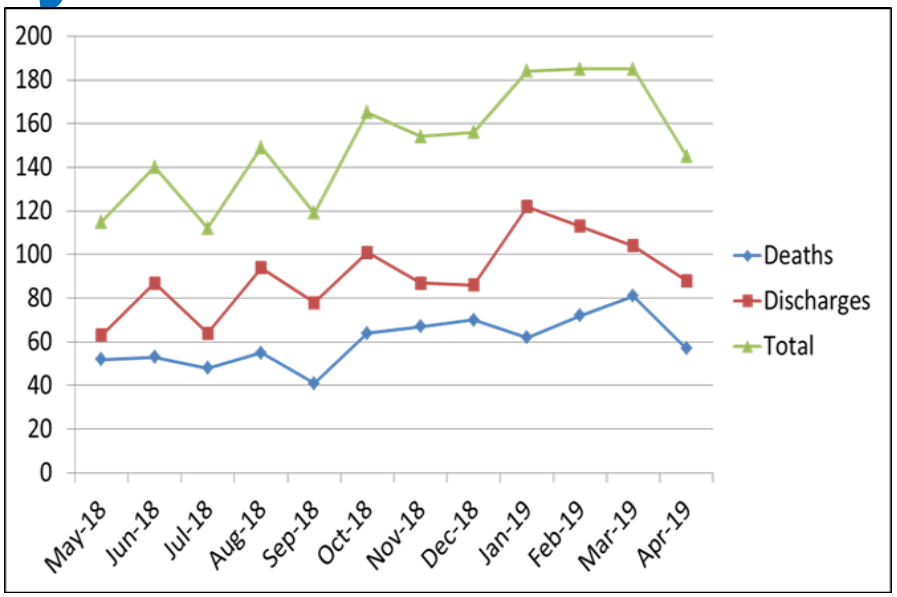
Notes

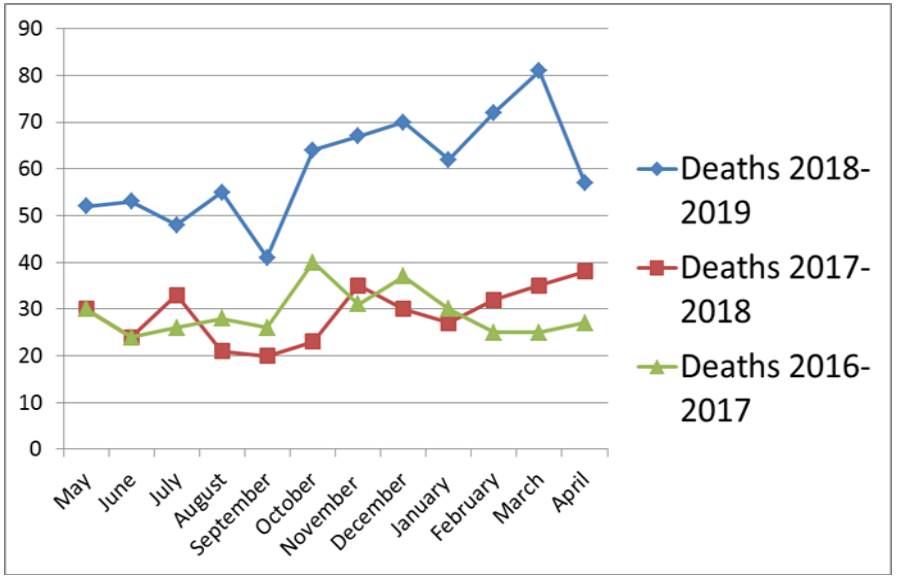
The ratings for children and young people's services and end of life care are from our inspection in April 2016. We did not inspect these core services on this occasion.

SPCT increased activity 2018-2019

- SPCT reviewed 1809 patients in 2019 [Approximately 50% increase].
- 1087 were discharged
- 722 patients who died across BSUH were reviewed by SPCT [22% increase on previous years]
- This is still only 47% of all deaths across the trust

"1 in 3 Patients in Hospital are believed to be living in the last year of life"

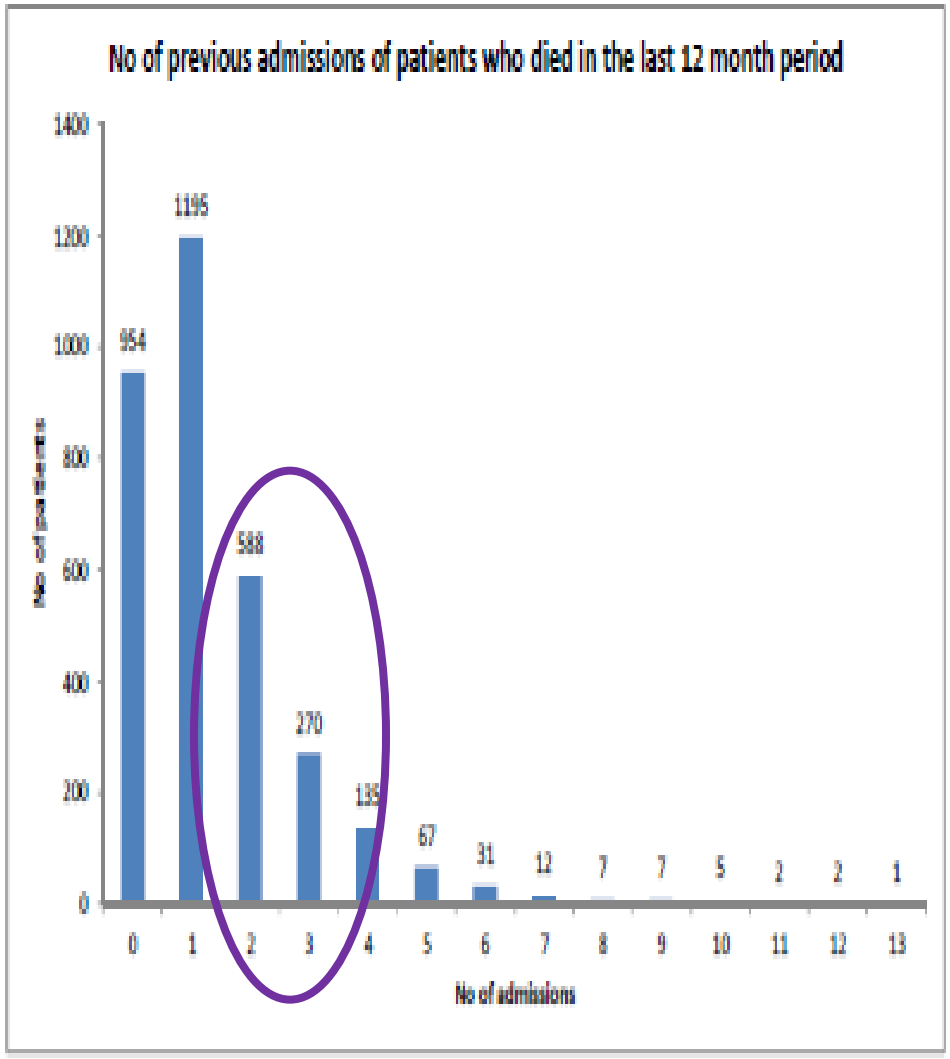




Conveyance & Admission avoidance DATA

Our relationship with SECAMB :

- Over 100 care plans made
- Highlight : 22% V 60% Conveyance

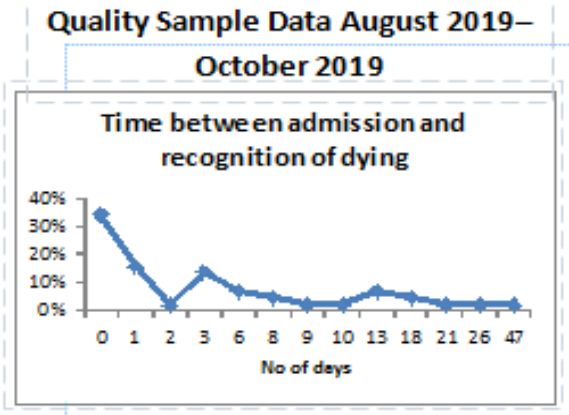


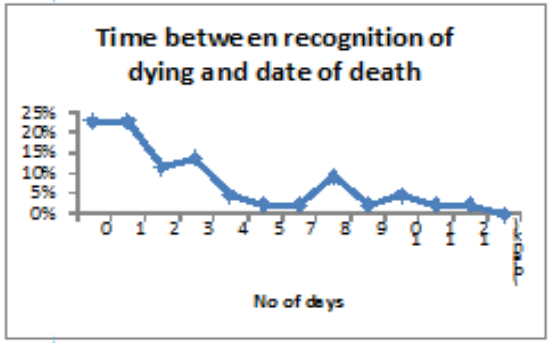
BSUH End of Life Care Steering Group:

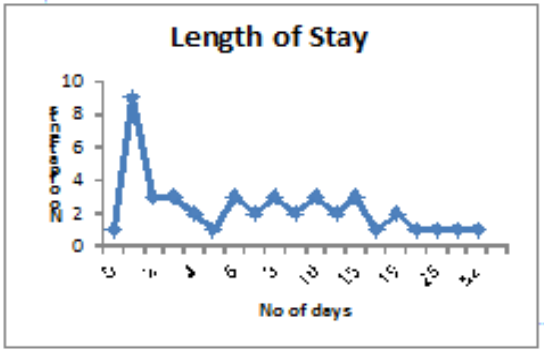
- Our EOLCSG now includes:
  - NED, Divisional Representation, Ward Staff, Quality and Safety team & Health Watch.

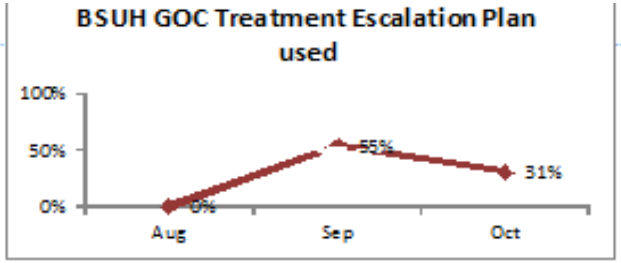
- We collaborate with the:
  - Deteriorating Patient steering Group [DPSG],
  - Trust Mortality Review Group [TMRG]
  - Dementia Steering Group

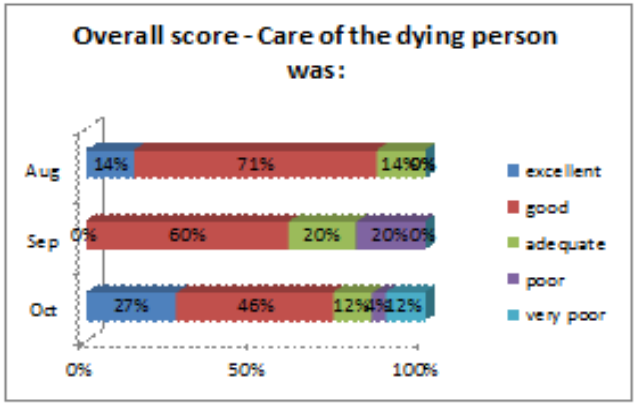
BSUH EOLC Dashboard

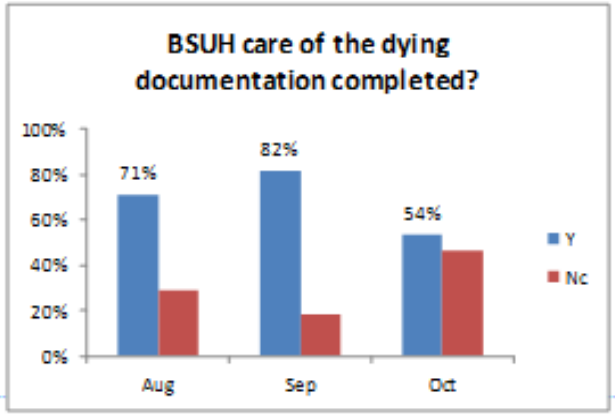


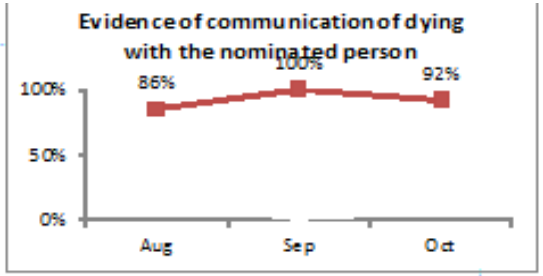


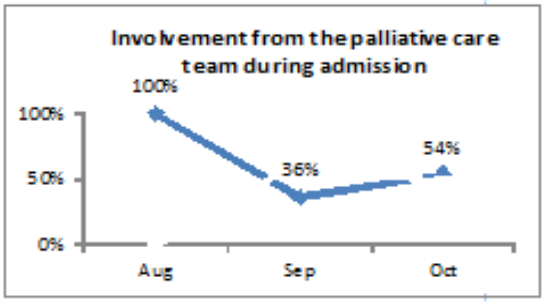


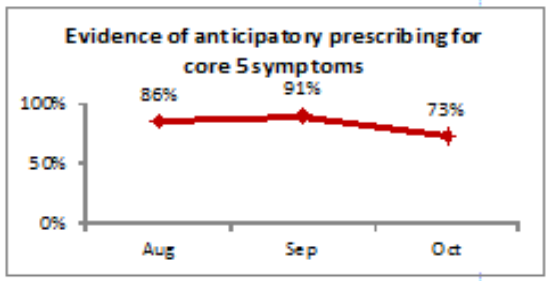


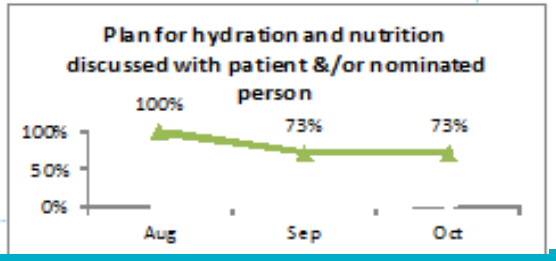










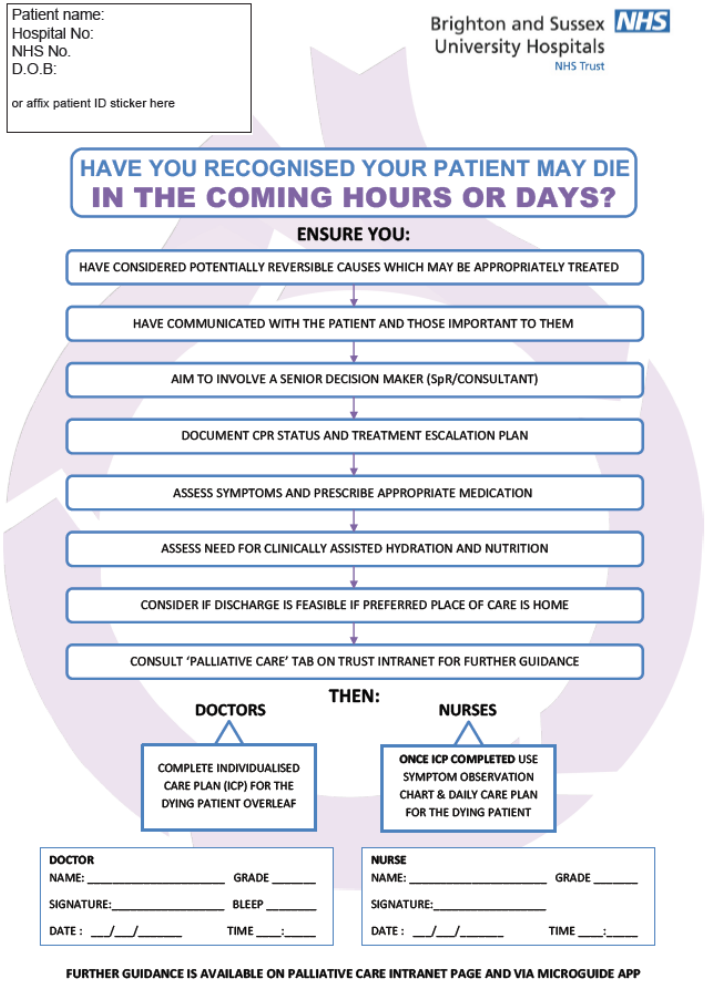


Plaudits, Complaints, FFT and Datix

"The staff on Jowers Ward were wonderful. I arrived to visit my mother (unannounced). No-one knew I was coming to see her & three members of staff were in her room - one holding her hand, one talking to her & one attending to everything else. They said they were taking it in turns just in case she passed. They didn't want her to die alone. Just above and beyond what nurses are paid to do. Wonderful people all of them."

We are proud of: BSUH Individualised Care Plan for a Dying Person

- Working with our Junior Drs and EOLC Link Network to develop and introduce the BSUH Care Plan for a Dying Person



Patient name:
Hospital No:
NHS No.
D.O.B:

or affix patient ID sticker here

Brighton and Sussex NHS
University Hospitals
NHS Trust

HAVE YOU RECOGNISED YOUR PATIENT MAY DIE IN THE COMING HOURS OR DAYS?

ENSURE YOU:

- HAVE CONSIDERED POTENTIALLY REVERSIBLE CAUSES WHICH MAY BE APPROPRIATELY TREATED
- HAVE COMMUNICATED WITH THE PATIENT AND THOSE IMPORTANT TO THEM
- AIM TO INVOLVE A SENIOR DECISION MAKER (SpR/CONSULTANT)
- DOCUMENT CPR STATUS AND TREATMENT ESCALATION PLAN
- ASSESS SYMPTOMS AND PRESCRIBE APPROPRIATE MEDICATION
- ASSESS NEED FOR CLINICALLY ASSISTED HYDRATION AND NUTRITION
- CONSIDER IF DISCHARGE IS FEASIBLE IF PREFERRED PLACE OF CARE IS HOME
- CONSULT 'PALLIATIVE CARE' TAB ON TRUST INTRANET FOR FURTHER GUIDANCE

THEN:

DOCTORS

COMPLETE INDIVIDUALISED CARE PLAN (ICP) FOR THE DYING PATIENT OVERLEAF

NURSES

ONCE ICP COMPLETED USE SYMPTOM OBSERVATION CHART & DAILY CARE PLAN FOR THE DYING PATIENT

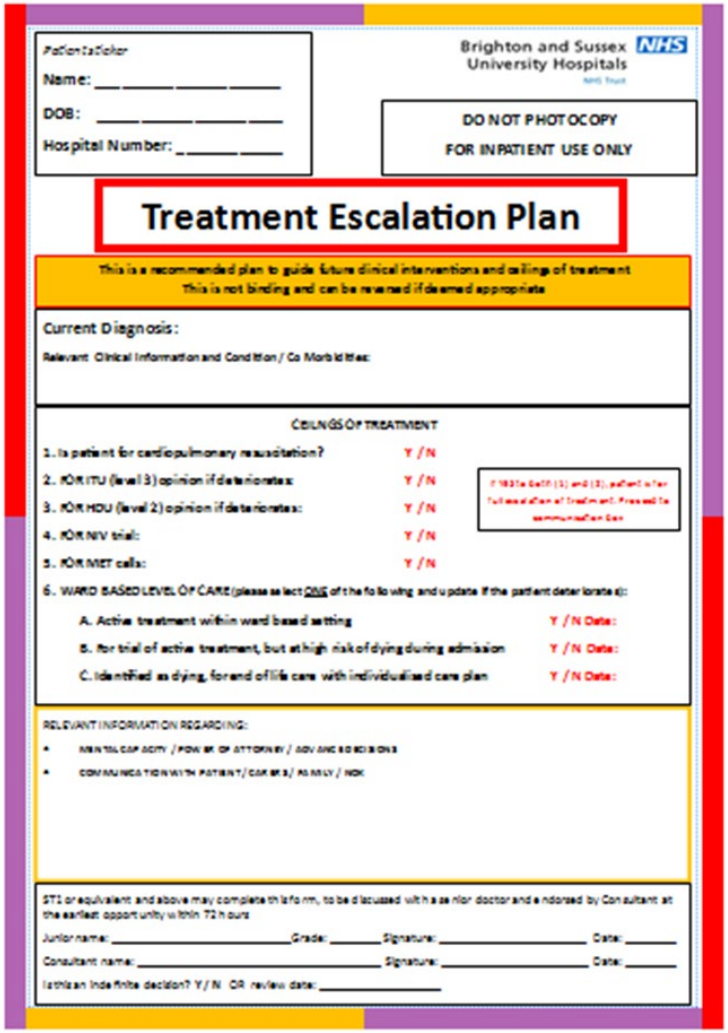
DOCTOR
NAME: _____ GRADE _____
SIGNATURE: _____ BLEEP _____
DATE : __/__/_____ TIME ___:___

NURSE
NAME: _____ GRADE _____
SIGNATURE: _____
DATE : __/__/_____ TIME ___:___

FURTHER GUIDANCE IS AVAILABLE ON PALLIATIVE CARE INTRANET PAGE AND VIA MICROGUIDE APP

We are proud of: Our work with the DPSG

- BSUH True North Objective: Reducing avoidable death and harm.
- There is variation in escalation processes and procedures across BSUH in identifying and responding to the deteriorating patient
- We have designed a Treatment Escalation Plan that is now being piloted across BSUH with positive feedback
- We have been instrumental in lobbying for a Sussex **ReSPECT** Collaborative, that is now a KSS wide project



Patient sticker

Name: _____

DOB: _____

Hospital Number: _____

Brighton and Sussex University Hospitals NHS

DO NOT PHOTOCOPY

FOR INPATIENT USE ONLY

Treatment Escalation Plan

This is a recommended plan to guide future clinical interventions and ceilings of treatment
This is not binding and can be reversed if deemed appropriate

Current Diagnosis:

Relevant Clinical Information and Condition / Co Morbidities:

CEILINGS OF TREATMENT

1. Is patient for cardiopulmonary resuscitation? Y / N
2. FOR ITU (level 3) opinion if deteriorates: Y / N
3. FOR HDU (level 2) opinion if deteriorates: Y / N
4. FOR NIV trial: Y / N
5. FOR MET calls: Y / N

If YES to both (1) and (2), patient is for full escalation of treatment. Proceed to communication box

6. WARD BASED LEVEL OF CARE (please select ONE of the following and update if the patient deteriorates):
   - A. Active treatment within ward based setting Y / N Date:
   - B. For trial of active treatment, but at high risk of dying during admission Y / N Date:
   - C. Identified as dying, for end of life care with individualised care plan Y / N Date:

RELEVANT INFORMATION REGARDING:

- MENTAL CAPACITY / POWER OF ATTORNEY / ADVANCE DECISIONS
- COMMUNICATION WITH PATIENT / CARERS / FAMILY / NOK

ST1 or equivalent and above may complete this form, to be discussed with a senior doctor and endorsed by Consultant at the earliest opportunity within 72 hours

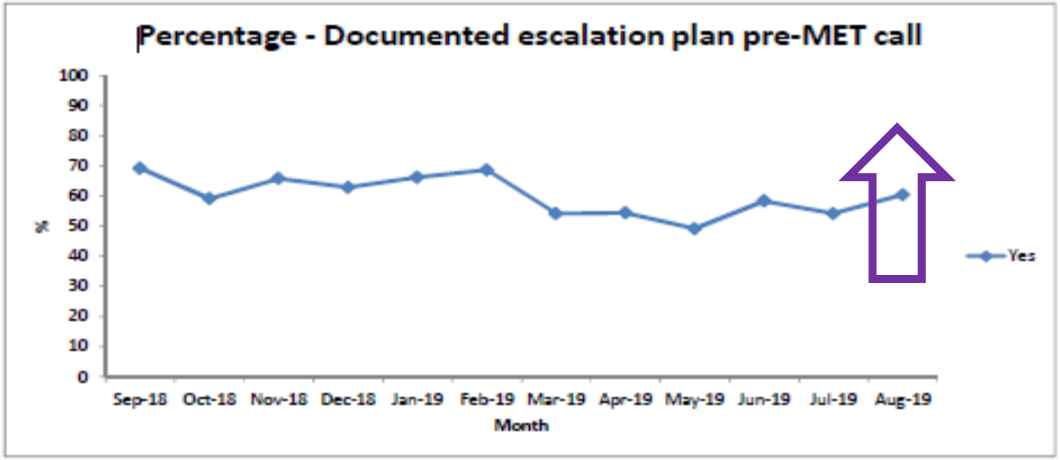
Junior name: _____ Grade: _____ Signature: _____ Date: _____

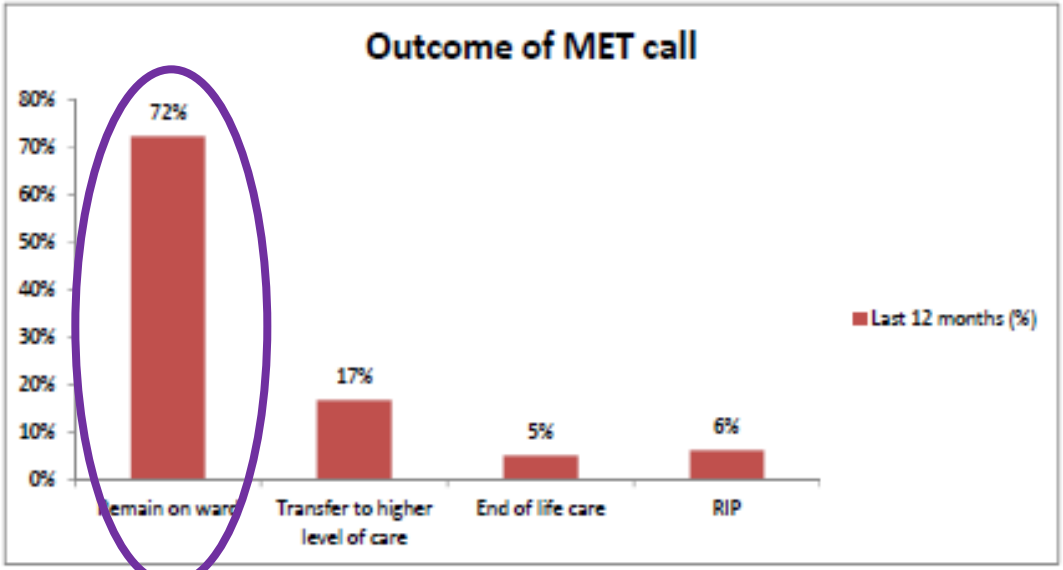
Consultant name: _____ Signature: _____ Date: _____

Is this an indefinite decision? Y / N OR review date: _____

Met Call Data

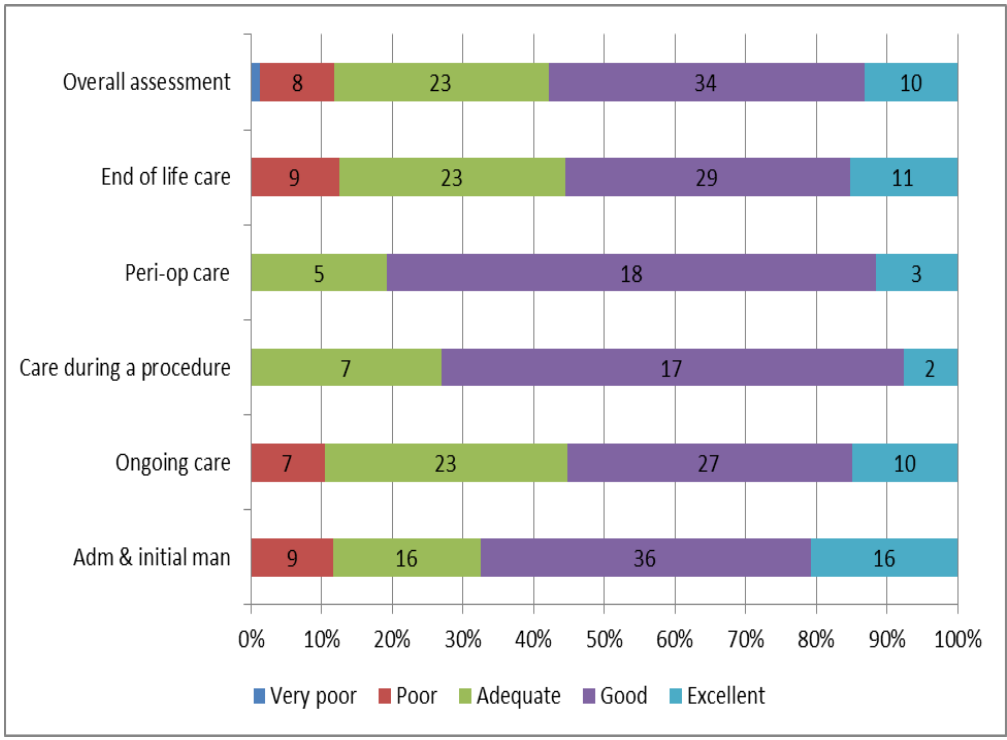
- Develop Metcall Metric aligned to post Met-call debriefs



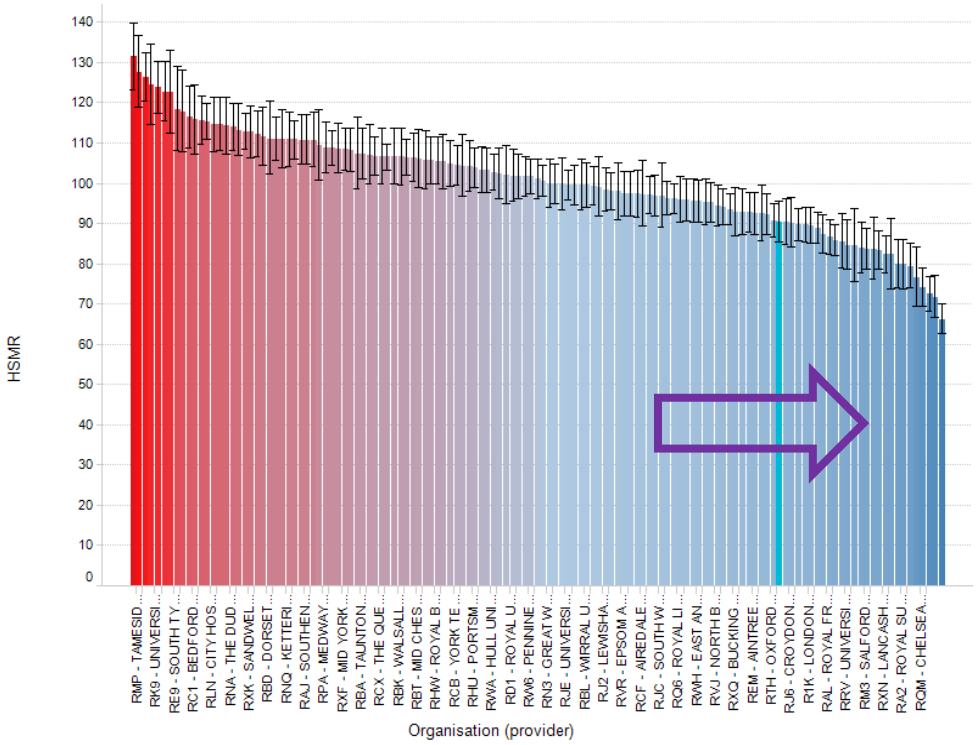


We are proud of: Our work with TMRG

- Royal College of Physicians: Learning from Death through Structured Judgment Reviews
- SPCT Leads deliver majority of SJR training for BSUH
- SJR Friday Clinic: pilot to bring trained staff together on the last Friday of the month to undertake SJRs. Aim is to improve confidence & ability to undertake SJRs, share learning and ensure MDT input
- Working with the Mortality Lead for Intensive Care, the Lead Clinical Nurse for Palliative and EOLC along with a Clinical Fellow, plan to review best practice in M&M meetings.



Activity & impact on HSMR



HSMR	Obs. - Exp	Comorbidity score per super-spell	Crude rate (%)	Palliative care per 1,000 super-spells
90.42	-134.25	4.76	3.62%	32.46

What we are doing: Patient Experience

- Collaborating with the BSUH Small Acts of Friendship Charity:
  - Developing Friendship Bags for those important to a person at the bedside of a dying person
  - Developing Bereavement Bags to collect a persons belongings with a recognisable image
  - Planning ‘Swan Rooms’ with CoTE
  - Memory Boxes for bereaved young children
  - Memory Prints for Sudden Deaths in ED
  - ‘Book Box’ mobile resource to help explain serious illness to children

Integrating our training into the BSUH Education Strategy, BSMS and Brighton University

- Establishing a training programme to highlight the NHSE 5 Priorities for caring for a dying person
- Sage & Thyme: Communication skills training
- EOLC Study Day
- Stat/Man Study Day: Introduction to Palliative & EOLC
- Preceptorship Programme
- Health Care Cert: Person Centered Caring @ the end of life
- F1/2 & CMT Training: Shared Decision Making, Early Recognition of Palliative and Supportive Care Needs in the acute setting
- “What is the Goal of Care Study Day”
- Care After Death & Verification of Death Competency for Clinical Site Managers

“All have been well evaluated”

We are proud of: Our links with Brighton Medical School and Brighton University

- Palliative Care Consultant oversees an extensive programme of EOLC Teaching and communication skills training
- Preparation for Clinical Practice prior to first job as a Junior Dr
- Oncology/Palliative Care module placements for Post graduate degrees
- Student RNs [in house & at university]

“All have been well evaluated”

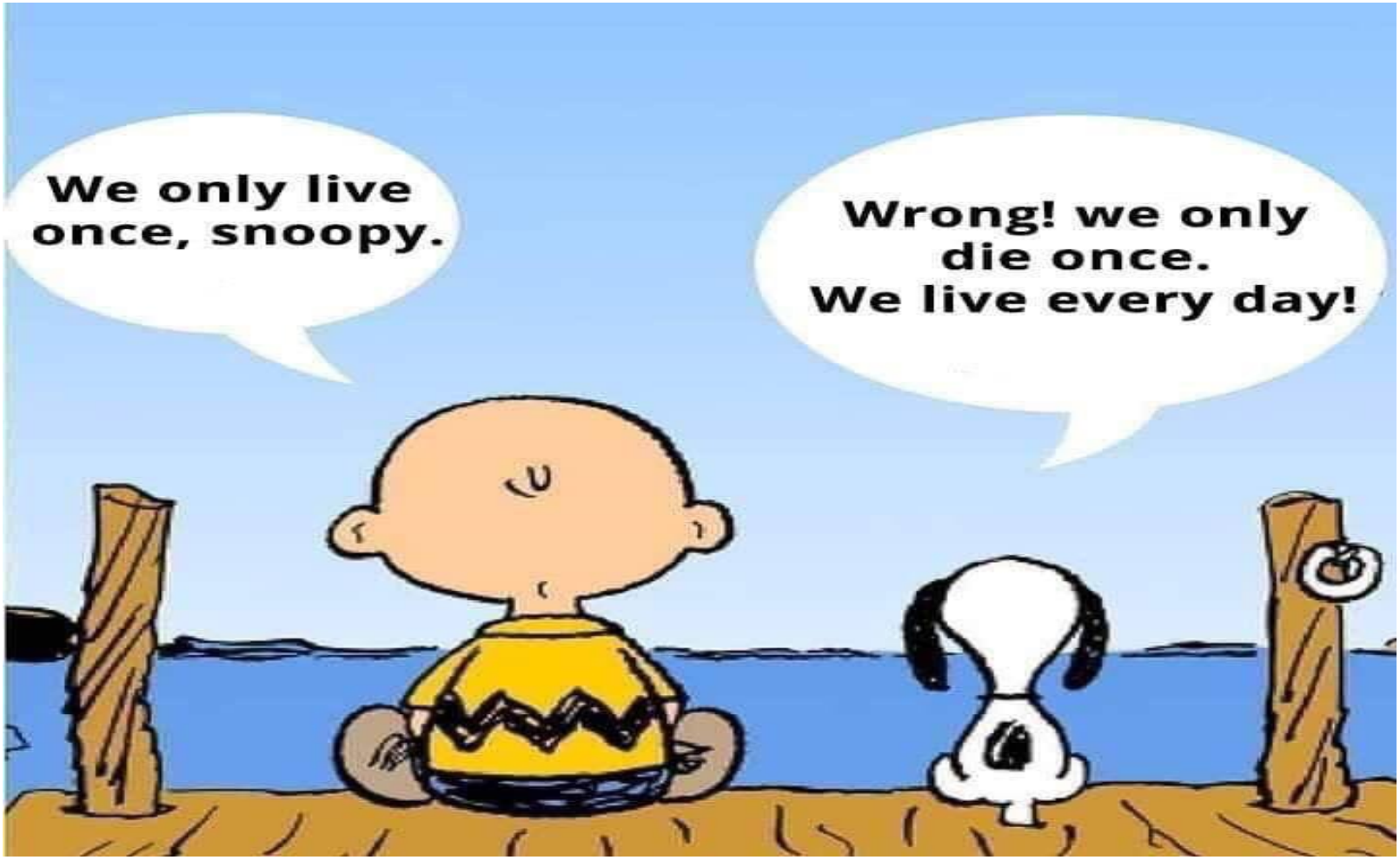
We are challenged by:

- Patient Experience when a person is dying or has died in an acute hospital
- Environment: Side Rooms/Bereavement Offices
- No SPCT 7/7 service
- Under Resourced SPCT : Palliative Care Tariff

Patient First: Our Approach

- Continuous Improvement:
  - SPCT 7/7
  - Provide expertise to a greater % of dying patients
  - RCP Learning from Death: Medical Examiner and M&M
  - Enhanced Supportive Care Project
  - Ongoing data collection
  - Patient feedback to support QI projects

"How people die remains in the memory of those who live on"



Brighton and Sussex University Hospitals NHS Trust

Agenda Item:	14	**Meeting:**	Trust Board	**Meeting Date:**	November 2019
Report Title:	Flu Vaccination Campaign Update				
Sponsoring Executive Director:	Carolyn Morrice, Chief Nurse				
Author(s):	Clare Williams, Nurse Director				
Report previously considered by and date:					
Purpose of the report:					
Information		☐	Assurance		✓
Review and Discussion		☐	Approval / Agreement		☐
Reason for submission to Trust Board in Private only (where relevant):					
Commercial confidentiality		☐	Staff confidentiality		☐
Patient confidentiality		☐	Other exceptional circumstances		☐
Link to Trust Strategic Themes:					
Patient Care		✓	Sustainability		☐
Our People		✓	Quality		✓
Systems and Partnerships		☐			
Any implications for:					
Quality	Nothing to note				
Financial	Nothing to note				
Workforce	Nothing to note				
Link to CQC Domains:					
Safe		✓	Effective		☐
Caring		✓	Responsive		☐
Well-led		✓	Use of Resources		☐
Communication and Consultation:					
Communication Team actively involved in the flu Vaccination Campaign					
Executive Summary:					
The report provides the Trust Board with an update of the current Flu Vaccination campaign for 19/20 and an evaluation of the Flu Vaccination campaign for 18/19.					
Key Recommendation(s):					
The Committee is asked to note					

Flu vaccination campaign 2019/20 – summary plan (and 2018/19 evaluation)

1. Introduction

The Trust undertakes an annual staff flu vaccination programme and over the last 3 years this has been set against a national CQUIN target. The 2019 flu vaccination programme launched on Monday 7th October 2019 and will run until 28th February.

For 2019 the CQUIN target is for 80% of frontline staff to be vaccinated. In 2018 BSUH achieved a vaccination rate of 58% against a national target of 75%

2. Flu vaccination campaign 2018/19 – lessons learned.

The 2018/19 campaign did not achieve compliance against the national target and fell short by 17%. A review following the campaign highlighted 8 key areas for focus which are summarised below.

1. Increase number of Workplace vaccinators across the organisation.
2. Advance arrangements to ensure coverage for satellite areas (such as Hove Polyclinic and Brighton General Hospital).
3. Increased support for vaccinators, including enhanced information on vaccines and flu facts (utilising the national PHE materials and training).
4. Focus on staff wellbeing, and alignment to the Trust's wellbeing / people objective.
5. Focussed approach with a dedicated "push".
6. Dedicated coverage for night/weekend staff, and twilight roaming required.
7. Ensure sufficient materials for roaming vaccinators.
8. A Need for Drop in clinics at a variety of locations around the sites, rather than one base at each site.

3. Flu Vaccination campaign 2019/20

The 2019 programme launched on the 7th October 2019 and took into consideration the 8 identified areas to improve from 18/19. The improvements are listed below?

1. 100 local workplace vaccinators spread across RSCH/RACH/PRH/SEH, including a small team of roaming vaccinators.
2. All satellite areas have been contacted and advance arrangements in place.
3. Flu vaccinators have received training and have access to Flu facts leaflet
4. Flu vaccinators have received training on the importance of staff well being
5. Flu campaign focussed for 10 weeks October to December 2019
6. Staff have access to night, twilight and early morning vaccinators and roamers
7. New kit provided for roamers including vaccinator trolleys, sweets and stickers
8. Safety and quality team are a central point for all enquiries and organising sessions on request, a robust list of drop in clinical supported by OH. All clinic dates, list of vaccinators and roamers listed on the intranet

The Flu Vaccinator campaign 2019/20 has been overseen by a "Flu team" led by the Interim Chief Nurse (Nurse Director). The "Flu team" meet fortnightly and consist of representation from nursing, safety, communication, pharmacy and CQUIN lead.

The communication strategy builds of the success of last year utilising Workplace, Info-net, Buzz and Chief Executive Message. The Plan included:

- Executive team vaccination during the first week of the campaign, with a photo
- A series of internal articles around the reasons people reject the vaccination
- FAQ for vaccinators to address those same concerns and provide pertinent information about the benefits of vaccination
- Consistent posters, leaflets and messaging – "time to get your annual flu jab"
- Social media updates, including a flu jab selfie campaign and video "vox pops"
- Updated local clinic dates and times

The "Flu Team" provide weekly dashboard updates, reported to the executive team, NHSE/I and CCG. As of the 12th November the compliance is presented in table 1.

Table 1.

BSUH Flu Vaccination Campaign (as at 12th November 2019)		
Staff type	**Vaccinated (No of staff)**	**Vaccinated (%)**
Medical	546	46%
Nursing	1123	49%
Other professionally qualified	303	52%
Support to clinical staff	784	52%
Non-clinical	674	27%
Total (All)	3430	42%
Total (Frontline)	**2756**	**49%**

To gauge how well the messages are being received and establish the most prevalent reasons for flu vaccination decline, the 'reason for decline' will be collected on the flu vaccination decline form throughout the campaign. This will highlight the key reasons and help align communications activity to address them.

4. NHSE/1

In light of BSUH not achieving the national target in 18/19, the trust received a letter from NHSE/I dated 17th September setting out their ambition to increase uptake on the flu vaccinations across the NHS. Along with the letter, NHSE/I included a self-assessment checklist for Trusts to review and provide 'public assurance via trust boards", which has been undertaken (appendix 1)

The completed self-assessment form can be found in appendix 1.

7. Conclusion and Evaluation

In conclusion the success of the 19/20 Flu vaccination campaign will be reflected in the number of staff vaccinated, the campaign reflects the lesson learned from 18/19 and the trust ambition to deliver the baseline target of 80%, which ensures compliance with the Flu Vaccination CQUIN.

Following the 19/20 campaign an After Action Review (AAR) will take place following the campaign season, and a survey circulated to workplace vaccinators to inform future campaigns.

Appendix 1 – Self – assessment

A	Committed Leadership	Compliance	Comments
A1	Board record commitment to achieving the ambition of 100% of front line healthcare workers being vaccinated, and for any healthcare worker who decides on the balance of evidence and personal circumstance against getting the vaccine should anonymously mark their reason for doing so.		Full communication campaign sharing Trust commitment to offering the flu vaccine to all staff. Process in place for collection of 'declines' data
A2	Trust has ordered and provided the quadrivalent (QIV) flu vaccine for healthcare workers.		Stocks of quadrivalent (and Trivalent for staff aged 65+) ordered and arrived.
A3	Board receive an evaluation of the flu programme 2018/19, including data, successes, challenges and lessons learnt.		Board Paper to be presented November 2019.
A4	Agree on a board champion for flu campaign.		Interim Chief Nurse. Now Chief Nurse.
A5	All board members receive flu vaccination and publicise this		Completed and publicised in social media during launch.
A6	Flu team formed with representatives from all directorates, staff groups and trade union representatives.		Flu team set up chaired by the Interim Chief Nurse (Nurse Director) consists of nursing, doctors, AHP, Communications and S&Q representatives. Vaccinator team covers all divisions and receive regular communication.
A7	Flu team to meet regularly from September 2019		Weekly phone huddles in place. Flu team meet regularly every other week.
B	**Communications Plan**	**Compliance**	**Comments**
B1	Rationale for the flu vaccination programme and facts to be published – sponsored by senior clinical leaders and trades unions		Facts & Myths leaflet written with information on the info-net.
B2	Drop in clinics and mobile vaccination schedule to be published electronically, on social media and on paper		Drop in clinics are electronically published - mobile vaccination schedule is shared with relevant managers on a one to one basis
B3	Board and senior managers having their vaccinations to be publicised		Completed and publicised in social media, including photos and “vox-pops”
B4	Flu vaccination programme and access to vaccination on induction programmes		All Trust Inductions covered by PD team
B5	Programme to be publicised on screensavers, posters and social media		Communication campaign includes posters and social media. Screensaver in plan
B6	Weekly feedback on % uptake for directorates, teams and professional groups		Weekly update provided at staff group level to Exec/NHS E and CCG
C	**Flexible accessibility**	**Compliance**	**Notes**
C1	Peer Vaccinators, ideally at least one in each clinical area to be identified, trained, released to vaccinate and empowered.		100 workplace vaccinators including 20 roamers in place.
C2	Schedule for easy access drop in clinics agreed		All publicised on the info-net
C3	Schedule for 24 hour mobile vaccinators to be agreed		Several vaccinators work nights & planned twilight/early morning sessions in place.
D	**Incentives**	**Compliance**	**Notes**
D1	Board to agree on incentives and how to publicise		Vaccinators provided with sweets and stickers for staff. Thank you lunch planned for vaccinators in December
D2	Success to be celebrated weekly		Regular updates in Buzz and weekly messages and shared on workplace.

Brighton & Sussex University Hospitals Trust

Winter Plan 2019/20

Brighton and Sussex University Hospitals NHS Trust

Section 1 Introduction & Context

- All Trusts required to submit a Winter Plan that will form part of the System Winter Plan
- Internal and external assurance that the Trust has robust plans in place to manage increased demand over winter
- The number of stranded (LLoS) patients has increased alongside an increase in ED demand and admissions and this is increasing the bed deficit
- Bed model confirms a bed deficit at both hospitals – at peak demand without action there is a 72 bed shortfall at RSCH and 48 bed shortfall at PRH
- There is no escalation capacity at RSCH; PRH can be supported by escalation capacity but there are significant workforce constraints – medical and nursing
- The Trust lost significant elective capacity during winter 18/19 including day case at PRH – 60+ cancellations per month on the day during peak demand
- The System will provide community capacity to help mitigate the bed deficit and is supportive of collaborative, new ways of working
- System capacity principally benefits RSCH; clinical workforce constraints limit ability to roll out new models of care to PRH at the same pace

Section 1. Winter Plan Objectives

Overall objective is to maximise our existing resources to ensure our patients have consistent access to safe, high quality services:

Alignment with Patient First

	Patient Experience	Sustainability	People	Quality	System & Partnerships
# of days with a forecast bed deficit			✓		✓
Achieve 4 hour A&E trajectory	✓			✓	✓
No 12 hour breaches	✓		✓	✓	✓
Cease corridor use	✓	✓	✓		
Achieve Cardiac Day Case ringfence	✓	✓		✓	
Maintain elective activity at planned levels	✓	✓		✓	✓
Minimise use of temporary workforce		✓	✓		

Section 1. Improvement approach

- Clinically driven with solutions and plans created and owned by the Divisions
- The Operational Productivity Strategic Initiative has provided a robust and inclusive framework to take forward programmes of work to optimise the use of theatres and beds
- The outputs and development priorities from these programmes form the basis for the Winter Plan and provides sustainable solutions and continuous improvement programmes that will continue throughout the year
- Requires rapid acceleration of best practice models of care validated by ECIST, Ambulatory Care Network and NHSI
- An increased control environment is enabled by process standard work and clarity of clinical roles and responsibilities
- Improvements are focused on:
  - Avoiding admissions for patients likely to become stranded
  - Improved discharge planning to reduce the number of stranded patients and their length of stay
  - Increase early discharges to facilitate flow earlier in the day
  - Reducing non-admitted breaches

Section 1. What is different in 19/20

- System is providing more community bed capacity in recognition of the increasing demand and bed deficit at both hospitals
- The Acute Medical Model at RSCH should reduce the current ED bottleneck and reduce the number of admissions of patients likely to become stranded. The implementation will be led by the Chief Operating Officer
- A structured programme of discharge improvement addressing clearly defined problems – reduction in Delayed Transfers of Care and Long Length of Stay and increase in early discharges led by the Chief Nurse
- Dedicated Resilience leads based at each hospital
- Consolidation of day case activity into the Day Surgery Unit and SOTC at PRH protects day surgery throughput and creates a dedicated 15 bed escalation ward available from January 2020
- Completion of the Millennium Beds Project creates 18 additional beds at RSCH from mid February 2020 that could be used for escalation or otherwise used to maximise flow (subject to agreement of the operational and workforce plan)
- Robust governance in place reporting weekly to the Winter Plan Delivery Group and the Executive Huddle

Section 1 – Bed modelling summary

	Do Nothing Bed Deficit	Mitigated Bed Deficit
RSCH	**52 - 72**	**28 – 48**
PRH	**22 - 38**	**0 - 13**

Notes

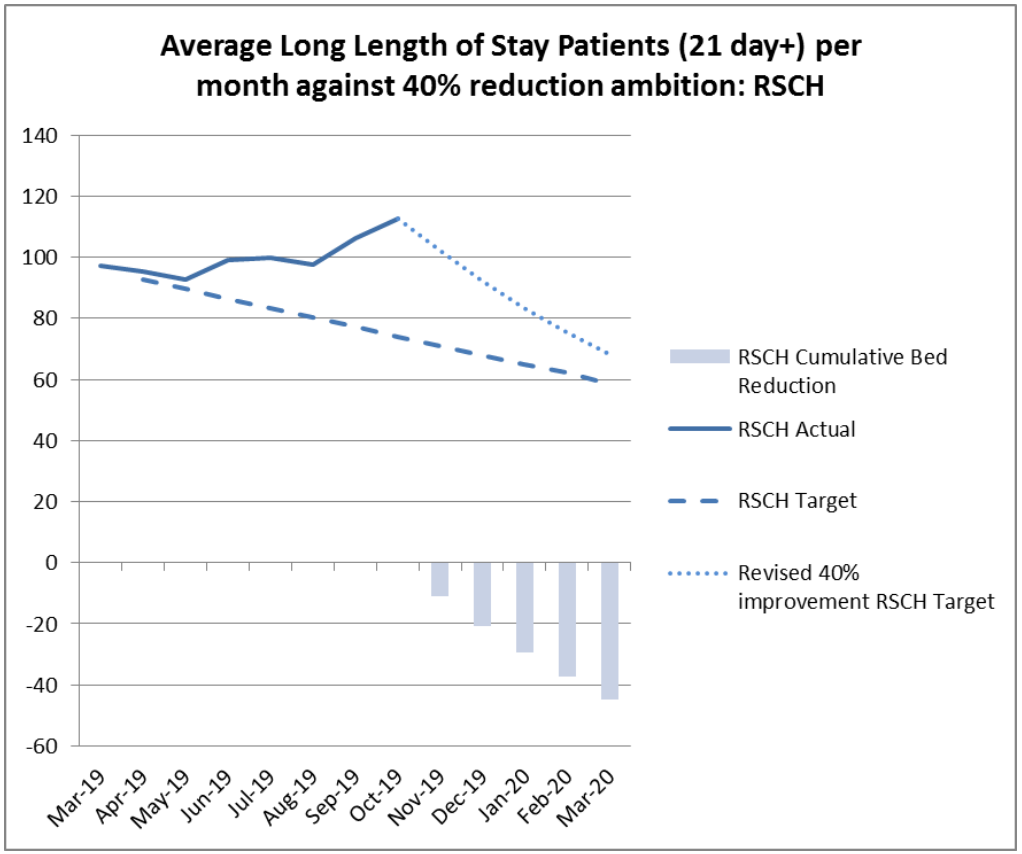
1. RSCH mitigated bed deficit assumes a 50% benefit from system capacity which enables admission avoidance and reduction in LLOS but requires the Acute Medical Model and improved discharge planning. Does not include the benefit of the Millennium beds (potential 18 bed gain dependent on the operational plan) due to open mid-February

2. PRH mitigated bed deficit assumes all escalation capacity is open. Medical and nursing staffing constraints may prevent this

3. The bed model is based on 95% occupancy which is a 5% reduction on RSCH current occupancy and a 2.5% reduction on PRH current occupancy but is the average occupancy level that enables good flow

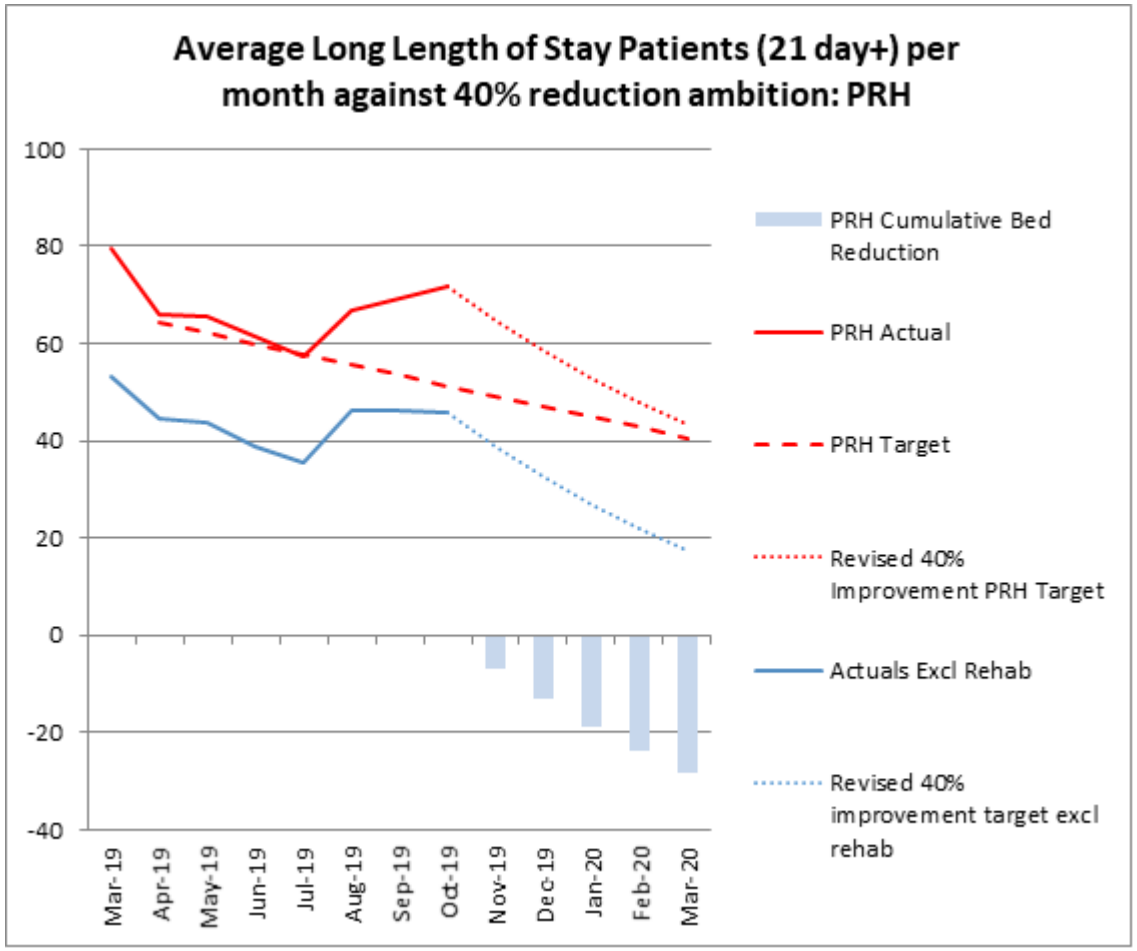
4. The reduction in the number of LLOS patients required is very significant and in excess of the 40% requirement

Section 1 RSCH .LLOS Patients Over 21 Days



- October to Date average 113 over 21 day LOS patients against ambition target of 74 October, and 59 March-20
- A reduction of 45 beds from current bed requirement will make a significant contribution in terms of aiding flow.
- Attached chart shows potential gain to be had from 9.6% improvement month on month

Section 1. PRH Super Stranded (Long Length of Stay Actual and Ambition)



- October to Date average 72 over 21 day LOS patients against ambition target of 51 October, and 40 March-20
- A reduction of 30 beds from current bed demand will make a significant contribution in terms of aiding flow.
- Attached chart shows potential gain to be had from 9.6% improvement month on month
- The challenge is exacerbated by Rehab beds being included as part of Trust target (circa 23 average since Mar-19) on the assumption that these patients are not medically ready for discharge

Section 2. Improvement Actions

Section 2. Improvement Interventions

The following section outlines the Trust and systems actions aimed at improving winter resilience and reducing gap in capacity.

System Actions

- RSCH & Newhaven Downs
- PRH

Pathway Redesign

- Frailty Pathway
- Acute Medical Model

Discharge Improvement Programme

Tactical Actions

- Live Bed State
- Triggers
- Full capacity protocol
- Christmas planning

Enabling Workstreams

- Escalation capacity
- Day Case Theatre Optimisation
- Workforce Optimisation
- ED performance & Actions to reduce non-admitted breaches

Section 2. Benefits map

		Benefit			
		Flow	Non-Elective Capacity	Elective Capacity	Admission avoidance
System Support	Newhaven Downs	■	■		■
	Community Beds	■	■		■
	Domiciliary Care Packages	■	■		■
Pathway Redesign	Frailty Model		■		■
	Acute Medical Model RSCH	■	■		■
	Major Trauma Ward		■		
Tactical measures	Discharge Improvement Programme	■	■	■	■
	Live Bed State	■			
	Triggers	■			
Enabling Workstreams	Escalation Capacity		■	■	
	Day Case Theatre Optimisation			■	■
	Workforce Optimisation	■	■	■	■

Section 2. System Actions - RSCH

Confirmed community capacity for RSCH

Location	Number of Beds	Opening
Newhaven Downs	7 + 9	Sept + Jan
Lindridge	14	Sept
SCFT	6	Jan
City Beds	10	Dec
Ireland Lodge	5	Oct

- Craven Beds – 17 beds opening date to be confirmed
- 400 hours of domiciliary care
- Additional GP sessions in A&E

Potential additional investment (being negotiated)

- Acute Floor Clinical Fellows
- Clinical navigators (streamers)
- HRDT Redesign – community and social worker collaborative
- System Discharge Hub Co-ordinator
- GP sessions in A&E

Section 2. System Actions - PRH

- The system actions are less clear for PRH and not yet reflected in the bed model
- 6 Community Beds
- 150 hours of Domiciliary Care
- Discharge to Assess Beds – Albourne as possible location

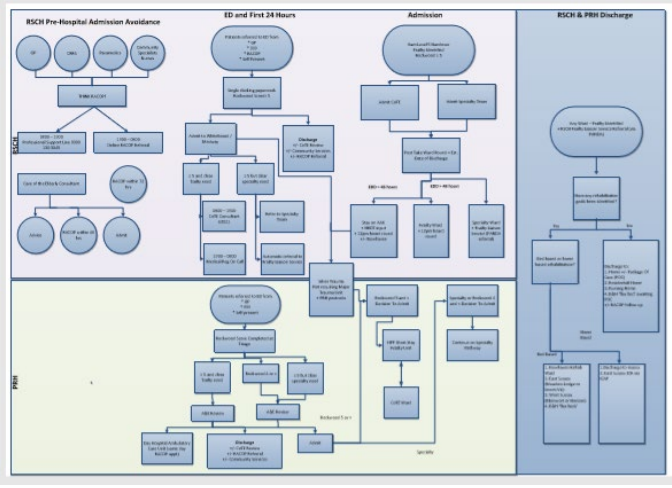
Maximising system support

- Additional community capacity – beds and domiciliary care hours has a material impact on reducing the bed deficit at RSCH; need to confirm for PRH
- Discharge planning is key to ensuring patients are mapped and transferred to community capacity in a timely way
- Frailty pathway and Acute Medical Model facilitate better integration with community and social services to turn around patients at the front door – enabled HRDT redesign

Pathway Redesign 1 – Frailty Model

Key features of the frailty pathway

Admission Avoidance
- Direct access to frailty specialist advice for all referral routes(at RSCH only due to medical workforce constraints at PRH)
- Maximising use of RACOP ‘hot clinics’



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Acute Floor Management
- Single clerking
- Frailty Assessment using Rockwood score
- Defined assessment pathways
- HRDT input
- Frailty led Board Round

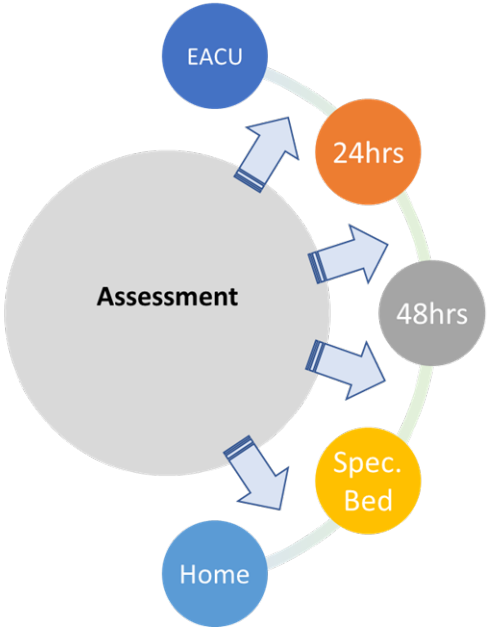
Discharge
- Mapping to community beds and services

Inpatient Management
- Frailty Liaison Service support at RSCH
- Short stay frailty unit on HPP at PRH

Section 2. Pathway Redesign – Acute Medical Model RSCH

Assess to Admit Model

(Number of Spaces required to be agreed with specialties)



- Emergency Ambulatory Care Unit (EACU)
  - Hot Clinics
  - Medical Day Unit
- 24hr Short Stay Admission
  - Specialty Specific
  - Medicine, Surgery, Frailty etc.
- 48hr Short Stay Admission
  - Specialty Specific
  - Medicine, Surgery, Frailty etc.
- Speciality Bed <48hr Admission
  - Specialty Specific
  - Medicine, Surgery, Frailty etc.
- Home
  - Discharged without Follow-Up
  - Discharged with Follow-Up (Primary Care/Hot Clinics)

Expected Benefits

- Reduced conversion rate
- 30% of patients treated and discharged on the same day
- Contributes to a reduced number of stranded patients (by stopping their admission)
- Reduction in “Aggregated Patient Delay”
- Improvement in the 4 hour standard (reduced number of admitted breaches)

Section 2. Pathway Redesign 2 – Acute Medical Model RSCH

Key features of the Acute Medical Model

- Direct streaming to all areas of the Acute Floor to maximises opportunities to turnaround patients at the front door who might become ‘stranded’
- Dedicated acute and frailty workforce within the Acute Floor
- AAU Juniors to progress management plans
- Clinical Fellows and Registrars providing 24/7 senior decision-making
- Increases senior specialty input into AAU
- Post take medical patients in Majors will be managed as AAU at peak demands
- Enabled by:
  - Nursing and Medical leadership
  - Redesign of the junior doctor rotas which enables single clerking across all areas of the Acute Floor and protects junior doctor workforce on the base wards
  - AAU bed and assessment trolley capacity and onward flow in to the hospital from ED
  - MADE scheduled prior to go live

Section 2. Discharge Improvement Programme

Discharge Improvement Programme
Structured improvement programme to increase early discharge and reduce LLOS led by the Chief Nurse

- Early Discharge target – 45% weekdays and 25% weekends
- LLOS reduction is equivalent to the bed deficit
    - RSCH – reduce cohort by 52 – 72*
    - PRH – reduce cohort by 22 – 38*

* Unmitigated bed deficit at each hospital

Section 2. Discharge Improvement Programme – Early Discharge

Key features of the Early Discharge Improvement Programme*

- Every Specialty with a target number of discharges per day and target number of early discharges as a proportion
- Supported by improvement trajectories and ward level visual management - performance managed by the matrons and HoNs
- Criteria led discharge pilot in 10 wards in December
- Live Bed State rolled out at RSCH and PRH by the end of December
- Targeted improvement plans for:
  - EDD compliance by end of November
  - Discharge Lounge by end of November
  - TTOs by end of December
  - Early repatriation by end of December
- Integrated Discharge Hub established with system partners by end December – daily management of LLOS and early discharge

* A number of planned improvements will benefit early discharge and LLOS/DTOC reduction

Section 2. Discharge Improvement Programme – LLOS reduction

Key features of the LLOS Reduction Programme*

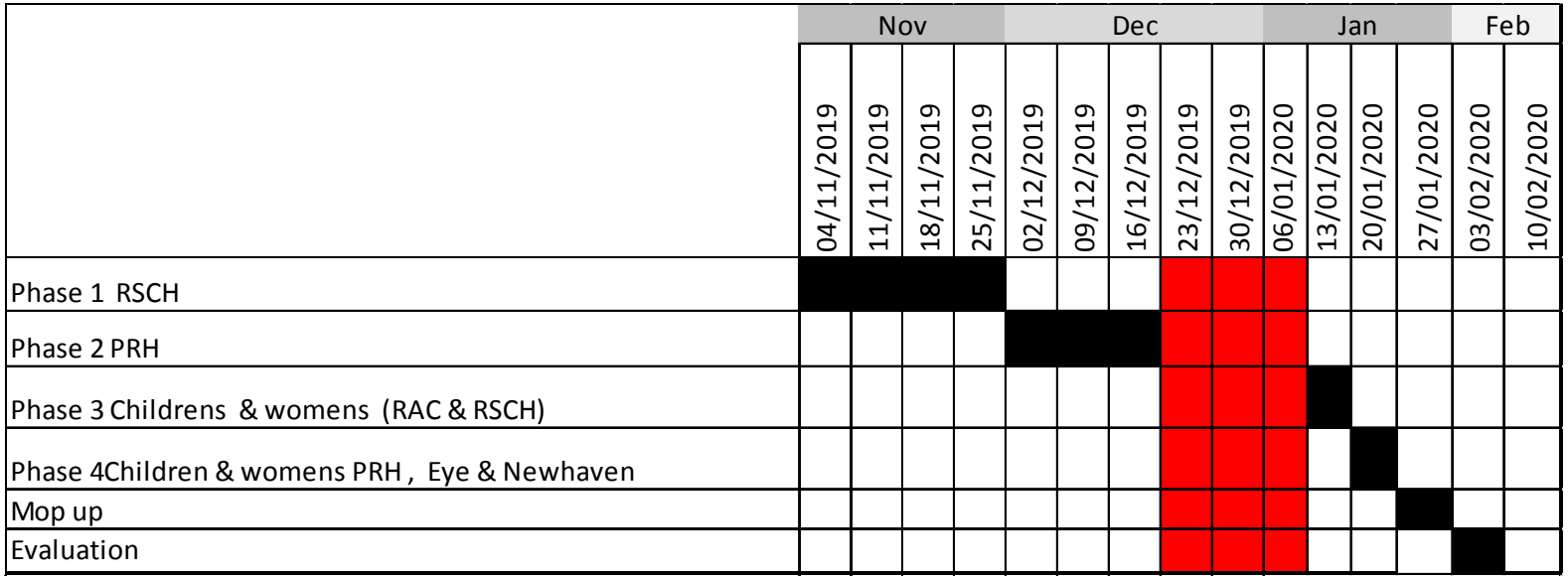
- System bed capacity and domiciliary care packages provide more discharge options
- Admission avoidance enabled by the Acute Medical Model at RSCH will reduce admission of patients more likely to become stranded
- Structured programme of improvement based on defined problems – by mid-November we will know the top contributors to delays by specialty and ward. Trust-wide improvement themes are:
  - access to community beds
  - Consultant attendance at Senior Daily Review
  - timely access to AHP assessment
- Review of weekly review of LLOS to assess impact on LLOS (which appears to be adverse) and go live with agreed process improvements by 6th December
- Improve compliance with the use of the Purple Planner on admission and align with new standard discharge pathways – Chief Nurse led PDSA review of learning
- Launching 'PJ Paralysis' improvement programme from November – all staff will have completed training by end of January

* A number of planned improvements will benefit early discharge and LLOS/DTOC reduction

Section 2. Tactical Measures - Live Bed State

Implementation of a real time bed management dashboard

- Piloted on four wards in early October – good results and learning
- Some indication of improvement in early discharges during the pilot phase
- Medway training in advance of phased roll out and then continuous (ADT training – Admission, Discharge and Transfer)



Section 2. Tactical Measures - Triggers

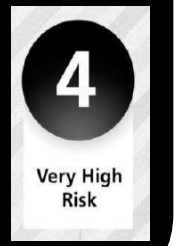
Trust wide and divisional triggers inform actions. Trust wide trigger examples below.

1. Critical Pathways, HDU/ITU bed available- All Sites Including RACH, PCI, Stroke,NOF & Trauma,neuro & Urology beds available
2. ED Triggers RSCH. Resus space available, No more than 6 patients in PAT/Holding area, 25 patients in UCC, no more than 3 ambulances being >15mins, 30 patients in Zone 1, 2A & 2B areas. Patients at 3hrs have plans. PRH ED Triggers 23 patients in Dept, Resus space available, patients at 3hrs have plans, ambulance assessment space .
3. Staffing adequate to cover all Critical areas, ED,ITU & Maternity
4. Capacity Balance sufficient to support all activity
5. DTOCS < 0-14
6. 7 day los <370
7. 14 los <210
8. 21 Day LOS is <130
9. All Services Operational

1. Actions in Opel 2 have failed to deliver capacity
2. No Capacity in Critical Care- but plans in place to create within 1 hr ITU /2hrs for HDU
3. ED triggers > 5 at RSCH, PRH >3
4. Significant unexpected drop in staffing and unable to safely Critical areas
5. Capacity Balance >Minus 40 at RSCH, >Minus 15 @PRH
6. DTOCS .> 28
7. 7 DAY los >390
8. 14 day los >230
9. 21 Day LOS >150
10. Emerging infection control issues impacting services
11. Inability to offload ambulances within 60 minutes
12. Escalation beds Open > 6 RSCH, > 4 PRH

1. Critical Pathways- Limited Capacity - Plans in place to create sufficient Capacity
2. ED Triggers- RSCH-3 triggers activated Triggers PRH, 2 Triggers activated
3. Lower levels of staffing available but sufficient to maintain services
4. Capacity Balance <Minus 30 @RSCH,< MINUS 10 @PRH
5. DTOCS 5-18
6. 7 day los <390
7. 14 day los<230
8. 21 Days LOS <150
9. Emerging infection control issue some beds affected but able to maintain services

1. Actions in OPEL 3 have failed to deliver Capacity
2. No Capacity in Critical Pathways- No plan in place to create capacity within 4 hrs in Critical Care
3. ED triggers > 5 at RSCH, PRH>3
4. Staffing inadequate to maintain critical services with no plan to resolve
5. Capacity balance >Minus 50 @RSCH, >Minus 20 @PRH
6. DTOCS>35
7. 7 day LOS>420
8. 14 day LOS >260
9. 21 DAY LOS>170
10. Infection Control Issues causing closure of services
11. Inability to Off load ambulances greater than 1 .5 hr wait anticipated
12. All Escalation Beds Open
13. Significant Risk of 12 hr DTA breach



Section 2. Tactical Measures – Christmas Plan

- Replicate process and learning from PRIDE
- Detailed plan will be developed by 6th December
- Key deliverables will be:

  a) Outlier target numbers
  b) Escalation beds closed
  c) HDU/ITU ward fit
  d) Divisional resilience rota
  e) Workforce plan
  f) Protecting constitutional targets & elective plan – daycase Increases/ OP provision
  g) MADE prior

Section 2. Enabling Workstream – Workforce Optimisation

- Planning Principles
    - Maximise nursing and medical rotas (all grades of doctor) to minimise the use of agency & temporary workforce
    - Reduce frequency of escalation & number of escalation beds and escalation areas open
    - Maximise opportunities to deploy substantive and bank staff to escalation areas to reduce the use of agency
    - Enhance the current control environment – agreed levels of sign off for use of temporary workforce, cancellation of elective lists and adherence to standard work for discharge planning and early discharge
- A detailed workforce plan can be developed subject to the operational plan for escalation capacity
- Keep under review alongside programme KPIs and adjust

Brighton and Sussex University Hospitals NHS Trust

Agenda Item:	16	**Meeting:**	Board	**Meeting Date:**	27 Nov 19
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		☐	Assurance	✓	
Review and Discussion		☐	Approval / Agreement	✓	
Reason for submission to Trust Board in Private only (where relevant):					
Commercial confidentiality		☐	Staff confidentiality	☐	
Patient confidentiality		☐	Other exceptional circumstances	☐	
Link to Trust Strategic Themes:					
Patient Care		✓	Sustainability	✓	
Our People		✓	Quality	✓	
Systems and Partnerships		✓			
Any implications for:					
Quality					
Financial					
Workforce					
Link to CQC Domains:					
Safe		✓	Effective	✓	
Caring		✓	Responsive	✓	
Well-led		✓	Use of Resources	✓	
Communication and Consultation:					

Executive Summary:

This report provides the Board with a report on matters for which the Trust has complied with a NHS I or other regularly requirement. This report does not seek to duplicate matters that are subject to separate agenda items at today's board meeting.

Learning from deaths report (attached as an appendix to this report)

The Trust is required to receive reports on learning from deaths. The Board is reminded that the detail of this report has been scrutinised by the Quality Assurance Committee especially in respect of the Trust's processes for learning from the review of deaths. The focus continues 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.

Health and Safety Annual Report (attached as an appendix to this report)

The Trust produces an Annual report 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.

Key Recommendation(s):

The Board is recommended to

NOTE the Trust's learning from deaths report and note the focus on learning from the SJRs.

NOTE the 2018/19 Health and Safety Annual Report.

Brighton and Sussex University Hospitals NHS Trust

Agenda Item:	16.1	**Meeting:**	Board	**Meeting Date:**	27 Nov 2019
Report Title:	APPENDIX 2 - Learning from Deaths Report Q2 2019/20				
Sponsoring Executive Director:	Dr George Findlay - Chief Medical Officer, Dr 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	✓		Assurance	✓	
Review and Discussion	☐		Approval / Agreement	☐	
Reason for submission to Trust Board in Private only (where relevant):					
Commercial confidentiality	☐		Staff confidentiality	☐	
Patient confidentiality	☐		Other exceptional circumstances	☐	
Link to Trust Strategic Themes:					
Patient Care	✓		Sustainability	☐	
Our People	☐		Quality	✓	
Systems and Partnerships	☐				
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	✓		Effective	✓	
Caring	✓		Responsive	✓	
Well-led	✓		Use of Resources	☐	
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 1600 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 specified 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 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 (SIRM), 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 SIRM 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 SJR's.

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.

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. Locally, 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 has released a short training video on the IRIS system.

5.1.1 In addition; supportive multidisciplinary SJR sessions are held monthly, led by the Palliative Care Team.

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 DoH 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).

	Q3 18/19	Q4 18/19	Q1 19/20	Q2 19/20	Total
Total Deaths (adult inpatients not LD)	414	473	350	323	1562
Total deaths reviewed using SJR (adult inpatients not LD)	26	43	21	5	96
Deaths more likely than not a result of problems in care (adult inpatients not LD)	1	0	0	0	1
LD Deaths	7	4	2	0	13
LD deaths reviewed using SJR	6	3	1	0	10
LD deaths more likely than not a result of problems in care	0	0	0	0	0
Total % of adult deaths reviewed	**7.8%**	**9.6%**	**6.25%**	**1.55%**	**6.73%**

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.

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; most of the deaths are reviewed by the Palliative Care Team, and this is reflected by the themes that are identified. The Divisional teams will be targeted to improve representation and participation in SJRs.

7.5 All SJRs review 6 discreet areas of care. Figure 1 shows the level of care received by patients in the last 4 quarters[1].

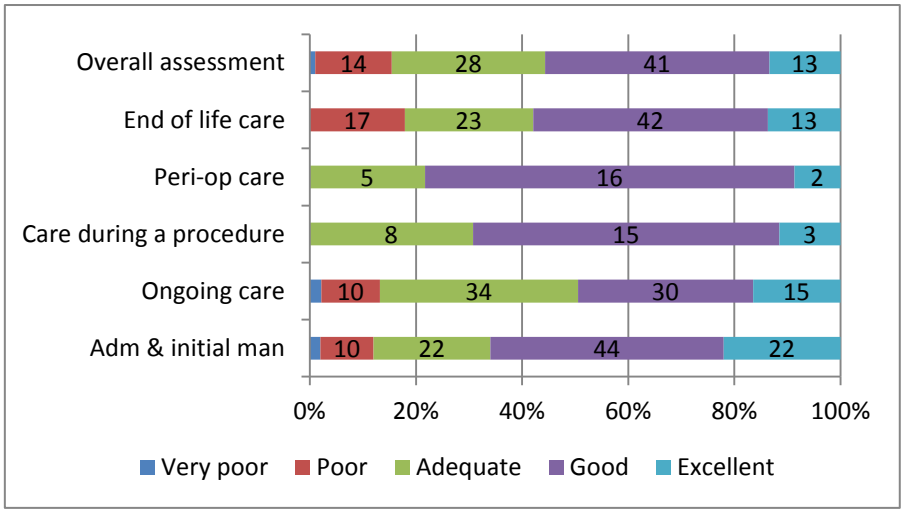


Figure 1

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.

[1] Q3 & Q4 18/19 & Q1 & Q2 19/20

7.7 Following an evidence review which found no tools for reviewing the deaths of children and young people, the Paediatric Team have developed a paediatric version of the SJR. The team use the Child Death Overview Panel (CDOP) form. The CDOP focus on population level data rather than learning from individual cases. The tool is now available on PANDA and is the result of a consensus in the paediatric team. BSUH are switching to a new strategic process whereby the CDOP panel will be held in the acute trust, there will be some duplication but the SJR will inform the CDOP process.

7.8 The team presented learning from paediatric deaths which have been reviewed using the new tool including improved staff support for deaths on the adult ITU and poor scanning of notes.

7.9 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 2 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.

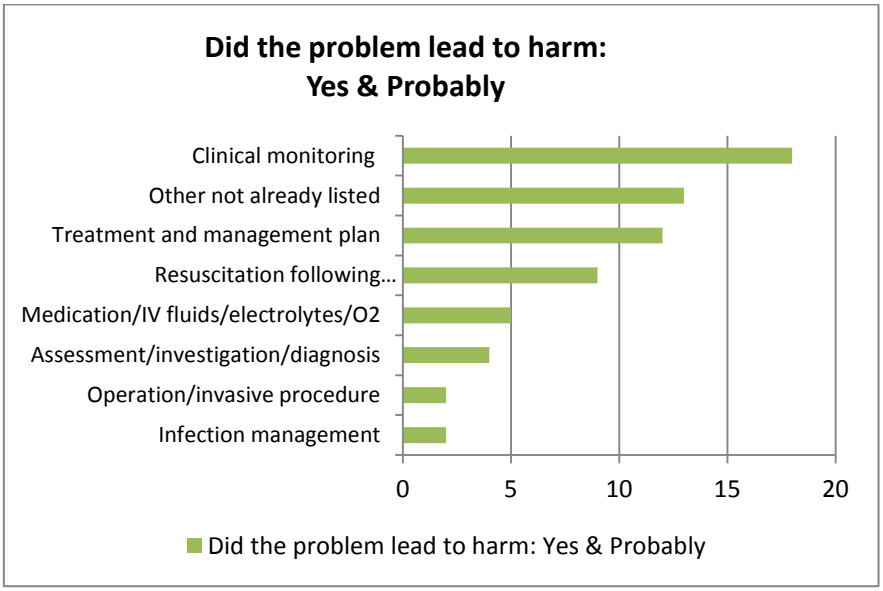


Figure 2

7.10 The most common 'problem' area is 'clinical monitoring' which includes 'failure to plan, to undertake or to recognise and respond to changes.

7.11 The further improve clinical monitoring, the trust is currently introducing Patientrack to improve hospital wide physiological surveillance of patients and thereby improve patient safety. This is integral to the Trust Patient First Strategy; improving hospital mortality rate and reducing patient harm.

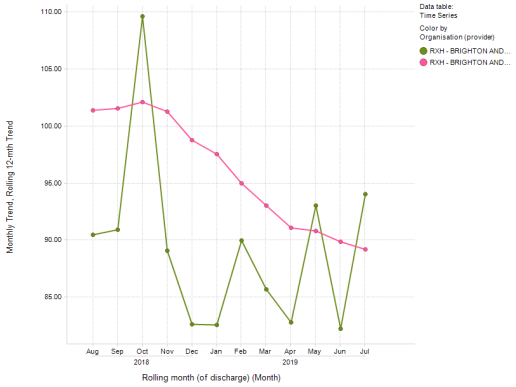
7.12 Patientrack is live in 16 ward areas at RSCH with an ongoing roll out programme of one ward per week aiming to have all adult ward areas, paediatrics and maternity live by 16th December (on both sites). This system allows staff to view patients remotely; ward managers to view their whole ward (NEWS score and timing of observations); and NEWS auto-calculation prompts a response according to the score which the user must acknowledge mirroring the policy requirement.

7.13 The further improve trust awareness and understanding of the importance of appropriate, patient centred and holistic care planning, 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 enables SJR data to be linked to M&M data –a concept which is now being piloted before roll out across the Trust.

7.14 The TMRG have also been recently working with the ME's to embed ME questions into PANDA, enabling junior doctors to submit data remotely saving time and allowing flexibility around this process. This work is currently been paused as a new national IT ME system is being developed centrally – but will be revisited once the national system is available.

8. SHMI[2] & HSMR[3]

8.1 The trend in SHMI for in month and rolling data is shown below in Figure 3



8.2 HSMR data available is for the 12 months to July 2019. HSMR for BSUH is 89.16.[4] The trend for in month and rolling HSMR is shown below in figure 4

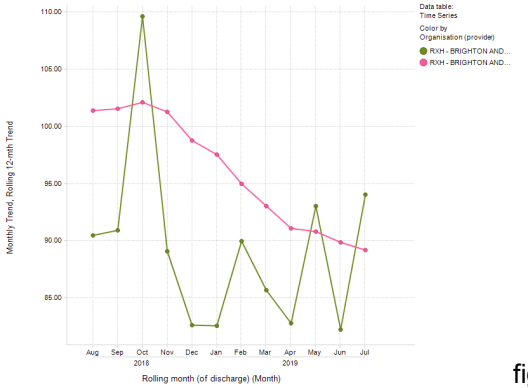
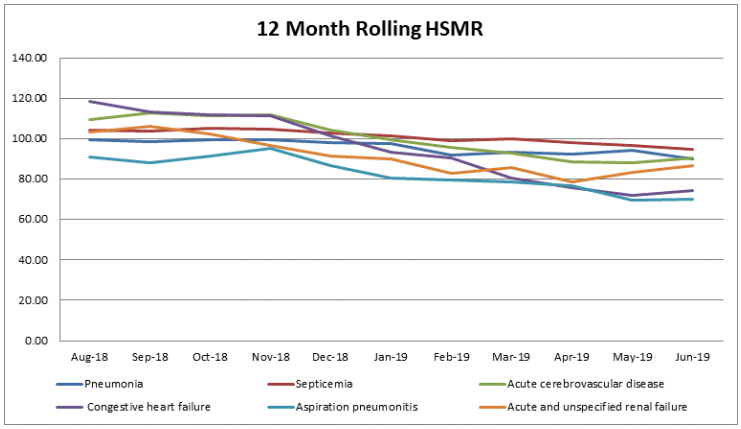


figure 4

8.3 BSUH True North Objectives include 'to be in the best 20% of Trusts in the country for the Hospital Standardised Mortality Rate (HSMR)'. BSUH are currently ranked 24th of 132 Trust's **putting them in the top 20% of performing Trusts.**

8.4 Analysis of the top 6 CCS Diagnostic Groups[5] amongst patients that die within BSUH, shows that HSMR is trending downwards for all 6 :



[2] 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

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

[4] National average is 100

[5] Pneumonia (except that caused by TB)/ Septicemia (except in labour) / Acute cerebrovascular disease / Congestive heart failure (non hypertensive) / Aspiration pneumonitis / Acute and unspecified renal failure / Intracranial injury / Cardiac arrest and VF / Acute MI

9. Summary

9.1 In accordance with the requirements of National Guidance on Learning from Deaths, BUSH has published the specified data on deaths.

9.2 Overall there is a fall in the rate of deaths being reviewed, the Divisions will be targeted to improve representation and participation in SJRs

9.3 The Paediatric Team have developed a tool for the reviewing the deaths of children and young people.

9.4 Clinical monitoring remains the most commonly reported problem in care. The Trust are currently implementing Patientrak which will improve the quality of care to patients and reduce harm.

9.5 A mortality outlier notification regarding the National Bowel Cancer Audit is the result of a data quality error.

9.6 BSUH are currently in the top 20% of Trusts for HSMR.

9.7 Deep dive reviews conducted into mortality statistic data alerts for chronic ulcer, ventilation support, other operations on ventricle of the brain, neurostimulation and urethral catheterisation of bladder have identified no concerns in the quality and safety of care.

9.8 Deep dive reviews are ongoing into mortality alerts associated with complication of device; implant or graft' ; other Fractures' (SHMI > 100 i.e. above national average); primary excision of cervical intervertebral disc' ; other operations on peritoneum

10. Recommendation

10.1 The Board is asked to NOTE the implementation of the Learning from Deaths Policy and the learning from the outcomes of the mortality reviews.

Dr Rob Haigh

BSUH Medical Director

6.11.2019

NHS
Brighton and Sussex University Hospitals NHS Trust

Agenda Item:	16.2	**Meeting:**	Board	**Meeting Date:**	27 Nov 19
Report Title:	APPENDIX 2 Trust Health and Safety Committee Summary Report 2018 to 2019				
Sponsoring Executive Director:	Denise Farmer, Chief of Organisational Development and Workforce				
Author(s):	Lyn Allinson, Head of Risk Management				
Report previously considered by and date:	Trust Health and Safety Committee 22nd October 2019 Quality Governance Steering Group – 23rd October 2019				

Purpose of the report:			
Information	☐	Assurance	✓
Review and Discussion	✓	Approval / Agreement	✓

Reason for submission to Trust Board in Private only (where relevant):			
Commercial confidentiality	☐	Staff confidentiality	☐
Patient confidentiality	☐	Other exceptional circumstances	☐

Link to Trust Strategic Themes:			
Patient Care	✓	Sustainability	☐
Our People	✓	Quality	✓
Systems and Partnerships	☐		

Any implications for:	
Quality	Failure to manage risk, health and safety arrangements effectively compromises the safety and well-being of all patients, staff and visitors to Trust sites. Risk, Health and Safety is also a legal requirement and part of our regulatory requirements under NHS Improvement and the Care Quality Commission.
Financial	
Workforce	

Link to CQC Domains:			
Safe	✓	Effective	☐
Caring	✓	Responsive	☐
Well-led	✓	Use of Resources	☐

Communication and Consultation:

To Board members.

Executive Summary:

This Report provides an update on the progress made by the risk management team in line with the implementation of the Trust's Health and Safety Policy Statement and other related policies and highlights the progress made in respect of the objectives for Health and Safety and Risk arrangements in the financial year 2018/19.

Key Recommendation(s):

The Board is asked to:

- Note the Annual report.

1. Introduction

1.1 The Trust Risk, Health and Safety Annual Report summarises the position and progress made against the Trust Health and Safety Policy, Statement of Intent and the implementation of the Risk, Health and Safety Policies and Procedures used by the Trust to minimise the risk to all.

1.2 The Health & Safety Policy Statement and Board Approved Statement of Intent require those responsible for health and safety within the Trust premises and for Trust activities to:

- Comply with health and safety legislation;
- Implement health and safety arrangements through a risk-managed approach;
- Comply with monitoring and reporting mechanisms appropriate to internal and external key stakeholders and statutory bodies;
- Develop partnership working and consultation throughout the Trust to ensure health and safety arrangements are maintained within the Trust environment for staff, contractors, visitors and patients.

1.3 The Trust monitors risk, health and safety arrangements via the Trust Health and Safety Committee (bi-monthly) – the Consultation Committee which reports though Compliance Group (which in turn reports to the Trust Board via the Quality Governance Steering Group (QGSG) and Trust Executive Committee (TEC).

1.4 The Health and Safety Committee (H&SC) also receives reports from several other committees, steering groups and/or key pieces of work in relation to health and safety, or that cover a significant concern, which requires a specific task to enable it to be managed safely. During 2018/19 a new governance structure was introduced.

In 2018/19 the key issue monitored by H&SC where:

- Slip, Trips and Falls;
- Safer Sharps;
- Transport of Dangerous Goods;
- Control of Substances Hazardous to Health (COSHH);
- Radiation Safety;
- Security Management including Violence and Aggression.

1.5 The full Health and Safety Committee annual report reviewed and agreed by BSUH Health and Safety Committee on the 22nd October 2019 includes a new format for the annual Risk, Health and Safety Compliance plan for next financial year of 2019/20. The format of the plan has utilised key Health and Safety Executive guidance, statutory requirements, risk profiling and BSUH current governance structure in its development.

The aim of this plan is provide a framework of objectives and compliance measures to form the reporting structure for Health and Safety committee and it's sub-groups to be updated during 2019/20 which will form the annual report for 2020/21.

Adjustments will be made to the annual plan following ongoing review during the year.

2. Key Performance Indicator set for 2018/19

2.1 **Summary update**

Key Performance Indicators	Objective 2018/19	Progress 2018/19
1. Health and Safety Environmental Risk Assessments	All ward and department to complete an Environmental Risk Assessment (ERA) and ensure actions highlighted are managed.	Achieved
2. Health and Safety Report	Escalate from Health and Safety committee an agreed concerns or improvements to BSUH Compliance Group.	Achieved
3. Risk Register	To ensure there is continued assurance and oversight of the Trust Risk Register.	Ongoing 2019/20
4. Policies	Ensure policies are in date and published on Trust intranet.	Achieved
5. Training	Attendance at statutory and mandatory safety training	Ongoing 2019/20
6. Incident Reporting	All Incidents are reported and acted upon.	Ongoing 2019/20
7. Safety Alerts	Maintain full compliance with deadlines.	Achieved
8. Visits & Inspections	Coordinate Health and Safety Executive visits. Resulting responses and action plans to be monitored progress by the Health and Safety Committee.	Achieved
9. Conclusion Actions	Implementation of the Safer Sharps legal framework and guidance from the HSE.	Ongoing 2019/20
	To ensure Datix software system is fit for purpose.	Ongoing 2019/20
	To review possible IT solutions for the management of all risk assessments.	Ongoing 2019/20

2.2 Performance Review – current status- July 2019

KPI	Performance
1	**Health and Safety Audits / Environmental Risk Assessments** New format for 2019 presented to Trust Health and Safety Committee (H&SC) April 2019 for discussion and approval. Additional content added re Stress and Sharp injuries.
2	**Health and Safety Report** This report and associated KPIs will be presented bi-monthly to the H&SC. The reporting format has been agreed during 2018/19 will continue in 2019/20 with further development of reports provided to the H&S committee.
3	**Health and Safety Risk Register** Currently under review with PMO office to make fit for the organisation need moving forward. Business case currently being finalised with options to improve Datix Risk Register to Cloud IQ version. Upgrade to last version of Datix completed in June /July 2019 and agreement to install on new server by IT in 2019.
4	**Health and Safety Policies** Policies are reviewed in-line with the current matrix for review and then presented to the Trust H&SC for comment and then ratification at Trust Executive Committee (TEC). Improvement to timescales for publishing updated policies will be an objective from October 2018. Several have missed review date since January 2019. These overdue policies are detailed on H&SC action log. Significant progress will be made in resolving out of date policies following review at August 2019 H&SC for September 2019 TEC ratification in 2019.
5	**Health and Safety Training** A full review of all training packages has been completed. There remains an issue re levels of attendance on Fire Warden course. Also attendance needs improvement on the Risk / COSHH assessors' course so each department / ward has access to trained assessor. Due to the poor

KPI	Performance
	attendance levels, the course has been changed to 1 per month on alternate sites from January 2019. Training Department Management team has changed STAM to follow the DOH Core training standards which requires a review of STAM training. There has been a highlighted dip in Health and Safety and Fire safety from 90% compliance and other STAM training compliance in April to August 2019 at new STAM training meeting. Actions are required to resolve this gap and L&D to report.
6	**Health and Safety, Incident Statistics, Responses and Trends** Due to staffing levels it has been difficult to maintain administration of the actions and responses to health and safety accident and incident data. There continues to be a cull of open incidents (over 1 year) awaiting investigation which have been closed with no action taken. There was a critical issue with Datix incident access by manager. This was due to a system wide error caused by a conflict in setting up individual on the system. Root cause has been identified and resolved.
7	**Safety Alerts** The process for processing safety alerts is labour intensive & requires constant monitoring for responses. A business case for software to improve the process is currently on hold due to the review of organisation needs for the Datix software.
8	**Health and Safety Inspection and Visits** The Trust has co-operated with all visits from Enforcement Agencies relating to health and safety and actions have been taken where required. A visit completed with no action by the HSE to review Muscular Skeletal disorders and Violence and Aggression in Nov 2018. Summary of verbal update provide to the committee. The Trust responded a letter of contravention HSE following a visit on the 30th October relating a RIDDOR report relating to TB. Response sent by Chief Executive within deadline which was accepted by HSE and updates on action plan monitored by HSE committee. Report provided within the Radiation Safety Group report to H&SC about a recent visit by EA relating to a warning notice and response provided. The HSE further visited the Trust in March / April 2019 RSCH site relating to a RIDDOR incident report re slip, trip and fall incident on the north service road. The action to resolve pavements repairs is completed and signed off by HSE but barriers still progressing on South Service road. Quotes have been agreed and work to commence ASAP. This is being led by Estates team.

4. Conclusion

Significant improvements have been made in relation to Risk, Health and Safety. In order to comply with the CQC recommendations, the department rolled out the 2nd year of an Environmental Risk Assessment for each ward and department, to ensure the compliance with the risk assessments required under Health and Safety legislation.

The objectives set for 2018/19 where reviewed at the Trust Health and Safety Committee by exception were almost all partially or fully achieved, which is significant improvement from the previous year.

During 2019/20 there will be a significant change in emphasis of the Health and Safety Committee to focus on assurance of the Trust in relation to Risk, Health and Safety Statutory compliance.

BSUH Health and Safety Committee membership continue to strive for excellence in supporting the key objective of the Trust and its wards / departments in providing a safe environment for staff, contractors, visitors and patients as well as anyone else who may be affected by acts or omissions.

A T Drive called 'Risk Assessments' has been set up which allows managers to review and download risk assessments from a central location. This work started in 2016/17 with the development of corporate risk assessments for Control of Substance Hazardous to Health Assessments, Environmental Risk Assessments and slip, trip and fall assessments for common routes around the site and was completed in conjunction with the Equality and Diversity team.

During 2018/19 work continued in respect to the drive to enhance the Trust's procedures in relation to COSHH substances. Their use in the Trust was reviewed which included reducing the number of products used, updating the COSHH assessments, ensuring a standard COSHH folders was provided for each ward and department with up to date COSHH assessments signed and dated. This is an ongoing piece of work steam for 2019/20 to ensure the COSHH assessments and folders on wards and departments are updated annually.